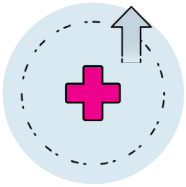
Medicare Advantage

What Changes Did the Centers for Medicare & Medicaid Services (CMS) Propose in the 2020 Advance Notice?

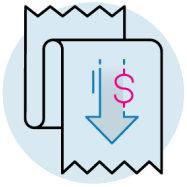
What is Medicare Advantage?

MA delivers affordable coverage by limiting out-of-pocket costs and offering additional benefits that the government-run traditional Medicare doesn't cover – such as integrated vision, hearing, dental, and wellness programs. In 2019, 90 percent of Medicare beneficiaries can choose a MA plan with prescription drug coverage for no additional premium.



Research shows MA plans achieve better health outcomes than the traditional Medicare program

Average payments to MA plans are equivalent to traditional Medicare costs.



Many doctors and hospitals are adopting MA plan practices for their patients on traditional Medicare. As a result, the improved care and reduced costs "spill over" to benefit traditional Medicare patients, too.

What is the Advance Notice?

The Advance Notice was released in two parts – CMS released Part I of the 2020 Advance Notice on December 20, 2018 and Part II on January 30, 2019. Together they lay out the proposed policies governing plan payment for 2020. Stakeholders have until March 1, 2019 to comment on the Advance Notice prior to CMS issuing a Final Notice on April 1, 2019.

Medicare Advantage by the Numbers

nearly 22 million — one in every three people eligible for Medicare choose MA for their coverage

367 members of Congress — 7 out of 10 - signed a bipartisan letter in support of Medicare Advantage

90 percent — MA enrollees satisfied with coverage

Year-Over-Year Impact	2020 Advance Notice
Effective growth rate	4.59%
Star rating	-0.14%
Risk model revision	0.28%
Change to MA coding intensity	0%
FFS normalization	-3.08%
Encounter data transition	-0.06%
EGWP payment policy	0.0%
Expected Average Change in Revenue	**1.59%**

What Did CMS Propose to Do?

RISK ADJUSTMENT

Based on provisions in the 21st Century Cures Act, CMS is changing how it adjusts payments to MA plans based on health status – also known as risk adjustment – to account for the number of a patient's clinical conditions. CMS first proposed this change last year but delayed its implementation. An analysis by Wakely Consulting Group found that the changes proposed by CMS would lower risk scores for large numbers of Medicare-Medicaid "dual eligible" beneficiaries with multiple chronic conditions. This could result in reduced funding available to ensure this vulnerable population has access to the comprehensive benefits and care management services they need.

For 2020, CMS is proposing the same model as it had in the 2019 Advance Notice, but with the possible addition of new conditions to account for dementia and pressure ulcers. In order to phase these changes in over time, CMS is proposing to blend the new model and last year's model at 50 percent each for 2020. CMS would increase the blend of the new model to 100 percent by 2022.

ENCOUNTER DATA

CMS began to adjust risk scores in 2016 based on diagnoses from encounter data, which are detailed claims data for MA enrollees that plans have been submitting to CMS since 2012. For 2020, CMS has proposed to increase the proportion of risk scores based on encounter data from 25 percent to 50 percent.

Despite prior assurances that the switch to encounter data will be budget neutral, CMS's proposal will cut payments to MA plans. For 2020, CMS estimates that payments will be reduced by 0.06 percent, but according to the FY2019 President's Budget the policy of phasing in encounter data would reduce MA funding by $11.1 billion over 10 years. MedPAC has found that encounter data risk scores are lower than under the legacy system, and that the encounter data is not complete.

NORMALIZATION

Each year CMS applies a "normalization" factor to the risk score to account for trends in traditional Medicare coding and beneficiary health status. This factor ensures bids and county benchmarks can be compared on the same basis. CMS proposed a 3.08 percent reduction in MA funding to account for large increases in the risk scores for traditional Medicare enrollees.

CODING INTENSITY

For 2020, CMS proposes to make the statutory minimum coding intensity adjustment, consistent with 2019. This adjustment reduces MA plan risk scores by 5.9 percent. This adjustment accounts for more complete diagnosis coding in the MA program than traditional Medicare and is separate from the normalization factor.

What CMS Did Not Do

FIX THE BENCHMARK CALCULATION

In 2017, MedPAC recommended that CMS calculate county benchmark rates used to set MA payments by using only costs for Medicare beneficiaries with both Parts A and B coverage (a requirement to enroll in an MA plan). The current approach includes beneficiaries with only Part A – who cost less than beneficiaries with Parts A and B – and creates artificially low benchmarks. A subsequent legal analysis indicates CMS should use MedPAC's recommended approach based on a plain reading of the Social Security Act.

What Should CMS Do?

To ensure MA funding levels are stable and continue to support high-quality care and comprehensive benefits, in the 2020 Final Notice CMS should:

- Exclude Part A-only enrollees from the calculation of county benchmark rates.
- Explore options that would limit the cut from the "normalization" factor increase.
- Implement the alternative Payment Condition Count risk adjustment model that accounts for dementia and pressure ulcers, but continue to improve the model to protect dual eligible beneficiaries with multiple chronic conditions in future years.
- Ensure plan risk scores are not lowered due to increasing the use of encounter data.

  In addition, CMS should consider the negative implications collecting the health insurance tax will have on the stability of MA plan benefits and premiums. The tax is scheduled to resume in 2020 after a one-year suspension and would result in an estimated $241 increase in annual premiums for MA enrollees.