Medicare Advantage program: status report

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MEDPAC

Summary of MA program status

- MA enrollment grew six percent in 2015
- MA plans available to 99 percent of beneficiaries in 2016
- Rebates $81 per member per month in 2016, up from $75 in 2015
- Progress toward financial neutrality
  - Average plan bid is below FFS
  - Payments above FFS due to quality bonuses
- Quality of care mostly stable

Source: MedPAC analysis of 2016 MA bid data. *Data are preliminary and subject to change*.

Inter-county MA benchmark inequities

- Double quality bonuses
  - Based on formula for 2004 payments when many benchmarks were set well above FFS
  - Not linked to improved quality performance
    - Pays double for same quality performance
    - Academic study found no increase in quality, more plans
- Benchmark caps
  - Limits benchmarks for more than 1,400 counties based on 2010 benchmarks and FFS spending
  - Usually reduces quality bonus
  - Counties with same FFS spending can have different benchmarks

Implications of eliminating the benchmark caps and double quality bonuses

- Eliminating the double bonuses would reduce Medicare spending by 0.6 percent
- Eliminating the benchmark caps would increase Medicare spending by 0.5 percent
- Some counties are both capped and qualified for double bonuses
- Net decrease in Medicare spending of 0.1 percent

Source: MedPAC analysis of 2016 MA bid data. *Data are preliminary and subject to change*.

Implications of eliminating the benchmark caps and double quality bonuses (cont.)

- 63 percent of plans, covering 82 percent of MA enrollees, would see payments change by less than 0.5 percent
- Five percent of plans, covering two percent of MA enrollees, would see payments decrease by two percent or more
- Three percent of plans, covering one percent of MA enrollees, would see payments increase by two percent or more
- Payments decrease 0.1 percent for for-profit plans and 0.2 percent for not-for-profits

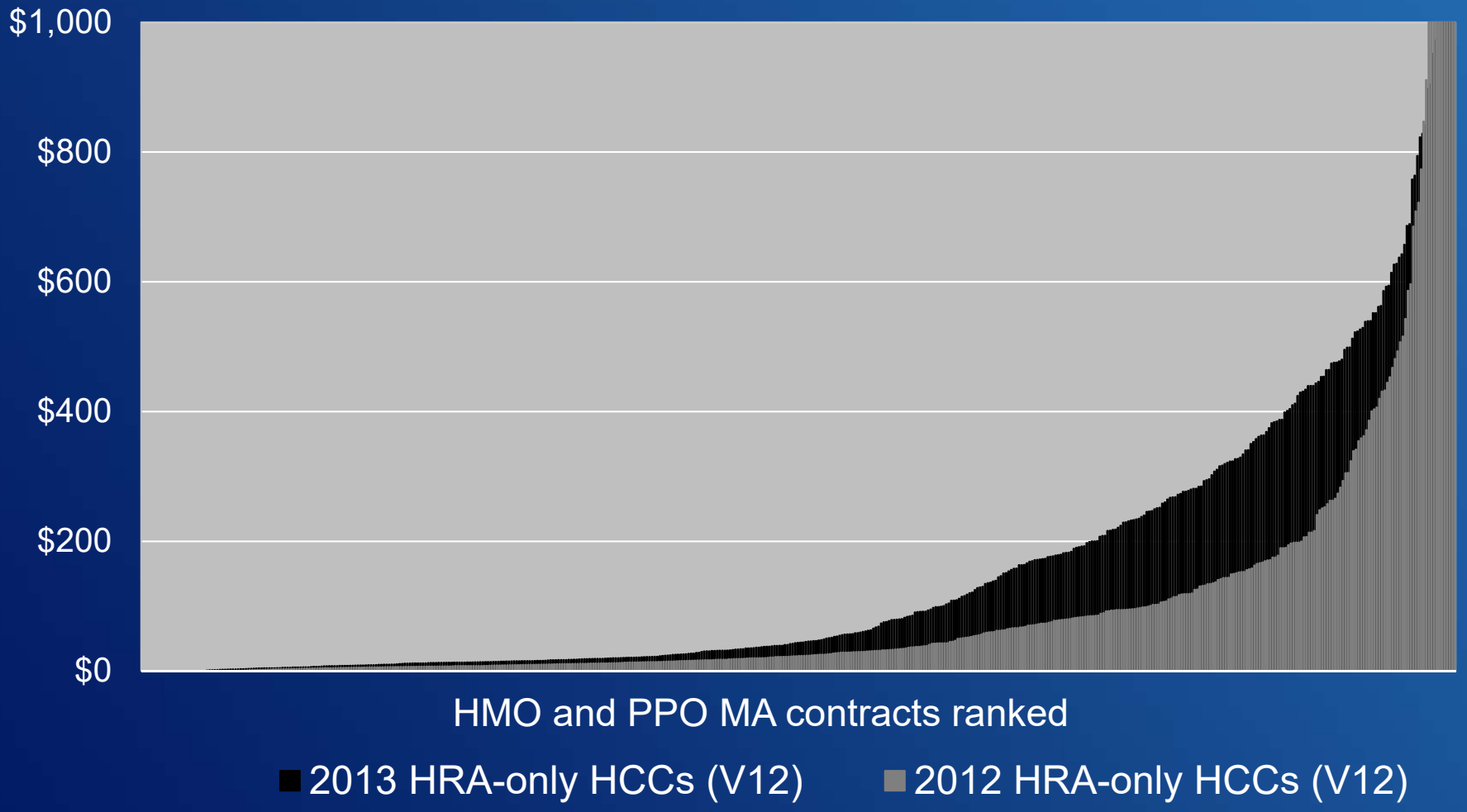
Source: MedPAC analysis of 2016 MA bid data. *Data are preliminary and subject to change*.

Health risk assessments

- HRAs identify health risks, disease, disability
  - Important part of care coordination and planning
- In 2012:
  - About 30% of HCCs on HRAs had no related treatment
  - About $2.3b in Medicare payments for HRA-only HCCs
- In 2013:
  - About 50% increase in number of HRAs administered
  - 10 - 17% increase in number of HRA-only HCCs

Source: MedPAC analysis of 2012 & 2013 MA encounter data. *Data are preliminary and subject to change*.

Per capita increase in payment for HRA-only HCCs, by contract



Source: MedPAC analysis of 2012 & 2013 MA encounter data. *Data are preliminary and subject to change*.

HRA issues

- Draft recommendation:
  - HRA cannot be sole indicator of diagnosis for risk-adjusted payment
  - Addresses HRAs in any setting, not just the home
- Plan incentive to administer HRAs remains
  - Help coordinate or plan care, reduce spending
- Non-Medicare services not affected by HCCs
  - Funded through premiums and Medicare rebate
- 2-years of diagnostic data in risk adjustment
  - Longer window for MA diagnosis documentation

Hypothetical impact of draft recommendation #2

- Assuming a minimum coding intensity adjustment of 5.7%
  - Removing HRA diagnoses and using 2 years of diagnostic data could account for 5% of coding intensity
  - Across-the-board adjustment could be lowered to 0.7%
- Differential impact across plans
  - High-coding plan, higher effective adjustment (e.g., 8.7%)
  - Low-coding plan, lower effective adjustment (e.g., 1.7%)
  - Aggregate adjustment is 5.7%
- However, evidence shows that coding intensity impact is higher than 5.7%
  - Remaining across-the-board adjustment is likely higher than 0.7%