Medicare Advantage: Calculating benchmarks and coding intensity

Andrew Johnson and Scott Harrison
November 4, 2016
Today’s presentation

- MA risk adjustment
- MA coding intensity
- How MA benchmarks are set
- Which FFS spending data should be used to set benchmarks
MA risk adjustment

- Medicare pays MA plans a capitated rate
  - Rate = base $ amount
  - $ \times \text{beneficiary-specific risk score}

- Risk scores adjust payment
  - Increase base rate for more costly beneficiaries
  - Decrease base rate for less costly beneficiaries

- Risk scores produced by CMS-HCC model
  - Includes demographic characteristics & HCCs (medical conditions) identified by diagnosis codes
MA and FFS diagnostic coding

- Less coding incentive in FFS Medicare
  - Payment for physician and outpatient services is not based on diagnosis codes
- Strong financial coding incentive in MA
  - Higher payment for more HCCs documented
  - Higher MA risk scores for equivalent health status
- After 1 year in FFS, risk scores for beneficiaries who switched into MA increased
  - 6% faster than FFS stayers in first year
  - 2% faster than FFS stayers each subsequent year
Diagnostic coding intensity impact on payment

- MA risk scores used for payment were 10% higher than FFS in 2015

<table>
<thead>
<tr>
<th>Risk scores</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old model</td>
<td>8 %</td>
<td>9 %</td>
<td>10 %</td>
</tr>
<tr>
<td>New model</td>
<td>NA</td>
<td>7 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Payment blend</td>
<td>8 %</td>
<td>7 %</td>
<td>10 %</td>
</tr>
</tbody>
</table>

- CMS reduced all MA payments in 2015 by statutory minimum factor 5.16 percent
- After statutory adjustment, 2015 MA risk scores 4% higher than FFS due to coding

Source: MedPAC analysis of enrollment and risks score files. Estimates are preliminary and subject to change.
MedPAC 2016 recommendation

- Develop a risk adjustment model that uses two years of FFS and MA diagnostic data
  - 1 to 2 percent overall impact & enhanced equity
- Exclude diagnoses only documented through health risk assessments from risk adjustment
  - 2 to 3 percent overall impact & enhanced equity
- Apply a coding adjustment that fully and equitably accounts for the remaining differences in coding between FFS and MA
  - 5 to 7 percent overall impact
Equitably addressing remaining coding intensity impact

MA contracts with >2,500 enrollees  *(PACE and SNPs excluded)*

Source: MedPAC analysis of enrollment and risks score files. Estimates are preliminary and subject to change.
How Medicare benchmarks are set

- Based on per-capita, risk-adjusted Medicare FFS spending
- Counties divided into FFS spending quartiles (115%, 107.5%, 100%, and 95%)
- Quartile value multiplied by FFS to get the benchmark
Measuring county-level FFS spending for use in MA benchmarks

- CMS calculates average per capita FFS Part A and Part B spending for each county to set the benchmarks
- Mismatch in FFS spending data used
  - MA benchmarks are based on spending of all FFS beneficiaries (100% of FFS beneficiaries)
  - MA enrollment allowed only for beneficiaries with both Part A and Part B (87% of FFS beneficiaries)
Issues with including beneficiaries with Part A-only in benchmark calculations

- Understates benchmarks because 12% of all FFS beneficiaries are Part A-only, and they cost less than those with both Part A and Part B
- The share of Part A-only varies by county
- The average share of Part A-only is increasing
Medicare beneficiaries with different enrollment status, 2009-2015 (in percent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care/All Medicare</td>
<td>24.0</td>
<td>24.6</td>
<td>25.3</td>
<td>26.7</td>
<td>28.3</td>
<td>30.2</td>
<td>31.6</td>
</tr>
<tr>
<td>Part A and Part B / all FFS</td>
<td>88.8</td>
<td>88.6</td>
<td>88.3</td>
<td>87.7</td>
<td>87.3</td>
<td>87.0</td>
<td>86.8</td>
</tr>
<tr>
<td>Part A not Part B / all FFS</td>
<td>10.2</td>
<td>10.4</td>
<td>10.8</td>
<td>11.5</td>
<td>11.8</td>
<td>12.1</td>
<td>12.4</td>
</tr>
<tr>
<td>Part B not Part A / all FFS</td>
<td>1.0</td>
<td>1.0</td>
<td>0.9</td>
<td>0.9</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Use only beneficiaries with A and B in FFS calculation for benchmarks?

- Some counties are affected more than others
- As MA penetration increases, the proportion of Part A-only will grow and FFS calculations will become less reflective of MA enrollment
Implications of using only beneficiaries with A and B

- Payments to MA plans would likely rise about 1 percent, or about $20 billion over 10 years
- The benchmarks in some counties with high MA penetration (and high shares of Part A-only) could rise by up to 3 percent, while the benchmarks of counties with relatively low shares of Part A-only might not rise at all
Is there Commission interest in making a recommendation to calculate MA benchmarks using FFS beneficiaries enrolled in both Part A and Part B that would increase Medicare spending?