Medicare Advantage Policy Issues

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MEDPAC

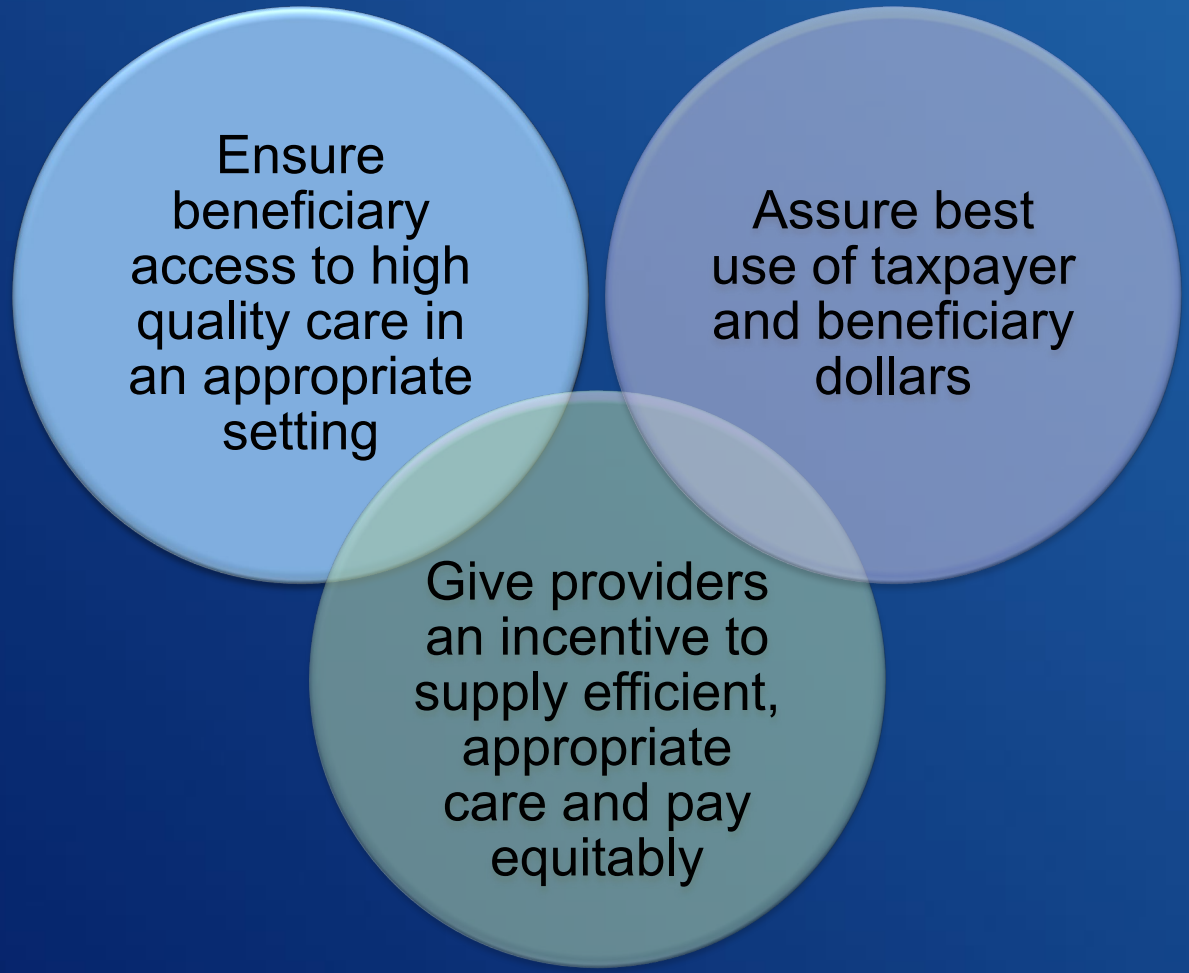
Roadmap of today's discussion

- Background on the Medicare Payment Advisory Commission (MedPAC)
- The Medicare Advantage program
  - Background
  - Recent MedPAC analysis and recommendations
  - Emerging issues for discussion

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
  - Serve 3-year terms, can be reappointed
  - Meet in public 7x a year
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Commissioners take public votes on recommendations
- Two standing reports to Congress; also various mandated reports

MedPAC's principles of Medicare payment



The Medicare Advantage program

- The Medicare Advantage (MA) program allows beneficiaries to receive their Medicare benefits through private plans
- Plans must offer the basic Medicare benefit (Parts A and B)
  - Nearly all plans also cover prescription drugs (Part D)
  - Nearly all plans offer extra benefits: Reduced cost sharing, supplemental services
  - Some plans charge a premium (in addition to the Part B premium)
- MA plans are paid a monthly capitated amount for each enrollee
  - Amount varies by geography, enrollee health status, and plan quality rating
- MA has become an increasingly larger share of the Medicare program

How Medicare pays MA plans

- Payments based on plan bids, county benchmarks, and quality scores
- Bids are plans' estimates of cost to cover Part A and Part B benefits
- Benchmarks are set as a percentage of county FFS spending by quartile
  - Range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties
  - Benchmarks are increased for plans with a quality rating of 4+ stars
- If bid < benchmark, Medicare pays the bid plus a percentage (varies by plan quality score) of the difference as a "rebate"; Medicare keeps the rest of the difference
- If bid > benchmark, Medicare pays benchmark, enrollee pays premium to make up the difference

Note: MA (Medicare Advantage), FFS (fee-for-service). MedPAC publications are the definitive reference source for all analyses and results.

The MA program is robust and growing

- Despite MA payment reductions under the ACA (fully phased in by 2017) between 2018 and 2023:
  - MA share of eligible enrollees rose from 37 to 49 percent*
  - Average number of plan choices (beneficiary-weighted) increased from 20 to 41 plans
  - Share of beneficiaries with $0 premium plan option available rose from 84 to 99 percent
  - Average annual plan rebate amount, which is used to fund extra benefits, increased from ≈$1,140 to ≈ $2,350 per enrollee, the highest in the program's history

Note: MA (Medicare Advantage), ACA (Affordable Care Act of 2010). *Reflects CMS enrollment data from 2018 through 2022, due to data availability.
MedPAC publications are the definitive reference source for all analyses and results.

Issue: MA coding generates excess payments

- Differences in diagnostic coding incentives between FFS and MA lead to higher MA risk scores for similar health status
  - 2021 MA risk scores were about 10.8% higher than FFS
  - After accounting for CMS coding adjustment of 5.9%, 2021 MA risk scores were still more than 4.9% higher than FFS due to coding differences
  - Between 2007 and 2023, MA coding intensity generated nearly $124 billion in excess payments
- Chart review and health risk assessments (HRAs) are key drivers of coding intensity accounting for nearly two-thirds of excess payments to MA plans

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.
Source: MedPAC analysis of enrollment and risks score files.

MedPAC recommendation: Addressing MA coding intensity (March 2016)

- Use two years of MA and FFS Medicare diagnostic data to calibrate the risk adjustment model
- Remove health risk assessments (HRAs) from risk adjustment
- Adjust plan payments to reflect any residual coding intensity

Note: MA (Medicare Advantage), FFS (fee-for-service). MedPAC publications are the definitive reference source for all analyses and results.

Issue: Quality in MA cannot be meaningfully evaluated

- Quality bonus program (QBP) is not a good basis of judging quality for Medicare beneficiaries in MA
  - Large and dispersed contracts, exacerbated by consolidations
  - Too many measures, some based on small sample
  - Cannot be compared to FFS in local market
- QBP accounts for at least $15 billion annually in MA payments
- Under relaxed PHE rules, 90 percent of MA enrollees are in a quality bonus plan, generating a payment windfall for plans in 2023

Note: Medicare Advantage (MA), Public health emergency (PHE). MedPAC publications are the definitive reference source for all analyses and results.

MedPAC recommendation: Replace MA QBP with MA Value Improvement Program (VIP) (June 2020)

Flaws with current QBP design	Redesigned MA VIP
• Too many measures, not focused on outcomes and patient/enrollee experiences	• Score a small set of population-based measures
• Contract-level quality measurement is too broad and inconsistent	• Evaluate quality at the local market level
• Ineffective accounting for social risk factors	• Use a peer grouping mechanism to account for differences in enrollees' social risk factors
• "Cliff" effect where only plans receiving a set rating receive bonuses	• Establish a system for distributing rewards with no "cliff" effects
• Bonus financing is through added program dollars, unlike most FFS quality incentive programs	• Distribute plan-financed rewards and penalties

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Note: MA (Medicare Advantage), QBP (quality bonus program). MedPAC publications are the definitive reference source for all analyses and results.

Issue: Favorable selection

- Risk score based on average cost for beneficiaries with defined characteristics/conditions
- There is variation in beneficiary cost underlying the average; some beneficiaries will have higher costs and some will have lower costs
- MA favorable selection occurs when average MA costs are lower than their risk scores predict (separate from MA coding)
- Research suggests that risk scores, on average, overpredict spending for the MA population, before considering any coding differences between FFS and MA

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.

Issue: MA plan and beneficiary incentives contribute to favorable selection

- Beneficiaries may find MA generally attractive due to the availability of supplemental benefits at no additional cost
- Plan networks and perceived delays in care from prior authorization may discourage enrollment by beneficiaries with certain health conditions
- Beneficiaries who expect to use more medical services may prefer to stay in FFS and purchase supplemental insurance to cover out-of-pocket spending

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.

FFS-based benchmarks create a favorable bias for MA plans

- MA benchmarks reflect the higher level of costs associated with the FFS-enrolled population rather than a plan's enrollees
- MedPAC's analysis suggests that MA enrollees were 11% less costly than their risk score indicated in 2019
- Favorable selection allows plans to bid lower than FFS spending before producing any efficiencies in care delivery
  - Results in overpayments to MA plans
  - Introduces bias in risk-standardized comparisons with FFS

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.

March 2023 MedPAC public meeting discussion: Three alternative options for setting MA benchmarks

1. Use plan bids to calculate benchmarks (competitive bidding) instead of FFS spending data
2. Use all Medicare spending (local area FFS and MA) to calculate benchmarks
3. Establish benchmarks in an initial year and update using a fixed growth rate instead of FFS spending growth rates

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.

Emerging issues for discussion

- Post-hospital discharge to post-acute care/prior authorization
  - Variation between beneficiaries with FFS and MA
- Denials
- Encounter data submission
- Other issues?

Note: FFS (fee-for-service), MA (Medicare Advantage). MedPAC publications are the definitive reference source for all analyses and results.

Questions?

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Relevant MedPAC recommendations

- **Benchmarks:**
  - Eliminate the historical growth cap on MA benchmarks and the doubling of quality bonus increases in specified counties *(March 2016)*
  - Calculate MA benchmarks only with beneficiaries enrolled in both Parts A and B *(March 2017)*
  - Replace MA benchmarks with a new policy that applies an equal blend of per capita local and national FFS spending, a rebate of at least 75 percent, and a discount rate, along with prior benchmark recommendations (*June 2021*)
- **Risk adjustment:** Use two years of data, exclude diagnoses from health risk assessments, fully account for MA and FFS coding differences *(March 2016)*
- **Encounter data:** Improve completeness of MA encounter data by, among other policies, establishing thresholds for completeness, applying a withhold, and submitting through MACs *(June 2019)*
- **Quality:** Replace the MA QBP with a value incentive program *(June 2020)*
- **Geographic basis:** Establish geographic areas for payment to MA plans *(June 2005)* and quality assessment *(March 2010, March 2018, June 2020)*

Note: MA (Medicare Advantage), FFS (fee-for-service), MAC (Medicare administrative contractor), QBP (quality bonus program).