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Medicare Advantage–Proposed Benchmark Update and Other Adjustments for CY2018: In Brief

Paulette C. Morgan
Specialist in Health Care Financing

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Introduction

Medicare Advantage (Part C or MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Unlike under original Medicare,[1] where providers are paid for each item or service provided to a beneficiary, the same capitated monthly payment is made to an MA plan regardless of how many or few services a beneficiary actually uses. The plan is at-risk if costs for all of its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing.

Capitated payments to plans are determined, in part, on a benchmark, or maximum payment. Benchmarks are updated each year by a measure of Medicare spending growth and by other adjustments. The Secretary of Health and Human Services (Secretary) published the Advance Notice of Methodological Changes for Calendar Year 2018 capitation rates on February 1, 2017,[2] which provided preliminary estimates of the measures of spending growth used to update MA benchmarks, as well as other adjustments and proposals for updating the benchmark rates. In the Advance Notice, the Secretary estimated that the measure of growth would be positive, which suggests that benchmarks in 2018 would increase relative to their 2017 levels. However, other benchmark and payment adjustments may have a negative effect on plan payments. On average, the Secretary estimated the change in revenue resulting from the policies announced in the Advance Notice would increase plan payments by 0.25%. After accounting for estimated growth in plan risk scores, the Secretary expects average plan payments to grow 2.75% relative to payments in 2017.[3] The final CY2018 benchmarks are expected to be published on April 3, 2017.

This report provides a brief background on how MA payments are determined through a comparison of a plan's estimated cost (bid) and the maximum amount Medicare will pay a plan (benchmark). The report then discusses the calculation of the benchmark (or maximum possible payment) under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and related administrative action. The report then describes some of the provisions in the Advance Notice of Methodological Changes for CY2018, which would either adjust the benchmarks or make other adjustments, some of which are statutorily specified and some of which are at the discretion of the Secretary.

Determining Payments to Plans

As discussed above, MA plans are paid a per-person monthly amount. The Secretary determines a plan's payment by comparing its *bid* to a *benchmark*. A bid is the plan's estimated cost of providing Medicare-covered services (excluding hospice, but including the cost of medical services, administration, and profit). In general, the Secretary has the authority to review and

[1] For more information on the original Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2018 Call Letter," February1, 2017, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf. Although the notice covers many topics, this report summarizes only select parts of the notice that address capitation rates for MA plans.

[3] Centers for Medicare & Medicaid Services, Department of Health and Human Services, "2018 Medicare Advantage and Part D Advance Notice and Draft Call Letter," fact sheet, February 1, 2017, at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-02-01.html.

negotiate plan bids to ensure that they reflect revenue requirements. A benchmark is the maximum amount the federal government will pay for providing those services in the plan's service area.[4] If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Medicare Part B or Part D premiums, or some combination of these options. Starting in 2012, the size of the rebate is dependent on plan quality; rebates range from 50% to 70% of the difference between the bid and the benchmark.[5] If a plan's bid is equal to or above the benchmark, its payment equals the benchmark amount and each enrollee in that plan will pay an additional premium that is equal to the amount by which the bid exceeds the benchmark.[6] Finally, payments to plans are risk adjusted to take into account the demographic and health history of those who actually enroll in the plan.[7]

The majority of proposed changes for 2018 from the Advance Notice discussed in this report are in reference to the benchmark—the maximum possible payment. Any change in an MA benchmark could have an indirect effect on plan payments because the benchmark is used in conjunction with the bid to determine MA plan payments. For example, if an MA benchmark decreases from one year to the next, and the plan bids the benchmark in each year, the plan payment would therefore decrease. If a plan had, however, bid below the benchmark in each year, the plan payment (the bid plus the rebate) most likely would be reduced, but it could remain the same or increase, depending on the size of the benchmark reduction and the size of the change in the plan bid in each year (e.g., the plan's bid is higher in the second year than in the first). If an MA benchmark decreased from one year to the next but the plan bid above the benchmark each year, the total payment to the plan (the benchmark plus an additional premium from each enrollee) could increase, decrease, or remain the same, depending on the plan bid each year. If a benchmark increases from one year to the next and the plan bids below the benchmark, in most cases the plan payment would also increase, and would only decrease if a plan bid substantially less in the second year. So while proposed benchmark changes affect the maximum possible payment from the Centers for Medicare & Medicaid Services (CMS), benchmark changes alone do not determine changes in payments.

Some of the proposed changes for 2018 refer to changes in risk adjustment. After the plan payment is determined through the comparison of the bid and the benchmark, the payment is risk adjusted to account for the health history and demographics of the beneficiaries who actually enroll in a plan. Any changes to the risk adjustment methodology, therefore, affect plan payments

[4] In general, a plan's service area is defined by zip code and may consist of a county, groups of counties, whole states or the entire nation, unless the plan is participating in the Regional MA program, in which case the plan's service area consists of a region, or multiple regions, as defined by the Secretary. Benchmarks are calculated on a county-by-county basis. A plan submits a single bid for its service area, and CMS calculates a single benchmark for that plan based on the counties included in the plan's service area.

[5] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) benchmark changes made plan payments dependent on plan quality for the first time. Plan quality affects payments in two ways. First, it determines the size of the rebate when a plan bid is below the benchmark. Second, it increases the benchmark if the plan quality is of a sufficient level. For example, in general, in 2018, a 4-star plan that bid below the benchmark would receive a 5 percentage point quality adjustment to the benchmark and 65% of the difference between its bid and benchmark as a rebate; a 3-star plan that bid below the benchmark would not qualify for a quality adjustment to its benchmark but would receive 50% of the difference between the bid and the benchmark as a rebate.

[6] Though plans are required to use their rebate to provide extra benefits, reduce cost sharing, or reduce the Part B or D premium, any plan, regardless of whether the bid was above or below the benchmark, can include extra benefits that are paid for entirely through a premium increase.

[7] For background information on risk adjustment of MA payments, see archived CRS Report R42134, *Medicare Advantage Risk Adjustment and Risk Adjustment Data Validation Audits*.

(because the risk-adjustment factor is multiplied by the non-risk-adjusted payment) but are not adjustments to the benchmarks.

The next section discusses how the benchmarks are calculated.

Benchmark Calculations

Separate benchmarks are calculated for each county. The methodology for calculating the benchmarks is applied consistently across counties. The level of the benchmark in any particular county can be affected by the practice of medicine in original fee-for-service (FFS) Medicare, and how that affects spending in original Medicare in the county relative to other areas of the country. This section discusses the calculation of the benchmarks,[8] as well as subsequent administrative action affecting benchmarks.

Current Calculation

The MA county benchmarks are set at a percentage of FFS spending in each county. To project per capita FFS spending in each county for the upcoming calendar year, first the Secretary calculates historic spending data from original Medicare claims files and estimates a trend to determine the *growth* (or the percent increase) in national FFS Medicare per-capita spending (also known as growth in fee-for-service United States Per Capita Costs, or FFS USPCC). The growth in FFS USPCC for 2018 is estimated to equal 2.79%. This is calculated as the percentage increase between the prior projected national FFS USPCC of $825.20 in 2017 and the current projected FFS USPCC of $848.21 in 2018, or [2.79% = ($848.21- $825.20) / $825.20 × 100].

To determine per capita spending *for each county*, the national estimated level of FFS per capita cost ($848.21 for 2018) then is multiplied by a county-level geographic index (the average geographic adjustment, or AGA) to determine the relative difference in the estimated FFS per capita spending in each county. The AGA is calculated using a 5-year rolling average of claims data for beneficiaries in original Medicare living in each county, and includes weighting for enrollment and average risk scores.

In addition, several adjustments are made to the county per capita FFS estimates, which are either specified in statutes or made at the Secretary's discretion, to more accurately reflect estimated spending for the year in question. These adjustments are discussed in more detail in the "Summary of Selected Benchmark Changes and Other Adjustments in the Advance Notice" section of this report.

Two adjustments are then applied to the per. pita FFS estimates of spending for each county for the benchmark calculation. First, FFS estimates for each county are multiplied by a percentage

[8] For a detailed description of the MA changes included in the ACA, see archived CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*. The ACA changes to the MA benchmark methodology are fully phased-in for 2018. The ACA changes to the benchmark calculation do not apply to Program of All-Inclusive Care for the Elderly (PACE) plans. Benchmarks for PACE plans are calculated using the methodology in effect prior to the ACA. Under that methodology, a county benchmark is equal to the previous year's benchmark increased by the growth in overall Medicare spending (as measured by the National Per Capita MA Growth Percentage, or NPCMAGP); however, in certain years designated by the Secretary as rebasing years, the benchmark is the greater of either (1) the previous year's benchmark increased by the NPCMAGP, or (2) projected per capita fee-for-service (FFS) spending in the original Medicare program in that county (also known as the adjusted average per capita cost, or AAPCC). Rebasing means the Secretary recalculates per capita FFS spending for each county.

specified in statutes—95%, 100%, 107.5%, or 115%—with higher percentages applied to counties with the lowest FFS spending.[9] In other words, the 25% of counties with the lowest FFS spending will receive the highest percentage (115%) of per capita FFS as their MA benchmark. The 25% of counties with the highest FFS spending will receive the lowest percentage (95%) of per capita FFS.

Second, benchmarks are adjusted by plan quality. Starting in 2012, plans with at least a 4-star rating on a 5-star quality-rating scale established by CMS are required to receive an increase in their benchmark.[10] In 2018, a plan receiving 4, 4.5, or 5 stars on a 5-star quality rating system[11] may receive a 5% increase in their benchmark. This means that in 2018, a plan that might otherwise have had a benchmark of [100% × per capita FFS] could receive a benchmark set at [105% × per capita FFS] if the plan had a star quality rating of 4 or more stars. The benchmark quality increases are doubled for qualifying plans in a qualifying county.[12] The ACA also requires that benchmarks (including any quality adjustment) be capped at the level they would have been in the absence of the ACA. In 2017, in half of U.S. counties, the 5 percentage point quality bonus adjustment to the MA benchmark is constrained by the pre-ACA benchmark cap. In some cases, this means the quality bonus for plans with 4 stars or more may be less than 5 percentage points (or possibly no increase at all). In other cases, the benchmark for plans with less than 4 stars (or 0 percentage point quality adjustment) also may be constrained by the pre-ACA benchmark levels. The payment cap is a statutory provision[13] and the Secretary indicated in the Advance Notice that the provision will continue to be in effect for 2018.

[9] The Secretary will occasionally recalculate (or rebase) county-level per capita FFS spending, and when this happens, counties could transition between being a 100% of FFS spending county, for example, to being a 95% of FFS spending county. If a county quartile designation switches, the county will have a one-year transition to the new county designation. In this example, the county benchmark would be set at 97.5% of FFS spending for one year before the full transition to being a 95% of FFS spending county.

[10] MA plans with low enrollment may not have had enough enrollees to either generate the quality data or give an accurate assessment of plan quality; new plans or plans with low enrollment, as determined by the Secretary, also qualifies for a 3.5 percentage point benchmark increase. In addition, a quality bonus demonstration altered the star bonus adjustments for 2012 through 2014. CMS, Department of Health and Human Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2012 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2012 Call Letter," February 18, 2011, p. 8, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2012.pdf. "Evaluating the causal impact of the [Quality Bonus Payment] QBP demonstration on quality is constrained by several factors.... As a result we provide descriptions of the payments made as a result of the QBP demo, contemporaneous changes in Star Ratings, enrollment, and benefits, but we cannot identify the unique contribution of the QBP demo from the effects of other factors [on] the observed changes." Sai Ma, COR, *Evaluation of the Medicare Quality Bonus Payment Demonstration*, L & M Policy Research, LLC, Contract: HHSM-500-2011-00083C, Washington, DC, February 2016, p. 1, https://innovation.cms.gov/files/reports/maqbpdemonstration-finalevalrpt.pdf.

[11] See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[12] A *qualifying county* is defined as a county with (1) lower-than-average per capita spending in original Medicare, (2) 25% or more beneficiaries enrolled in MA, as of December 2009, and (3) a payment rate in 2004 based on the minimum amount applicable to a metropolitan statistical area (i.e., an urban floor rate). The first of these three criteria is updated each year, and depending on the results, a county may or may not meet that criterion in any one year. The remaining two criteria are based on historical data; a county must meet both of those criteria if it is ever to be a qualifying county.

[13] Social Security Act Section 1853(n)(4).

Summary of Selected Benchmark Changes and Other Adjustments in the Advance Notice

The Advance Notice contains estimated values for some of the factors that update the MA benchmarks, as well as the Secretary's proposed methodological changes to the benchmarks and risk adjustment. This section describes a selection of these factors and proposed changes. The provisions are divided into those that are adjustments to the benchmark versus those that pertain to the risk-adjustment methodology.

Regarding Proposed Benchmark Updates and Changes

- The Growth in the Fee-for-Service United States Per Capita Cost (FFS USPCC): This is a measure of the growth in original Medicare spending used to calculate per capita FFS spending, which is part of the benchmark calculation. For 2018, the value is preliminarily estimated at a **2.79% increase over the FFS USPCC for 2017.**
- The National Per Capita MA Growth Percentage (NPCMAGP): This is a measure of the overall growth in Medicare spending. It applies to the calculation of benchmarks for plans under the Program of All-Inclusive Care for the Elderly (PACE), which are not subject to the ACA methodology.[14] It also applies to pre-ACA benchmarks, which are the caps for MA benchmarks. For 2018, the value is preliminarily estimated at a **2.70% adjustment to the previous year's (pre-ACA) benchmark.**
- Phase-out of Indirect Medical Education (IME):[15] Prior to 2008, the value of IME payments to hospitals was included in the calculation of the MA benchmarks. However, an IME payment also was made from CMS to eligible teaching hospitals when an MA enrollee was admitted. Effectively, CMS was making an adjustment for IME twice—once directly to the MA plans through an adjustment to the MA benchmark, and once directly to the teaching hospital. A provision in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) required the Secretary to phase out the value of IME from the MA benchmarks.[16] **This adjustment will affect benchmarks differently depending on the value of IME that is to be phased-out, but the reduction will not be greater than 5.4% of the per capita FFS rate in a county**.

[14] The PACE program provides Medicare, Medicaid, and other medically necessary services to eligible frail elderly individuals through an interdisciplinary caregiver team. Organizations participating in the PACE program may receive a capitated payment from Medicare and Medicaid for each enrollee eligible for those programs. Individuals aged 55+ who meet other requirements may be eligible for PACE. Medicare or Medicaid eligibility or enrollment is not a PACE requirement. See, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf.

[15] Medicare IME payments support the indirect costs associated with residency programs, such as the higher patient care costs from additional testing that residents may order as part of their training. See CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*.

[16] The phase-out of IME from MA benchmarks began in in 2010. The effect of the phase-out formula was to phase out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. This means that in counties where IME spending was very low, the IME phase-out was complete in a single year. For areas where IME makes up a larger percentage of original Medicare spending in the county, the IME phase-out still will be taking place in 2018. The maximum reduction for any specific county in 2018 is 5.4% of the per capita FFS rate, as indicated in the Advance Notice.

- Calculation for Qualifying Counties: A qualifying county is defined as a county with (1) lower-than-average per capita spending in original Medicare, (2) 25% or more beneficiaries enrolled in MA, as of December 2009, and (3) a payment rate in 2004 based on the minimum amount applicable to a metropolitan statistical area (i.e., an urban floor rate). When calculating per capita spending in original Medicare, CMS had previously excluded the costs of direct graduate medical education (GME) from the county calculation, but had not excluded those costs for the national average. For 2018, CMS proposes to remedy the inconsistency by including the value of GME in both the estimate of county per capita FFS spending and the national average, for purposes of this calculation. **This change would cause county spending estimates to increase, and fewer counties would be qualifying counties.**
- New Data for FFS Estimates: Estimates of county per capita FFS spending are part of the benchmark calculation. For 2018, the Secretary will "rebase," or update, the claims data used to calculate the average geographic adjustment (AGA) by dropping the 2010 data from the five-year rolling average calculation and adding one additional year (2015). Thus, for 2018, the AGA will be based on claims data from 2011 to 2015. **This change may increase benchmarks in some counties, while decreasing them in others.**
- Adjustment to county FFS Estimates to Reflect Current Prices: County-level per capita FFS estimates are calculated using historic claims data, which take into account the prices and quantities of items and services used. Starting in 2014, the Secretary began taking into account current payment policies and applying these policies to the historic claims data upon which the FFS estimates are based to better reflect expected expenditures under current program rules. Since then, the practice of adjusting historical data has continued and in 2017 included current payment policy adjustments related to hospital inpatient and outpatient services, skilled nursing facilities, home health, physician services, disproportionate share hospital payments, durable medical equipment prices in competitive bidding areas, and shared savings payments and losses made to selected Center for Medicare and Medicaid Innovation programs, such as the Medicare Shared Savings Program Accountable Care Organizations (ACOs) [17] and Pioneer ACOs.[18] For 2018, the Secretary is proposing to also take into account current pricing policy for the national mail-order program for diabetic supplies under the durable medical equipment competitive bidding program, and expanding the adjustments for selected shared savings programs to include shared savings payments under the Comprehensive Primary Care Initiative[19] and some other programs. The Secretary is also investigating whether Medicare payment policy changes included in the Increasing Choice, Access, and Quality in Healthcare for Americans Act (P.L. 114-255)[20] warrant additional adjustments to the FFS estimates. **The adjustment is expected to increase benchmarks in some counties while decreasing them in others.**

[17] See, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/.

[18] See, https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/.

[19] See, https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

[20] CRS Report R44730, *Increasing Choice, Access, and Quality in Health Care for Americans Act (Division C of P.L. 114-255)*.

- Employer Group Waiver Plan (EGWP) benchmark calculation: Medicare statutes allow the Secretary to waive certain requirements to encourage employers and unions to provide MA plans specifically to their own Medicare-eligible retirees or members; these plans are referred to as Employer Group Waiver Plans, or EGWPs.[21] Research has found that EGWPs consistently bid higher than MA plans open to all Medicare beneficiaries.[22] "[EGWPs] can negotiate benefit and premium particulars with employers after the Medicare bidding process is complete. Conceptually, the closer their bid is to the benchmark ... the better it is for the plan and the employers because a higher bid brings in more revenue from Medicare."[23] The opposite may be true for non-EGWPs which would have an incentive to bid below the benchmark and obtain a rebate which could be used for extra benefits or reduced cost sharing to attract enrollees.

  For 2017, the Secretary waived the requirement that EGWPs submit plan bids to establish their payment, and instead established an alternative payment calculation. The *base* payment was comprised of a 50:50 blend of two calculations. The first calculation was an enrollment weighted average bid-to-benchmark ratio for non-EGWP plans in the prior year (2016) for each quartile. The second calculation was the enrollment weighted average EGWP bid-to-benchmark ratio from 2016 for each quartile. A *rebate* was calculated by comparing the base payment described above to the county or service area benchmark related to that EGWP plan's quality and applying the rebate percentage at a given plan quality. The two-part base calculation was meant as a method to transition EGWPs to a payment comprised entirely of the non-EGWP bid-to-benchmark ratio, and corresponding rebate calculation.

  For 2018, the Secretary is requesting comments on whether to continue to phase-in the EGWP payment methodology (i.e., for another year, should the EGWP payments be based on information from both non-EGWP bid-to-benchmark ratios and EGWP bid-to-benchmark ratios from 2016) or whether to fully phase-in the EGWP payment so that it is based entirely on non-EGWP 2017 bid-to-benchmark ratios. **If the Secretary were to base EGWP payments entirely on non-EGWP bid-to-benchmark ratios, the resulting payments would likely be lower than if the Secretary continued to phase-in the methodology.**

- Star Quality Rating Related to Beneficiary Access and Plan Performance Problems: MA benchmarks and rebates are adjusted based on plan quality, as measured by a 5-star quality-rating system. The star rating system for 2017 takes into account up to 44 different measures of quality, which are evaluated and updated each year to ensure that they reflect current clinical guidelines and differentiate plan quality. The measures of quality are weighted, with greater weight given to measures of quality improvement from one year to the next and outcome measures, and less weight applied to measures of beneficiary experience and access, and process.

  Between January 2012 and March 8, 2016, CMS would automatically reduce the plan's *current* overall star rating level to 2.5 (or by 1 star if the quality rating had previously

[21] Social Security Act Section 1857(i).

[22] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, Washington, DC, March 2014, p. 333, http://www.medpac.gov/docs/default-source/reports/mar14_ch13.pdf?sfvrsn=0.

[23] Ibid.

been 2.5 stars or lower) when an MA plan was found to have violated Medicare rules and intermediate sanctions were put in place (such as suspension of marketing and enrollment, or civil monetary penalties). The star rating reduction would remain in place during the period the enforcement actions were in place. Those same enforcement actions would also be incorporated into the star quality rating at a later time because one of the star measures (Beneficiary Access to Performance Problems or BAPP measure – an access measure with a weight of 1.5) took into account these actions as well, meaning plans face two different reductions for the same enforcement action. In addition, commenters had pointed out that the automatic reduction in the overall star rating was more severe on higher rated plans (because of the immediate drop to 2.5 stars) relative to the less severe reduction of 1 star for plans that already had a low star quality rating.[24] Following this, in a March 8, 2016 memo, CMS indicated it would reassess the impact of sanctions on star ratings, and suspend the automatic sanction-based star rating reduction. CMS stated in the memo that it would propose a revised approach to take effect in CY 2018. In a Request for Comment issued on November 10, 2016, CMS stated that it was considering the following options: reinstating the automatic reduction, potentially with less a dramatic effect on the overall star rating; introducing an audit measure in the star ratings; or revising the BAPP measure to reflect more accurately the occurrence and severity of sanctions.

In the Advance Notice, CMS stated it does not intend to reinstate the automatic reduction in current overall star ratings as a result of intermediate sanctions. Instead, CMS indicated that it would modify the BAPP measure in several ways. CMS proposes using data from a more recent time period; specifically, instead of using enforcement action information from CY2016 to calculate the CY2018 BAPP star measure, CMS proposes to use information from July 2016 through June 2017. CMS proposes to adjust BAPP to take into account the severity of a civil monetary penalty and the number of beneficiaries affected, rather than an absolute affect not taking into account those factors. CMS also proposes to cap the total effect of civil monetary penalties on the BAPP score. CMS proposes to reduce the weight of the BAPP measure for 2018 to 1, and increase it in 2019 to 1.5 to again align with other access measures. **This proposal may result in higher star ratings for some plans that face enforcement actions.**

Regarding Proposed Updates and Changes to Risk Adjustment

- Coding Intensity Adjustment: In general, MA plan payments are risk adjusted to account for the variation in the cost of care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries and thus to discourage plans from preferential enrollment of healthier individuals. In part because MA plan payments are adjusted by diagnosis, MA plans tend to identify more diagnoses for a given patient than providers in original Medicare, some of whom are paid not by diagnosis but by the unit of work. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) required the

[24] Jennifer Shapiro, Acting Director of Medicare Drug and Benefit and C&D Data Group, *Suspension of the policy Providing for Automatic Reduction of Star Ratings for Contracts Operating Under Intermediate Sanctions*, Centers for Medicare & Medicaid Services, March 8, 2016, p. 1, and Amy Larrick Chavez-Valdez, Director of Medicare Drug Benefit and C&D Data Group, *Request for Comment: Enhancements to the Star Ratings for 2018 and Beyond*, Centers for Medicare & Medicaid Services, November 10, 2016, p. 2, https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Comments-2018-Stars.pdf.

Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under Parts A and B of Medicare for plan payments in 2008, 2009, and 2010. The ACA requires the Secretary to conduct further analyses on the differences in coding patterns and adjust for those differences after 2010. It specifies minimum coding intensity adjustments starting in 2014. **For 2018, the coding intensity adjustment is estimated to be a reduction of 5.91% (the statutory minimum) applied to MA enrollee risk scores, which are used to risk adjust plan payments. This represents a change of .25 percentage points relative to the adjustment applied the previous year which was a reduction of 5.66%.**

- Risk Model Normalization: CMS uses a model to determine how different demographic characteristics and diagnoses affect the relative cost of enrollees for the purpose of risk adjusting MA payments. When CMS calibrates the risk-adjustment model, it does so for a specific set of FFS data and a specific total expenditure in a particular year, and it standardizes the model so that a beneficiary with average Medicare spending has a risk score of 1.0. (A beneficiary who is older and sicker than average, and thus has higher-than-average health spending, would have a risk score greater than 1.0, and a beneficiary who is younger and healthier than average, and thus has lower-than-average health spending, would have a risk score of less than 1.0.)

  In years when the model is not recalibrated, it has to be normalized to account for population and coding pattern changes since the calibration year. For example, if the population and coding pattern changes had resulted in a 3% increase in risk codes since the calibration year, then if CMS did not normalize the model, the plans would be overpaid by 3% relative to a normalized population and spending level. If the normalization factor was 1.03, then the risk score for each beneficiary would be divided by 1.03, and a beneficiary with a risk score of 1.2 would have a normalized risk score of 1.165, or [1.2 / 1.03 = 1.165], which is a lower risk score. Prior to 2015, CMS had used a linear (straight line) model with 5 years of FFS data to determine the normalization factor; this method typically resembled a general inflation in risk scores.

  In 2015, CMS adopted a new method for calculating the normalization factor. This new method used a non-linear (curved) model that was more sensitive to and better accounted for the healthier, less expensive "baby boomers" entering the program. This change gave greater weight to the low risk scores of the baby boomers, and resulted in a decrease in the year-to-year change in risk score data used to calculate the normalization factor. As a result, the 2015 normalization factor corrected for a general *deflation*, rather than inflation in the risk score data. It resulted in a normalization factor that was less than 1.0 for 2015, which increased, rather than decreased, the normalized risk scores for 2015. For example, a beneficiary with a risk score of 1.2 in 2015 had a normalized risk score of 1.210 or [$1.2/0.992^{25}$= 1.210]. This method was also used for 2016 and 2017.

  In 2018, the Secretary proposes to revert back to the liner model for calculating the normalization score. In updating the calculation for 2018, CMS found that the most recent year of risk score data upon which the calculation was based (2016) was higher

[25] Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 4, 2014, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf.

than data for the previous 4 years, or [2012 = 0.997, 2013 = 0.995, 2014 = 0.999, 2015 = 1.001, 2016 = 1.022].[26] Because the non-linear model is more sensitive to year-to-year changes, the non-linear model predicted a 2018 normalization score of 1.069. CMS is "not confident" that risk scores will rise to that level in 2018. A linear model estimates a 2018 normalization score of 1.017.[27] [(1.2/1.069 = 1.123) < (1.2/1.017= 1.180)] **This proposal is expected to decrease risk scores, which are multiplied by plan payments. However, use of the linear model proposed by the Secretary will decrease risk scores by less than the risk scores that would result from the non-linear model.**

- Encounter Data Used for Risk Adjustment: Payments to plans are risk adjusted to reflect the actual demographic and health history of beneficiaries who enroll in them. The demographic data come from administrative records, whereas the health history data (i.e., diagnoses) are collected by plans and submitted to CMS. Prior to 2012, the data were submitted through the Risk Adjustment Processing System (RAPS). Beginning in 2012, CMS also started collecting encounter data—data that included not only diagnoses but also the actual services performed by physicians in the office or in a hospital setting, as well as the medical equipment used by beneficiaries in their homes and other information.[28] The encounter data collected through the Encounter Data System (EDS) include more information from more sources of care than the data collected in the RAPS system. For 2018, like in 2017, the Secretary proposes to calculate beneficiary risk scores, in part, based on encounter data. Specifically, 75% of an enrollee's risk score would be based on information collect through RAPS, while the remaining 25% of the risk score would be based on information collected from EDS. CMS is also seeking comment on methods to provide stability in the risk scores for 2018. **This adjustment may affect plans differently depending on the risk scores calculated from the encounter data for their enrollees.**

Discussion

How Would These Changes Affect My Congressional District?

The final benchmarks for 2018 are expected to be published on April 3, 2017. CMS does not provide estimated benchmarks with the Advance Notice. It would be very difficult to estimate district-level effects for several reasons. First, the measure of growth estimated in the Advance Notice is likely to differ in the Final Announcement. Second, some of the proposed adjustments might or might not be included in the Final Announcement. But more to the point, some of the

[26] CMS does not currently have an explanation for why the risk score data is so much higher in 2016.

[27] Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2018 Call Letter," February1, 2017, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf.

[28] GAO issued a report in 2014 indicating that CMS should take action to validate the completeness and accuracy of the encounter data. GAO issued an update to that report in 2017 finding that CMS had made limited progress in implementing GAO's previous recommendations, and has not yet used medical records review to validate the data. U.S. Government Accountability Office, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, GAO-14-571, July 2014, at http://www.gao.gov/assets/670/665142.pdf, and U.S. Government Accountability Office, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*, GAO-17-223, January 2017, at http://www.gao.gov/assets/690/682145.pdf.

adjustments proposed in the Advance Notice will change the relative amounts of the benchmarks in different areas. In other words, it would not be informative to simply multiply the 2017 per capita FFS spending data for each county by the growth in the FFS USPCC, because that national measure of growth will not incorporate the additional proposed changes to the geographic adjustment factor, which will not be published until the Final Announcement. In addition, the effect of the changes proposed in the Advance Notice depends, in part, on a variety of factors related to plan behavior. For example, the effect of proposed changes could depend on a plan's star quality rating, which can change from year to year, or its diagnosis coding practices, which are not publicly available.

Author Contact Information

Paulette C. Morgan
Specialist in Health Care Financing
pcmorgan@crs.loc.gov, 7-7317