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Medicare Advantage (MA)—Proposed Benchmark Update and Other Adjustments for CY2016: In Brief

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February 25, 2015

Congressional Research Service
7-5700
www.crs.gov
R43921

CRS REPORT
Prepared for Members and
Committees of Congress

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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 one or two measures of Medicare spending growth and by other adjustments. The Secretary of Health and Human Services (Secretary) published the Advance Notice of Methodological Changes for CY2016 capitation rates on February 20, 2015,[2] in which she 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 two measures of growth would be positive, which suggests that benchmarks in 2016 would increase relative to their 2015 levels. However, other benchmark and payment adjustments may have a negative effect on plan payments. On average, the Secretary estimates the change in revenue resulting from the policies announced in the Advance Notice will lower average plan payments by 0.95%. However, after accounting for estimated growth in plan risk scores, the Secretary expects average payments to plans to grow 1.05% relative to payments in 2015.[3] The final CY2016 benchmarks are expected to be published on April 6, 2015.

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 how the calculation of the benchmark (or maximum possible payment) has changed with 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 CY2016, 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. The report concludes with answers to a few questions on the CY2016 MA payments.

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

[2] Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2016 Call Letter," February 20, 2015, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2016Advance.html. 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 (CMS), Department of Health and Human Services, "CMS Proposes 2016 Payment and Policy Update for Medicare Health and Drug Plans," press release, February 20, 2015, at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20-3.html.

Determining Payments to Plans

As discussed above, MA plans are paid a per-person monthly amount.[4] 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 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. 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 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 2016 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, depending on the size of 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. So while proposed benchmark changes affect the maximum possible payment from the Centers for Medicare & Medicaid Services (CMS), benchmark changes alone do not determine payments.

Some of the proposed changes for 2016 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

[4] For a more detailed description of the calculation of plan payments, see CRS Report RL30526, *Medicare Payment Updates and Payment Rates.*

[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 2016, a 4-star plan that bid below the benchmark would receive a 5 percentage point quality adjustment to the *ACA-determined portion of its 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*.

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

The next section discusses recent changes to the benchmark calculations—background useful to understand the proposed MA benchmark updates and adjustments.

Benchmark Calculations

Separate benchmarks are calculated for each county. The methodology for calculating the benchmarks is applied consistently across counties. Several factors may affect the level of the benchmark in any particular county, including the practice of medicine in original Medicare and prior legislation designed to expand private plan participation in Medicare.

This section discusses the calculation of the benchmark prior to the ACA, the changes made by the ACA,[8] as well as subsequent administrative action. For benchmarks in certain counties, the methodology in place prior to the ACA will still be relevant to the calculation of benchmarks in 2016.[9]

Prior to the ACA

Prior to the ACA, a county benchmark was 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 was 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).[10]

To project per capita FFS spending in each county, 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 FFS Medicare (also known as growth in fee-for-service United States Per Capita Costs, or FFS USPCC).[11] To determine per capita spending *for each county*, the national estimated level of FFS per capita cost ($780.12 for 2016) then is multiplied by a county-level

[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.*

[9] As discussed in more detail later in this report, counties that have a six-year transition to the ACA benchmark methodology will have a portion of their 2016 benchmark based on the pre-ACA methodology. Data to determine whether a county has a six-year phase-in are available on the CMS website at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2015Rates.html. The data are located in the 2015 Medicare Advantage ratebook and Prescription Drug rate information, in the 2015 Rate Calculation Data (ZIP file), risk2015.csv file. The column to examine is titled "Transition Year."

[10] When the Secretary recalculates per capita fee-for-service (FFS) spending in a county, it is referred to as "rebasing."

[11] The Advance Notice indicated that the projected fee-for-service U.S. per capita costs (FFS USPCC) for 2015 is $768.84 and that the current projected FFS USPCC for 2016 is $780.12. That means that the projected growth in FFS USPCC is equal to 1.47%, or [1.47% = ($780.12 - $768.84) / 768.84 × 100].

geographic index (the average geographic adjustment, or AGA) to determine the relative difference in per capita spending in each county.

In addition, several adjustments are made to the benchmark, which are either specified in statutes or made at the Secretary's discretion, to more accurately reflect estimated spending. 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.

Changes Made by the ACA and Subsequently

The ACA, as amended, changed the benchmark calculation, bringing it closer to or below the value of FFS spending. Under the new calculation, the county benchmarks are set at a percentage of FFS spending in each county. The calculation of per capita FFS spending under the ACA is the same as specified in the section above. The percentage multiplied by per capita FFS spending in each county will be either 95%, 100%, 107.5%, or 115%, with higher percentages applied to counties with the lowest FFS spending.[12] 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. The transition to the new methodology will take place over two, four, or six years, with a longer transition period for counties in which the new methodology would result in larger benchmark decreases. **Table 1** below shows the factors included in the benchmark calculation.

In 2016, counties with a two- or four-year benchmark phase-in have benchmarks entirely determined by the new ACA methodology (shown in the right-hand portion of **Table 1**). Counties with a six-year phase-in are still transitioning from the pre-ACA to the ACA methodology; for those counties, one-sixth of their benchmark is based on the pre-ACA methodology (shown in the left-hand portion of **Table 1**), and five-sixths are based on the ACA methodology in 2016. Twenty-seven percent of counties have a six-year phase-in.

In addition to changing the basic benchmark formula, the ACA also requires benchmarks to be adjusted based on plan quality. Starting in 2012, plans with at least a 4-star rating on a 5-star quality-rating scale are required to receive an increase in their benchmark.[13] In 2012, qualifying plans were to receive a 1.5 percentage point increase in their benchmark according to the ACA; in 2013, the increase was specified at 3.0 percentage points, and starting in 2014, the increase is 5.0 percentage points. This means that in 2012, a plan that might otherwise have had a benchmark of [100% × per capita FFS] could receive a benchmark set at [101.5% × per capita FFS] if the plan has a star quality rating of 4 or more stars. The benchmark quality increases are doubled for qualifying plans in a qualifying county.[14] 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.

[12] The Secretary will occasionally recalculate per capita FFS spending, and 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.

[13] 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 qualified for a benchmark increase.

[14] A *qualifying county* is defined as a county with (1) lower-than-average per capita spending in original Medicare, (2) (continued...)

Table 1. The Two Possible Bases for the 2016 MA Benchmark Calculation

The Pre-ACA Methodology	And/Or Only	The ACA Methodology		
Greatest of ...		**"Blended Benchmark Amount"**		
1. Capitation Rate for the Previous Year Increased by "National MA Growth Percentage" **OR** **2.** Per Capita Fee-for-Service Spending in the County as measured by the "Average Adjusted per Capita Cost" *in years when the Secretary rebases Fee-for-Service Costs*		Product of ...		
		Base Benchmark Amount	**AND**	*Applicable Percentage for the Year Specified*
		which is equal to Per Capita FFS Spending in the County as measured by the "Average Adjusted per Capita Cost"		which is either 95%, 100%, 107.5%, or 115% and subject to a star quality rating adjustment if the plan qualifies

Source: Table created by the Congressional Research Service.

Notes: For counties with a two-year or four-year phase-in to the ACA methodology, their benchmarks are fully phased in to the ACA methodology described on the right side of the figure and only that part of the figure is relevant for the calculation of their benchmark. Counties with a six-year phase-in have benchmarks that use both methods in 2016, so both the pre-ACA methodology and the ACA methodology are used to calculate those benchmarks. The Secretary indicated that 2016 will be a rebasing year. In non-rebasing years, the pre-ACA methodology consists only of an increase in the previous year's benchmark.

From 2012 through 2014, however, the Secretary established a national quality bonus demonstration, thus modifying the quality bonus adjustments specified in the ACA. The purpose of the demonstration was to "test whether providing scaled bonuses to MA organizations with three or more stars will lead to more rapid and larger year-to-year quality improvements in their quality scores, compared to what would have occurred under the current law bonus structure."[15] The demonstration increased the size of the adjustments, expanded the number of plans that qualified for a bonus to include 3 star and 3.5 star plans, and allowed benchmarks with quality bonuses to be higher than the pre-ACA benchmark levels, in addition to other adjustments.[16] The demonstration was estimated to cost more than $8 billion, and it offset a portion of the savings achieved in the ACA.[17] The demonstration ended in 2014.

For 2015, benchmark quality adjustments reverted to those specified by the ACA and the requirement that benchmarks under the ACA be no larger than they would have been prior to the

(...continued)

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).

[15] 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.

[16] U.S. Government Accountability Office, *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Cost and Design Shortcomings*, GAO-12-409R, March 21, 2012, p. 3, at http://www.gao.gov/assets/590/589473.pdf.

[17] The Congressional Budget Office (CBO) estimated the ACA provisions changing MA plan payments (including benchmark changes and other adjustments) would save $135.6 billion over the FY2010-FY2019 period, not taking into account interaction effects. CBO, March 20, 2012, "Letter to Speaker Pelosi providing an estimate of the direct spending and revenue effects of the Patient Protection and Affordable Care Act of 2010 as amended by H.R. 4872, the Reconciliation Act of 2010," at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

ACA was again enforced. As such, the benchmarks for almost half of the counties are constrained by the pre-ACA benchmark caps. 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.

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

The Secretary published the Advance Notice of Methodological Changes for CY2016 capitation rates on February 20, 2015.[18] It 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 under both the pre-ACA and the ACA methodology. For 2016, the value is preliminarily estimated at a **1.47% increase over the FFS USPCC for 2015.**
- The National Per Capita MA Growth Percentage (NPCMAGP): This is a measure of the overall growth in Medicare spending and is used to update the benchmarks under the pre-ACA methodology as described above. For 2016, the value is preliminarily estimated at a **2.68% adjustment to the previous year's benchmark.** This number only applies to a portion of the benchmark calculation in six-year phase-in counties.
- Phaseout of Indirect Medical Education (IME):[19] 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

[18] CMS, Department of Health and Human Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2016 Call Letter," February 20, 2015, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2016Advance.html.

[19] "[Indirect Medical Education] IME payments are designed to support the higher costs of patient care associated with teaching, such as residents' 'learning by doing,' greater use of emerging technologies, and patient severity," Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare*, June 2010, p. 109, at http://www.medpac.gov/chapters/jun10_ch04.pdf.

benchmarks.[20] **This adjustment will affect benchmarks differently depending on the value of IME that is to be phased out, but it will not be greater than 4.2% of the per capita FFS rate in any one county**.

- New Data for FFS Estimates: Estimates of per capita FFS spending are part of the pre-ACA and ACA benchmark methodologies. For 2016, the Secretary will "rebase," or update, the claims data used to calculate the average geographic adjustment (AGA) by dropping the 2008 data from the five-year rolling average calculation and adding one additional year (2013). Thus, for 2016, the AGA will be based on claims data from 2009-2013. **This change may increase benchmarks in some locations, while decreasing them in others.**
- Adjustment to FFS Estimates to Reflect Current Prices: Per capita FFS estimates are calculated using historic expenditure data, which takes into account the prices and quantities of items and services used. For 2014 rates, the Secretary began taking into account current pricing policies for hospital, home health, and physician wage indexes and applying these policies to the historic claims data upon which the FFS estimates are based to better reflect expected expenditures. For 2015, the Secretary also began taking into account changes in pricing associated with the competitive bidding program for durable medical equipment,[21] as well as changes in payments for uncompensated care. The Secretary will continue to reprice historical claims data for 2016. **The adjustment is not expected to change overall MA spending, but it will increase benchmarks in some locations, while decreasing them in others.**
- Secretary's Assumption Regarding the Sustainable Growth Rate (SGR): Prior to 2014, the Secretary had calculated the NPCMAGP and USPCC based on current law at the time final rates were published on the first Monday in April each year. For several years, current law as of the beginning of April included an estimated decrease in payments to physicians under the Medicare SGR formula for the following year, and that assumption was incorporated into the calculation of the NPCMAGP and the USPCC. In 2014, the Secretary changed her assumption[22] and instead assumed that Congress, as it had done in several prior years, would act to prevent the reduction in physician payments. This assumption resulted in an increase in the 2014 estimates of growth, relative to those published in the Advance Notice 2014. The increase was a single occurrence that took place only in 2014—the first year the Secretary made the assumption. For 2016, the Secretary will continue to assume that Congress will act to prevent a decrease in physician payments. **This assumption will have no effect on 2016 benchmarks.**
- Updated Estimate for the Department of Veterans Affairs (VA)-Department of Defense (DOD) Adjustment to FFS Costs: The Secretary is required to adjust per

[20] The phaseout of IME from MA benchmarks began in in 2010. The effect of the phaseout 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 phaseout was complete in a single year. For areas where IME makes up a larger percentage of original Medicare spending in the county, the IME phaseout still will be taking place in 2016. The maximum reduction for any specific county in 2016 is 4.2% of the per capita FFS rate, as indicated in the Advance Notice.

[21] See CRS Report R43123, *Medicare Durable Medical Equipment: The Competitive Bidding Program.*

[22] For further information, see CRS General Distribution Memo, "Legal Issues Related to the Secretary's Authority to Set Payment Rates Under the Medicare Advantage Program," March 26, 2013, available upon request.

capita FFS spending estimates used for the benchmark calculation by the amount of additional payments that would have been made in an area if Medicare beneficiaries had not received services from DOD or VA facilities. The Secretary previously had found that Medicare beneficiaries eligible to receive care through VA or DOD facilities did not significantly reduce Medicare spending but that beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP, a Tricare option available to selected military retirees), did significantly reduce Medicare spending in certain areas. Since CY2012, CMS has adjusted FFS to account for USFHP membership. The Secretary proposes to update the DOD adjustment with more recent claims data for Medicare-DOD dual enrollees. **This update would affect benchmarks in 5.5% of counties by an average increase of $1.16 (ranging from a decrease of $0.08 per month to an increase of $20.74).**

- Star Rating Adjustment: MA benchmarks and rebates are adjusted based on plan quality, as measured by a 5-star quality-rating system.[23] The star rating system takes into account nearly 50 different measures of quality pertaining to health screenings and assessments, chronic condition management, beneficiary experience, and customer service. The measures are 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. MA plans that enroll high percentages of Medicaid-Medicare dual-eligible beneficiaries or beneficiaries eligible for the Low-Income Subsidy (LIS) under the Part D drug program have suggested that having a large number of these beneficiaries disadvantages the plans with respect to their star ratings. The Secretary undertook analyses of the quality measures and found that a subset of measures showed differential performance for dual-eligible and LIS beneficiaries. The Secretary proposes to reduce the weights for those quality measures for 2016 and continue to study the causes of the differential effects. **This proposal could potentially increase star ratings (and possibly the quality benchmark adjustment) for certain plans.**

Regarding Proposed Updates and Changes to Risk Adjustment

- Clinically Revised CMS-Hierarchical Condition Categories (HCC) Risk-Adjustment Model: Payments to plans are risk adjusted to account for the demographics and health histories of the beneficiaries who enroll in the plans. The risk-adjustment model is called the CMS-HCC. It takes into account the severity of a beneficiary's illness, the accumulated effect of multiple diseases, and interactive effects—instances in which having two or more specified diseases or characteristics results in expected health care expenditures that are larger than the simple sum of the effects. The health history data is based on diagnosis codes,[24] which are grouped into related diagnoses and further grouped into conditions categories with similar clinical characteristics and expected costs. For

[23] See http://cdn5.medicarehelp.org/wp-content/uploads/2014/10/2015_Tech_Notes_2014_10_03.pdf.

[24] The diagnosis codes used to build the CMS-Hierarchical Condition Categories (HCC) model are the International Classification of Disease, Ninth Revision, codes, which denote signs, symptoms, injuries, diseases, and conditions of beneficiaries in original Medicare. The risk adjustment to the plan payment is based on diagnosis codes collected by each enrollee's own doctors and submitted to the plan, which then submits them to CMS.

2014, the Secretary updated the CMS-HCC model, taking into account more recent data and a clinical revision of the diagnoses included in each HCC.[25] Certain condition categories were added, some were deleted, and the diagnoses assigned to some HCCs were changed. For 2014 and 2015, the Secretary used a blend of the updated model and the previous model to risk adjust payments. The Secretary is proposing to use only the clinically updated model to risk adjust payments in 2016. **This change is expected to decrease risk scores used to adjust plan payments.**

- 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 than providers in original Medicare, some of whom are paid not by diagnosis but by the unit of work.[26] The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) required the 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 2016, the coding intensity adjustment is estimated to be a -5.41% adjustment (the statutory minimum) applied to MA enrollee risk scores, which are used to risk adjust plan payments.**
- 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 it normalized to 1.165, or

[25] For a detailed description of the update to the CMS-HCC model, see the Advance Notice and Rate Announcements for CY2014, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

[26] For more information about how physicians are paid under Medicare, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System.*

[1.2 / 1.03 = 1.165], which is a lower risk score. In 2015, the Secretary adopted a new method for calculating the normalization factor that better accounted for the less expensive "baby boomers" entering the program. This new method resulted in a normalization factor that was less than 1.0 for 2015, which increased, rather than decreased, the normalized risk scores for 2015. The Secretary proposes to continue using the new normalization calculation for 2016. The normalization factor in the Advance Notice for 2016 is 0.992.[27] A beneficiary with a risk score of 1.2, for example, would have a normalized risk score for 2016 of 1.210, or [1.2 / 0.992 = 1.210], which is a higher risk score. **This proposal is expected to increase risk scores, which are multiplied by plan payments.**

- Encounter Data Used for Risk Adjustment: MA payments to plans are risk adjusted to reflect the actual demographic and health history of beneficiaries who enroll in the plan. The demographic data comes from administrative records, whereas the health history data (i.e., diagnoses) are collected by plans and submitted to CMS through the Risk Adjustment Processing System (RAPS). Beginning in 2012, CMS started collecting encounter data—data that included not only diagnoses but also the actual services performed by physicians or in a hospital setting, as well as the medical equipment used by beneficiaries in their homes and other information.[28] The encounter data includes more information from more sources of care than the data collected in the RAPS system. For 2016, the Secretary proposes to calculate beneficiary risk scores, in part, based on encounter data. **This adjustment may affect plans differently depending on the risk scores calculated from the encounter data for their enrollees.**

Discussion

Are the Benchmark Decreases in the Advance Notice in Addition to the Benchmark Reductions in the ACA, or a Result of the ACA?

Most of the adjustments to the benchmark described in the Advance Notice are not in addition to the ACA changes, but are the result of changes specified in the ACA and prior legislation. The Congressional Budget Office (CBO) estimated the provisions changing MA plan payments would save $135.6 billion over the FY2010-FY2019 period, not taking into account interaction effects.[29]

[27] There are multiple CMS-HCC risk-adjustment models for specific populations, such as beneficiaries who receive End-Stage Renal Disease (ESRD) dialysis, or beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE) plan. Each CMS-HCC model has a different normalization factor. Most beneficiaries have their payments risk adjusted by the CMS-HCC model (V22), which has a predicted normalization factor of 0.992 and will result in higher risk scores. Other models have normalization factors that will result in decreased risk scores.

[28] See, 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.

[29] Because the ACA provisions more strongly connect the calculation of MA benchmarks with FFS Medicare spending, the ACA provisions affecting FFS Medicare spending also are expected to affect MA spending. CBO estimated the interaction effects of other provisions with MA as saving an additional $70.3 billion over the FY2010-FY2019 period. CBO, March 20, 2012, "Letter to Speaker Pelosi providing an estimate of the direct spending and revenue effects of the Patient Protection and Affordable Care Act of 2010 as amended by H.R. 4872, the Reconciliation Act of 2010," at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

The 2016 benchmark decreases are reflected in the CBO savings estimate. Other adjustments in the announcement, such as the reduction in IME, are changes that were specified in legislation enacted prior to the ACA.

Other adjustments are not explicitly required in the ACA or prior legislation. Although the ACA made broad adjustments to the benchmark calculation, the Secretary, for example, has since prior to the ACA been afforded discretion in making "risk adjustments" to the MA reimbursement payment for risk factors such as "age, disability status, gender, institutional status" or "such other factors ... the Secretary determines to be appropriate."[30] In other words, the ultimate calculation of the reimbursement rate will be, in part, a product of the Secretary's discretion that is afforded under the Social Security Act.

How Would These Changes Affect My Congressional District?

The final benchmarks for 2016 will be published on April 6, 2015. 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 measures of growth (NPCMAGP and FFS USPCC), as well as some of the other adjustments, are likely to change in the Final Announcement. But more to the point, some of the adjustments proposed in the Advance Notice are expected to be budget-neutral overall but will change the relative amounts of the benchmarks in different areas. In other words, it would not be informative to simply multiply the 2015 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 depends on the star quality ratings of the plans serving a district, which can change from year to year, and on plans' diagnosis coding practices, which are not publicly available.

Are the 2016 Benchmarks Subject to the Same Caps as the 2015 Benchmarks?

The ACA provision limiting the benchmark amounts (including any quality-bonus adjustment) to the benchmark amounts that would have been in place in the absence of the ACA is in effect for 2016. In the absence of the ACA, the MA benchmarks would have increased by either the NPCMAGP (estimated at 2.68% for 2016) or set at the level of per capita FFS spending, if that amount was larger (given that 2016 will be a rebasing year). So, while there is still a benchmark cap for 2016, it may be a larger cap than in 2015, given the estimated growth in the pre-ACA benchmarks.

[30] Section 1853(a)(1)(C) of the Social Security Act.

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