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Medicare Advantage (MA)–Proposed Benchmark Update and Other Adjustments for CY2020: In Brief

Updated February 7, 2019

Congressional Research Service
https://crsreports.congress.gov
R45494

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 how 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 annually by a measure of Medicare spending growth and by other adjustments. The Secretary of the Department of Health and Human Services (Secretary) published the Advance Notice of Methodological Changes for Calendar Year 2020 (Advance Notice) MA capitation rates on January 30, 2019,[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 change in revenue resulting from the proposed policies would increase plan payments by 1.59% before accounting for risk score coding trends. After accounting for estimated growth in plan risk scores, the Secretary expects average plan payments to grow 4.89% relative to payments in 2019.[3] The final CY2020 benchmarks are expected to be published on April 1, 2019.

This report provides 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), most recently amended by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and related administrative action. It also describes risk adjustment. The report then summarizes some of the provisions in the Advance Notice that would adjust the benchmarks, modify the risk adjustment model, or make other changes, some of which are specified statutorily and some of which are at the Secretary's discretion.

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 (HHS), "Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2020 Draft Call Letter," January 30, 2019, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2020Advance.html. Although the notice covers many topics, this report summarizes only selected parts of the Advance Notice that address capitation rates for MA plans, as well as proposals included in "The Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) CMS-HCC Risk Adjustment Model" published December 20, 2018, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part1.pdf.

[3] CMS, HHS, "2020 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter," fact sheet, January 30, 2019, at https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-advance-notice-part-ii-and-draft-call-letter.

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, the plan's 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 depends 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; 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.

The majority of proposed changes for CY2020 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 indirectly affect 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. However, if a plan bid below the benchmark in each year, the plan payment (the bid plus the rebate) most likely would be reduced but 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 increased from one year to the next and the plan bid below the benchmark, in most cases the plan payment also would increase and would decrease only if a plan bid substantially less in the second year. So although 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 2020 refer to changes in risk adjustment. After the plan payment is determined through 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 (because the risk-adjustment factor is multiplied by the non-risk-adjusted payment) but are not adjustments to the benchmarks.

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[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] 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 2020, 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 the 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 its 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 Part 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.

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,[7] as well as administrative action affecting benchmarks.

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, the Secretary first calculates historic spending data from original Medicare claims files and estimates a trend to determine the *growth* (or the percentage 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 2020 is estimated to equal 4.52%. This figure is calculated as the percentage increase between the prior projected national FFS USPCC of $891.07 in 2019 and the current projected FFS USPCC of $931.38 in 2020, or [4.52% = ($931.38 - $891.07) / $891.07 × 100].

To determine per capita spending *for each county*, the national estimated level of FFS per capita cost ($931.38 for 2020) 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 five-year rolling average of claims data for beneficiaries in original Medicare 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 capita FFS estimates of spending for each county for the benchmark calculation. First, FFS estimates for each county are multiplied by a percentage specified in statutes—95%, 100%, 107.5%, or 115%—with higher percentages applied to counties with the lowest FFS spending.[8] In other words, the 25% of counties with the lowest FFS

[7] For a detailed description of the MA changes included in the ACA, 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. 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. In addition, county benchmarks affected by the cap discussed in this report are constrained to a benchmark using the pre-ACA methodology. 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.

[8] The Secretary will occasionally recalculate (or *rebase*) county-level per capita FFS spending. When this happens, a county could transition from 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

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.[9] 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 2020, a plan receiving 4, 4.5, or 5 stars on a 5-star quality-rating system may receive a 5 percentage point increase in its benchmark. This means that in 2020, 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.[11] 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 2018, in half of U.S. counties, the MA benchmark adjusted by a 5 percentage point quality bonus is constrained by the pre-ACA benchmark cap. In some cases, this means the quality bonus for plans with 4 or more stars 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,[12] and the Secretary indicated in the Advance Notice that the provision will continue to be in effect for 2020.

Risk Adjustment

Medicare Advantage payments are risk adjusted to compensate plans for the relatively higher medical costs associated with enrollees who are older or sicker and the relatively lower medical costs associated with enrollees who are younger or relatively healthy. The size of the payment adjustment is based on a mathematical model that predicts the relative effect of specified diagnosis groupings and demographic factors on subsequent health care spending.[13] Several different risk adjustment models have been used under MA, with each successive model increasing in complexity and explanatory power. The current model is hierarchical (taking into account more significant manifestations of diseases), additive (summing effects across unrelated disease states), and interactive (accounting for situations where having two specific diseases

transition to being a 95% of FFS spending county.

[9] See CMS, "Part C and D Performance Data," at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[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 qualify for a 3.5 percentage point benchmark increase. MA benchmarks, including any quality bonus adjustment to the benchmarks, are subject to the benchmark cap.

[11] 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. Benchmarks adjusted by qualifying county bonus adjustments are subject to the benchmark cap.

[12] Social Security Act §1853(n)(4).

[13] For more detail, see Gregory C. Pope et al., *Evaluation of the CMS-HCC Risk Adjustment Model*, RTI International, Final Report, March 2011, at https://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf.

results in healthcare expenditures that are greater than their sum). This model is referred to as the CMS Hierarchical Condition Category (CMS-HCC) model.

Most recently, the 21st Century Cures Act (P.L. 114-255) requires the Secretary, in part, (1) to *evaluate* the impact of adding additional diagnosis codes to the CMS-HCC model related to mental health, substance use disorders, and chronic kidney disease severity and (2) to *take into account* the number of diseases or conditions of an individual enrolled in the plan as variables in the model. These provisions are to be phased in over a three-year period beginning in 2019.[14] For 2019, the Secretary added factors for mental health, substance use disorders, and chronic kidney disease severity, referred to in P.L. 114-255. However, the Secretary proposed an update to the CMS-HCC model that included counts of conditions already included in the model but delayed finalizing the addition of condition count variables to allow more time for plans to analyze the effects.

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

The Advance Notice for 2020 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 and those that pertain to risk-adjustment.

Regarding Proposed Benchmark Updates and Changes

- Growth in the Fee-for-Service United States Per Capita Cost (FFS USPCC): The FFS USPCC 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 2020, the value is preliminarily estimated at a **4.52% increase over the FFS USPCC for 2019.**
- National Per Capita MA Growth Percentage (NPCMAGP): The NPCMAGP 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.[15] It also applies to pre-ACA benchmarks, which are the caps for MA benchmarks. For 2020, the value is preliminarily estimated at a **4.84% adjustment to the previous year's (pre-ACA) benchmark.**
- Phaseout of Indirect Medical Education (IME):[16] Prior to 2008, the value of IME payments to hospitals was included in the calculation of the MA benchmarks.

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

[15] 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 CMS, "Chapter 1: Introduction to Pace" in *Programs of All-Inclusive Care for the Elderly (PACE)*, June 9, 2011, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf.

[16] Medicare indirect medical education (IME) payments support the indirect costs associated with residency programs,

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 (P.L. 110-275) required the Secretary to phase out the value of IME from the MA benchmarks.[17] **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 6.6% of the per capita FFS rate in a county.**

- New Data for FFS Estimates: Estimates of county per capita FFS spending are part of the benchmark calculation. For 2020, the Secretary will rebase, or update, the claims data used to calculate the average geographic adjustment (AGA) by dropping the 2012 data from the five-year rolling average calculation and adding one additional year (2017). Thus, for 2020, the AGA will be based on claims data from 2013 to 2017. **This change may increase benchmarks in some counties and decrease 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 expanded to include 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 price changes associated with competitive bidding; and shared savings payments and losses (or other methods of payment) under specified Center for Medicare & Medicaid Innovation models and demonstrations. For 2020, the Secretary is proposing to include physician fee schedule bonuses for physicians working in Health Professional Shortage Areas (HPSAs). These bonuses are not otherwise reflected in the claims files used to calculate the FFS USPCC, but represent Medicare spending within HPSAs. **The adjustment is expected to increase benchmarks in some counties and decrease them in others**.
- 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

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*, and CRS In Focus IF10960, *Medicare Graduate Medical Education Payments: An Overview*.

[17] 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 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 2020. The maximum reduction for any specific county in 2020 is 6.6% of the per capita FFS rate, as indicated in the Advance Notice.

Waiver Plans, or EGWPs.[18] Research found that EGWPs consistently bid higher than MA plans open to all Medicare beneficiaries.[19] According to the Medicare Payment Advisory Commission (MedPAC), "[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."[20] The opposite may be true for non-EGWPs, which would have an incentive to bid below the benchmark and obtain a rebate that could be used for extra benefits or reduced cost sharing to attract enrollees.

Starting in 2017, the Secretary waived the requirement that EGWPs submit plan bids to establish their payment and instead established an alternative payment calculation based on the bids of non-EGWPs. The phase-in of that methodology was completed in 2019. An EGWP *base* payment for 2019 is calculated as an enrollment weighted average bid-to-benchmark ratio for non-EGWPs in the prior year (2018), further weighted by plan-type enrollment,[21] for each quartile, multiplied by the benchmark based on the EGWP's quality. A *rebate* is calculated by comparing the base payment to the county or service area benchmark related to that EGWP's quality and applying the proper rebate percentage. The EGWP payment is the sum of the base and the rebate; however, the EGWP is not provided with information about the proportion of the payment that is base versus rebate. In part because the payment receive by the EGWP does not distinguish between base and rebate, EGWPs were not allowed to buy down the Medicare Part B premium as a supplemental benefit in 2019.

For 2020, the Secretary recommends using the 2019 methodology. However, the Secretary recommends allowing EGWPs to use a portion of their payment to buy down enrollee Part B premiums (even though EGWP payment does not distinguish between the base and the rebate.) **The proposal is not expected to change payments to EGWPs but would allow them to offer a supplemental benefit that is currently available non-EGWP plans.**

- Star Quality Rating Update: MA benchmarks and rebates are adjusted based on plan quality, as measured by a 5-star quality-rating system. The star rating system for 2019 takes into account up to 48 different measures of quality, which are evaluated and updated annually 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 afforded to measures of beneficiary experience and access, and process.

  Similar to a policy implemented for 2019 and included in proposed rulemaking, the Secretary proposes to adjust 2020 star ratings in the event of extreme and

[18] Social Security Act §1857(i).

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

[20] Ibid.

[21] Calculations are done separately for local health maintenance organization (HMO) versus local and regional preferred provider organizations (PPO) then summed. Research by MedPAC shows that, on average, HMO-type MA plans tend to bid lower relative to FFS than PPO-type MA plans.

uncontrollable circumstances, such as major hurricanes. To qualify, an MA contract would have to meet specific criteria related to the service area, the timing of the disaster, the proportion of the contract within the affected area, as well as whether specified disaster declarations and designations apply. In addition, the Secretary is proposing removal of several quality measures for low statistical reliability or changes in clinical guidelines. **The proposals (or adjustments) may result in higher or lower star ratings for particular plans but are expected to result in an overall reduction of payments of 0.14%.**

Regarding Proposed Updates and Changes to Risk Adjustment

- Coding Intensity Adjustment: In general, MA plan payments are risk adjusted to account for 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 affected by enrollee diagnoses, 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 (P.L. 109-171) required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under Medicare Parts A and B 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 2020, the coding intensity adjustment is estimated to be a reduction of 5.90% (the statutory minimum) applied to MA enrollee risk scores, which are used to risk adjust plan payments. This adjustment is the same amount as the one applied in 2019.**
- Proposed Risk Adjustment Model Update: As required by law, the Secretary is proposing to implement an update to the risk adjustment model that includes a set of variables that count the number of diseases an enrollee has, in addition to the 83 disease/condition variables already in the model. The Secretary also presents for discussion an alternative model that includes three additional condition categories (dementia with complications, dementia without complications, and pressure ulcers of skin with partial thickness skin loss.) For 2020, the Secretary is proposing to phase in the new Payment Condition Count (PCC CMS-HCC) model by 50%, while 50% of the risk adjustment would be based on the risk score calculated with the prior (2017) CMS-HCC model. **This proposal may increase or decrease the risk scores of individual plans but is expected to increase plan payments by 0.28% relative to 2019.**
- Risk Model Normalization: As discussed above, 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.

CMS has used different models to determine the normalization factor. Prior to 2015 and since 2018, CMS has used a linear (straight-line) model with five years of FFS data to determine the normalization factor; this method typically resembled a general inflation in risk scores. The Secretary proposes to continue using this methodology for 2020. Consistent with the proposal to phase in the PCC CMS-HCC model (discussed above), CMS proposes to calculate a separate normalization score for each of the two models. The proposal results in larger normalization factors relative to 2019, with a proposed normalization factor of 1.075 to be used with the risk score calculated with the 2017 CMS-HCC model and a proposed factor of 1.069 to be used with the risk score calculated with the PCC CMS-HCC model. **This proposal is expected to decrease risk scores, which are multiplied by plan payments. Overall, this proposal is expected to reduce plan payments by 3.08%.**

- Encounter Data Used for Risk Adjustment: The demographic data used in risk adjustment 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 to collect 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.[22] 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 2019, the Secretary calculated beneficiary risk scores, in part, based on encounter data. Specifically, 25% of the risk score was based on encounter data, FFS diagnoses for enrollees who recently enrolled in MA from Original Medicare, and inpatient diagnoses collected through RAPs,[23] and the remaining 75% of an enrollee's risk

[22] A 2014 GAO report recommended that CMS validate the completeness and accuracy of the encounter data. A 2017 update found that CMS had made limited progress in implementing GAO's previous recommendations. GAO, *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 GAO, *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. In the rate announcement for CY2019, CMS indicated that in the last few years it has taken steps to assess and improve the encounter data submission process and the integrity of the encounter data. See CMS, HHS, *Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 2, 2018, p. 55, at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.

[23] CMS observed in the CY2019 Announcement that inpatient diagnosis data from the EDS are low relative to the

score was based on data collected through RAPS and FFS diagnoses. In 2020, the Secretary is recommending increasing the proportion of the risk score based on encounter data. Specifically, the Secretary recommends calculating 50% of risk scores based on encounter data, FFS claims, and RAPs inpatient records (to be used with the PCC CMS-HCC model), and 50% based on RAPs records and FFS claims (to be used with the 2017 CMS-HCC model). **This adjustment may affect plans differently depending on the risk scores calculated from the encounter data for their enrollees. Overall, this proposal is expected to reduce plan payments by 0.06%.**

Discussion: How Would These Changes Affect a Specific Congressional District?

The final benchmarks for 2020 are expected to be published on April 1, 2019. CMS does not provide estimated benchmarks with the Advance Notice. It would be 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. More to the point, some of the 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 multiply the 2019 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 Information

Paulette C. Morgan
Specialist in Health Care Financing

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corresponding data provided through the RAPS. Thus, CMS is supplementing the inpatient diagnosis data from the EDS, with data from RAPS. CMS, HHS, "Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," p. 55, April 2, 2018.

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