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Highlights of the 2015 CMS Advance Notice and Call Letter: An Oliver Wyman Client Briefing

In late February, CMS released the Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies, and 2015 Call Letter. (The full document can be found here.) The notice outlines planned changes to the capitation rate and risk adjustment methodology for Part C plans, payment and benefit changes for Part D plans, and preliminary estimates of national per capita Medicare Advantage growth for 2015. Given the overall importance of MA, we would like to highlight the most significant of the proposed changes and their potential implications for health plans.

Changes to the Payment Methodology

MA Benchmark Reductions: In 2015 the majority of counties will be covered by the new rate methodology created by the Affordable Care Act (ACA), with reimbursement calculated as a set percentage of fee-for-service (FFS) cost. Other counties will continue to use a rate that blends the MA benchmark and a set percentage of FFS cost. County FFS rates will be rebased in 2015, influencing the amount used to calculate the MA benchmark. Our actuaries estimate that moving to the new rate methodology will reduce MA payment benchmarks by an average 2.4 percent across the entire country.

Changes Related to Risk Adjustment: The ACA increased the 2014 coding intensity adjustment to a minimum of 4.91 percent, and 2015 will see payments reduced by an additional 0.25 percent. The reduction is balanced by a change in the methodology for calculating the risk adjustment normalization factor, resulting in a 3.2 percent increase in the impact of risk scores on reimbursement.

Ratebook Changes: The 2015 national per capita Medicare Advantage growth percentage (NPCMAGP) is estimated at -3.55 percent and the 2015 FFS United States per capita cost growth (USPCC) percentage is estimated at -1.65 percent. The NPCMAGP is based in part on CMS's estimate that underlying per capita costs will shrink by 0.7 percent in 2015. The preliminary growth estimate assumes that Congress will enact the "doc fix," preventing a cumulative 20.9 percent reduction in Medicare physician payment rates from taking effect in 2015. Oliver Wyman actuaries estimate that the combined preliminary NPCMAGP and the FFS USPCC growth percentage will reduce MA payments by 1.9 percent.

Implications for MA plans: There appears to be consensus that MA reimbursement cuts will continue in 2015, with estimates ranging from 3 percent to 6 percent. (Detailed estimates can be found here—subscription required.) Oliver Wyman's actuarial models predict an overall reduction of 5.9 percent. This is a similar cut to what plans endured in 2014, and is a meaningful loss of revenue. Ability to weather the cuts will vary, but we expect most plans to look to increased risk coding (to drive reimbursement) in the near term while continuing to build value-based provider partnerships to reduce underlying cost of care in the long term.

Changes to Quality Bonus Payments

The initial Star Ratings demonstration ends on December 31, 2014. In 2015 only plans that received a Star Rating of four or better will receive a 5 percent bonus payment. CMS does not propose to extend the demonstration (which paid a smaller bonus to three-star plans), and provided no additional guidance on the program structure for 2016.

Implications for MA plans: Plans on the cusp of a four-Star Rating should focus on improving their score, because the requirements to reach the four-star threshold are greater each year. Plans that fail to reach the four-star level will lose revenue— tens to hundreds of millions of dollars for large Blues and nationals). In addition, plans that do not receive the 5 percent bonus payment will likely be forced to reduce benefits and raise premiums to make up for the lost revenue, placing them at a disadvantage compared with plans that receive the 2015 bonus payment.

Changes to Risk Adjustment

The major proposed change in risk adjustment is to exclude, for payment purposes, diagnoses identified during assessments conducted through a home visit unless confirmed by a subsequent clinical encounter. As indicated in the 2014 Advance Notice, CMS is concerned that plans are using risk assessments solely for purposes of risk coding and not providing appropriate follow-up care to beneficiaries. Specifically, the fact that a beneficiary's PCP does not consistently receive this information and use it to inform care causes CMS to view the significant increase in the prevalence of risk assessments as a tool to drive higher risk scores and creates coding pattern differences between MA and FFS.

Implications for MA plans: This change will have significant impact on health plans if implemented as outlined. Most plans that actively manage risk adjustment have robust programs to perform home risk assessments, allowing them to fill gaps in diagnosis and coding—and address gaps in care. But often the connection back to the PCP is at best a formality. CMS has yet to define "subsequent clinical encounter", but it appears that the agency wants health plans to strengthen their relationships with providers, increase the level of data sharing, and build new procedures, with a goal of having more risk assessments occur in a clinical setting and encouraging a follow-up visit to the doctor when risk factors are found.

Risk adjustment vendors, which increasingly focus on in-home risk assessments, could also be significantly affected. To preserve revenue, vendors must build greater data connectivity and information sharing to facilitate the "subsequent clinical encounter" validation. Vendors could also expand their services to include in-office risk assessment for larger systems and practices. If this proposal is enacted, vendor consolidation will likely also accelerate.

For additional information, contact our Government Programs team:

Jim Fields
jim.fields@oliverwyman.com

Martin B. Graf
martin.graf@oliverwyman.com

Melinda Durr
melinda.durr@oliverwyman.com

Glenn Giese
glenn.giese@oliverwyman.com

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