



For Immediate Release
March 9, 2009

Contact: Erin Shields
(202) 224-4515

BAUCUS APPLAUDS CMS CHANGES TO MEDICARE ADVANTAGE PAYMENTS

CMS changes implement law to make payments more accurate, equitable to traditional Medicare

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) is applauding changes made by the Center for Medicare and Medicaid Services (CMS) that will make the payments in the Medicare Advantage (MA) program more accurate and equitable to traditional Medicare. In a letter sent on Friday to Acting CMS Administrator Charlene Frizzera, Baucus expressed support for the CMS plan to take into account issues of “up-coding,” or over-diagnosis of patients, when making payments to MA plans. Currently, MA plans are highly motivated to review patient files and identify and “code” diseases that patients may have. Each new disease this “up-coding” identifies, whether it is treated or not, can increase the Medicare payment the MA plan receives. The CMS changes will eliminate many of the monetary incentives MA plans currently have to “up-code” patients. These incentives currently increase payments to MA plans even beyond the existing 14 percent excess compared to traditional Medicare. The CMS changes would also ensure that the agency implements MA payments in a way that is consistent with traditional Medicare, promoting equity and accuracy within the program.

“During these tough financial times, we need to make sure that we are not wasting taxpayer dollars by allowing the Medicare Advantage system to run inefficiently,” said Baucus.

“Medicare Advantage payments should be more accurate and equitable to traditional Medicare and that is the goal of these important changes. These changes will preserve federal health care dollars, which are vital to maintaining the financial integrity of the Medicare program.”

These changes were originally required by law to begin in 2007, but were postponed by CMS until now. CMS has announced these changes for calculating MA service rates in 2010. The full text of Baucus’s letter follows here.

--more--

March 6, 2009

Ms. Charlene Frizzera
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Frizzera:

I am writing regarding the "Advance Notice of Methodological Changes for Calendar Year 2010 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies," published by the Centers for Medicare & Medicaid Services (CMS) on February 20, 2009.

In accordance with Section 1853(k)(2)(B)(iv)(III) of the Social Security Act, the Advance Notice proposes to adjust payments to Medicare Advantage plans (MA) in order to account for the differences in patterns of coding health risk between the MA and fee-for-service (FFS) programs. This proposal will improve the accuracy of MA payments in 2010. It signals a long overdue commitment to follow the Medicare statute and manage the MA program as Congress intended.

The statutory requirement to make accurate payments to private plans in Medicare is not new. The Balanced Budget Act of 1997 instructed CMS to develop a risk adjustment system for Medicare+Choice, as it was then known, in order to ensure that payments accurately take into account the health status of plan enrollees. In 2000, CMS began a lengthy phase-in of the new risk adjustment system that is still underway. In addition, CMS first implemented these risk adjusted payments in a budget neutral manner, which increased overall payments to the plans and was contrary to Congressional intent.

The Deficit Reduction Act of 2005 (DRA) required CMS to make risk adjusted payments on a non-budget neutral basis. The DRA also required CMS to study differences in coding health status between the fee-for-service program and MA and established the requirement to adjust those coding differences in the 2007 through 2010 payment years. However, CMS made no adjustments for coding differences from 2007 to 2009, even though their own studies showed that differences existed.

--more--

Differences in health risk coding can arise because MA plans are highly motivated to identify and code diseases in their enrolled populations. With each new disease identified, whether it is treated or not, the Medicare payment to a plan can increase. Physicians in FFS are not encouraged to code as intensely, so MA plan risk scores can increase at a greater rate than FFS risk scores, making MA enrollees look less healthy and more costly without any change in their actual health status. Hence, upcoding has no bearing on the clinical outcomes or cost of care for MA enrollees. It is a mechanism by which MA plans can maximize reimbursement from the government beyond what they would otherwise receive under the law.

CMS' proposal to adjust for coding differences across MA plans is also consistent with payment policy in FFS Medicare, as those providers in have been subject to adjustments due to changes in coding patterns for many years. CMS has proposed or implemented across-the-board adjustments for hospitals, home health agencies, skilled nursing facilities, and others in past years to account for historical or projected coding changes that are not attributable to a change in actual case mix. Medicare Advantage plans should not be exempt from such statutory adjustments.

Finally, I strongly encourage CMS to release through the Advance Notice all relevant information concerning proposed MA payment adjustments, such as the coding intensity adjustment for 2010. Proposed changes should be fully explained and transparent to the public to the same extent that they are for the FFS program through regulation.

I commend CMS for its effort to more thoroughly follow the law in making MA payments more accurate. Medicare beneficiaries and American taxpayers deserve no less. I look forward to working with you to continue improving the Medicare program.

Sincerely,



Max Baucus

Cc: Jonathan Blum, HHS

###