



April 2016

MEDICARE ADVANTAGE

Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans

Accessible Version

GAO Highlights

Highlights of [GAO-16-137](#), a report to congressional requesters

Why GAO Did This Study

Veterans enrolled in Medicare can also enroll in the VA health care system and may receive Medicare-covered services from either their Medicare source of coverage or VA. Payments to MA plans are based in part on Medicare FFS spending and may be lower than they otherwise would be if veterans enrolled in Medicare FFS receive some of their services from VA. Because this could result in payments that are too low for some MA plans, CMS is required to adjust payments to MA plans to account for VA spending, as appropriate. CMS determined an adjustment was needed for 2017, but not for 2010 through 2016.

GAO was asked to examine how VA's provision of Medicare-covered services to Medicare beneficiaries affects payments to MA plans. GAO (1) estimated VA spending on Medicare-covered services and how VA spending affects payments to MA plans and (2) evaluated whether CMS has the data it needs to adjust payments to MA plans, as appropriate. GAO used CMS and VA data to develop an estimate of VA spending on Medicare-covered services. GAO reviewed CMS documentation and interviewed CMS and VA officials.

What GAO Recommends

CMS should (1) assess the feasibility of revising its methodology for determining if an adjustment to the benchmark is needed by obtaining diagnoses and utilization data from VA and (2) make any additional adjustments to MA plan payments as appropriate. HHS disagreed with the first recommendation, but agreed with the second. GAO maintains that VA data may improve CMS's analysis.

View [GAO-16-137](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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What GAO Found

In fiscal year 2010, the Department of Veterans Affairs (VA) health care system provided \$2.4 billion in inpatient and outpatient services to the 833,684 veterans enrolled in Medicare Advantage (MA), a private plan alternative to Medicare fee-for-service (FFS). While the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), generally pays Medicare FFS providers separately for each service provided, MA plans receive a monthly payment from CMS to provide all services covered under Medicare FFS. These monthly payments are based in part on a bidding target, known as a benchmark, and risk scores, which are used to adjust the payment amount to account for beneficiary demographic characteristics and health conditions. Both the benchmark and risk scores are calibrated based on Medicare FFS spending. Therefore, VA's provision of Medicare-covered services to veterans enrolled in Medicare FFS likely resulted in lower Medicare FFS spending and, in turn, lower overall payments to MA plans. However, the extent to which these payments reflect the expected utilization of services by the MA population remains uncertain. Specifically, payment amounts may still be too high or could even be too low, depending on the utilization of VA services by veterans enrolled in MA plans and veterans enrolled in Medicare FFS. If, for example, veterans enrolled in MA receive a greater proportion of their services from VA relative to veterans enrolled in Medicare FFS, then the benchmark may be too high. Conversely, payments may be too low if MA-enrolled veterans tended to receive fewer Medicare-covered services from VA relative to veterans enrolled in Medicare FFS. Assessing these possible differences would require data on the services veterans receive from MA. CMS began collecting these data in 2012 but, as of August 2015, had yet to take all the steps necessary to validate the accuracy of the data, as GAO has previously recommended.

CMS also lacks data on VA diagnoses and utilization that may improve its methodology for determining if an adjustment to the benchmark is needed to account for VA's provision of Medicare-covered services to veterans enrolled in Medicare FFS. Federal standards for internal control call for management to have the operational data it needs to meet agency goals to effectively and efficiently use resources and to help ensure compliance with laws and regulations. While CMS determined that no adjustment was necessary for 2010 through 2016 based on a 2009 study it performed, CMS's methodology did not account for services provided by and diagnoses made by VA, which can only be identified using VA's data. CMS officials updated the agency's study in 2016 using the same methodology, but with more recent data. CMS officials told GAO that they did not plan to incorporate VA utilization and diagnoses data into their analysis because (1) they do not currently have such data and (2) incorporating these data would introduce additional uncertainty into the analysis. However, if an adjustment is needed but not made or if an adjustment is too low due to limitations with CMS's methodology, it could result in some plans being paid too much and others too little. If CMS does revise its methodology and determines that an adjustment to the benchmark is necessary, it may need to make additional adjustments to MA plan payments, as discussed in this report.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DOD	Department of Defense
FFS	fee-for-service
HHS	Department of Health and Human Services
HMO	health maintenance organization
MA	Medicare Advantage
PFFS	private fee-for-service
PMPM	per member per month
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization
VA	Department of Veterans Affairs

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April 11, 2016

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Richard Burr
United States Senate

The Honorable Michael B. Enzi
United States Senate

Both veterans and nonveterans may enroll in Medicare Advantage (MA), a private plan alternative to Medicare fee-for-service (FFS). Unlike in Medicare FFS, where providers are generally paid separately for each service provided, the Centers for Medicare & Medicaid Services (CMS) pays MA plans a fixed per member per month (PMPM) payment to provide all services covered under Medicare FFS.¹ This payment does not vary on the basis of the individual services beneficiaries receive. Veterans enrolled in an MA plan can also enroll in the Department of Veterans Affairs (VA) health care system and may receive Medicare-covered services

¹CMS is the agency within the Department of Health and Human Services (HHS) that is responsible for administering the Medicare program.

from either source.² A 2012 study estimated VA provided \$13 billion in covered services to 1.2 million veterans who were also MA enrollees between 2004 and 2009.³ The authors characterized VA spending on Medicare-covered services as “duplicate federal payments,” although they stated that they were unable to quantify the amount of excess federal payments to MA plans on behalf of VA enrollees because they did not have access to data needed to determine how the services provided by VA affect CMS payments to MA plans. Information on this relationship is critical because any potential excess federal payments could be reduced, or eliminated, if MA payments were sufficiently lower as a result of MA-enrolled veterans obtaining care through VA instead of their MA plans.

VA’s provision of Medicare-covered services could also result in PMPM payments to some individual MA plans that are too low. CMS generally calculates the benchmark—a bidding target used in determining PMPM payments to MA plans—from average per capita Medicare FFS spending in the counties in which a plan operates and other factors. When veterans from those counties are enrolled in Medicare FFS but receive Medicare-covered services from VA, average per capita Medicare FFS spending is lower than it otherwise would have been if veterans received all of their services from Medicare FFS; this can lower the benchmark and correspondingly lower PMPM payments to MA plans. The resulting PMPM payment would be the same for both veterans and nonveterans. However, the amount may, on average, be too high for veterans and too low for nonveterans. As a result, individual MA plans that enroll a disproportionately high number of nonveterans may receive a PMPM payment that is too low.

²VA operates one of the largest health care delivery systems in the nation. We use the term “Medicare-covered services” to refer to the hospital and other inpatient stays covered under Medicare Part A and the hospital outpatient, physician, and other services covered under Medicare Part B. When we refer to VA providing Medicare-covered services in this report, we mean that VA provided services through its health care delivery system to a VA enrollee who was also a Medicare enrollee and who could have obtained the same services through Medicare FFS or an MA plan, depending on the individual’s enrollment. The term “veteran” in this report is synonymous with a VA enrollee who is also a Medicare enrollee, whereas a “nonveteran” is a Medicare enrollee who is not a VA enrollee. In 2010, the time period of our review, there were 833,684 individuals who met our definition of a “veteran” by being enrolled in both VA health care and an MA plan.

³See Amal N. Trivedi et al., “Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Affairs Health Care System,” *The Journal of the American Medical Association*, 308, no. 1 (July 4, 2012): 67-72.

To address the possibility that PMPM payments for nonveterans are too low, CMS is required to adjust payments to MA plans, as appropriate, to account for the effect of VA's provision of Medicare-covered services.⁴ In 2009, CMS used Medicare FFS data to develop an estimate of the effect of VA spending on MA plan payments.⁵ Based on the results of its study, CMS determined that no adjustment was necessary from 2010 through 2016. In 2016, CMS updated its 2009 study using more recent data and determined that an adjustment would be necessary for 2017.⁶ Given the potential implications for MA plan payments, it is especially important that CMS's estimate is based on reasonable data and sound methodology.

You asked us to examine how VA's provision of Medicare-covered services affects payments to MA plans. In this report, we

- estimate the amount that VA spends to provide Medicare-covered services to veterans enrolled in MA plans and how VA spending on these services affects CMS payments to MA plans; and
- evaluate the extent to which CMS has the data it needs to determine an appropriate adjustment, if any, to MA payments to account for VA's provision of Medicare-covered services to MA-enrolled veterans.

To estimate the amount that VA spends to provide Medicare-covered services to veterans enrolled in MA plans, we first identified all months in which individual veterans were enrolled in VA health care and an MA plan during fiscal year 2010 using enrollment data from CMS and VA. We conducted our analysis for fiscal year 2010 because that was the most

⁴42 U.S.C. § 1395w-23(c)(1)(D)(i),(iii). For purposes of making an adjustment, as appropriate, CMS is required to estimate, on a per capita basis, the amount of additional Medicare FFS payments that would have been made in a county if individuals entitled to such benefits had not received services from the Department of Defense (DOD) or VA. Because our objectives were to address how VA spending may affect MA payments, we did not include DOD within our scope of work.

⁵This estimate was determined by calculating average per capita county Medicare FFS spending—which is used in determining the benchmark—for nonveterans and comparing it to the average per capita county Medicare FFS spending for all Medicare FFS beneficiaries, after adjusting for beneficiaries' health conditions and demographic characteristics. See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (Baltimore, Md.: Feb. 20, 2009).

⁶See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies and 2017 Call Letter* (Baltimore, Md.: Feb. 19, 2016).

recent analysis year for which data were available at the time we began our study. We then estimated VA spending on Medicare-covered inpatient and outpatient services using VA utilization and cost data, both for services provided by VA and for VA care in the community.⁷ To determine how VA spending on these services affects CMS payments to MA plans, we reviewed CMS documentation and interviewed CMS officials.

To evaluate the extent to which CMS has the data it needs to determine an appropriate adjustment, if any, to MA payments to account for VA's provision of Medicare-covered services to MA-enrolled veterans, we reviewed CMS documentation and interviewed CMS officials.

To assess the reliability of the data we used in our analyses, we reviewed related documentation, interviewed knowledgeable officials from CMS and VA, and performed appropriate electronic data checks. This assessment allowed us to determine that the data were reliable for our objectives. See appendix I for more details on our scope and methodology.

We conducted this performance audit from July 2013 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA Health Care

For fiscal year 2015, VA estimated it received \$59.2 billion in appropriations, including collections, to fund health care services for veterans, manage and administer VA's health care system, and operate

⁷In certain cases, such as when VA is unable to provide specialty care services or wants to ensure that veterans are provided timely and accessible care, VA pays private providers to provide services to veterans. VA refers to these types of services as VA care in the community.

We excluded prescription drug services from our analysis.

and maintain the VA health care system's capital infrastructure.⁸ VA estimated that in fiscal year 2015 it provided health care services—including inpatient services, outpatient services, and prescription drugs—to 6.7 million eligible patients.⁹

Medicare Advantage

For calendar year 2015, the Medicare Trustees estimated that CMS paid MA plans about \$155 billion to provide coverage for 16.4 million Medicare beneficiaries.¹⁰ Beneficiaries of MA can enroll in one of several different plan types, including health maintenance organizations (HMO), private fee-for-service (PFFS) plans, preferred provider organizations (PPO), and regional PPOs.¹¹ Medicare pays MA plans a capitated PMPM amount. This amount is based in part on a plan's bid, which is its projection of the revenue it requires to provide a beneficiary with services that are covered under Medicare FFS, and a benchmark, which CMS generally calculates from average per capita Medicare FFS spending in the plan's service area and other factors. If a plan's bid is higher than the benchmark, Medicare pays the plan the amount of the benchmark, and the plan must charge beneficiaries a premium to collect the amount by which the bid exceeds the benchmark.¹²

⁸For example, VA's collections include third-party payments from veterans' private health care insurance for the treatment of nonservice-connected conditions and veterans' copayments for outpatient medications.

⁹According to VA officials, this figure includes 694,000 individuals who were VA employees, enrollees in the Civilian Health and Medical Program of VA, enrollees in the Spina Bifida Healthcare Program, children of women Vietnam War veterans, caregivers of veterans, recipients of humanitarian care, or active duty service members.

¹⁰This amount includes payments for some non-MA plans, such as cost plans and Program of All-Inclusive Care for the Elderly plans. The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2014 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: July 28, 2014), 163 and 167.

¹¹Beneficiaries in HMOs are generally restricted to seeing providers within a network. Beneficiaries enrolled in PFFS plans may generally see any provider that accepts the plan's payment terms. However, since 2011, these plans have generally been required to maintain a network of contracted providers, and beneficiaries that see out-of-network providers may pay higher cost-sharing amounts. Beneficiaries in PPOs can see both in-network and out-of-network providers but pay higher cost-sharing amounts if they use out-of-network services. Regional PPOs serve state or multistate regions established by CMS.

¹²Medicare compares a plan's bid to the benchmark after adjusting the benchmark to reflect the health status of the plan's enrollees.

If the plan's bid is lower than the benchmark, Medicare pays the plan the amount of the bid and makes an additional payment to the plan called a rebate.¹³ Plans may use this rebate to fund benefits not covered under Medicare FFS.

CMS uses risk scores to adjust PMPM payments to MA plans to account for beneficiaries' health status and other factors, a process known as risk adjustment. For beneficiaries enrolled in MA, risk scores are generally determined on the basis of diagnosis codes submitted for each beneficiary, among other factors, and are adjusted annually to account for changes in diagnoses from the previous calendar year.¹⁴ In addition, risk scores for beneficiaries who experience long-term stays of more than 90 days are calculated differently to account for the differences in expected health expenditures. While risk scores are based on diagnoses from the previous year, changes to the risk score to account for long-term hospital stays of more than 90 days are reflected in the calendar year when the stay occurred.

Change to Benchmark Calculation

The Patient Protection and Affordable Care Act (PPACA) changed how benchmarks are calculated so that they will be more closely aligned with Medicare FFS spending. Specifically, the benchmark changes, which are to be phased in from 2012 through 2017, will result in benchmarks tied to a percentage of per capita Medicare FFS spending in each county. In general, for those counties in the highest Medicare FFS spending quartile, benchmarks will be equal to 95 percent of county per capita Medicare FFS spending, and for those counties in the lowest Medicare FFS spending quartile, benchmarks will be equal to 115 percent of per

¹³Prior to 2012, if a plan's bid was less than the benchmark, the plan received a rebate equal to 75 percent of the difference between the bid and the benchmark. Starting in 2012, CMS began phasing in a new formula for calculating rebates that is based in part on measures of the quality of care provided by the MA plan. Under this new formula, rebates from 2014 onward can equal between 50 percent and 70 percent of the difference between the bid and the benchmark.

¹⁴Enrollees new to Medicare are assigned risk scores that are not based on submitted diagnoses.

capita Medicare FFS spending.¹⁵ Prior to 2012, benchmarks in all counties were at least as high as per capita Medicare FFS spending, but were often much higher. For example, while counties generally had benchmarks that were derived from per capita county Medicare FFS spending, the benchmarks were generally increased annually by a minimum update equal to the national growth rate percentage in Medicare FFS spending. In cases where the growth rate used to update the benchmark was greater than the rate at which per capita Medicare FFS spending grew within a county, it would result in a benchmark that was higher than the average per capita county Medicare FFS spending rate. In addition, some urban and rural counties had benchmarks that were “floor” rates, which were set above per capita county Medicare FFS spending rates to encourage insurers to offer plans in the areas. According to a CMS study reported in the 2010 MA Advance Notice, approximately 96 percent of counties had benchmarks that were set based on a minimum update or were floor rates.¹⁶

Required MA Payment Adjustment for VA Spending

Especially in counties with a relatively high proportion of veterans, average per capita Medicare FFS spending may be low if many veterans receive health care services from VA instead of Medicare providers. Because benchmarks are calculated based in part on Medicare FFS spending, MA payments may be lower in such counties and may not reflect Medicare’s expected cost of caring for nonveterans. CMS is required to estimate, on a per capita basis, the amount of additional Medicare FFS payments that would have been made in a county if Medicare-eligible veterans had not received services from VA. If needed, CMS is also required to make a corresponding MA payment adjustment.¹⁷ To address these requirements, CMS reported the results of its study analyzing the cost impact of removing veterans eligible to receive

¹⁵See 42 U.S.C. § 1395w-23(n)(2)(B),(D). If there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year is the average of the applicable percentage for the previous year and the applicable percentage that would otherwise apply for the year. For additional information on how PPACA changed the way MA plan payment amounts are set, including other PPACA provisions that may result in benchmark increases, see GAO, *Medicare Advantage: Comparison of Plan Bids to Fee-for-Service Spending by Plan and Market Characteristics*, [GAO-11-247R](#) (Washington, D.C.: Feb. 4, 2011).

¹⁶See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year 2010*.

¹⁷42 U.S.C. § 1395w-23(c)(1)(D)(iii).

services from VA on 2009 Medicare FFS county rates in the 2010 MA Advance Notice.¹⁸ CMS reported that, on average, removing veterans from the calculation of counties' per capita Medicare FFS spending rate had minimal impact on per capita spending and that the differences in expenditures between all Medicare beneficiaries and nonveterans were more attributable to normal, random variation than to distinctly different spending for the two populations. Based on CMS's study results, the agency concluded that no adjustment for VA spending on Medicare-covered services was necessary to 2010 through 2016 MA payments. In 2016, CMS updated its 2009 study using more recent data and determined that an adjustment would be necessary for 2017.¹⁹

Overall Payments to MA Plans Likely Were Lower Due to VA's Provision of \$2.4 Billion in Services to MA-Enrolled Veterans, but Appropriateness of Resulting Payments Still Uncertain

VA provided about \$2.4 billion in Medicare-covered inpatient and outpatient services to the 833,684 MA-enrolled veterans in fiscal year 2010. In total, VA provided approximately 61,000 inpatient services and 8.2 million outpatient services to veterans enrolled in MA plans. During that same time period, CMS paid MA plans \$8.3 billion to provide all Medicare-covered services to veterans enrolled in an MA plan.

VA's provision of services to MA-enrolled veterans resulted in overall payments to MA plans that were likely lower than they otherwise would have been if veterans had obtained all of their Medicare-covered services through Medicare FFS providers and MA plans. Specifically, because VA provides services to MA-enrolled veterans, the three components that determine payments to MA plans—benchmarks, bids, and risk scores—are likely lower than they otherwise would be, which results in lower overall payments to MA plans.

- **Benchmarks**—Because benchmarks are generally calculated in part from per capita county Medicare FFS spending rates, any VA spending on Medicare-covered services for veterans enrolled in Medicare FFS would be excluded from the benchmark calculation. As a result, the benchmark would be lower and, in turn, payments to MA plans would also be lower. This would be particularly true following

¹⁸See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year 2010*.

¹⁹See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year 2017*.

the implementation of the PPACA revisions to the benchmark calculation—to be phased in from 2012 through 2017—as the PPACA revisions further strengthened the link between the benchmark and average per capita county Medicare FFS spending rates.

- Bids—MA payments also may be lower to the extent that MA plans set bids based on historical experience. MA plan bids may reflect the fact that in previous years enrolled veterans received some Medicare-covered services from VA instead of the MA plan. If so, MA plan bids would be lower and, in turn, MA payments would also be lower.
- Risk scores—VA’s provision of Medicare-covered services may result in lower risk scores because, like benchmarks, they are calibrated based on Medicare FFS spending for beneficiaries with specific diagnoses identified by Medicare. As a result, any VA spending on Medicare-covered services for veterans enrolled in Medicare FFS that is related to these diagnoses would be excluded when the model is calibrated. In addition, MA plans would generally not have access to diagnoses made by VA. Therefore, when VA identifies and treats a diagnosis not identified by the veteran’s MA plan, it would not be incorporated into the veteran’s risk score. Because PMPM payments to MA plans are risk-adjusted, a lower risk score would result in lower payments to MA plans.²⁰

Although VA spending on Medicare-covered services likely results in lower CMS payments to MA plans, the extent to which these payments reflect the expected utilization of services by the MA population remains uncertain. Specifically, payment amounts may still be too high or could even be too low, depending on the utilization of VA services by veterans enrolled in MA plans and veterans enrolled in Medicare FFS.²¹ As noted earlier, both benchmarks and risk scores are generally calibrated based on

²⁰VA’s provision of Medicare-covered services can also affect risk scores if VA provides long-term stays not identified by CMS. Because CMS has a different risk score model for institutionalized beneficiaries, risk scores could increase or decrease under the institutional model, depending on beneficiaries’ health conditions.

²¹Similar to how differences in the use of services between MA and Medicare FFS beneficiaries vary across geographic areas, differences in the use of VA services between MA and Medicare FFS veterans may also vary across counties. For example, while MA and Medicare FFS beneficiaries have similar rates of coronary artery bypass graft surgery in some hospital referral regions after adjusting for age, sex, and race, there are other hospital referral regions where Medicare FFS beneficiaries receive coronary artery bypass graft surgery at more than twice the rate of MA beneficiaries. See Daniel D. Matlock et al., “Geographic Variation in Cardiovascular Procedure Use among Medicare Fee-for-Service vs Medicare Advantage Beneficiaries,” *The Journal of the American Medical Association* 310, no. 2 (July 10, 2013): 155-162.

veterans and nonveterans enrolled in Medicare FFS. However, veterans enrolled in MA plans may differ in the proportion of services they receive from VA compared to veterans enrolled in Medicare FFS, which would affect the appropriateness of payments to MA plans.

- For example, payments to MA plans may be too high if veterans enrolled in MA receive a greater proportion of their services from VA relative to veterans enrolled in Medicare FFS. Under this scenario, the benchmark would reflect the higher use of Medicare services by Medicare FFS beneficiaries who are receiving fewer of their services from VA than are veterans enrolled in MA. As a result, the benchmark may be too high and, in turn, payments to MA plans may be too high.²² This effect of a higher benchmark may be at least partially offset by a risk score that is too high.²³
- In contrast, payments to MA plans may be too low if veterans enrolled in MA receive a lesser proportion of their services from VA relative to veterans enrolled in Medicare FFS. Under this scenario, the benchmarks may be too low and may result in MA plans being underpaid, although the effect may be partially offset by risk scores that are too low.

To assess whether there are service utilization differences between the MA and Medicare FFS veteran populations that result in payments to MA plans that are too high or too low, data on the services veterans receive from Medicare FFS, MA, and VA would be needed. Data on veterans' use of services through Medicare FFS and VA health care are available from CMS and VA, respectively. However, CMS does not currently have validated data that could be used to determine veterans' use of services

²²The extent to which payments to MA plans would be too high for veterans, nonveterans, or both, would depend on (1) differences, if any, in the number and types of Medicare-covered services that veterans and nonveterans with the same health conditions and demographic characteristics use, on average, annually and (2) the magnitude of the difference in proportion of services received from VA for veterans enrolled in Medicare FFS and veterans enrolled in an MA plan.

²³Risk scores may be too high because, for any given diagnosis, expected Medicare spending will be determined based on Medicare FFS expenditures that reflect a higher use of Medicare services by enrolled veterans compared to that of veterans enrolled in an MA plan. Risk scores are used to standardize the benchmark to reflect expected per capita spending for the average beneficiary in a county, meaning that the Medicare per capita FFS county spending rate would be divided by the aggregate risk score for the county Medicare FFS population. Therefore, if the risk score is too high, it could at least partially offset the higher benchmark.

through MA. CMS began collecting data from MA plans on diagnoses and services provided to beneficiaries starting in January 2012. We reported in July 2014 that CMS had taken some, but not all, appropriate actions to ensure that these data—known as MA encounter data—are complete and accurate.²⁴ At that time, we recommended that CMS complete all the steps necessary to validate the data, including performing statistical analyses, reviewing medical records, and providing MA organizations with summary reports on CMS's findings. CMS agreed with the recommendation, but as of August 2015, had not completed all steps needed to validate the encounter data.

CMS Does Not Have the VA Diagnosis and Utilization Data That May Improve Its Methodology for Calculating Adjustments to MA Payments

CMS determined that no adjustment to 2010 through 2016 MA payments was needed to account for the provision of Medicare-covered services by VA, but used a methodology that had certain shortcomings that could have affected MA payments.²⁵ CMS is required to estimate, on a per capita basis, the amount of additional payments that would have been made in a county if Medicare-eligible veterans had not received services from VA and, if needed, to make a corresponding adjustment to MA payments. If CMS determined that an MA payment adjustment was necessary, it would make the adjustment by using a modified version of per capita county Medicare FFS spending rates that are adjusted to account for the effect of VA spending on Medicare-covered services. Per capita county Medicare FFS spending rates serve as the basis of the benchmarks used in determining MA payment rates. To determine whether an adjustment was needed, CMS obtained data from VA showing veterans who are enrolled in VA health care and Medicare FFS (that is, enrollment data). CMS then estimated the effect of VA spending on Medicare FFS spending by calculating average per capita county Medicare FFS spending for nonveterans and comparing it to the average per capita county Medicare FFS spending for all Medicare FFS beneficiaries, after adjusting for beneficiaries' risk. However, CMS's methodology did not account for two factors that could have important effects on the results: (1) services provided by and diagnoses made by VA but not identified by Medicare and (2) changes to the benchmark calculation under PPACA.

²⁴See GAO, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, [GAO-14-571](#) (Washington, D.C.: July 31, 2014).

²⁵See Centers for Medicare & Medicaid Services, *Advance Notice of Methodological Changes for Calendar Year 2010*.

First, because CMS used only Medicare FFS utilization and diagnosis data in its study, the agency's methodology did not account for services provided by and diagnoses made by VA—which could result in inaccurate estimates of how VA spending on services for Medicare FFS-enrolled veterans affects per capita county Medicare FFS spending. Only VA's utilization and diagnosis data can account for services provided by and diagnoses made by VA. Without this information, CMS's estimate of how VA spending affects per capita county Medicare FFS spending rates may be inaccurate.

- Specifically, estimates of per capita county Medicare FFS spending for all beneficiaries, including veterans, may be too low because services provided by VA would not be accounted for in Medicare FFS spending. Excluding those services could have the effect of deflating veterans' risk-adjusted Medicare FFS spending and therefore total per capita county Medicare FFS spending.
- Conversely, estimates of per capita county Medicare FFS spending for all beneficiaries, including veterans, may be too high because excluding diagnoses identified only by VA could result in Medicare risk scores that are too low, which would have the effect of inflating veterans' risk-adjusted Medicare FFS spending and therefore total per capita county Medicare FFS spending.

Thus, depending on the number and mix of services provided by and the diagnoses made by VA, risk-adjusted Medicare FFS spending for veterans may either be higher or lower than it would be if CMS accounted for VA-provided services and diagnoses.

Second, because CMS's study was done in 2009, it did not account for changes to the benchmark calculation that occurred under PPACA and that are to be phased in from 2012 through 2017. CMS noted in 2009 that only 45 of the 3,127 counties nationwide would have had per capita county Medicare FFS spending rate increases after accounting for VA spending. According to CMS, the number of affected counties was as low as it was in part because many counties had payment rate minimums, which often resulted in benchmarks that were higher than per capita county Medicare FFS spending. However, as noted earlier in this report, PPACA revised the benchmark calculation to more closely align benchmarks with average per capita county Medicare FFS spending rates. As these revised benchmark calculations are implemented, counties will no longer have benchmarks set based on minimum updates or floor rates. Because CMS did not update its 2009 study when determining whether an adjustment was necessary through 2016, the agency lacked accurate information on the number of additional counties

in which VA spending on Medicare-covered services would have made a difference in per capita county Medicare FFS spending rates.

When CMS updated its 2009 study to determine whether an MA payment adjustment was needed for 2017, it used the same methodology, albeit with more recent data. Doing so allowed CMS to account for the revised benchmark calculations implemented under PPACA. However, CMS cannot address the other limitation we identified without additional data. Specifically, CMS cannot account for services provided by and diagnoses made by VA. Officials said that they did not intend to incorporate VA utilization and diagnoses data into their analysis because they did not currently have such data and that incorporating these data would introduce additional uncertainty into the analysis. For example, CMS officials noted that there would be challenges associated with how much Medicare would have spent if the covered services had been obtained from Medicare providers instead of VA.

We agree that CMS would face challenges incorporating VA data into its analysis, but if an adjustment is needed and not made or if the adjustment made is too low, the PMPM payment may be too high for veterans and too low for nonveterans. Depending on the mix of veterans and nonveterans enrolled by individual MA plans, this could result in some plans being paid too much and others too little. Both CMS and VA officials told us that the agencies have a data use agreement in place that allows them to share some data, but this does not include data on services VA provides to Medicare beneficiaries. According to VA, as of December 2015, CMS has not requested its utilization and diagnosis data.

Federal standards for internal control call for management to have the operational data it needs to meet agency goals to effectively and efficiently use resources and to help ensure compliance with laws and regulations.²⁶ In this case, without VA data on diagnoses and utilization, CMS may be increasing the risk that it is not effectively meeting the requirement to adjust payments to MA plans, as appropriate, to account for VA spending on services for Medicare beneficiaries.

²⁶GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

If CMS revises its study methodology and determines that an adjustment to the benchmark to account for VA spending is needed, it may need to make additional MA payment adjustments to ensure that payments are equitable for individual MA plans. A benchmark adjustment would increase payments for nonveterans and would address the possibility that payments to MA plans with a high proportion of nonveterans would be too low. However, if CMS makes a benchmark adjustment, it would also increase MA payments for veterans. While the resulting higher payment to MA plans for nonveterans may be appropriate, higher payments for veterans may not be because veterans may be receiving some services from VA. In that case, payments to MA plans that enroll veterans would be too high, with the degree of overpayment increasing as the proportion of veterans enrolled by plans increases. To ensure that payments to MA plans are equitable regardless of differences in the demographic characteristics of the plans' enrollees, CMS is authorized to adjust payments to MA plans based on such risk factors that it determines to be appropriate.²⁷ Therefore, if CMS determines that an adjustment to the benchmark to account for VA spending is needed and the adjustment results in payments to MA plans that are too high for veterans, additional adjustments to payments to MA plans could be necessary.

Conclusions

Given that veterans enrolled in an MA plan and the VA health care system can receive Medicare-covered services from either source, it is important to consider how the provision of services by VA affects payments to MA plans. In fiscal year 2010, VA provided \$2.4 billion worth of inpatient and outpatient services to MA-enrolled veterans, which likely resulted in lower overall payments to MA plans. However, the appropriateness of these lower payments is uncertain, given potential differences in the proportion of services veterans enrolled in MA plans and Medicare FFS receive from VA. An estimate of the differences between the two populations of veterans would enable CMS to determine if additional actions are needed to improve the accuracy of PMPM payments. To this end, we recommended in July 2014 that CMS should validate the MA encounter data, which would be needed to determine if

²⁷See 42 U.S.C. § 1395w-23(a)(1)(C)(i), which provides that CMS shall adjust the payment amount to an MA plan “for such risk factors as age, disability status, gender, institutional status, and such other factors as [CMS] determines to be appropriate, including adjustment for health status . . . , so as to ensure actuarial equivalence.”

there are differences in utilization of services between veterans in MA and Medicare FFS.

In addition, it is important to ensure that VA spending on Medicare-covered services does not result in inequitable payments to individual MA plans for veterans and nonveterans. While CMS is required to adjust MA payments to account for VA spending on Medicare-covered services, as appropriate, the agency determined that no adjustment to the benchmark, which is based in part on per capita county Medicare FFS spending, was necessary for years 2010 through 2016. CMS updated the study it used to make this determination in 2016 and determined that an adjustment was necessary for 2017. However, both CMS's 2009 study and its 2016 study were limited because the agency did not have VA utilization and diagnoses data. Adjusting the study's methodology to incorporate these data could change the study's findings and result in CMS making a larger adjustment to the benchmark in future years. Such a benchmark adjustment could improve the accuracy of payments for nonveterans. However, a benchmark adjustment could also result in or exacerbate payments to MA plans that are too high for veterans, so additional MA payment adjustments could become necessary.

Recommendations for Executive Action

We recommend that the Secretary of Health and Human Services direct the Administrator of CMS to take the following two actions:

- Assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita county Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS under its existing data use agreement or by other means as necessary.
- If CMS makes an adjustment to the benchmark to account for VA spending on Medicare-covered services, the agency should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans.

Agency Comments and Our Evaluation

We provided a draft of this product to VA and the Department of Health and Human Services (HHS). HHS provided written comments on the draft, which are reprinted in appendix II. Both VA and HHS provided technical comments, which we incorporated as appropriate.

In its comments, HHS concurred with one of our two recommendations. HHS agreed with our recommendation that if CMS makes an adjustment

to the benchmark to account for VA spending on Medicare-covered services, it should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans. HHS acknowledged that CMS is required to estimate, on an annual basis, the amount of additional Medicare FFS payments that would have been made in a county if Medicare-eligible veterans had not received services from VA and, if necessary, to make a corresponding MA payment adjustment. In the 2017 MA Advance Notice, CMS provided the results of its updated analysis, which used the same methodology as its 2010 analysis, but with more recent data. Based on its findings, CMS plans to make an adjustment to 2017 MA payment rates to account for VA spending on Medicare-covered services. In its comments, HHS stated that CMS will assess whether an additional adjustment to MA plan payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans. We encourage CMS to complete its assessment prior to finalizing its 2017 payments to ensure that payments to MA plans will be equitable when the adjustment to account for VA spending on Medicare-covered services is made.

HHS did not concur with our recommendation that CMS should assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita county Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS. HHS stated that CMS uses Medicare FFS spending rates when setting the benchmark, which excludes services provided by VA facilities. In addition, HHS stated that incorporating VA utilization and diagnosis data into CMS's analysis may not materially improve the analysis and the resulting adjustment. HHS indicated that it will continue to review the need for incorporating additional data or for methodology changes in the future. As we note in the report, only VA's utilization and diagnosis data can account for services provided by and diagnoses made by VA. Depending on the number and mix of services provided by and the diagnoses made by VA, risk-adjusted Medicare FFS spending for veterans may either be higher or lower than it would be if CMS accounted for VA-provided services and diagnoses. Therefore, relying exclusively on Medicare FFS spending to estimate the effect of VA spending on Medicare FFS-enrolled veterans could result in an inaccurate estimate of how VA spending on services for Medicare FFS-enrolled veterans affects per capita county Medicare FFS spending. While there may be challenges associated with incorporating VA utilization and diagnosis data into CMS's analysis, we maintain that CMS should work to do so given the implications that not incorporating the data may have on the accuracy of payment to MA plans. We continue to believe that an important first

step would be for CMS to assess the feasibility of incorporating VA utilization and diagnosis data in a way that can overcome the challenges identified by CMS and potentially lead to a more accurate adjustment.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



James Cosgrove
Director, Health Care

Appendix I: Scope and Methodology

This appendix describes the scope and methodology used to (1) estimate the amount that the Department of Veterans Affairs (VA) spends to provide Medicare-covered services to veterans enrolled in Medicare Advantage (MA) plans and how VA spending on these services affects Centers for Medicare & Medicaid Services (CMS) payments to MA plans; and (2) evaluate the extent to which CMS has the data it needs to determine an appropriate adjustment, if any, to MA payments to account for VA's provision of Medicare-covered services to MA-enrolled veterans.

To estimate the amount that VA spends to provide Medicare-covered services to veterans enrolled in MA plans, we first identified veterans with at least 1 month of overlapping enrollment in an MA plan and in VA health care in fiscal year 2010. VA provided us with an enrollment file that included veterans enrolled in VA health care for at least 1 month in fiscal year 2010 and whom VA had identified as having at least 1 month of Medicare private plan enrollment. To determine months of MA enrollment in fiscal year 2010, we matched the VA enrollment file to Medicare's calendar year 2009 and 2010 Denominator Files based on whether beneficiaries had the same Social Security number and either the same date of birth, sex, or both. We excluded those beneficiaries who did not have at least 1 month of overlapping MA and VA health care enrollment. In addition, we excluded veterans in the VA enrollment file that did not have a VA enrollment start date, were listed as having died prior to fiscal year 2010, or were not enrolled in one of the four most common MA plan types.¹ After all exclusions, we identified 833,684 veterans with at least 1 month of overlapping enrollment in an MA plan and VA health care in fiscal year 2010.

We identified all inpatient and outpatient services provided by VA to those veterans in our population during fiscal year 2010. VA can provide inpatient and outpatient services directly at one of its medical facilities or it can contract for care, known as VA care in the community; we received inpatient and outpatient utilization files for both types of VA-provided care. We excluded prescription drug services from our analysis, as payments to MA plans for coverage of Part D services are determined differently than

¹The four most common MA plan types are health maintenance organizations (HMO), local preferred provider organizations (PPO), regional PPOs, and private fee-for-service (PFFS) plans. In calendar year 2010, approximately 96 percent of MA beneficiaries were enrolled in one of these four plan types. See Marsha Gold et al., *Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2010).

are payments for other Medicare-covered services. We also excluded services that were received during a month when the veteran was not enrolled in both VA health care and an MA plan. We considered an inpatient stay, which can last multiple days, to be during a month when the veteran was enrolled in both VA health care and an MA plan if 1 or more days of the stay occurred during a month in which the veteran was enrolled in VA health care and an MA plan. In some instances, hospital stays had an admittance date prior to fiscal year 2010 or a discharge date after it, and in those cases, we included only the portion of the stay that occurred during fiscal year 2010.

We excluded those inpatient and outpatient services that were provided by VA but were not covered by Medicare. For inpatient services directly provided by VA, we used the category of care assigned to each service by VA to exclude service categories not covered by Medicare, such as intermediate and domiciliary care. In addition, we excluded services provided by VA that went beyond Medicare benefit limits. Because MA plans may have different benefit limits than Medicare fee-for-service (FFS), we analyzed the benefits offered by a sample of 45 MA plans for 2014 for services covered by Medicare FFS that have benefit limits.² We identified the most common benefit limits for those services and used those as our benefit limits for VA services. In cases where some or all MA plans had service categories with lifetime reserve days (e.g., inpatient days beyond the 90 days Medicare covers per benefit period, up to an additional 60 days per lifetime), we made the assumption that beneficiaries had 25 percent of their lifetime reserve days remaining.³ For inpatient services provided through VA care in the community, we excluded hospice services; services with cancelled payments; and services with a classification of dental, contract halfway house, pharmacy, reimbursement, or travel. For outpatient services directly provided by VA, we excluded services that were not included in the Medicare physician fee schedule; ambulance fee

²Specifically, we analyzed MA plans' benefit limits for inpatient stays, inpatient mental health stays, skilled nursing facility stays, physical therapy, speech therapy, and occupational therapy.

³We also developed an alternative estimate of VA spending on Medicare-covered services using the same data. For cases where service categories had lifetime reserve days, we assumed that veterans had 100 percent of their lifetime reserve days remaining. In addition, we made the same inpatient and outpatient exclusions as our reported estimate except that we included outpatient services that had restricted coverage or were excluded from the Medicare physician fee schedule by regulation. The results of this alternative estimate were similar to our reported results.

schedule; clinical lab fee schedule; durable medical equipment, prosthetics/orthotics, and supplies fee schedule; anesthesiology fee schedule; or ambulatory surgical center fee schedule. We also excluded services that had a Medicare physician fee schedule status code indicating they were a deleted code, a noncovered service, had restricted coverage, or were excluded from the physician fee schedule by regulation. For outpatient services provided through VA care in the community, we made the same exclusions as for outpatient services provided by VA and also excluded hospice care services and services with cancelled payments.

We calculated total VA spending and CMS payments to MA plans for beneficiaries for months in which they were enrolled in both VA health care and an MA plan in fiscal year 2010 and evaluated how, if at all, VA spending on these services affects CMS payments to MA plans. To calculate VA's estimated spending, we assigned all Medicare-covered services directly provided by VA a cost, using VA's average cost data; and for services provided through VA care in the community, we used the amount that VA disbursed to the service provider. We calculated total MA spending for veterans enrolled in MA and VA using actual CMS payments to MA plans for our population in fiscal year 2010. To evaluate how VA spending on Medicare-covered services affects CMS payments to MA plans, we reviewed CMS documentation and interviewed CMS officials.

To evaluate the extent to which CMS has the data it needs to determine an appropriate adjustment, we reviewed CMS documentation and interviewed CMS officials. As part of this effort, we also evaluated CMS's methodology for a study it used as the basis of its decision to not adjust county per capita Medicare FFS spending rates for VA spending on Medicare-covered services. Our evaluation was based on a review of CMS documentation and an interview with CMS officials.

To assess the reliability of the data we used in our analyses, we reviewed related documentation, interviewed knowledgeable officials from CMS and VA, and performed appropriate electronic data checks. This assessment allowed us to determine that the data were reliable for our objectives.

We conducted this performance audit from July 2013 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 22 2016

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans* (GAO-16-137).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: ACTION NEEDED TO ENSURE APPROPRIATE PAYMENTS FOR VETERANS AND NONVETERANS (GAO-16-137)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to protecting taxpayer dollars, including by continuously evaluating opportunities to reduce overlap in federal spending while maintaining program effectiveness and efficiency.

Medicare Advantage (MA) plans are offered to veterans and non-veterans as a private plan alternative to Medicare fee-for-service (FFS). Veterans may enroll in a MA plan and can also enroll in the Department of Veterans Affairs (VA) healthcare system to receive Medicare-covered services from either source. However, unlike in Medicare FFS, where providers are generally paid separately for each service provided, HHS pays MA plans a fixed per member per month payment (PMPM) to provide all Medicare covered services. This PMPM amount is based on a plan's projection of revenue it requires to provide coverage as well as a benchmark, which HHS calculates from an average per capita Medicare FFS spending in the plan's service area. Most recently, the Affordable Care Act now requires a change in how benchmarks are calculated so that MA payments have an additional reliance on FFS costs beginning in payment year 2012 with MA benchmark payment rates based completely on Medicare FFS costs by 2017.

As the GAO reported, HHS is required to estimate, on an annual basis, the amount of additional Medicare FFS payments that would have been made in a county if Medicare-eligible veterans had not received services from VA and if necessary, make a corresponding MA payment adjustment. Based on previous study results, HHS concluded that no adjustment for VA spending on Medicare-covered services was necessary for payments made from 2010 to 2016. As described in the Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter released on February 19, 2016, HHS has updated its analysis to determine whether an adjustment is needed. Based on this updated analysis, HHS is proposing to make appropriate adjustments to the 2017 rates for experience of VA dual-benefit eligible beneficiaries.

HHS appreciates the GAO's analysis and suggestions for program improvements.

GAO Recommendation

Assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita county Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS under its existing data use agreement or by other means as necessary.

HHS Response

HHS non-concurs with GAO's recommendation. While HHS appreciates the GAO's recommendation, we account for VA-provided Medicare covered services by using data obtained from the VA showing veterans who are enrolled in VA health care and Medicare FFS. Since Medicare FFS spending rates serve as a basis of the benchmarks used in determining MA payments, these payments similarly reflect exclusions of services provided by VA facilities. Additionally, VA utilization and diagnosis data may not materially improve the analysis and the

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: ACTION NEEDED TO ENSURE APPROPRIATE PAYMENTS FOR VETERANS AND NONVETERANS (GAO-16-137)

resulting adjustment currently proposed. However, we will continue to review the need for additional data sources or methodological changes in the future.

GAO Recommendation

If CMS makes an adjustment to the benchmark to account for VA spending on Medicare-covered services, the agency should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans.

HHS Response

HHS concurs with this recommendation. As noted in the response, based on our current methodology, HHS is proposing to make appropriate adjustments to the 2017 rates for experience of VA dual-benefit eligible beneficiaries. CMS will assess whether an additional adjustment to MA payments is needed.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gregory Giusto, Assistant Director; Christine Brudevold; Christine Davis; Jacquelyn N. Hamilton; Dan Lee; Elizabeth T. Morrison; Christina C. Serna; and Luis Serna made key contributions to this report.

Appendix IV: Accessible Data

Agency Comment Letter

Text of Appendix II:
Comments from the
Department of Health and
Human Services

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DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

MAR 22 2016

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The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADVANTAGE: ACTION NEEDED TO ENSURE APPROPRIATE PAYMENTS FOR VETERANS AND NONVETERANS (GAO-16-137)

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Payment Policies and 2017 Call Letter released on February 19, 2016, HHS has updated its analysis to determine whether an adjustment is needed. Based on this updated analysis, HHS is proposing to make appropriate adjustments to the 2017 rates for experience of VA dual-benefit eligible beneficiaries.

HHS appreciates the GAO's analysis and suggestions for program improvements.

GAO Recommendation

Assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita county Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS under its existing data use agreement or by other means as necessary.

HHS Response

HHS non-concurs with GAO's recommendation. While HHS appreciates the GAO's recommendation, we account for VA-provided Medicare covered services by using data obtained from the VA showing veterans who are enrolled in VA health care and Medicare FFS. Since Medicare FFS spending rates serve as a basis of the benchmarks used in determining MA payments, these payments similarly reflect exclusions of services provided by VA facilities. Additionally, VA utilization and diagnosis data may not materially improve the analysis and the

Page 3

resulting adjustment currently proposed. However, we will continue to review the need for additional data sources or methodological changes in the future.

GAO Recommendation

If CMS makes an adjustment to the benchmark to account for VA spending on Medicare-covered services, the agency should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans.

HHS Response

HHS concurs with this recommendation. As noted in the response, based on our current methodology, HHS is proposing to make appropriate

adjustments to the 2017 rates for experience of VA dual-benefit eligible beneficiaries. CMS will assess whether an additional adjustment to MA payments is needed.

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