

CHAPTER

13

**The Medicare Advantage
program: Status report**

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2019, the MA program included over 3,000 plan options offered by 184 organizations, enrolled over 22 million beneficiaries (34 percent of all Medicare beneficiaries), and paid MA plans an estimated \$274 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and quality in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate, risk adjusted per enrollee, rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare

In this chapter

- Trends in enrollment, plan availability, and payments
- Medicare Advantage encounter data
- Medicare Advantage risk adjustment and coding intensity
- Quality in Medicare Advantage is difficult to evaluate
- Future direction of MA payment policy

program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which subsidized MA plans by providing payments above FFS rates, and that they be set so that the payment system does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS nationally; nevertheless, plans have received increased payments because of higher risk coding and quality bonus rules. With the legislated MA payment reductions over the past few years, plan bids and payments have fallen in relation to FFS spending while MA enrollment continues to grow. Plans have improved efficiencies, leading to more competitive bids that enable MA plans to continue to increase enrollment by offering extra benefits that beneficiaries find attractive, suggesting that further efficiencies are possible in MA.

Enrollment—Between November 2018 and November 2019, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 22.6 million enrollees. About 34 percent of Medicare beneficiaries were enrolled in MA plans in 2019, up from 33 percent in 2018. Among plan types, HMOs continued to enroll the most beneficiaries (14.1 million), with 21 percent of all Medicare beneficiaries in HMOs in 2019. During this period, enrollment in local preferred provider organizations (PPOs) grew by 22 percent, regional PPO enrollment decreased by 8 percent, and private fee-for-service (PFFS) enrollment decreased by 26 percent. Special needs plan enrollment grew by 13 percent, and employer group enrollment grew by 6 percent.

Plan availability—Access to MA plans remains high in 2020, with most Medicare beneficiaries having access to many plans. Almost all beneficiaries have had access to some type of MA plan since 2006, and HMOs and local PPOs have become more widely available in the past few years. Nearly all Medicare beneficiaries (98 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 73 percent of beneficiaries. Thirty-six percent of beneficiaries have access to PFFS plans. Overall, 99 percent of Medicare beneficiaries have access to an MA plan. On average, beneficiaries in 2020 have 27 available plans, an increase from 23 in 2019.

An analysis of the MA program's market structure shows that, compared with 2018, MA enrollment in 2019 is slightly more concentrated. The top 10 MA organizations (ranked by enrollment) had 76 percent of total enrollment in 2019, compared with 74 percent in 2018. Enrollment is more concentrated in nonmetropolitan areas, where the top two companies have 55 percent of plan enrollment, compared with 43 percent in metropolitan areas.

Plan payments—Using the 2020 plan bid data, before adjusting fully for coding intensity, we estimate that 2020 MA benchmarks (including quality bonuses)—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—will average 107 percent of FFS spending. (Excluding quality bonuses, we project that base benchmarks will average 103 percent of FFS spending in 2020.) Benchmarks in 2020 are lower relative to FFS than in earlier years. Lower benchmarks have led to more competitive bids from plans: Bids have dropped from roughly 100 percent of FFS before the Affordable Care Act of 2010 to 88 percent of FFS in 2020. For 2020, about 82 percent of plans, accounting for 87 percent of projected MA enrollment, have bids below FFS spending. When a plan bids below the benchmark, its payment rate is its bid plus a share of the difference between its bid and the benchmark. We estimate that total Medicare payments to MA plans will average about 100 percent of FFS spending in 2020. Quality bonuses in 2020 will account for 2 percentage points to 3 percentage points of these payments. We estimate that uncorrected coding intensity would add 2 percentage points to 3 percentage points to these payments relative to FFS.

Encounter data—MA program policies currently rely on a large amount of plan information collected for a specific purpose (e.g., bid information, diagnostic information, quality data). Much of this information is summarized from plans' internal utilization data. In 2012, CMS began collecting detailed information about each encounter an MA enrollee has with a health care provider. MA plans are required to submit encounter data about all items and services provided to MA enrollees. Detailed and complete encounter data would be the best vehicle for learning about how, and how much, care is provided to the one-third of Medicare beneficiaries who receive their benefits through an MA plan.

The Commission has long been interested in using MA encounter data to gather information about MA plan practices and utilization that can then be used to inform Medicare policies, by improving MA payment policy, providing a useful comparator with the FFS Medicare program, or generating new policy ideas that could be applied across the entire Medicare program. However, we previously found that the encounter data submitted for 2014 and 2015 (preliminary) lacked completeness and accuracy, making them insufficient for these purposes. The Commission recommended that, given the value of complete encounter data, CMS should include assessments of data completeness in plan performance metrics, implement a payment withhold as a financial incentive for plans to improve data completeness and accuracy, and require submissions of providers' claims directly to Medicare administrative contractors if performance thresholds are not met.

We have updated our assessment of encounter data completeness using encounter data for 2015 (final), 2016, and 2017 dates of service. Although the encounter data have improved incrementally, we continue to find that encounter data are insufficiently complete for most uses. We plan to continue tracking the completeness of encounter data and the share of MA contracts with sufficiently complete encounter data in future years.

Risk adjustment and coding intensity—Medicare payments to MA plans are enrollee specific, based on a plan’s payment rate and an enrollee’s risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. Most claims in FFS Medicare are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify ordering a procedure. In contrast, MA plans have had a financial incentive, since the current risk adjustment model was introduced, to ensure that their providers record all possible diagnoses: Higher enrollee risk scores result in higher payments to the plan.

Our updated analysis for 2018 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 8 percent higher than scores for similar FFS beneficiaries. This estimate is higher than the prior year due to faster MA risk score growth relative to FFS risk score growth, which, except for 2016 and 2017, has been the norm since 2007. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a higher adjustment, the agency has never done so. In 2018, the adjustment reduced MA risk scores by 5.91 percent, leaving MA risk scores and payments about 2 percent to 3 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. In 2019 and subsequent years, the minimum adjustment for coding intensity will be 5.9 percent until risk adjustment incorporates MA diagnostic, cost, and use data. The Commission previously recommended that MA risk adjustment exclude diagnoses collected from health risk assessments, use two years of diagnostic data, and apply an adjustment for any residual impact of coding intensity in order to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity.

Quality in MA—The Commission has previously reported its concerns with the MA star rating system and recommended improvements. The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA. With one-third of the Medicare population enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare is

necessary for proper evaluation. The ability to compare MA and FFS quality and to compare quality among MA plans is also important for beneficiaries. Recognizing that the current quality program, though costly to Medicare, is not achieving its intended purposes, the Commission continues to work on developing a new value incentive program for MA.

Future direction of MA payment policy—Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits; however, some policies are deeply flawed and are in need of immediate improvement. For the immediate future, the Commission is assessing an alternative model to evaluate MA plan quality at the local level and distribute quality-based bonuses. Over the longer term, the Commission will review MA benchmark policy to improve equity and efficiency in the MA program.

On average across the nation, MA payments are about 2 percent higher than expected FFS expenditures for similar beneficiaries. In setting payment policy in the FFS sector, the Commission consistently applies a level of fiscal pressure on providers to promote the efficient provision of care while maintaining beneficiary access to good quality care. FFS payment policies can affect MA payments through the benchmarks, which are based on local FFS expenditure levels. Relying on fiscal pressure only in the FFS sector means that currently all savings to the program that come from MA must be generated through FFS spending reductions. However, given the level of overutilization in FFS and other factors not discussed in this chapter—the volume-inducing effects of traditional FFS, compounded by Medigap’s effect of insulating beneficiaries from true health care costs, and inappropriate spending owing to fraud and waste—we cannot conclude that achieving payment parity between MA and FFS Medicare would leverage any efficiency from the MA program. Consistent with the original incorporation of full-risk private plans in Medicare in 1982, in which private plans would be paid 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, the principle of equal treatment of the MA and FFS programs will need to include equal levels of cost and quality pressure in the two programs. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2019, the MA program included over 3,000 plan options offered by 184 organizations, enrolled over 22 million beneficiaries (34 percent of all Medicare beneficiaries), and paid MA plans an estimated \$274 billion (not including Part D drug plan payments). The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions), and develop robust information systems that can potentially provide timely feedback to providers. Plans also can provide incentives for beneficiaries to seek care from more efficient providers and give beneficiaries more predictable cost sharing; one trade-off is that choice of providers in plan networks is more limited than in FFS Medicare.

By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it lacks incentives to coordinate care and is limited in its ability to make care delivery more efficient. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a choice between private MA plans and traditional FFS Medicare that does not unduly favor one component of the program over the other through Medicare's payment systems or its monitoring and enforcement efforts.

Efficient MA plans can capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in those plans. However, some of the extra benefits that MA plans provide their enrollees result from payments that would have been lower under FFS Medicare for similar beneficiaries, in some parts of the country. Thus, some of those benefits are subsidized by higher government spending and higher beneficiary Part B premiums (including the premiums for enrollees in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To

encourage efficiency and innovation, MA plans need to face some degree of financial pressure similar to what the Commission recommends for providers in the traditional FFS program. One method of achieving equal financial pressure is to link private plans' payments more closely to FFS Medicare costs within the same market by modifying MA benchmarks. Alternatively, equal financial pressure can be achieved by establishing a government contribution that is equally available for enrollment in either FFS Medicare or an MA plan. The Commission will continue to monitor plan payments and performance and begin to develop policies to further improve the efficiencies of MA.

Each year, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and current quality indicators in MA.

Trends in enrollment, plan availability, and payments

In contrast to traditional FFS Medicare, beneficiaries in MA enroll in private health plans. Medicare pays plans a fixed rate per enrollee rather than FFS Medicare's fixed rate per service.

Types of MA plans

Our analysis of the MA program uses the most recent data available and reports results by plan type. The analysis does not cover non-MA private plan options that may be available to some beneficiaries, such as cost plans. The MA plan types are:

- ***HMOs and local preferred provider organizations (PPOs)***—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- ***Regional PPOs***—These plans are required to offer a uniform benefit package and premium across CMS-

designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.

- **Private FFS (PFFS) plans**—These plans may or may not use provider networks, depending on where they operate. The Medicare Improvements for Patients and Providers Act of 2008 mandated that, in areas with two or more network MA plans, PFFS plans have provider networks. Therefore, PFFS plans have to either locate in areas with fewer than two network plans or operate as network-based PFFS plans. Congress anticipated that the legislation would reduce the availability of and enrollment in these plans that did not manage care as efficiently as their HMO and PPO competitors.
- **Medicare Medical Savings Account (MSA) plans**—MSA plans are a combination of a high-deductible plan and a medical savings account. The plan is paid the full MA benchmark and places a deposit into the member's account that the member can use to help meet the plan deductible on Medicare services. In 2019, they were available in 14 states with a total enrollment of about 7,000 beneficiaries. However, because enrollment has been limited (beneficiaries dually eligible for Medicare and Medicaid are not eligible to enroll in MSA plans) and because the plans do not bid, we do not include them in our analyses.

Two additional plan classifications cut across plan types: special needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (those beneficiaries who are dually eligible for Medicare and Medicaid, require an institutional level of care, or have certain chronic conditions). SNPs must be CCPs. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. For more detailed information on SNPs, see our March 2013 report (Medicare Payment Advisory Commission 2013). As we recommended in an earlier report, employer plans no longer submit bids (since 2016), so we have only enrollment data for them. Therefore, they are not included in our access and payment analyses. For more detailed information on employer plans, see our March 2015 report (Medicare Payment Advisory Commission 2015).

How Medicare pays MA plans

Plan payment rates are determined by the MA plan bid—which represents the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which is based on local FFS spending and is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits. (Medicare also pays plans for providing the Part D drug benefit, but Medicare's Part D payments are determined through the Part D bidding process, and most, but not all, plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark. The benchmark that is compared with an individual plan's bid is a plan-specific risk-adjusted average, weighted by the plan's projected enrollment from counties in its service area. If a plan's bid is above the benchmark, its MA payment rate is equal to the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. If a plan's bid is below the benchmark, its payment rate is its bid plus a share (between 50 percent and 70 percent, depending on a plan's quality ratings) of the difference between the plan's bid and the benchmark. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for payment of the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can also devote some of the rebate to administration costs and margins. Plans may also choose to include additional supplemental benefits in their packages and charge premiums to cover those additional benefits. (A more detailed description of the MA program payment system can be found at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_ma_final_sec.pdf?sfvrsn=0.)

MA plan enrollment continued to grow faster than total Medicare beneficiary growth in 2019

Between November 2018 and November 2019, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 22.6 million enrollees (compared with lower growth in the same period for the total Medicare

**TABLE
13-1**

MA plan enrollment continued rapid growth in 2019

	MA enrollment (in millions)		Percent change in enrollment	2019 MA enrollment as a share of total Medicare
	November 2018	November 2019		
Total	20.5	22.6	10%	34%
Plan type				
CCP	20.3	22.5	11	32
HMO	13.1	14.1	7	21
Local PPO	5.9	7.2	22	11
Regional PPO	1.4	1.2	-8	2
PFFS	0.1	0.1	-26	<1
Restricted availability plans included in totals above				
SNPs*	2.8	3.2	13	5
Employer group*	4.2	4.5	6	7
Urban/rural				Share of Medicare population in MA
Urban	17.9	19.4	8	36
Rural	2.5	3.2	26	23

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). CCPs include HMO, local PPO, and regional PPO plans. Rural areas include counties designated as micropolitan counties and counties that are neither metropolitan nor micropolitan as defined by the Office of Management and Budget. Urban areas include metropolitan counties. The sum of column components may not equal the stated total due to rounding.
*SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

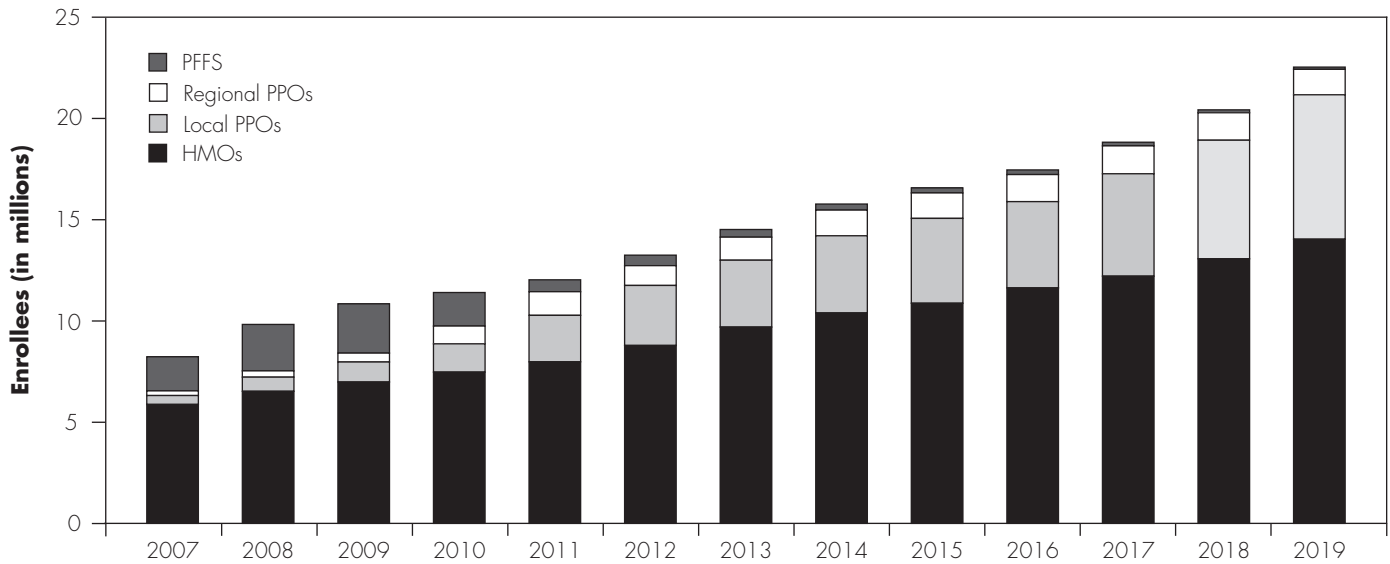
population and for FFS enrollment). During this period, MA enrollment rose from 33 percent (data not shown) to 34 percent of all Medicare beneficiaries (Table 13-1). The Commission’s previous work suggests that, although some beneficiaries enroll in MA immediately upon becoming eligible, most MA enrollees initially enroll in FFS Medicare and subsequently move to MA. For more on enrollment patterns, see our March 2015 report (Medicare Payment Advisory Commission 2015).

Among plan types, although enrollment grew more slowly from 2018 to 2019 in HMOs (7 percent) than in local PPOs (22 percent), HMOs continued to enroll the most beneficiaries (14 million) in 2019, with 21 percent of all Medicare beneficiaries in HMOs. Between 2018 and 2019,

enrollment in regional PPOs and PFFS plans dropped by 8 percent and 26 percent, respectively (Table 13-1). In 2019, SNP enrollment grew by 13 percent, and employer group enrollment grew by 6 percent.

Enrollment patterns differ in urban and rural areas. Over a third of urban beneficiaries are enrolled in MA compared with less than a quarter of beneficiaries residing in rural counties. In 2019, about 37 percent of rural MA enrollees were in HMO plans compared with about 67 percent of urban enrollees (not shown in Table 13-1). By contrast, 2 percent of rural enrollees were in PFFS plans compared with less than 1 percent of urban enrollees.

The share of Medicare beneficiaries enrolled in MA plans in 2019 varied widely by geography. In some metropolitan

**FIGURE
13-1****Medicare Advantage enrollment, 2007-2019**

Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization).

Source: MedPAC analysis of CMS enrollment files.

areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans. For example, in Anchorage, AK, where only employer group plans are available, 1 percent of beneficiaries were enrolled in MA. In other areas (Miami, FL; Pittsburgh, PA; Buffalo and Rochester, NY; and several areas in Puerto Rico), MA enrollment was 60 percent or more.

MA enrollment growth in 2019 continued a trend that started in 2003. Since 2003, overall enrollment has more than tripled (Figure 13-1, which begins with 2007). Trends vary by plan type. HMOs have grown steadily each year since 2003, but growth in other plan types has been more variable.

Plan availability for 2020

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2020, with most Medicare beneficiaries having access to many plans. Some measures

of availability have improved for 2020. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 13-2). In 2020, 98 percent of Medicare beneficiaries have an HMO or local PPO plan (local CCP) operating in their county of residence, up from 97 percent in 2019. Regional PPOs are available to 73 percent of beneficiaries in 2020, nearly the same as in 2019. Access to PFFS plans in 2020 is lower, available to 36 percent of beneficiaries, down from 38 percent in 2019. Overall, 99 percent of Medicare beneficiaries have access to an MA plan, and 99 percent have access to a CCP (total CCP data not shown in Table 13-2), similar to 2019.

The availability of SNPs improved across types of special needs population served. In 2020, 90 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 89 percent in 2019), 52 percent live where SNPs serve beneficiaries with chronic conditions

**TABLE
13-2****Access to Medicare Advantage plans remains high****Share of Medicare beneficiaries with access to at least one MA plan, by type**

Type of plan	2016	2017	2018	2019	2020
Any MA plan	99%	99%	99%	99%	99%
Local CCP	96	95	96	97	98
Regional PPO	73	74	74	74	73
PFFS	47	45	41	38	36
Special needs plans					
Dual eligible	83	86	86	89	90
Chronic condition	54	44	47	47	52
Institutional	50	52	56	63	67
Zero-premium plan with drug coverage	81	81	84	90	93
Average number of choices					
County weighted	9	10	10	13	15
Beneficiary weighted	18	18	20	23	27
Average monthly rebate for nonemployer, non-SNP plans	\$81	\$89	\$95	\$107	\$122

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). "Local CCP" includes HMO and local PPO plans. These figures exclude employer-only plans. Special needs plans are included in the three special needs plan rows but excluded from all other rows. A zero-premium plan with drug coverage includes Part D coverage and has no premium beyond the Part B premium. "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county. The plan rebate is the per beneficiary per month amount that the plan is offering as premium-free extra benefits.

Source: MedPAC analysis of CMS bid data and population reports.

(up from 47 percent in 2019), and 67 percent live where SNPs serve institutionalized beneficiaries (up from 63 percent in 2019). Overall, 94 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

In 2020, 93 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium), up from 90 percent in 2019 (Table 13-2). About 60 percent of nonemployer, non-SNP MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2020, 77 percent of beneficiaries have access to plans that offer some reduction in the Part B premium, up from 63 percent in 2019, but only 4 percent of 2020 enrollment was projected to be in these premium-reduction plans (data not shown).

For 2020, rebates (which can include allocations to plan administration and profit margin) for nonemployer, non-SNP plans will average \$122 per enrollee per month (nearly \$1,500 annually per enrollee). Notwithstanding MA plans being subject to the Affordable Care Act of 2010 (ACA) insurer fees in 2020 but not 2019, the average total rebates are 14 percent (\$15 per enrollee per month) higher than in 2019 and are the highest in the program's history. Plans project that \$60 per enrollee per month (49 percent) of rebates will go toward reductions in cost sharing for Medicare services.¹ (Among the allocated \$60 per enrollee per month for cost sharing, administrative expenses and margin account for 11 percent and 3 percent, respectively.) Plans project that \$22 per enrollee per month (18 percent) of rebates will be used for Part A and Part B supplemental benefits, which often include at least some

**TABLE
13-3**

Projected benchmarks, bids, and payments as a share of fee-for-service expenditures for 2020, by plan type

Share of FFS spending in 2020

Plan type	Benchmarks	Bids	Payments
All MA plans	107%*	88%*	100%*
HMO	107	87	100
Local PPO	109	94	104
Regional PPO	105	91	97
PFFS	106	105	105
Restricted availability plans included in totals above			
SNP	107	90	100

**Values would be increased by 2 to 3 percentage points if coding intensity were to be reflected fully using our most recent estimate (i.e., payments for all MA plans would average 102 percent to 103 percent of FFS spending if the coding differences were fully reflected).*

Note: FFS (fee-for-service), MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2020 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

*All numbers in this table have been risk adjusted and reflect quality bonuses, but they have not been adjusted for coding intensity differences between MA and FFS that exceed the statutory minimum adjustment.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

coverage for services such as dental, vision, fitness, or hearing services. On a more limited basis, some plans have started using rebates for supplemental benefits intended to help address social determinants of health.^{2,3} (Among the allocated \$22 per enrollee per month for supplemental benefits, administrative expenses and margin account for 12 percent and 4 percent, respectively.) Other uses of rebate dollars are for reductions in Part D premiums (13 percent of projected rebates), Part D supplemental benefits (18 percent of projected rebates), and reduction in Part B premiums (2 percent of projected rebates); MA plans cannot allocate administrative expenses or margin to these categories of benefits.

The average number of plans available in a county increased, and the number of counties without any plans decreased. On average, 15 plans are available in each county in 2020, up from 13 in 2019 (Table 13-2, p. 375). Plan availability can also be calculated weighted by the number of beneficiaries living in the county to give a sense of the number of plan choices available to the average beneficiary. Under that calculation, the average beneficiary

in 2019 has 27 available plans, an increase from 23 plans in 2019. In most counties, many MA plans are available to beneficiaries. For example, in 2020, beneficiaries in 30 counties—including 15 in Ohio and 10 in Pennsylvania—can choose from at least 50 plans. Beneficiaries in another 95 counties, including the major markets of Cincinnati, Cleveland, Los Angeles, Miami, New York City, and California’s Orange County, have at least 40 plan choices. At the other end of the spectrum, more than 240 counties, representing 1 percent of beneficiaries, have no MA plans available (Medical Savings Account plans and SNPs are not included in general availability measures); however, some of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).⁴

2020 benchmarks, bids, and payments relative to FFS spending

Using plans’ bid projections, we compare the Medicare program’s projected MA spending with projected FFS spending on a like set of FFS beneficiaries with similar geographic and risk profiles. We calculate and present

three sets of percentages: the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending. Benchmarks are set each April for the following year. Plans submit their bids in June and incorporate the recently released benchmarks. Benchmarks reflect FFS spending estimates for 2020 made by CMS actuaries at the time the benchmarks were published in April 2019.

The bid data mask the impact of differences in MA and FFS diagnostic coding, which inflate overall bids, benchmarks, and payments to MA plans by 2 percentage points to 3 percentage points. However, using the bid data allows for subgroup comparisons, such as by MA plan type shown in Table 13-3. Ignoring the impact of unaddressed coding differences, we estimate that for 2020, overall MA benchmarks including quality bonuses will average 107 percent, overall MA bids will average 88 percent, and overall payments will average 100 percent of FFS spending (Table 13-3). The benchmarks and payments are unchanged from 2019, while the bids are down from 89 percent of FFS (data not shown). Quality bonuses add about 2 to 3 percentage points to payments as a percentage of FFS spending.

The ratio of MA plan payments to FFS spending for 2020 varies by plan type (Table 13-3). For example, HMOs as a group bid an average of 87 percent of FFS spending, yet payments for HMO enrollees are estimated to average 100 percent of FFS spending because of benchmarks averaging 107 percent of FFS spending. Local PPOs' bids average 94 percent of FFS spending, and PFFS plans have average bids of 105 percent of FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 104 percent and 105 percent of FFS spending, respectively. Payments for beneficiaries enrolled in regional PPOs average 97 percent of FFS because of the regional PPOs' relatively low benchmarks.

We analyzed bids and payments to SNPs separately because these plans are available only to subpopulations of Medicare beneficiaries, and bidding behavior can differ from that of other plan types. In the past, SNPs' bids and payments tended to be slightly higher (relative to FFS spending) than payments to the other nonemployer MA plans. In the two most recent years in aggregate, however, SNP bids are slightly higher than other MA plans, but their payments are similar to the average plan.

In the past, we recommended that CMS pay employer plans differently because the employer bids were not usually submitted for a competitive purpose, while the bids for other plans are submitted to compete for enrollment. For more details on employer plans and our recommendation, see our March 2014 report (Medicare Payment Advisory Commission 2014). As we recommended, CMS no longer pays the employer plans based on their bids, but instead pays them based on the bidding behavior of the nonemployer plans. As a result, we expect that payments to employer plans will look somewhat like the payments to the plans in our analysis.

How Medicare calculates MA benchmarks

Under the ACA, each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the average per capita FFS Medicare spending for the county's beneficiaries.⁵ Each county's benchmark, excluding quality bonuses, is determined by organizing the counties into quartiles based on their FFS spending. Each quartile contains 785 or 786 counties. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans, and high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings. Counties (excluding the territories) are assigned to quartiles based on average FFS spending; the highest spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next highest spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest spending quartile has benchmarks set at 115 percent of local FFS spending. (U.S. territories are treated like counties in this low-spending quartile.) Counties can move among quartiles from year to year and in doing so receive a blended quartile factor; for example, a county moving from the 100 percent quartile in 2018 to the 107.5 percent quartile in 2019 would have a blended rate of 103.75 percent.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and their benchmarks are 10 percent higher than the standard benchmarks.⁶ Unlike nearly all of Medicare's FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars.

**TABLE
13-4****Distribution of 2020 MA bids relative to FFS**

Bid-to-FFS ratio	Share of bids	Share of projected MA enrollment
Less than 0.7	4%	4%
0.7 to 0.8	13	18
0.8 to 0.9	30	33
0.9 to 1.0	35	33
1.0 to 1.1	14	11
More than 1.1	4	2

Note: MA (Medicare Advantage), FFS (fee-for-service). Employer group plans and special needs plans are not included. Ratios do not account for unaddressed coding intensity differences. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and FFS expenditures.

The Commission's original conception of a quality incentive program for MA plans was a system that would be budget neutral and financed with a small percentage of plan payments (Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2004). A budget-neutral system is consistent with the Commission's principle of providing equal treatment of private MA plans and traditional FFS Medicare (Medicare Payment Advisory Commission 2019b).

Variation in MA bids and payments

In 2020, benchmarks are lower relative to FFS than in earlier years. Declining benchmarks have exerted fiscal pressure and have led to more competitive bids from plans. Before the ACA (in 2010), benchmarks averaged about 112 percent of FFS and the bids averaged 100 percent of FFS. In 2020, about 82 percent of plans bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits (Table 13-4). These plans are projected to enroll about 87 percent of MA enrollees, excluding those in employer group and SNP plans. About 4 percent of MA enrollees are projected to enroll in plans that bid lower than 70 percent of FFS spending; 2 percent are projected to enroll in plans that bid more than 110 percent of FFS spending.

Although plan bids average less than FFS spending, payments for these plans' enrollees can often exceed FFS spending because the benchmarks (including the quality bonuses) can be high relative to their area's FFS spending. Figure 13-2 shows how plans bid relative to FFS

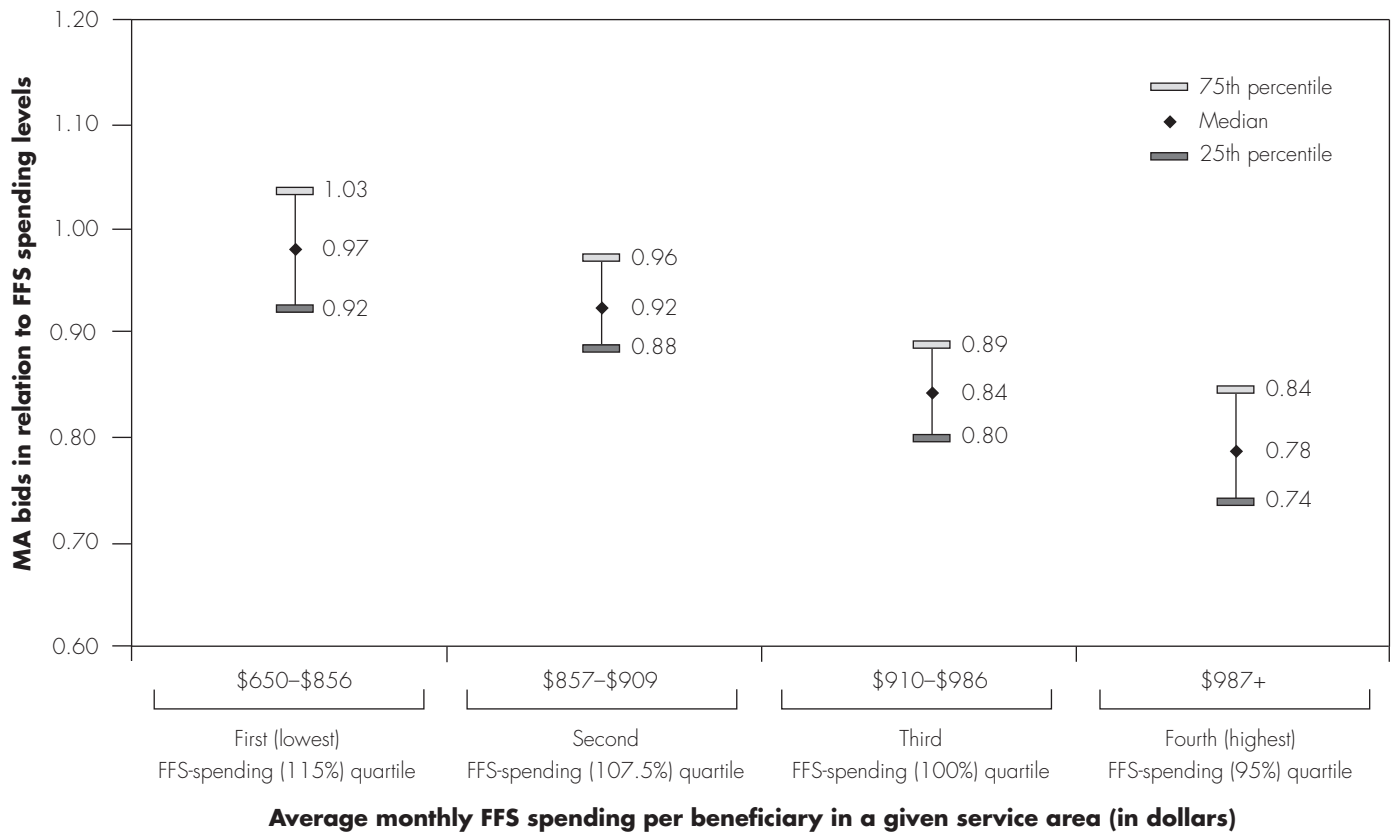
for service areas with different ranges of FFS spending. Each of the four FFS ranges covers the bids of at least 540 plans that include at least 3.7 million projected enrollees. As expected, plans bid higher (relative to FFS) in areas with relatively low FFS spending and bid lower (relative to FFS) where FFS spending is relatively high. However, even most plans in service areas with the lowest FFS spending—less than \$857 per month on average—bid less than the FFS spending level for 2020 (Figure 13-2). In plan service areas averaging \$857 or more per month in FFS spending, most plans are likely to bid far below the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. As benchmarks have declined over the past few years, plans serving areas with benchmarks set at 115 percent of FFS spending (the lowest spending quartile, corresponding to areas with benchmarks below \$857 per month in 2020) have been bidding below FFS far more frequently. The median bid for areas in this quartile has declined from 1.11 times FFS in 2013 to 0.97 times FFS in 2020. However, the increased efficiency of plan bids in these areas, which were presumed to be the most challenging for MA plans to compete in, have not translated to Medicare savings. For 2020, Medicare is still paying an average of 110 percent of FFS spending in these areas because the benchmarks average 117 percent of FFS when quality bonuses are included.

MA margins

The continued growth in MA enrollment, the ability of MA plans to bid well below FFS expenditure levels, and

FIGURE 13-2

Medicare Advantage bids in relation to FFS spending levels, 2020



Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 3,380 plan bids and excludes employer group plans, special needs plans, and plans in the territories. Ratios do not account for unaddressed coding intensity differences.

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

plans’ ability to provide generous extra benefits point to continued strong financial health in the MA sector. Margins for MA sponsors have remained stable. The most recent data available, from 2018, show that MA plans reported margins that average 1.9 percent; however, after removing 20 outlier contracts that reported greater medical expenses than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and no revenue to cover administrative expenses), MA margins averaged 3.3 percent.⁷ This figure excludes Part D—for which we do not have 2018 data—and the following plan categories that do not submit bids: employer group plans, the Medicare–Medicaid demonstration plans, cost-reimbursed plans, Program of

All-Inclusive Care for the Elderly, and medical savings account plans.

We estimate that if we were to include Part D drug plan margins, doing so would raise the average MA plan margin by approximately 0.5 percent; and if employer plan data were available, the margin levels may be higher. The absence of data on employer plans—20 percent of MA enrollment in 2018—limits our ability to determine the average margin level in the MA sector. For prior years, when employer plans were included in the bid data, we found that employer plan margins were higher than the margins of other MA plans (Medicare Payment Advisory Commission 2016). Our last estimate of margins that

**TABLE
13-5**

Share of Medicare Advantage enrollment by parent organization, October 2019

Metropolitan areas		Nonmetropolitan areas	
Parent organization	Share of total MA enrollment in metropolitan counties	Parent organization	Share of total MA enrollment in nonmetropolitan counties
UnitedHealth Group Inc.	26%	UnitedHealth Group Inc.	29%
Humana Inc.	17	Humana Inc.	26
CVS Health Corporation	10	CVS Health Corporation	10
Kaiser Foundation Health Plan Inc.	8	Anthem Inc.	4
Anthem Inc.	5	Blue Cross Blue Shield of Michigan	3
WellCare Health Plans Inc.	2	WellCare Health Plans Inc.	2
Blue Cross Blue Shield of Michigan	2	BlueCross BlueShield of Tennessee	2
CIGNA	2	Geisinger Health	1
InnovaCare Inc.	1	CIGNA	1
Centene Corporation	1	UPMC Health System	1
Total, top 10 organizations	76	Total, top 10 organizations	80

Note: MA (Medicare Advantage). Includes only Medicare Advantage plans (coordinated care plans, private fee-for-service, and Medicare Savings Account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. The nonmetropolitan counties include those designated as micropolitan counties and counties that are neither metropolitan nor micropolitan as defined by the Office of Management and Budget. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS monthly enrollment reports, October 2019 (which excludes enrollment for contracts where an organization has fewer than 11 enrollees), and Census data on county designations.

included Part D and employer group plans was calculated on 2013 data. In that analysis, we found that overall plan margins were 4.2 percent.

Margins vary by plan tax status. In the 2018 data, nonprofit plans reported a margin of 0.7 percent; for-profit entities reported a pretax margin of 4.0 percent.⁸ As noted in our March 2018 report to the Congress, the large difference in margins (3.3 percentage points) between for-profit and nonprofit entities could reflect that bid data do not include employer group plans (Medicare Payment Advisory Commission 2018b). Given the relatively high margins of employer group plans in prior years, including these plans may particularly increase MA margins for nonprofit plans whose overall MA business is disproportionately more reliant on employer group plans. Further, for-profit entities’ MA plan margins are slightly lower in 2018 because MA plans were subject to payment

of the ACA insurer fees in 2018 but not 2017. In 2018, the insurer fees represented about 1.5 percent of total revenue.

All categories of SNPs had positive margins in 2018. Dual-eligible SNPs (D–SNPs), for Medicare–Medicaid dual-eligible beneficiaries, had margins of 6.6 percent. SNPs for enrollees with certain chronic conditions (C–SNPs) had margins of 8.1 percent. Institutional SNPs (I–SNPs) had margins of 9.6 percent. The 2018 profit margin among nonprofit D–SNPs was 3.0 percent.

Market structure of the Medicare Advantage program

The MA market has become more concentrated over the years, particularly after 2011. In 2007, the top 4 organizations had 45 percent of MA enrollment, and the top 10 had 61 percent of total enrollment. At the beginning of 2011, the year before the effective date of

**TABLE
13-6**

Distribution of population by number of MA parent organizations operating in the county, October 2019

Number of MA parent organizations in county	As share of total Medicare population	As share of MA enrollment
None	2%	<0.1%
1	1	0.1
2	1	0.2
3	3	1
4	7	6
5 or more	87	92

Note: MA (Medicare Advantage). Excludes plans offered only to employer group-sponsored retirees. Components may not total 100 percent due to rounding. The less than 0.1 percent of MA enrollees residing in areas with no MA organizations are "out-of-area" enrollees whose recorded address is outside of the designated service area of their plan.

Source: MedPAC analysis of CMS enrollment reports.

ACA payment changes, the shares remained essentially the same at 46 percent and 60 percent, respectively. In 2018, the top 4 organizations had 59 percent of enrollment (and increased to 62 percent in 2019), and the top 10 organizations had 74 percent of total enrollment, which increased slightly to 76 percent in 2019.

There are differences between metropolitan and nonmetropolitan areas (Table 13-5). In metropolitan areas in 2019, the top 2 organizations had 43 percent of the 19.3 million MA enrollees residing in these areas (1 percentage point higher than in 2018; data not shown). In nonmetropolitan areas, the top 2 organizations accounted for over half the enrollment (55 percent of the 3.2 million MA enrollees residing in these areas, unchanged from 2018).

Another way of looking at the market structure and level of competition in the MA program is to determine the number of parent organizations offering MA options in markets across the country. In 2019, 97 percent of Medicare beneficiaries resided in a county where at least three companies offered MA plans to individual Medicare beneficiaries (Table 13-6), compared with 92 percent in 2017. Thus, although the MA market is relatively concentrated by some measures, most beneficiaries reside in geographic areas where multiple companies offer MA options.

Medicare Advantage encounter data

In 2012, CMS began collecting detailed information about each encounter an MA enrollee has with a health care provider. MA plans are required to submit information about all items and services provided to MA enrollees. Our June 2019 report to the Congress gives greater detail about the encounter data submission and screening process, feedback provided to plans about submitted data, potential uses of encounter data, and our assessment of encounter data completeness and accuracy (Medicare Payment Advisory Commission 2019a).

The Commission has long been interested in using MA encounter data to gather information about MA plan practices and utilization that can then be used to inform Medicare policies, either by informing improvements to MA payment policy, providing a useful comparator with the FFS Medicare program, or generating new policy ideas that could be applied across the entire Medicare program. However, we found the encounter data submitted for 2014 and 2015 (preliminary) lacked completeness and accuracy, making them insufficient for these purposes (Medicare Payment Advisory Commission 2019a). Complete and accurate encounter data could replace several data submissions (often summarized from plans' internal utilization data), the use of FFS data for MA risk adjustment, and other provider submissions

used to implement Medicare policies. Such data could also provide more rigorous oversight for the one-third of Medicare beneficiaries receiving their benefit through an MA plan and greater assurance that the \$274 billion of taxpayer money paid to MA plans is spent appropriately.

Through discussion leading to our June 2019 chapter on encounter data, the Commission concluded that encounter data are promising and the value of complete and accurate encounter data to the program will be significant; thus, they should continue to be collected (Medicare Payment Advisory Commission 2019a). The Commission recommended the following:

The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of Medicare Advantage (MA) encounter data and:

- rigorously evaluate MA organizations' submitted data and provide robust feedback;
- concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and
- institute a mechanism for direct submission of provider claims to Medicare administrative contractors
 - as a voluntary option for all MA organizations that prefer this method
 - starting in 2024, for MA organizations that fail to meet thresholds or for all MA organizations if program-wide thresholds are not achieved.

MA encounter data validation

When plans submit encounter data, CMS performs automated front-end checks before accepting each record. Errors or problems cause the system to reject the submission, which means no record will appear in the encounter data files unless the plan resubmits the data. If encounters are not present in the data files, we are unable to tell whether that absence is a result of the plan not submitting or the system not accepting the record.

One set of our analyses compared encounter data for certain service types with external sources (collected from sources other than MA plans) of MA service use:

- inpatient stays—Medicare Provider Analysis and Review (MedPAR) file
- dialysis services—risk adjustment indicator

- home health services—Outcome and Assessment Information Set (OASIS)
- skilled nursing stays—Minimum Data Set (MDS)

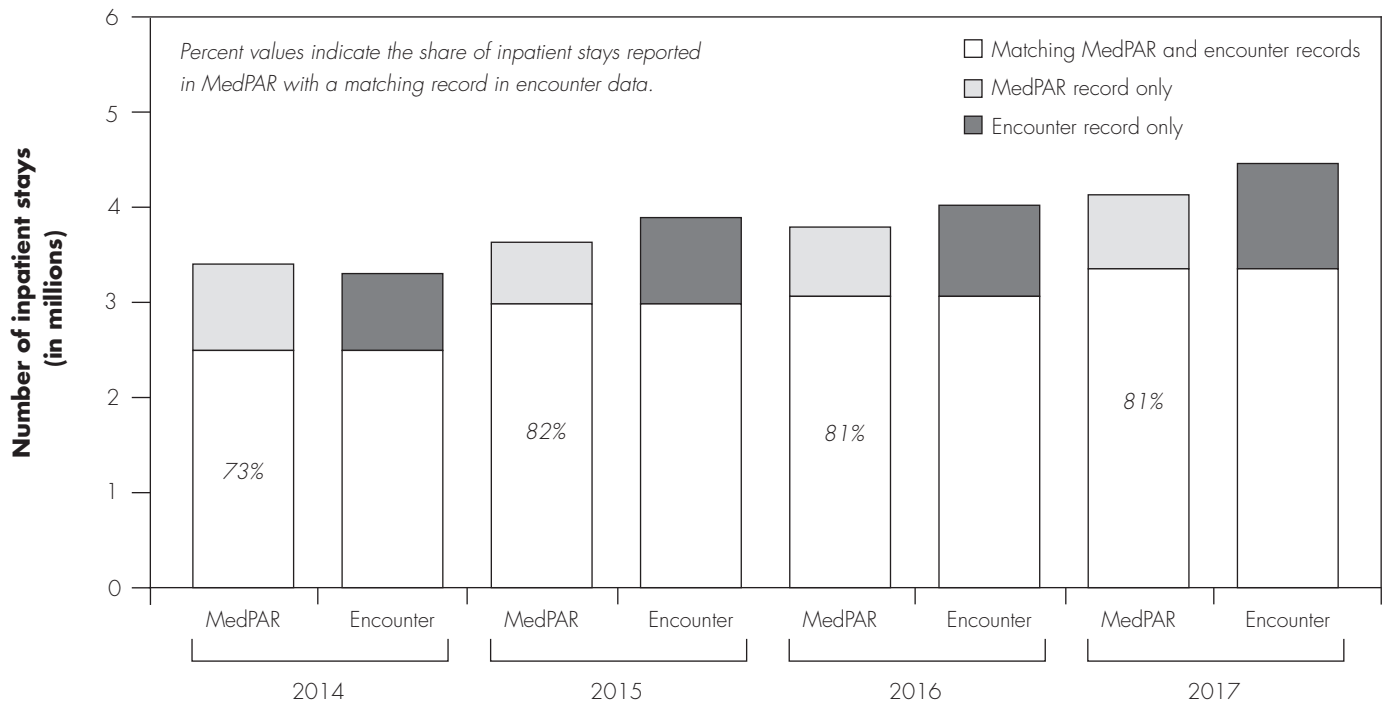
MedPAR data on inpatient stays are collected from information-only claims (i.e., a “no-pay” copy of an MA claim that is submitted to Medicare) that hospitals are required to submit for MA enrollee stays. The dialysis risk adjustment indicator is triggered when a dialysis facility submits a medical evidence form to CMS indicating that a patient has begun dialysis. OASIS assessment data are collected for all Medicare beneficiaries and submitted to CMS by home health agencies at the start of an episode and at several points afterward. MDS assessment data are collected and submitted to CMS by skilled nursing facilities (SNFs) within 14 days of admission for MA enrollees.⁹

Although some of these data sources are themselves incomplete—limiting how comprehensively we can assess encounter data—that incompleteness does not diminish findings that records are missing from encounter data. Each comparison data source provides evidence of services that were provided to MA enrollees, and CMS requires encounter records to be submitted for these enrollees and services. To the extent that the comparison data source is itself incomplete, these records either may appear only in the encounter data or may be missing from both the encounter and comparison data. When comparing two incomplete data sets, we can only identify a lower bound on the extent of the actual incompleteness of each. Moreover, we cannot compare the majority of physician and outpatient hospital encounter data with an external data source because there is no available alternative source of physician and outpatient hospital utilization information for MA enrollees.

Our comparisons test only whether there are encounter data corresponding to the MA services identified in external data sources. For all of the comparisons, we began by determining whether the same enrollee appears in the encounter data and comparison data set. For inpatient admissions, we also matched by date of service. Because the initial comparisons demonstrated a lack of completeness, we did not proceed to analyze subsequent questions, such as whether the records matched in terms of performing physician and diagnosis or procedure codes, among other included data elements. To ensure that encounter data are sufficiently complete and accurate to

FIGURE 13-3

Inpatient stays reported in MedPAR and encounter data* and share of MedPAR-recorded stays with matching encounter record, 2014 to 2017



Note: MedPAR (Medicare Provider Analysis and Review). An “inpatient stay” record is defined as a unique beneficiary identification number, admission date, and discharge date combination. Includes HMO and preferred provider organization contracts only.
 *Encounter data include encounter records and chart review records. Chart review records can either be associated with and provide additional information about an encounter record or be unlinked to any encounter records.

Source: MedPAC analysis of CMS data.

compare MA with FFS, a full validation analysis would need to assess additional important data elements.

In our initial analysis (included in Chapter 7 of our June 2019 report), we excluded contracts that are not required to submit encounter data. For the analysis presented here, we include only HMO and PPO contracts (representing more than 99 percent of MA plan enrollment), so some numbers may differ from those originally reported in the June 2019 chapter on encounter data.

Comparison of inpatient stays with MedPAR

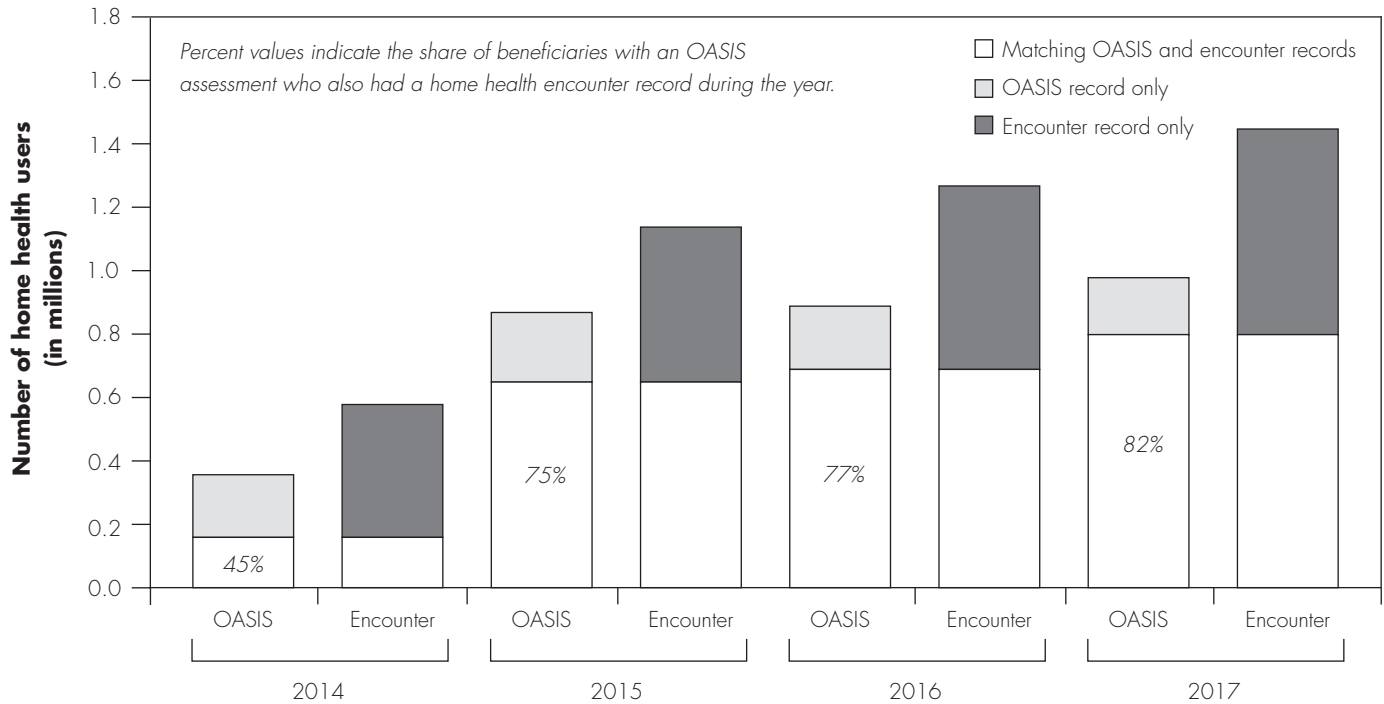
The MedPAR file contains information about inpatient hospital stays and is used to calculate disproportionate share hospital (DSH) and graduate medical education (GME) payments. Hospitals are required to submit

information-only claims records to Medicare administrative contractors (MACs) for all MA inpatient stays so CMS can include these records in the MedPAR file. Hospitals that receive DSH and GME payments have a financial incentive to submit complete information about MA enrollees. The only incentive for other hospitals to submit information-only claims is to meet program requirements.

Figure 13-3 shows that between 2014 and 2015, the share of inpatient stays reported in MedPAR with a matching encounter record increased from 73 percent to 82 percent but remained roughly constant in 2016 and 2017 at 81 percent. Although encounter data completeness improved over the period we analyzed, nearly 800,000 inpatient stays reported in MedPAR were missing in encounter data in 2017.

FIGURE 13-4

Home health users reported in OASIS and encounter data* and share of OASIS-recorded users with an encounter record, 2014 to 2017



Note: OASIS (Outcome and Assessment Information Set). Includes HMO and preferred provider organization contracts only.
 *Encounter data include encounter records and chart review records. Chart review records can either be associated with and provide additional information about an encounter record or be unlinked to any encounter records.

Source: MedPAC analysis of CMS data.

Comparison of home health use with OASIS

Home health agencies are required to submit an OASIS assessment to CMS for all Medicare beneficiaries at the start of a home health episode and at several points thereafter. However, OASIS assessments are not required to be sent to MA plans and generally do not affect payment from the plan. We compared MA enrollees with an OASIS assessment to MA enrollees with a home health encounter record during the calendar year. This analysis assesses only whether a beneficiary identifier was found in both data sources for the year.

Figure 13-4 shows that the share of home health users identified through OASIS assessments who also had a home health encounter record during the year rose between 2014 and 2017 from 45 percent to 82 percent. Figure 13-4 also highlights that for 2017, many more

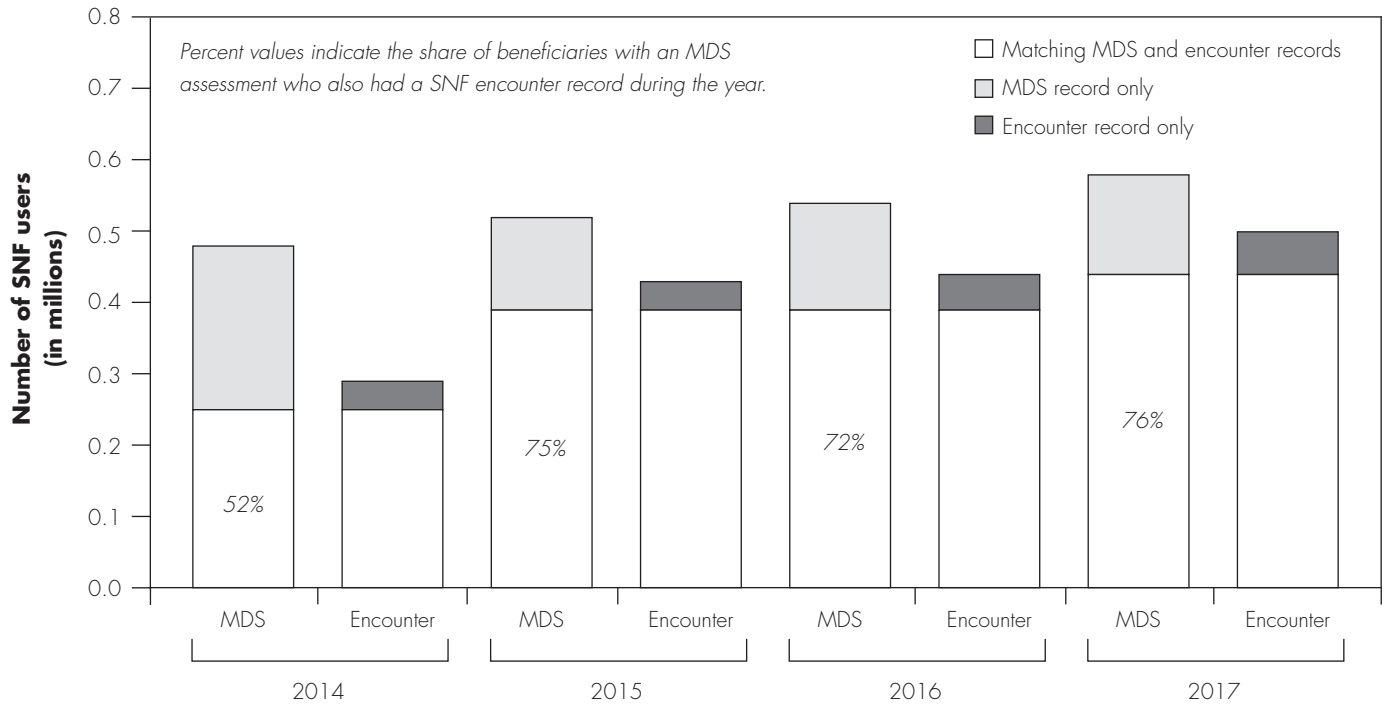
home health users are identified in encounter data than in OASIS data, demonstrating that the ability to assess completeness of home health encounter data is limited by the incompleteness of OASIS data. Despite this limitation, the OASIS data identify nearly 180,000 home health users that are missing from the encounter data.

Comparison of skilled nursing facility use with MDS

SNFs are required to submit an MDS assessment to CMS for all Medicare beneficiaries within the first 14 days of a SNF stay, and—for beneficiaries with SNF episodes that are of sufficient duration—quarterly and annual assessments are also required.¹⁰ However, MDS assessments are not required to be sent to MA plans and generally do not affect payment from the plan. We compared MA enrollees who had an MDS assessment

FIGURE 13-5

SNF users without full Medicaid eligibility reported in MDS and encounter data* and share of MDS-recorded users with an encounter record, 2014 to 2017



Note: SNF (skilled nursing facility), MDS (Minimum Data Set). Includes HMO and preferred provider organization contracts only.
 *Encounter data include encounter records and chart review records. Chart review records can either be associated with and provide additional information about an encounter record or be unlinked to any encounter records.

Source: MedPAC analysis of CMS data.

with enrollees who had a SNF encounter record during the calendar year. This analysis assesses only whether a beneficiary identifier was found in both data sources for the year and excludes MA enrollees who are eligible for full Medicaid benefits.¹¹

We would expect more enrollees to have a SNF encounter record than an MDS assessment because MA enrollees with a SNF stay of less than 14 days may not have an MDS assessment. However, Figure 13-5 shows that fewer MA enrollees had a SNF encounter record than an MDS assessment during each calendar year. Between 2014 and 2017, the share of SNF users in MDS data who also had a SNF encounter record increased from 52 percent to 76 percent, but these findings also show that there were nearly 140,000 SNF users without any SNF encounter records.

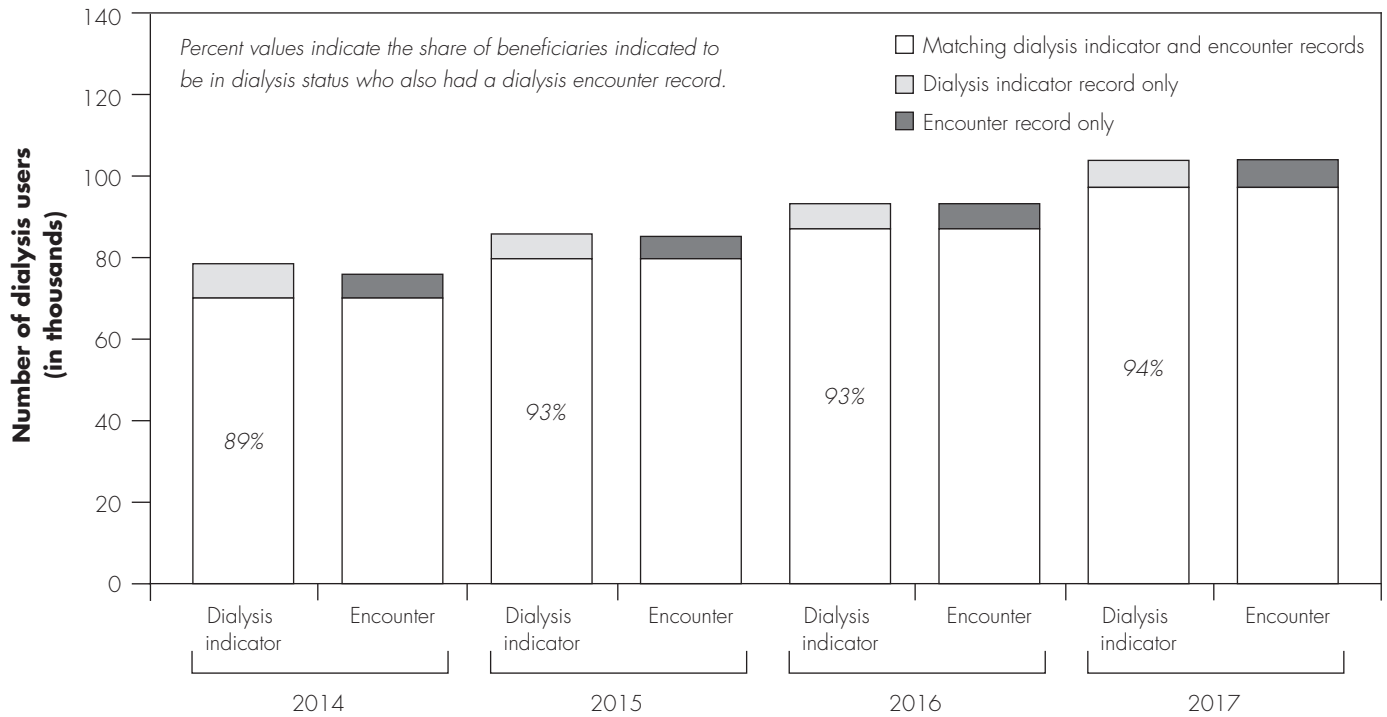
Comparison of dialysis users with risk adjustment indicator data

Dialysis facilities submit a medical evidence form to CMS when a patient with end-stage renal disease begins dialysis. The form triggers an indicator, which, for MA enrollees, results in Medicare’s payment being based on the dialysis risk adjustment model. For each calendar year, we compared MA enrollees with the dialysis indicator to MA enrollees with a dialysis encounter record. This analysis assesses only whether a beneficiary identifier was found in both data sources for the year.

Figure 13-6 (p. 386) shows that the proportion of MA enrollees with the dialysis indicator (i.e., a dialysis medical evidence form submitted to CMS) who also had at least one dialysis encounter grew between 2014 and 2017 from 89 percent to 94 percent. The dialysis indicator

**FIGURE
13-6**

Dialysis users reported in risk adjustment indicator and encounter data* and share of indicated dialysis users with an encounter record, 2014 to 2017



Note: Includes HMO and preferred provider organization contracts only.

*Encounter data include encounter records and chart review records. Chart review records can either be associated with and provide additional information about an encounter record or be unlinked to any encounter records.

Source: MedPAC analysis of CMS data.

data suggest that about 6,000 dialysis users did not have a dialysis encounter record during the year; however, some users may stop using dialysis treatment without receiving a transplant, which could account for the lack of a dialysis encounter record for some enrollees with the dialysis indicator.

MA plans submitting relatively complete encounter data

To assess whether some MA plans submitted relatively complete encounter data, we conducted comparisons of encounter data with MedPAR, dialysis risk adjustment indicator, MDS, and OASIS data at the contract level. We limited our analysis to HMO or PPO contracts with 2,500 or more enrollees in 2017, including about 330 contracts and about 99 percent of HMO or PPO enrollment—about

96 percent of enrollment in contracts required to submit encounter data.

Of the 330 contracts, 30 contracts had match rates of at least 90 percent for all 4 data sets, representing about 5 percent of HMO and PPO enrollment. The 30 contracts comprised health system, regional, and national plan sponsors, whereas our analysis of 2015 data found just 7 contracts—primarily health system sponsors—with match rates of at least 90 percent for all 4 data sets. No contracts had match rates of 95 percent or greater on all four data sets in 2017.

We plan to continue tracking the completeness of encounter data and the share of MA contracts with relatively complete encounter data in future years.

Medicare Advantage risk adjustment and coding intensity

Medicare payments to MA plans are adjusted to account for differences in beneficiary medical costs through the CMS hierarchical condition category (CMS–HCC) model. The model uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. Higher risk scores generate higher payments for beneficiaries with higher expected expenditures and vice versa. CMS designed this risk adjustment model to maximize its ability to predict annual medical expenditures for Medicare beneficiaries, with some constraints. Therefore, in developing the model, CMS used statistical analyses to select certain HCCs for inclusion in the model based on each HCC’s ability to predict annual Medicare expenditures, ensuring that the diagnostic categories included in the model were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS applies additional criteria to ensure the validity and reliability of the model’s diagnostic data. To be used in determining payment to MA plans, (1) diagnoses must appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional, and (2) diagnoses must be supported by evidence in the patient’s medical record.¹²

Diagnostic data in the CMS–HCC model are used prospectively, meaning that diagnoses collected during one calendar year are used to predict Medicare costs for the following calendar year. A particular diagnosis code needs to be submitted only once during the data collection year for the related HCC to be counted in an enrollee’s risk score in the following payment year. Multiple submissions of the same diagnosis code and submissions of different diagnosis codes that are grouped in the same HCC do not affect an enrollee’s risk score.

Each demographic and HCC component in the risk adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated based on FFS Medicare claims data such that all Medicare spending in a year is distributed among the model components. Medicare payment for a particular MA enrollee is approximately equal to the sum of the dollar-

value coefficients for all components identified for that enrollee.¹³ Although the actual dollar amount a plan will receive for newly identifying a particular HCC depends on several additional factors, we consider a simplified example using average FFS Medicare spending to show of how coding additional HCCs increases payment to a plan. To illustrate, the annual Medicare payment to the MA organization in 2018 for an 84-year-old male who was not eligible for Medicaid (demographic component valued at \$5,707) with diabetes without complication (HCC 19, valued at \$1,058) would have been \$6,765, the sum of the two model components. Documenting each additional HCC for that enrollee can significantly increase the Medicare payment. If the same 84-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at \$3,031), the Medicare payment to the MA organization would increase from \$6,765 to \$9,796. The payment per MA enrollee for most HCCs when identified is between \$1,000 and \$5,000, although some HCCs increase payment by \$10,000 or more.

In addition to the direct increase in payment rates, plans benefit from coding more comprehensively by gaining an advantage through the determination of extra benefits. Plans that can offer extra benefits of greater value may attract more new enrollees. How diagnostic coding affects the determination of extra benefits is a function of the bidding rules. There are two steps in the bidding process that involve risk adjustment and the determination of extra benefits. In the first step, a plan states its revenue need—its bid—for providing the Medicare Part A and Part B benefit, based on its expected enrolled population, and determines a risk score for the expected population. The second step compares the bid with a benchmark, which is adjusted by the risk score for the plan’s expected population so that the comparison is based on a population with equivalent health status. If the bid is higher than the risk-adjusted benchmark, beneficiaries pay the difference in the form of a premium.¹⁴ When the bid is below the risk-adjusted benchmark, the plan receives part of the difference as a rebate that is used to provide extra benefits to beneficiaries. The size of the rebate (or the value of extra benefits) is a share of the difference between the bid and risk-adjusted benchmark.

Plans that put more effort into documenting all diagnosis codes, increasing their average risk score relative to other plans, can inflate the risk-adjusted benchmark used to determine the size of their rebate when compared with

**TABLE
13-7**

Illustrative example: Differences in plan risk scores affect the level of extra benefits

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted benchmark for this plan (benchmark multiplied by risk score)	Rebate base (risk-adjusted benchmark less cost of care)	Share of base for rebates	Value of extra benefits (rebate amount)
Nonbonus plans							
Plan A (3.5 stars)	\$900	0.97	\$952	\$924	\$24	65%	\$15
Plan B (3.5 stars)	900	1.03	952	981	81	65	53
Bonus plan							
Plan Z (4 stars)	900	0.97	1,000	970	70	65	46

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is \$900 for each of the three plans and that Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.

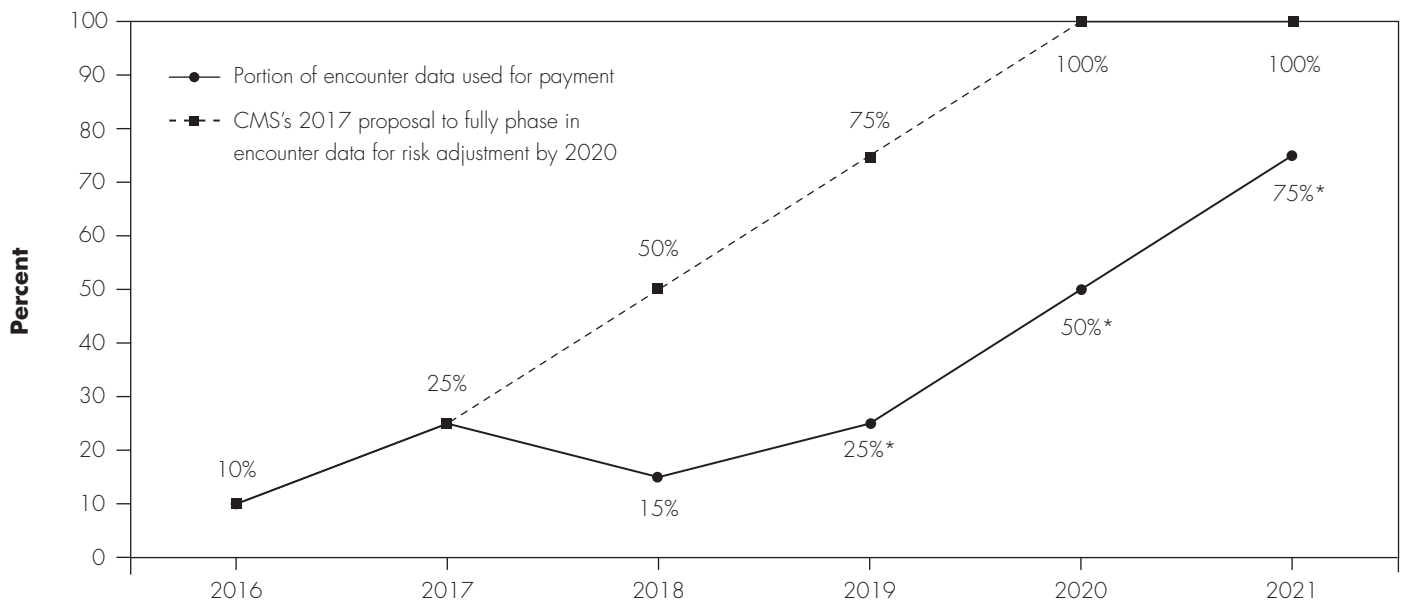
their bid. Table 13-7 illustrates this effect, using three hypothetical plans that have the same cost of care for their set of enrollees, at \$900 per month. Although all three plans have actual costs of \$900 per month, Plans A and Z have an expected risk score below 1.0 (at 0.97), and Plan B has an expected risk score of 1.03. All three plans have bids below the risk-adjusted benchmark and must provide extra benefits funded by rebates. Because Plan B has a higher risk score, its rebate is larger than Plan A and it can offer enrollees more benefits: \$38 per month more in extra benefits (\$53 minus \$15). If Plan B has inflated its risk score through greater diagnostic coding effort and its risk score otherwise would be the same as that of Plan A and Plan Z, Plan B will have an unfair competitive advantage. The higher risk score also gives Plan B, which has only 3.5 stars, an advantage over bonus-level Plan Z; Plan B has a higher total rebate amount: \$7 more. Thus, by increasing its risk score from 0.97 to 1.03, Plan B will be able to offer a level of extra benefits that is of more value than that provided through quality bonuses. Thus, differences in coding practices can more than offset the effect of MA quality bonuses and can have significant consequences for MA payment policy.

In the example illustrated in Table 13-7, plans have a risk score difference of 6 percentage points that reflects only coding practices. The Commission's analysis of MA coding practices suggests that there is a far wider range of

coding variation, with several contracts having risk scores inflated by 15 percent or 20 percent above FFS due to coding practices (see Figure 13-10, p. 394).

MA plans submit diagnostic information to CMS in two ways: (1) through the Risk Adjustment Processing System (RAPS), for which plans submit the minimum information necessary to identify which HCCs apply to each enrollee, and (2) through the encounter data system (EDS), for which MA plans submit detailed information about each health care encounter an enrollee has with a Medicare provider. CMS initially used RAPS to calculate risk scores, but in 2016, it began a transition to use encounters as the source of diagnostic information by generating two risk scores, one based on RAPS data and one based on EDS data.¹⁵ Figure 13-7 shows the use of encounter data for risk adjustment since 2016. In that year, payment was based on a blend of the RAPS risk score (90 percent) and the EDS risk score (10 percent). In 2017, CMS increased the portion of the payment based on EDS risk scores to 25 percent and stated an intention to continue to increase the use of EDS until 2020 (dashed line in Figure 13-7), when payment would be fully based on EDS risk scores. However, for 2018, CMS reduced the portion of the payment based on EDS risk scores to 15 percent.

For 2019, CMS noted that inpatient encounter record submissions were low relative to inpatient RAPS

**FIGURE
13-7****Use of encounter data for MA risk scores, 2016–2021**

Note: MA (Medicare Advantage).

*For 2019 and 2020, and proposed for 2021, CMS will add inpatient Risk Adjustment Processing System data to encounter data, making the true proportion of risk scores based on encounter data less than the percentage noted in the figure.

Source: CMS announcement of MA rates.

submissions and therefore based 25 percent of risk scores on pooled encounter data and inpatient RAPS data, with the remaining 75 percent of risk scores based on RAPS data alone. For 2020, CMS will base 50 percent of risk scores on pooled encounter data and inpatient RAPS data and 50 percent on RAPS data alone.

Given CMS's concern about the difference in inpatient stays submitted in encounter and RAPS data, we compared MA inpatient stays (defined using unique beneficiary identifier, admission date, and submission date) reported in encounter, RAPS, and MedPAR data. MedPAR data include copies of claims (i.e., "no-pay" claims) that hospitals submit directly to CMS, generally at the same time the hospital submits a claim to an MA plan for payment.¹⁶ In our June 2019 chapter on MA encounter data completeness, we reported the results of this comparison using 2015 RAPS and MedPAR data and preliminary 2015 encounter data (Medicare Payment Advisory Commission 2019a). We have since updated this

comparison with data for 2016 and 2017 and found similar results. For 2017, we found that:

- many more inpatient stays were reported in RAPS (6.6 million) than in MedPAR (4.3 million) or encounter data (4.7 million); however,
- a disproportionate share of inpatient stays reported in RAPS data (about 20 percent) had the same admission and discharge date compared with MedPAR data (about 2 percent) and encounter data (about 1 percent).

Because of the large number of "inpatient stays" reported in RAPS data with the same admission and discharge date, we compared these stays with physician visits and outpatient hospital visits reported in encounter data. We found that, of the 1.3 million same-day discharge stays reported in 2017 RAPS data, 92 percent had the same beneficiary identifier, admission date, and discharge date as a physician or outpatient hospital visit reported in encounter data.

We concluded that the RAPS provider type indicator field (identifying a record as from an inpatient hospital, outpatient hospital, or physician visit) likely does not accurately identify inpatient hospital stays. In 2019 and 2020, CMS pooled inpatient RAPS data with encounter data to rectify their concern that fewer inpatient stays were reported in encounter data relative to RAPS data. However, our results provide evidence that the number of inpatient stays reported in RAPS is inaccurate and is too high (i.e., we believe many “inpatient stays” reported in RAPS with admission and discharge on the same day represent physician office or outpatient hospital visits that were incorrectly reported as an “inpatient stay”). Therefore, CMS should not supplement encounter data with inpatient RAPS data when using blended risk scores. In doing so, CMS unnecessarily slows the transition to using encounter data for MA risk adjustment.

Differences in MA and FFS Medicare diagnostic coding

In the CMS–HCC risk adjustment model, CMS uses FFS Medicare claims data to estimate the size of the model coefficients. As a result, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported through physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes and provide little incentive to document diagnoses for FFS beneficiaries.¹⁷ If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have if the diagnoses had been reported. It is necessary for MA payment accuracy that diagnoses be coded with the same intensity in FFS Medicare and MA, meaning that if all diagnoses reported in one program would also be reported in the other program, coefficients would not be inflated. However, when MA plans submit more diagnoses for a particular beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS. We have found that because of the financial incentives for MAs to code as many diagnoses as possible, coding intensity is higher in MA than in FFS Medicare, whose structure lacks such incentives, and payments to MA plans are thus higher than intended.

In one analysis, we tested whether beneficiary risk scores grew faster in MA than in FFS, using data from 2007

through 2013. We built cohorts of beneficiaries who spent their first full calendar year of Medicare and all subsequent years through 2013 in the same program, either FFS or MA. For example, one cohort pair consisted of those beneficiaries who joined FFS Medicare during 2006 and then either (1) remained exclusively in FFS through 2013 or (2) switched into MA in January 2007 and remained in MA through 2013. We also examined five similar pairs of cohorts for beneficiaries whose first full years in Medicare were 2008 through 2012. Beneficiaries were assessed starting with their first full year of Medicare enrollment so that the subsequent differences in the risk score growth between the cohort pairs could be attributed to differences in coding.

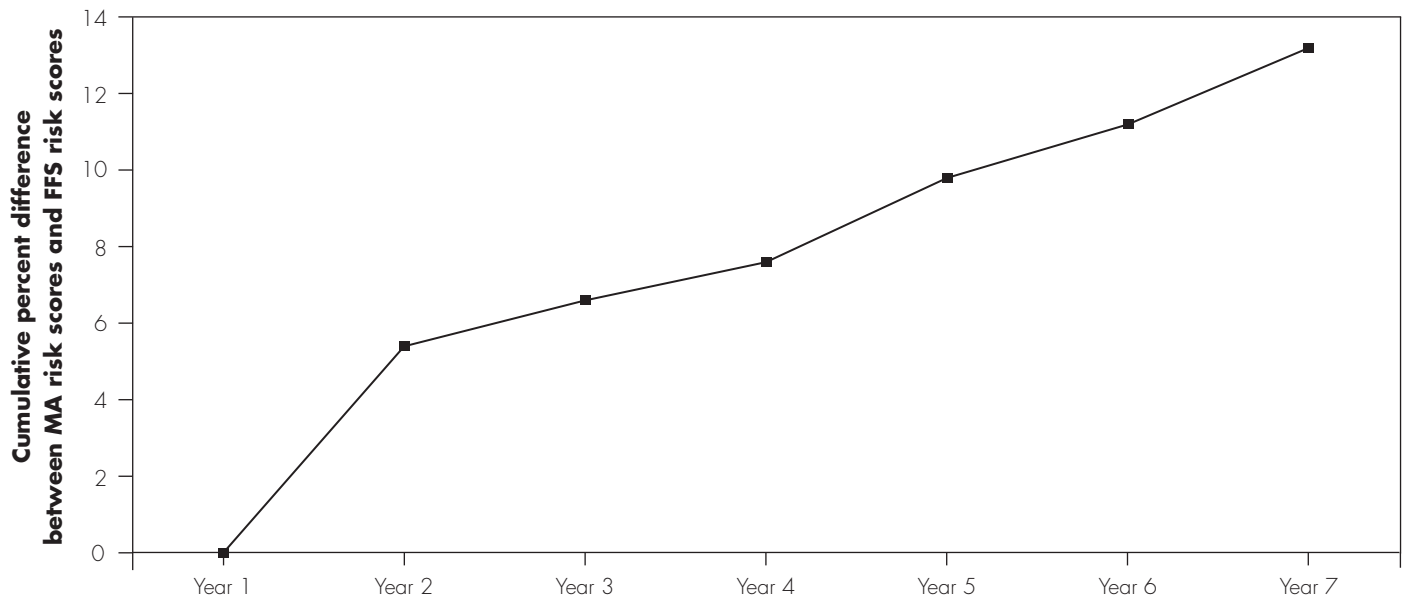
Figure 13-8 shows how average MA risk scores changed relative to the change in average FFS risk scores for all pairs of cohorts. From year 1 to year 2, average MA risk scores increased by about 6 percent more than FFS across all cohorts. For all subsequent years, average MA risk scores continued to increase more than FFS by about 1.5 percent across all cohorts.

Higher payments to MA plans due to differences in coding intensity in MA and FFS Medicare are the result of a failure in risk adjustment policy—the assumption that diagnoses are documented with the same intensity in FFS Medicare (where little incentive exists) and in MA (where significant incentive exists). MA plans that document additional diagnoses for their enrollees (relative to FFS Medicare) are properly reacting to incentives when those diagnoses are accurate and properly supported by medical evidence. MA plans also may report inaccurate diagnoses for the purpose of receiving unwarranted payments, but such improper reporting should be constrained by risk adjustment data validation audits.

We have discovered several mechanisms that MA plans can properly use to document diagnoses for MA enrollees that do not exist in FFS Medicare. These mechanisms highlight ways MA plans have generated much higher coding intensity than FFS Medicare. MA plans often identify enrollees with missing HCCs by using past information for an enrollee (e.g., electronic health records, claims, or risk score data) when it is available, or by using prescription drug data to identify enrollees with likely diagnoses (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Then plans need to ensure that all diagnoses are appropriately documented in the current year. Passive mechanisms leading to documentation

**FIGURE
13-8**

Average MA risk scores grew fastest relative to average FFS risk scores in the first cohort year, for all enrollment cohorts 2007 through 2013



Note: MA (Medicare Advantage), FFS (fee-for-service). Analysis includes six MA and FFS cohort pairs ending in 2013 and starting in 2007 through 2012.

Source: MedPAC analysis of CMS enrollment and risk score files.

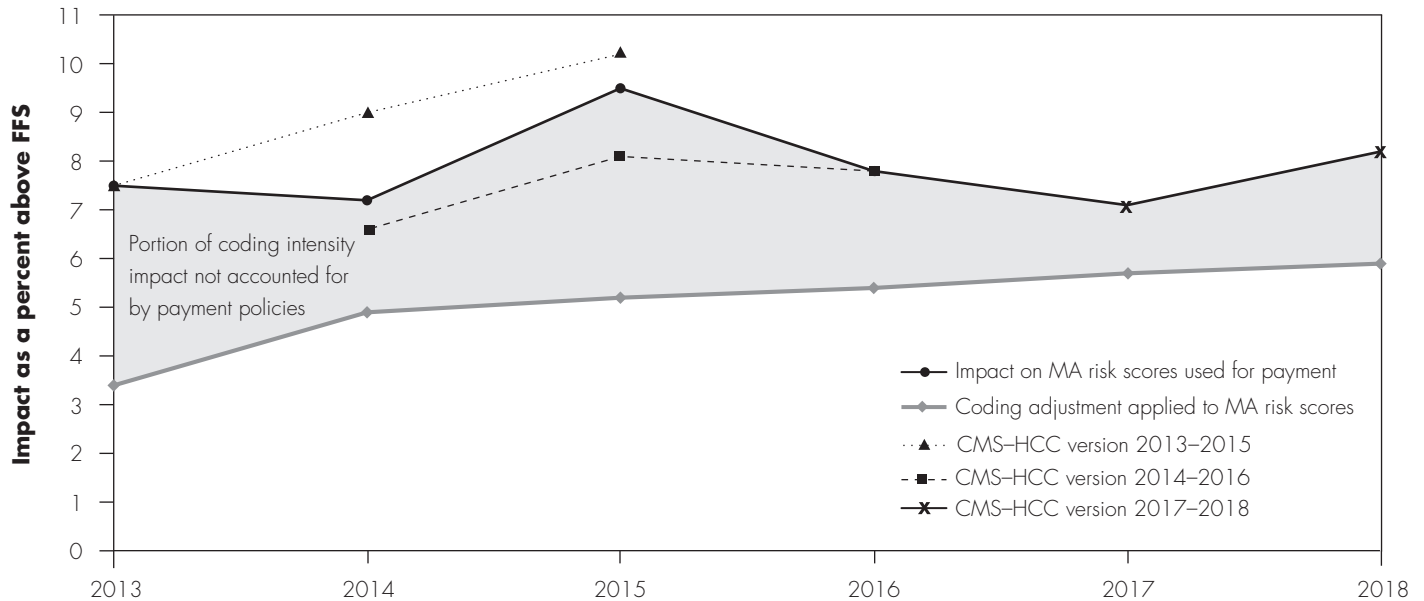
are driven by greater diagnostic information sharing, such as plan and provider relationships that allow plans greater access to electronic medical record diagnostic information (e.g., staff-model HMOs) and the use of capitated contracts through which physicians are paid a risk-adjusted sum, thereby passing the coding incentives on to physicians with direct access to medical records and diagnostic information. In addition, plans actively collect diagnoses through health risk assessments, chart reviews of earlier provider encounters, and pay-for-coding programs in which plans pay doctors to complete patient assessment forms that confirm diagnoses that have not yet been documented. While these efforts can be used to improve care management, some companies offering services to collect diagnostic information use language that targets enrollees based on a lack of documentation rather than a clinical need. Our March 2018 report to the Congress describes the passive and plan-initiated mechanisms that we believe contribute to higher rates of diagnosis documentation in MA, resulting in higher

payments (Medicare Payment Advisory Commission 2018b).

Policies to address the impact of coding differences

A series of congressional mandates has required CMS to reduce MA risk scores as a way of addressing the impact of coding differences. Because of the mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, the mandates specified a minimum reduction of about 4.9 percent, which increased gradually to about 5.9 percent in 2018, where it will remain until CMS estimates a risk adjustment model using MA cost and use data. CMS reduced MA risk scores by the minimum amount required by law for 2014 through 2019 (i.e., larger reductions would have been allowed).

CMS took an additional step to help control the increased coding intensity in MA by phasing in a new CMS-HCC model that removes some diagnoses suspected of being more aggressively coded by MA plans (e.g., lower severity

**FIGURE
13-9****Impact of coding intensity on MA risk scores was larger than coding adjustment, 2013-2018**

Note: MA (Medicare Advantage), FFS (fee-for-service), CMS-HCC (CMS-hierarchical condition category). All estimates account for any differences in age and sex between MA and FFS populations. A blend of two model versions was used for payment in 2014 and 2015.

Source: MedPAC analysis of CMS enrollment and risk score files.

kidney disease and polyneuropathy). Our analysis suggests that the new CMS-HCC model makes MA risk scores more similar to FFS scores by reducing them 2 percentage points to 2.5 percentage points relative to the old model. The new model was phased in during 2014 and 2015, and MA payments were based entirely on the new model in 2016.

Before 2017, the HCC model accounted for dual enrollment in Medicare and Medicaid with a set of variables that increased payment for such enrollees. This approach treated MA enrollees with partial Medicaid and MA enrollees with full Medicaid enrollment as a single group; however, enrollees with full Medicaid benefits have Medicare spending that is significantly higher than enrollees with partial Medicaid benefits. As a result, risk scores under the old model were systematically too low for full dual enrollees and too high for partial dual enrollees.¹⁸ In addition to the inaccuracy in individual

risk scores, partial dual enrollees make up a larger share of dual enrollees in MA than in FFS Medicare, causing the overall risk scores for MA enrollees enrolled in Medicaid to be inflated under the old model. CMS began differentiating between MA enrollees with full Medicaid and partial Medicaid enrollment in 2017 by using separate models that more accurately determined risk scores for partial benefit and full benefit Medicaid enrollees.¹⁹ We found that the model introduced in 2017 reduced MA risk scores by almost 1 percentage point by more accurately determining risk scores for subgroups of beneficiaries, particularly partial dual and full dual enrollees.

Coding differences increased payments to MA plans by about \$6 billion in 2018

To assess the overall impact of coding differences on payments to MA plans for a given year, we built retrospective cohorts of beneficiaries enrolled in either FFS or MA for all of 2018. We tracked each beneficiary

backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007. Our analysis calculates differences in risk score growth by comparing FFS and MA cohorts with the same years of enrollment (e.g., 2007 through 2018, 2008 through 2018), adjusting for differences in age and sex.

Figure 13-9 shows the impact of differences in coding intensity on MA risk scores relative to FFS for payment years 2013 through 2018 and the size of the coding intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity) in each year. The figure shows the impact of coding intensity that was not accounted for by payment policies and resulted in the additional Medicare spending for beneficiaries enrolled in MA (relative to the amount Medicare would have spent if the same beneficiaries had been enrolled in FFS Medicare). Three different versions of the CMS–HCC risk model were used for payment over this period. A blend of two of these model versions was used for payment in 2014 and 2015.

From 2017 to 2018, the impact of coding intensity on MA risk scores rose from about 7 percent to over 8 percent largely because MA risk scores grew faster than FFS risk scores. Changes in the use of encounter data raised 2018 MA risk scores by a small amount. Three factors influenced the impact of coding intensity over the 2013 to 2018 period: changes to the risk score model used for payment, changes in MA risk score growth relative to FFS risk score growth, and the addition of encounter data as a source of diagnostic information.

Changes in the risk model

Our analysis has found that newer versions of the CMS–HCC model have been less susceptible to diagnostic coding differences between MA and FFS. Figure 13-9 shows that the version phased in over 2014 to 2016, removing certain diagnoses with large differences in MA and FFS coding rates, reduced the impact of coding differences by 2 percentage points to 2.5 percentage points when fully phased in. The version introduced in 2017, adding separate aged/disabled and Medicaid enrollment status segments, reduced the impact of coding differences by almost 1 percentage point. No changes to the risk model were implemented in 2018.

Relative risk score growth rates

Between 2013 and 2015, our analysis shows that MA risk score growth outpaced FFS risk score growth, increasing

the overall impact of coding intensity on MA risk scores by 1 percentage point to 1.5 percentage points in each year. Between 2015 and 2017, MA risk scores continued to increase at about the same rate as in prior years, but FFS risk scores grew at a faster rate.²⁰ On net, relative risk score growth rates added very little to the impact of coding intensity between 2015 and 2017. Between 2017 and 2018, MA risk score growth again outpaced FFS risk score growth, adding about 1 percentage point to the overall impact of coding intensity.

Encounter data as a source of diagnostic information

Starting in 2016, CMS blended risk scores based on encounter data with risk scores based on RAPS data. We found that encounter-based and RAPS-based risk scores converged and were the same for about 92 percent of MA enrollees in 2016, 93 percent in 2017, and 95 percent in 2018.²¹ However, for enrollees with different encounter-based and RAPS-based risk scores, the RAPS score tends to be higher.

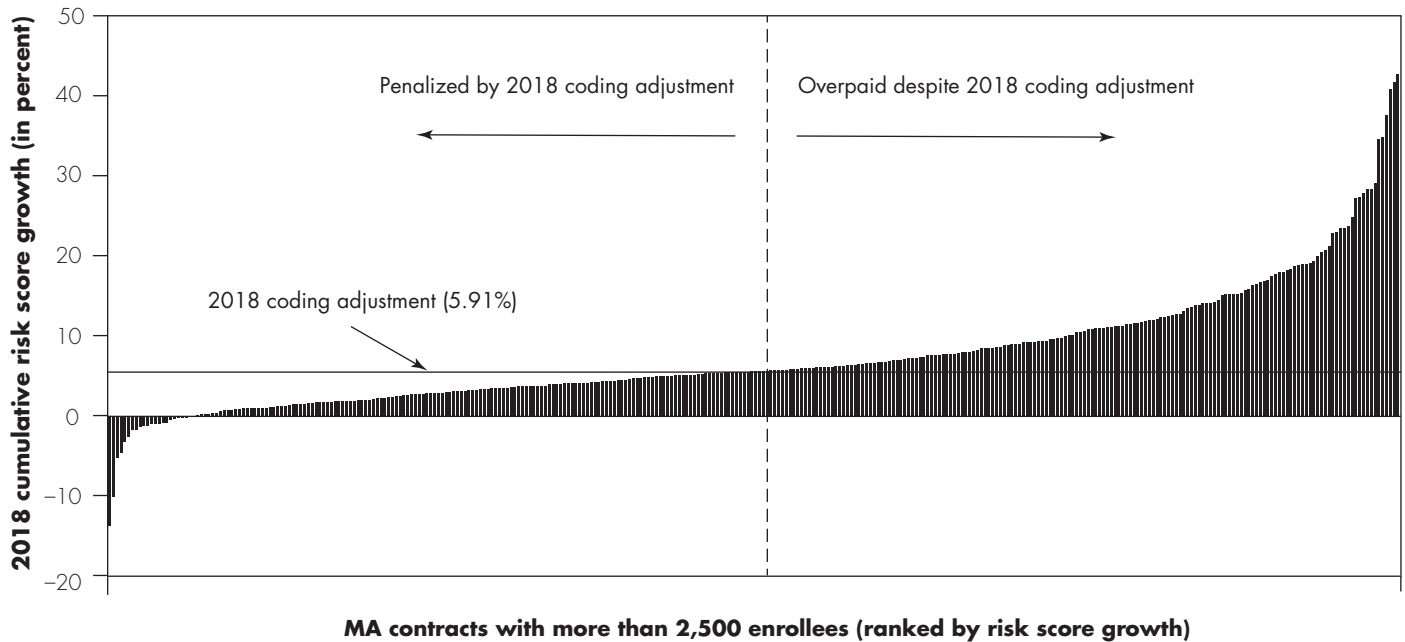
Overall, encounter-based risk scores were about 1 percent lower than RAPS-based risk scores in 2018. Because encounter-based risk scores increased relative to RAPS-based risk scores, and the use of encounter-based risk scores was slightly phased out in 2018 (see Figure 13-7, p. 389), the use of encounter data increased the overall impact of coding intensity by about 0.1 percentage point in 2018. For 2019, CMS applied 25 percent weight to risk scores using encounter data, supplemented with inpatient RAPS data, as the source of diagnoses.²² The remaining 75 percent of risk scores were based on diagnoses in RAPS data.

Overall impact of MA coding intensity

We found that MA risk scores for 2018 were about 8 percent higher than for a comparable FFS population. The increase from our 2017 estimate of 7 percent is the net of faster MA risk score growth (1.0 percentage point) and increasing the use of encounter data for risk scores (0.1 percentage point). Relative to FFS Medicare, we found that because of coding intensity, MA risk scores in 2018 were between 2 percent and 3 percent higher than CMS's adjustment for coding intensity (which was 5.91 percent in 2018). In other words, after accounting for all coding adjustments, payments to MA plans in 2018 were between 2 percent and 3 percent higher than Medicare payments would have been if MA enrollees had been treated in FFS

**FIGURE
13-10**

Cumulative MA risk score growth varied across contracts relative to local FFS, 2018



Note: MA (Medicare Advantage), FFS (fee-for-service). MA contracts with enrollment below 2,500 (representing about 1 percent of total MA enrollment), contracts for the Program of All-Inclusive Care for the Elderly, and special needs plans are not included.

Source: MedPAC analysis of CMS enrollment and risk score files.

Medicare and generated about \$6 billion in additional payments to MA plans. The magnitude of these findings is consistent with other research showing that the impact of coding differences on MA risk scores is larger than CMS's adjustment for coding (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Kronick and Welch 2014).

Variation in coding intensity across MA contracts

For 2018, we continued to find that nearly all MA contracts had risk scores that were higher than FFS scores and that the impact of coding intensity across MA contracts varied widely. This finding is based on a similar analysis we conducted of coding differences, but the change in risk score for each MA beneficiary was attributed to the contract (excluding contracts in the Program of All-Inclusive Care for the Elderly and SNPs) in which the beneficiary was enrolled in 2018,

thereby capturing the coding impact for each contract's 2018 payments. Figure 13-10 illustrates the variation across contracts with more than 2,500 enrollees in 2018 relative to FFS in their local service area.²³ Our finding that coding intensity varies across MA contracts is consistent with other research (Geruso and Layton 2015, Kronick and Welch 2014). Given this variation, CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by disadvantaging plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

Commission's prior recommendation on coding intensity

The Commission's long-standing position is that Medicare payment policies should not unduly favor MA or FFS Medicare. Excess payments to MA plans may benefit

enrollees in the MA program (when used to increase the value of extra benefits offered rather than increase profits) but cost taxpayers more than if these enrollees were covered in FFS Medicare. Further, additional payments to MA plans increase fiscal pressure on the depleting Hospital Insurance (Part A) Trust Fund as well as on the taxpayers and on the state Medicaid programs and beneficiaries who pay premiums to finance the Part B program.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences and would improve the equity of the adjustment across MA contracts. The recommendation, which would replace the current coding intensity adjustment, had three parts:

- develop a risk adjustment model that uses two years of FFS and MA diagnostic data;
- exclude diagnoses that are documented only on health risk assessments (HRAs) from either FFS or MA; and then
- apply a coding adjustment that fully and equitably accounts for the remaining differences in coding between FFS Medicare and MA plans.

Using two years of diagnostic data would improve the accuracy of both FFS and MA HCC information and would reduce year-to-year variation in documentation. The 21st Century Cures Act codifies the Secretary's authority to use two years of diagnostic data in MA risk adjustment, stating that, for 2019 and subsequent years, "the Secretary may use at least two years of diagnosis data." Removing diagnoses documented through only HRAs would mean that a diagnosis had to be treated in order to count in risk adjustment calculations. Diagnoses that were both documented on an assessment and treated would continue to count toward risk adjustment. However, of the HCCs documented on HRAs in MA, about 30 percent were not treated during the year compared with about 6 percent of diagnoses documented on HRAs in FFS.

Implementing these two policies would result in a more equitable adjustment across MA contracts than the current across-the-board adjustment because they target coding differences more effectively. Our analysis suggests that the combined effect of using two years of diagnostic data and excluding diagnoses from HRAs would effectively reduce MA risk scores by roughly 3 percentage points to 5

percentage points relative to FFS Medicare and thus would address roughly half of the impact of coding differences.

One approach to implementing the Commission's recommendation to adjust for any remaining coding intensity differences uses a method that would also improve equity across MA contracts. The method would group contracts into categories of high, medium, and low coding intensity and apply a coding intensity adjustment based on each group's average level of coding intensity. CMS has used a similar approach to select MA contracts for risk adjustment data validation (RADV) audits.²⁴ While this policy would leave some inequity within each group of contracts, overall inequity would be reduced. CMS could consider using a greater number of groups to further refine the equity of the overall adjustment.

Risk adjustment data validation

Medicare payments to MA plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. For both RAPS and encounter data, MA plan leadership signs an attestation that risk adjustment criteria are applied correctly and submitted data are accurate. However, only for encounter data does CMS independently verify that diagnoses result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional. The use of encounter data significantly improves oversight of payment data and offers the opportunity to ensure their validity before payments are made to MA plans. CMS must conduct RADV audits of both encounter and RAPS data to ensure that diagnoses are supported by the medical record, but RADV audits of RAPS data must also check whether diagnoses are made during an encounter with an appropriate type of provider.

RADV audits determine whether an MA plan was overpaid due to invalid data and calculate an overpayment amount to recover from the plan. CMS audits roughly 5 percent of MA contracts per year (about 30 contracts in early audit years) and uses a sample of 201 enrollees who had at least 1 HCC reported and met certain other criteria.²⁵ The sample includes 67 randomly selected enrollees from each of three strata (low, medium, and high) defined by beneficiaries' risk scores. For each

beneficiary, the audit calculates a payment error rate, defined as the portion of the beneficiary's HCC-based payment that was not based on valid data. Beneficiary payment error rates can be offset if any additional HCCs are found that were not submitted for payment but were supported by the beneficiary's medical record.²⁶ For the initial round of audits of 2007 data, CMS recovered overpayments for only beneficiaries in the sample of 201 enrollees. For subsequent audits, CMS is proposing to recover overpayments for the entire contract (of eligible enrollees) by extrapolating the payment error rates for the sampled enrollees. For extrapolation, a contract's payment error rate would be set at the lower 99th percent confidence interval of beneficiary-level error rates in the sample. If the contract payment error rate is greater than zero, the overpayment recovery amount would be the payment error rate at that confidence interval multiplied by the total payment for eligible enrollees in the contract.²⁷

RADV audits of MA contracts have been limited so far. Audits of 2007 RAPS data identified diagnoses that did not meet risk adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS recovered \$13.7 million in overpayments from audits of 37 contracts, based on overpayments only for the 7,437 beneficiaries included in the sample of beneficiaries for the contracts under audit (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008 through 2010. For audits of 2011, 2012, and 2013 payment years, CMS stated that it expects to recoup about \$650 million in overpayments based on the extrapolation method (Centers for Medicare & Medicaid Services 2018). CMS has proposed additional RADV audits focused on specific HCCs rather than whole contracts; however, CMS has not identified the scope of such audits or stated when they would begin. Audits of 2014 and 2015 data are in progress.

In reviewing the RADV audit process, government analysts noted that RADV audits are tasked with recouping billions of dollars in improper payments to MA plans based on RAPS data, but their report found a host of shortcomings with the audits, including that the audits should be more targeted at contracts with a higher likelihood of overpayments (Government Accountability Office 2016).

Increase the use of encounter data for risk adjustment

To ensure payment accuracy for the MA population, the importance of collecting complete and accurate encounter

data from MA plans cannot be overstated. So far, the main use of encounter data has been as a source of diagnoses for risk adjustment. Given the more robust review process upon submission of encounter data, the return of hundreds of millions of dollars in overpayments resulting from unsupported diagnoses in RAPS data, and the continued convergence of RAPS and encounter-based risk scores, we believe CMS should move as soon as possible to discontinue the collection of RAPS data and rely only on encounter data for risk adjustment.

For 2020, CMS will use encounter data along with inpatient RAPS data as the source of diagnoses for a new version of the risk adjustment model, which will be the basis for 50 percent of MA payments. This version of the model incorporates changes that, by statute, must be fully implemented for 2022 payment. We believe CMS should maintain the use of encounter data for the new version of the model, resulting in using only encounter data for risk adjustment by 2022. However, due to inaccuracy of the provider type indicator in RAPS data, CMS should not supplement encounter data with any RAPS data for use with the new model. A swift transition to using only encounter data for risk scores would be consistent with the Commission's support for increasing incentives for plans to submit complete encounter data, which could serve multiple purposes. For example, using encounter data as the basis for measuring MA plan quality would allow for consistent quality measurement between MA and FFS and would provide an additional incentive for MA plans to submit complete encounter data.

Quality in Medicare Advantage is difficult to evaluate

Beginning in 2012, the law established a quality bonus program (QBP) that ranks MA plans based on a 5-star system and provides bonuses to plans rated 5 stars or higher. The 5-star system, which predates the QBP, is also the basis of information that beneficiaries receive about MA plan quality through the Medicare.gov Plan Finder website. Over the years, the Commission has discussed the flaws in the 5-star system and the QBP and the continuing erosion of the reliability of data on the quality of MA plans (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting in MA is such that the Commission's yearly updates on MA can no longer

provide an accurate description of the quality of care in MA. The Commission's March 2019 report to the Congress contains a detailed discussion of the difficulty of evaluating the quality of care within the MA sector and changes in MA quality from one year to the next (Medicare Payment Advisory Commission 2019b).

With one-third of the Medicare population enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare, including in accountable care organizations (ACOs), is necessary for proper evaluation. MA plans have a number of management tools that are not available in FFS but permit plans to improve the quality of care for their enrollees—tools such as selective contracting, care management, information systems shared across providers, and utilization management that can prevent overutilization of potentially harmful care. We would therefore expect quality in MA to be better than in FFS, but a lack of sufficient data severely limits any definitive comparisons. Comparative assessments could help in evaluating MA performance and changes in performance over time, in evaluating payment policy in MA, and in determining the adequacy and appropriateness of the standards applied to MA plans (for example, by using quality results as an indirect measure of network adequacy in MA plans). The ability to compare MA and FFS quality, and to compare quality across MA plans, is also important for beneficiaries. Choosing between MA and FFS is a threshold choice that beneficiaries make before getting to the step of deciding among available MA plans.

A new MA value incentive program

Recognizing that the QBP is flawed, that quality in MA is currently difficult to evaluate, and that a costly program is not achieving its intended purposes, it is essential that the Medicare program evaluate MA plan performance and link payment to the quality of care plans provide. In the June 2019 report to the Congress, the Commission discussed ways to apply the Commission's quality principles to the MA program through a value incentive program (Medicare Payment Advisory Commission 2019a). The Commission is continuing work to model a value incentive program that incorporates the following key features:

- Use of a small set of population-based outcomes and patient/enrollee experience measures that, where practical, should align across all Medicare-accountable entities and providers, including MA plans and ACOs. To avoid undue burden on providers,

measures should be calculated or administered largely by CMS, preferably with data that are already being reported, such as claims and encounter data.

- Evaluation of quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA plans incentives to improve the quality of care provided in every geographic area.
- Quality measurement against a continuous scale of performance that clearly provides the incentive to improve quality at every level.
- Accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of beneficiaries with similar social risk factors so that plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care are not masked.
- Application of budget-neutral financing so that the MA quality system is more consistent with Medicare's FFS quality payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties.

Future direction of MA payment policy

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits. The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans often provide; however, some policies are deeply flawed and in need of immediate improvement.

For the immediate future, the Commission is assessing an alternative model to evaluate MA plan quality at the local level and distribute quality-based bonuses. Over the longer term, the Commission will review benchmark policy to improve equity and efficiency in the MA program. The Commission has standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016), and

(2) ensure the completeness and accuracy of encounter data as a means to improve the MA payment system, to serve as a source of quality data, and to facilitate comparisons with FFS (Medicare Payment Advisory Commission 2019a). Through reforms to the MA payment system, the Commission aims to better focus the program on the beneficiaries it serves and on ways to harness plan efficiency to improve Medicare’s long-term financial sustainability.

In setting payment policy in the FFS sector, the Commission consistently applies a level of fiscal pressure on providers to promote the efficient provision of care while maintaining beneficiary access to high-quality care. FFS payment policies of that nature can affect MA payments through the benchmarks, which are based on FFS expenditure levels. Relying on fiscal pressure only in the FFS sector means that savings to the program that come from MA must be generated indirectly through FFS spending reductions. The ACA-instituted payment reforms reduced MA program payments, causing some concern about whether MA would continue to grow and attract Medicare beneficiaries. However, this substantial fiscal pressure did not have the negative effect that some had predicted. Instead, bids have fallen in relation to FFS

spending—even in areas where sponsors might have found it challenging to operate successful plans, such as in low-FFS-spending areas where MA benchmarks are at 115 percent of FFS. Further, the value of extra benefits offered to MA enrollees—now equal to approximately \$1,450 annually per enrollee, or 13 percent of the basic benefit—has reached a historic high for the fourth consecutive year.

On average across the nation, MA payments are about 2 percent higher than FFS expenditure levels. However, given the level of overutilization in FFS and other factors not discussed in this chapter—the volume-inducing effects of traditional FFS, Medigap’s effect of insulating beneficiaries from the financial impact of their utilization, and inappropriate spending owing to fraud and waste—we cannot conclude that achieving payment parity between MA and FFS Medicare would leverage any efficiency from the MA program. Consistent with the original incorporation of full-risk private plans in Medicare (through the Tax Equity and Fiscal Responsibility Act of 1982), in which private plans would be paid 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, the principle of equal treatment of the MA and FFS programs will need to include equal levels of cost and quality pressure in the two programs. ■

Endnotes

- 1 CMS estimates that the 2020 monthly actuarial value of Medicare deductibles and coinsurance for a beneficiary without end-stage renal disease is \$165 (CMS 2020 MA Announcement). The Commission has previously summarized the evidence on the effects of cost sharing on Medicare spending and recommended an additional charge on supplemental insurance (Medicare Payment Advisory Commission 2012) and commissioned a study finding higher Medicare spending for beneficiaries with Medigap coverage (Hogan 2009).
- 2 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general use or for social determinant purposes.

The degree of projected spending for new types of supplemental benefits is not available in plan bid data. However, a recent report from Duke University found that, in 2020, relatively few MA plans have expanded their package of supplemental benefits to target beneficiaries with serious illness (Crook 2019). Only 7 percent of MA plans offered supplemental benefits in one of the following five categories: adult day care, palliative care, non-opioid pain management, in-home support services, or caregiver support.
- 3 New types of supplemental benefits may relate to different benefit flexibility.
- 4 Beneficiaries in some parts of the country have access to Section 1876 cost-reimbursed HMOs. Such plans arrange for the full range of Medicare services. They receive reasonable cost reimbursement for Part B physician and supplier services, but the Medicare program directly pays providers for inpatient and outpatient institutional services. Enrollees of cost plans are not locked into the plan and can receive any out-of-network services and have them paid by the Medicare program. The statute calls for the phasing out of cost plans in areas in which there are at least two competing MA CCPs that meet a minimum enrollment requirement. The cost plans are expected to transition to MA plans, and some have already begun the transition.
- 5 FFS spending is calculated for all Medicare beneficiaries, which include those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include the FFS spending for only those beneficiaries with both Part A and Part B.
- 6 Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark growth caps, which limited the benchmarks in many counties.
- 7 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. We identified outliers at the contract level to account for plans that may be subsidized by other plans (i.e., product pairing) within the same service area. Most of the outlier contracts we identified reported negative margins in the bid data for consecutive years. One plan sponsor consistently reports margins well above 100 percent, and this sponsor accounts for most of the beneficiaries excluded in the outlier contracts. These contracts are likely atypical because CMS requires MA plans with negative margins to submit a business plan to achieve profitability and expects MA plans to meet or exceed the year-by-year margin targets in the business plan.
- 8 All margin estimates in the remainder of this section exclude outlier contracts.
- 9 MDS assessment data are collected within 14 days of admission and at other points for traditional FFS Medicare beneficiaries.
- 10 Additional MDS assessments are required for beneficiaries enrolled in FFS Medicare.
- 11 MDS assessments are also required for Medicaid-covered nursing home stays. By excluding MA enrollees who are eligible for full Medicaid benefits from the analysis, we could be reasonably certain that non-Medicaid MA enrollees with an MDS assessment should also have a SNF encounter record.
- 12 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk adjustment model for several reasons: (1) Adding diagnoses from these sources does not improve the model’s ability to predict medical expenditures; (2) there are concerns about the reliability of diagnoses from providers with less clinical training (e.g.,

- home health and durable medical equipment); and (3) there is a high proportion of rule-out diagnoses (e.g., lab and imaging tests).
- 13 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied for a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. Different versions of the HCC model account for disability status and status as partially, fully, or not eligible for Medicaid, as well as enrollees who lack a full calendar year of diagnostic data, are institutionalized, or have end-stage renal disease. A plan's base rate varies according to the plan's bid and the local area's benchmark.
 - 14 In this case, the premium amount is determined based on the normalized, or non-risk-adjusted, bid and benchmark difference. However, greater coding intensity reduces the normalized bid, thereby reducing the premium that beneficiaries pay to Medicare. To the extent that higher coding intensity reduces premium amounts, Medicare is not reimbursed for the full amount intended by the payment policy.
 - 15 In 2015, CMS combined RAPS data and encounter data for risk adjustment, meaning that plans were paid for HCCs identified through at least one of the two data sources submitted to CMS.
 - 16 The copy of the claim sent to CMS is used in calculating various payment adjustments for hospitals.
 - 17 The share of FFS Medicare payments that flow through accountable care organizations and other advanced payment models is increasing and has the potential to increase diagnostic coding incentives in FFS Medicare, but we have yet to see an effect on our analysis.
 - 18 Partial Medicaid enrollment generally provides premium and cost-sharing assistance for Medicare benefits, while full Medicaid enrollment also covers additional services not covered in the Medicare benefit.
 - 19 The 2017 model also determines Medicaid enrollment status on a monthly basis during the payment year, which improves the accuracy of payment for these enrollees. The model has separate segments based on aged or disabled status, combined with no, partial, or full Medicaid enrollment status.
 - 20 FFS risk score growth matched MA risk score growth between 2015 and 2016 for the first time since the full implementation of the HCC model in 2007. Risk score growth between 2015 and 2016 was affected by the transition from International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes. MA risk scores were still higher than FFS risk scores for comparable beneficiaries (because of prior differences in coding rates). CMS's calculation of the risk score normalization factor, which functions to keep the average FFS risk score at 1.0 in each year, showed evidence of faster FFS risk score growth in 2016 and 2017 relative to prior years.
 - 21 CMS identifies diagnoses from physician visits using a different method for RAPS and encounter data. The two methods of filtering physician claims for use in risk adjustment were intended to produce equivalent results, but it is possible that RAPS-based and encounter-based risk scores would not be equivalent because of the different methods of filtering physician claims.
 - 22 CMS observed that encounter data inpatient submissions were low compared to corresponding RAPS inpatient submissions, and therefore supplemented encounter data with inpatient RAPS data to calculate risk scores. However, we believe a large number (1.5 million in 2015) of physician office visits and outpatient hospital visits have been inaccurately reported as "inpatient stays" in RAPS data. Therefore, we believe CMS should not supplement encounter data with inpatient RAPS data to adjust for the discrepancy between the two data sources.
 - 23 About 1 percent of MA enrollees are in a contract with fewer than 2,500 enrollees.
 - 24 For RADV audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.
 - 25 Other criteria include Part B enrollment for the full data collection year, continuous enrollment in the contract for the full data collection year and January of the payment year, and no end-stage renal disease or hospice status.
 - 26 Additional HCCs that were not submitted for payment but were supported in one of up to five medical records submitted through the audit can offset beneficiary payment error rates but will not result in additional payments to the MA plan. MA plans are required to submit diagnoses for payment.
 - 27 CMS proposed this method of determining overpayment recovery amounts in 2018 but has not yet issued a final rule (Centers for Medicare & Medicaid Services 2018).

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