

CHAPTER

13

**The Medicare Advantage
program: Status report**

R E C O M M E N D A T I O N S

13-1 For Medicare Advantage contract consolidations involving different geographic areas, the Secretary should:

- For any consolidations effective on or after January 1, 2018, require companies to report quality measures using the geographic reporting units and definitions as they existed prior to consolidation, and
- Determine star ratings as though the consolidations had not occurred, and maintain the pre-consolidation reporting units until new geographic reporting units are implemented per Recommendation 13-2.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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13-2 The Secretary should:

- Establish geographic areas for Medicare Advantage quality reporting that accurately reflect health care market areas, and
- Calculate star ratings for each contract at that geographic level for public reporting and for the determination of quality bonuses.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2017, the MA program included almost 3,300 plan options offered by 185 organizations, enrolled about 19 million beneficiaries (32 percent of all Medicare beneficiaries), and paid MA plans about \$210 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 current quality indicators in MA. As a result of the analyses, we provide recommendations for determining eligibility for bonuses under the quality bonus program.

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 alternative delivery systems that private plans can provide. Because Medicare pays private plans a risk-adjusted per person predetermined rate 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.

In this chapter

- Trends in enrollment, plan availability, and payments
- Medicare Advantage risk adjustment and coding intensity
- Quality in the Medicare Advantage program and the effect of contract consolidations

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which were generally higher than FFS, and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS even as plans have received increased payments because of higher risk coding and quality bonus rules. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while MA enrollment continues to grow. The pressure of lower benchmarks has led to improved efficiencies and more competitive bids that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive.

Enrollment—Between 2016 and 2017, enrollment in MA plans grew by about 8 percent (1.4 million enrollees) to 18.9 million enrollees. About 32 percent of all Medicare beneficiaries were enrolled in MA plans in 2017, up from 31 percent in 2016. Among plan types, HMOs continued to enroll the most beneficiaries (12.2 million), with 21 percent of all Medicare beneficiaries in HMOs in 2017. During this period, enrollment in local preferred provider organizations (PPOs) grew by 19 percent, regional PPO enrollment increased by 3 percent, and private fee-for-service (PFFS) enrollment decreased by 21 percent. Focusing on other plan characteristics, special needs plan (SNP) enrollment grew by 9 percent, and employer group enrollment grew by 16 percent.

Plan availability—Access to MA plans remains high in 2018, 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 (96 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 74 percent of beneficiaries. Forty-one percent of beneficiaries have access to PFFS plans. Overall, 99 percent of Medicare beneficiaries have access to an MA plan.

An analysis of the MA program's market structure shows that, compared with 2007, MA enrollment in 2017 is more heavily concentrated. The top 10 MA organizations (ranked by enrollment) had 72 percent of total enrollment in 2017, compared with 61 percent in 2007. Enrollment is more concentrated in nonmetropolitan areas, where the top two companies have 54 percent of all enrollment, compared with 42 percent in metropolitan areas.

Plan payments—Using the 2018 plan bid data, before adjusting fully for coding intensity, we estimate that 2018 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 90 percent, and 101 percent of FFS spending, respectively. Lower benchmarks have led to more competitive bids from plans: Bids have dropped from roughly 100 percent of FFS before the Patient Protection and Affordable Care Act of 2010 to 90 percent of FFS in 2018. For 2018, about 70 percent of plans, accounting for 77 percent of projected MA enrollment, have bids below FFS spending.

On average, quality bonuses in 2018 will add 4 percent to the average plan’s base benchmark and will add 3 percent to plan payments. The base benchmarks (that is, excluding the quality bonuses) are expected to average 103 percent of FFS spending in 2018, an increase from 102 percent in 2017, due to demographic changes in the Medicare population.

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 because higher enrollee risk scores result in higher payments to the plan.

Our updated analysis for 2016 shows that higher diagnosis coding intensity resulted in MA risk scores that were 8 percent higher than scores for similar FFS beneficiaries. This estimate is lower than the prior year due to the full implementation of a new risk model and an increase in FFS risk score growth, matching the growth rate of MA risk scores. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding. In 2016, the adjustment reduced MA risk scores by 5.41 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. The adjustment for 2018 is 5.91 percent. The Commission previously recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.

Quality measures—MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS’s 5-star rating system. In the past year,

contract consolidations undertaken for the purpose of obtaining bonus payments had the largest impact to date. At the end of 2017, 1.4 million enrollees were in a nonbonus contract that was absorbed by another contract with a rating of 4 stars or higher. The 1.4 million enrollees under the original contracts that were not in bonus-status contracts are in bonus status for the 2018 payment year because of the consolidations. Since 2013, over 4 million enrollees—over 20 percent of MA enrollees—have been moved among contracts to secure bonus payments that would not otherwise be payable. Thus, while over 70 percent of MA enrollees are classified as being in plans rated 4 stars or higher, taking into account the enrollees who are in bonus-status plans because of consolidations, the actual share could be as low as 50 percent.

The Commission recommends that contract consolidations not be allowed to affect star ratings and bonus payments when two contracts serving different geographic areas are consolidated. The determination of star ratings for each geographic area of the original contracts and the reporting of quality indicators that are the basis of the star ratings should continue as though the consolidation had not occurred. (Subsequent to the Commission’s vote on the recommendation, the Bipartisan Budget Act of 2018 directed the Secretary to address contract consolidations by averaging the star results of contracts that are being combined.) In conjunction with the recommendation addressing consolidations, the Commission restates its recommendation, first made in 2010, that the geographic unit for quality reporting should be the local health care market area.

In addition to the unwarranted bonus payments, the wave of contract consolidations has resulted in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area. The consolidations have also limited our ability to report quality results in MA in our usual manner of comparing year-over-year contract-level results. Alternative ways of looking at changes in quality over time—such as by using weighted average results across all plans—indicate that quality results are mixed, with most measures unchanged; among the small number of measures where there was a significant change, a greater number improved than declined. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2017, the MA program included almost 3,300 plan options offered by 185 organizations, enrolled about 19 million beneficiaries (32 percent of all Medicare beneficiaries), and paid MA plans about \$210 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, care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions), and robust information systems that can potentially provide timely feedback to providers. Plans also can reward beneficiaries for seeking care from more efficient providers and give beneficiaries more predictable cost sharing; one trade-off is that plans typically restrict the choice of providers.

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 modify care delivery. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a financially neutral choice between private MA plans and traditional FFS Medicare. Medicare's payment systems, as well as monitoring and enforcement efforts, should not unduly favor one component of the program over the other.

Efficient MA plans may be able to 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. Thus, some of those benefits are financed by higher government spending and higher beneficiary Part B premiums (including for those who are 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 and effective monitoring and

regulation, as the Commission recommends for providers in the traditional FFS program. One method of achieving financial neutrality is to link private plans' payments more closely to FFS Medicare costs within the same market. Alternatively, neutrality 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 track progress toward financial neutrality.

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, MA enrolls beneficiaries 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 (see endnote and text box on pp. 361–362).¹ The 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.² 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**—PFFS plans are not classified as CCPs. Before 2011, PFFS plans typically did not have provider networks, making them less able than other plan types to coordinate care. They usually paid providers Medicare’s FFS payment rates (instead of negotiated rates). Because PFFS plans generally lacked care coordination, had lower quality measures than CCPs, paid Medicare FFS rates, and had higher administrative costs than traditional FFS Medicare, they were viewed as providing little value. In response, the Medicare Improvements for Patients and Providers Act of 2008 mandated that, in areas with two or more network MA plans, PFFS plans can be offered only if they 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.

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, are institutionalized, 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. (See the Commission’s March 2013 report to the Congress, available at <http://www.medpac.gov>, for more detailed information on SNPs.) As we recommended in an earlier report, employer plans no longer submit bids, so we have only enrollment data for them. (See the Commission’s March 2015 report to the Congress for more detailed information on employer plans.)

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 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 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 payment amount above the bid 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. (CMS reviews the projected uses of the rebates, but the valuation of the rebate can be fully loaded, meaning that the plan can 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_17_ma_final.pdf?sfvrsn=0.)

MA plan enrollment continued to grow faster than total Medicare beneficiary growth in 2017

Between November 2016 and November 2017, enrollment in MA plans grew by 8 percent—or 1.4 million enrollees—to 18.9 million enrollees (compared with 3 percent growth in the same period for the total Medicare population). During this period, MA enrollment rose from 31 percent to 32 percent of all Medicare beneficiaries (Table 13-1).

The Commission’s previous work suggests that many beneficiaries enroll in MA immediately upon becoming eligible, but most of those who enroll in MA initially enroll in FFS Medicare and subsequently move to MA. For more on enrollment patterns, see our March 2015 report (Medicare Payment Advisory Commission 2015b).

Among plan types, HMOs continued to enroll the most beneficiaries (12.2 million) in 2017, with 21 percent of all Medicare beneficiaries in HMOs. Between 2016 and

**TABLE
13-1**

MA plan enrollment continued to grow faster than total Medicare beneficiary growth in 2017

	MA enrollment (in millions)		Percent change in enrollment	2017 MA enrollment as a share of total Medicare
	November 2016	November 2017		
Total	17.5	18.9	8%	32%
Plan type				
CCP	17.3	18.7	8	32
HMO	11.7	12.2	5	21
Local PPO	4.3	5.1	19	9
Regional PPO	1.3	1.4	3	2
PFFS	0.2	0.2	-21	<1
Restricted availability plans included in totals above				
SNPs*	2.3	2.5	9	4
Employer group*	3.2	3.7	16	6
Urban/rural				Share of Medicare population in MA
Urban	15.2	16.3	7	34
Rural	2.3	2.5	10	22

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.

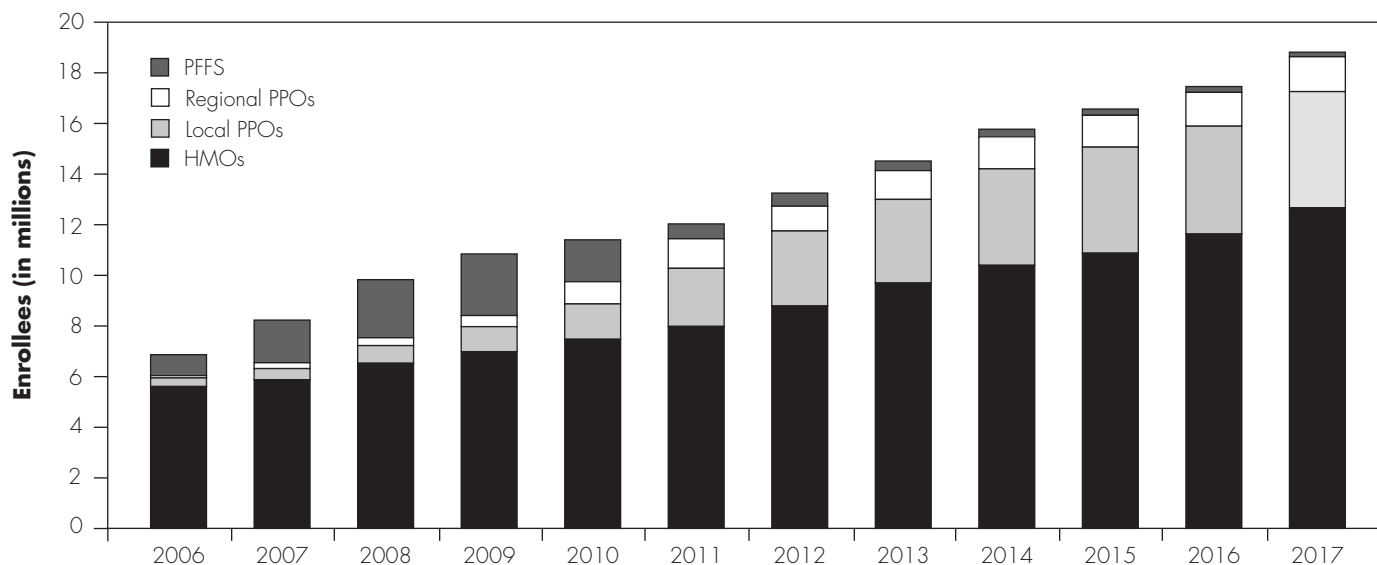
Source: MedPAC analysis of CMS enrollment files.

2017, enrollment in local PPOs grew by 19 percent and in regional PPOs by 3 percent. At the same time, PFFS enrollment dropped by 21 percent, but nevertheless rounded to 200,000 enrollees in both years (Table 13-1). In 2017, SNP enrollment grew by 9 percent, and employer group enrollment grew by 16 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 2017, about one-third of rural MA enrollees were in HMO plans compared with about 70 percent of urban enrollees (not shown in Table 13-1). By contrast, 4 percent of rural enrollees were in PFFS plans compared with less than 1 percent of urban enrollees.

Enrollment patterns also differ between those beneficiaries eligible for Medicare because they have reached 65 years of age (aged) and those who are eligible for Medicare on the basis of disability (disabled). We find that 33 percent of the aged and 26 percent of the disabled were enrolled in MA at the end of 2016 (the most recent CMS data are available only at summary levels and are not split by age and disability status). This difference has been narrowing somewhat over time: In 2011, 27 percent of aged beneficiaries and 18 percent of disabled beneficiaries were enrolled in MA.

The share of Medicare beneficiaries enrolled in MA plans in 2017 varied widely by geography. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were

**FIGURE
13-1****Medicare Advantage enrollment, 2006–2017**

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

Source: MedPAC analysis of CMS enrollment files.

enrolled in MA plans. For example, in Anchorage, AK (1 percent enrolled in MA), only employer group plans are available, whereas in other areas (Miami; Pittsburgh; Rochester, NY; and several areas in Puerto Rico), MA enrollment was 60 percent or more.

MA enrollment growth in 2017 continued a trend begun in 2003. Since 2003, overall enrollment has more than tripled (Figure 13-1 begins with 2006). 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 2018

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 2018, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2018. 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 13-3, p. 363). In

2018, 96 percent of Medicare beneficiaries have an HMO or local PPO plan (local CCP) operating in their county of residence, up from 95 percent in 2017 and 93 percent in 2012. Regional PPOs are available to 74 percent of beneficiaries in 2018, unchanged from 2017. Access to PFFS plans in 2018 is lower, available to 41 percent of beneficiaries, down from 45 percent in 2017. Overall, 99 percent of Medicare beneficiaries have access to an MA plan, and 98 percent have access to a CCP (total CCP data not shown in Table 13-3, p. 363), unchanged from 2017.

The availability of SNPs has changed slightly and varies by the type of special needs population served. In 2018, 86 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (the same percentage as in 2017), 47 percent live where SNPs serve beneficiaries with chronic conditions (up from 44 percent in 2017), and 56 percent live where SNPs serve institutionalized beneficiaries (up from 52 percent in 2017). Overall, 90 percent of beneficiaries reside in counties served by at least one type of SNP (not shown in table).

Who chooses to join MA plans and when do they choose?

The Commission examined Medicare Advantage (MA) enrollment patterns for 2016. For the purposes of this analysis, MA enrollees include members of cost plans, the Program of All-Inclusive Care for the Elderly, and participants in Medicare–Medicaid dual-eligible demonstration plans.³ The fee-for-service (FFS) population used in this analysis includes only those beneficiaries with both Part A and Part B because beneficiaries must have both Part A and Part B to enroll in MA.

Overall, 35 percent of Medicare beneficiaries with both Part A and Part B chose to enroll in MA plans for December 2016 (Table 13-2). The younger disabled population, those under age 55, chose MA plans 25 percent of the time. Beneficiaries ages 55 and older chose MA plans more frequently. Beneficiaries ages 70 to 74 chose MA plans at the highest rate (39 percent). Over three-quarters of MA enrollees are between the ages of 65 and 84. Of men and women, just over one-third of each enroll in MA. White beneficiaries are

(continued next page)

**TABLE
13-2**

Share of Medicare beneficiaries (who are enrolled in both Part A and Part B) choosing MA and share of total MA enrollees and special needs plan enrollees, by select characteristics, December 2016

	Percentage choosing MA	Percentage of total MA	Percentage of SNPs
Overall	35%	100%	100%
Age category			
Under 55	25	5	16
55–64	36	8	16
65–69	35	26	21
70–74	39	23	18
75–84	37	27	21
Over 84	33	10	8
Sex			
Male	35	43	40
Female	36	57	60
Race/Ethnicity			
White	33	77	54
Black	38	12	24
Asian	45	3	5
Hispanic	49	4	13
Other/Unknown	36	4	4
ESRD entitlement			
Entitled	19	<1	1
Not entitled	36	100	99
Dual status			
Dually eligible for Medicare and Medicaid	35	19	75
Not dually eligible	36	81	25
LIS status			
LIS	36	24	78
Not LIS	35	76	22

Note: MA (Medicare Advantage), SNP (special needs plan), ESRD (end-stage renal disease), LIS (low-income subsidy). SNPs are included in total MA. Under Part D, Medicare provides extra help with premiums and cost sharing to Part D enrollees who qualify for the LIS. Components may not sum to totals because of rounding.

Source: CMS beneficiary data (Common Medicare Environment file), 2017.

Who chooses to join MA plans and when do they choose? (cont.)

proportionally less likely to enroll in MA than any other racial/ethnic group, but they still make up 77 percent of the MA enrollment. Asian American and Hispanic beneficiaries are the most likely racial/ethnic groups to enroll in MA.

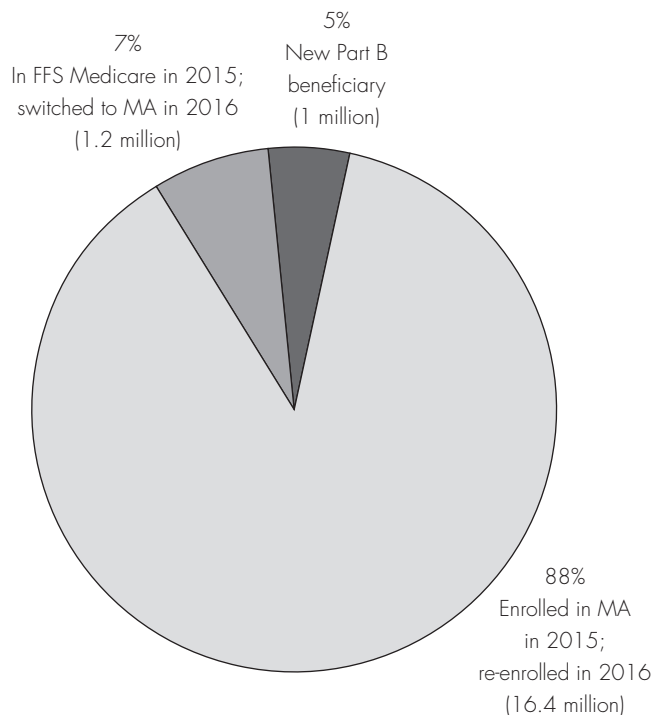
Beneficiaries who have end-stage renal disease (ESRD) are less likely to be in an MA plan, but those beneficiaries are not allowed to choose MA unless they were enrolled in a plan before they developed the disease. However, this prohibition has been reversed in legislation (the 21st Century Cures Act); beginning in 2021, beneficiaries with ESRD will be allowed to enroll in MA plans.

Beneficiaries dually entitled to both Medicare and Medicaid are about equally likely to enroll in MA plans as other beneficiaries.⁴ Beneficiaries who receive the low-income subsidy (LIS) for Part D are also about equally likely to enroll in MA as other beneficiaries. Almost a quarter of MA enrollees receive the LIS.

Younger, female, and minority beneficiaries are a greater share of special needs plan (SNP) enrollment than they are of overall MA enrollment. Dual-eligible beneficiaries and beneficiaries receiving the LIS make up most of the SNP population; 78 percent of SNP enrollees receive the Part D LIS. If SNP enrollees were excluded from the MA population numbers, we would see that 81 percent are White, 11 percent are dual eligible, and 16 percent receive the LIS (data not shown in the table). None of the other categorical shares of MA enrollment would change by more than a percentage point if SNP enrollees were excluded from the calculations.

FIGURE 13-2

Number of beneficiaries in MA, December 2016



Note: MA (Medicare Advantage), FFS (fee-for-service). MA in this text box includes non-MA enrollment in cost plans, Medicare–Medicaid dual-eligible demonstration plans, and Program of All-Inclusive Care for the Elderly plans.

Source: CMS beneficiary data (Common Medicare Environment file).

When do beneficiaries tend to enroll in MA?

Of the 18.6 million beneficiaries enrolled in MA in December 2016, 88 percent (16.4 million beneficiaries) were enrolled in an MA plan in December 2015 (Figure 13-2), while 7 percent (1.2 million beneficiaries) were in FFS Medicare with both Part A and Part B in December 2015 and switched into MA during 2016. Additionally, 5 percent of MA enrollees (1 million beneficiaries) had Part A and Part B for the first time during 2016 (most of these “new beneficiaries” were completely new to Medicare; some may have had only Part A before 2016).

Overall, in 2016, the 18.6 million MA enrollees were 35 percent of all Medicare beneficiaries with both Part A and Part B. The 1 million MA enrollees who were new beneficiaries were 28 percent of all beneficiaries who newly enrolled in both Part A and Part B during 2016, meaning that new beneficiaries were less likely to be enrolled in MA than the average beneficiary. The 1.2 million beneficiaries who switched from FFS to MA in 2016 were 4 percent of the FFS population. In contrast, about 400,000 beneficiaries switched from MA to FFS in 2016, which was about 2 percent of MA enrollment. ■

**TABLE
13-3****Access to Medicare Advantage plans remains high****Share of Medicare beneficiaries with access to at least one MA plan, by type**

Type of plan	2012	2013	2014	2015	2016	2017	2018
Any MA plan	100%	100%	100%	99%	99%	99%	99%
Local CCP	93	95	95	95	96	95	96
Regional PPO	76	71	71	70	73	74	74
PFFS	60	59	53	47	47	45	41
Special needs plans							
Dual eligible	78	82	82	82	83	86	86
Chronic condition	45	55	51	55	54	44	47
Institutional	41	46	47	47	50	52	56
Zero-premium plan with drug coverage	88	86	84	78	81	81	84
Average number of choices							
County weighted	12	12	10	9	9	10	10
Beneficiary weighted	19	19	18	17	18	18	20
Average monthly rebate for nonemployer, non-SNP plans	\$85	\$81	\$75	\$76	\$81	\$89	\$95

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). "Local CCPs" 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.

In 2017, 84 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 81 percent in 2017 (Table 13-3). Over half of nonemployer, non-SNP MA enrollment is in these zero-premium plans. Also, 40 percent of beneficiaries have access to plans that offer some reduction in the Part B premium (not shown in Table 13-3), but only 2 percent of enrollment is in these premium-reduction plans. For 2018, rebates (which can include allocations to plan administration and profit margin) for nonemployer, non-SNP plans will average \$95 per enrollee per month. The average rebates are higher than at any point in the program's recent history.

In most counties, a large number of MA plans are available to beneficiaries. For example, in 2018, beneficiaries in

Albany (Albany, NY), Harris (Houston, TX), Cuyahoga (Cleveland, OH), Hamilton (Cincinnati, OH), Los Angeles (CA), and Orange (CA) counties and 8 counties in southeastern Pennsylvania can choose from at least 40 plans. At the other end of the spectrum, almost 250 counties, representing 1 percent of beneficiaries, have no MA plans available; however, many of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).⁵ On average, 10 plans are available in each county in 2018. 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. According to that calculation, the average beneficiary in 2018 has 20 available plans, including 19 CCPs, an increase from 18 plans and 17 CCPs in 2017.

**TABLE
13-4**

Projected benchmarks, bids, and payments as a percentage of fee-for-service expenditures for 2018, by plan type

Share of FFS spending in 2018*

Plan type	Benchmarks	Bids	Payments
All MA plans	107%	90%	101%
HMO	106	88	100
Local PPO	110	99	106
Regional PPO	102	94	98
PFFS	107	105	106
Restricted availability plans included in totals above			
SNP	106	93	101

All values would be increased by 2 percent if coding intensity were to be reflected fully (i.e., payments for all MA plans would average 103 percent of FFS spending if the coding differences were fully reflected).

Note: FFS (fee-for-service), MA (Medicare Advantage), 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 2018 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.

2018 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. 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 2018 made by CMS actuaries at the time the benchmarks were published in April 2017. We estimate that 2018 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 90 percent, and 101 percent of FFS spending, respectively (Table 13-4). The benchmarks are up 1 percentage point from 2017. While the bids did not change from 90 percent of FFS, the payments rose from 100 percent of FFS because of the higher benchmarks relative to FFS.

How Medicare calculates MA benchmarks

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), each county’s benchmark, excluding quality bonuses, is 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, which include those with both Part A and Part B coverage and those with only Part A or Part B. Each county’s benchmark, excluding quality bonuses, is determined by organizing the counties into quartiles based on their FFS spending. Each quartile contains 786 or 787 counties. Low-FFS-spending counties have benchmarks higher than FFS to help attract plans, and high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings.

Counties (excluding the territories) are ranked by 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 county benchmarks is set at 100 percent of FFS spending, followed by the third highest quartile set at 107.5 percent of FFS spending.

**TABLE
13-5**

Share of Medicare beneficiaries living in counties by FFS spending quartile and average resulting unadjusted benchmark relative to FFS spending for 2012, 2017, and 2018

Year	Payment quartile based on FFS spending*				Average unadjusted** benchmark as a share of FFS spending
	Quartile 1: 115 percent (low FFS spending)	Quartile 2: 107.5 percent	Quartile 3: 100 percent	Quartile 4: 95 percent (high FFS spending)	
2012	16%	18%	24%	43%	101.5%
2017	20	23	23	33	103.0
2018	22	24	26	28	103.7

Note: FFS (fee-for-service).

*Total may not match number derived from components due to rounding.

**Adjustments would include county benchmark caps, double quality bonuses, and year-to-year quartile smoothing.

Source: CMS Medicare Advantage rate book and enrollment files.

The lowest spending quartile has benchmarks set at 115 percent of local FFS spending (the U.S. territories are treated like counties in this low-spending quartile).

By statute, plans awarded quality bonuses have benchmarks 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties (where plans can receive a double bonus), the benchmarks for plans awarded quality bonuses are 10 percent higher than the standard benchmarks. 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 (Medicare Payment Advisory Commission 2016).

Why did benchmarks seem to rise for 2018?

The benchmarks the plans are bidding against rose from a projected 106 percent of FFS in the 2017 bids (excluding employer plan bids) to 107 percent in the 2018 bids. This increase occurred even though no explicit policies would have increased the benchmarks relative to FFS spending. The increase itself is projected to be only 0.6 percent, but because we round to the nearest percent, the increase has the appearance of a 1 percent increase.

The primary reason behind the increase in the benchmark-to-FFS ratio is the movement of counties from one payment-rate quartile to another. More beneficiaries lived

in counties that moved to lower spending quartiles than lived in counties that moved to higher spending quartiles (Table 13-5). In other words, average FFS spending grew more rapidly in counties with relatively fewer Medicare beneficiaries than in counties with relatively higher numbers of Medicare beneficiaries. So, after the counties were reranked by FFS spending to create quartiles for 2018, a lower share of Medicare beneficiaries lives in the 786 highest spending counties (28 percent) than lived in the 786 highest spending counties ranked by 2012 FFS spending (43 percent).

The average beneficiary-weighted benchmark would have increased from 101.5 percent of average FFS spending in 2012 to 103.7 percent in 2018 simply because of the change in the beneficiary distribution among the quartiles. (Plan benchmarks are based on their projected enrollment, but the change in enrollment patterns looks similar to the change in Medicare beneficiary residence patterns.) The 2018 average benchmark relative to FFS spending can be calculated from Table 13-5 as $(0.22 \times 115) + (0.24 \times 107.5) + (0.26 \times 100) + (0.28 \times 95)$. (The 2012 and 2017 figures cannot be calculated exactly from the table due to rounding. These calculations exclude benchmark quality bonuses and caps, as well as some year-to-year smoothing adjustments.) We first noted the potential for this movement in our March 2011 report to the Congress but cannot identify its definitive cause and cannot rule out that the movement has a large random component. We will continue to monitor the county quartile movements.

**TABLE
13-6****Distribution of 2018 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	10	14
0.8 to 0.9	22	27
0.9 to 1.0	33	33
1.0 to 1.1	23	18
More than 1.1	8	4

Note: MA (Medicare Advantage), FFS (fee-for-service). Employer group plans and special needs plans are not included.

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

MA bids and payments for different plan types

Despite the slight increase in benchmarks for 2018, benchmarks are lower relative to earlier years. The benchmarks have exerted fiscal pressure and have led to more competitive bids from plans. Benchmarks before PPACA (in 2010) averaged about 112 percent of FFS, and the bids averaged 100 percent of FFS. The average nonemployer bid for 2018 is 90 percent of the projected FFS spending for beneficiaries with similar geographic and risk profiles, unchanged from 2017. About 70 percent of nonemployer non-SNP plans bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits in 2018 (Table 13-6). These plans are projected to enroll about 77 percent of nonemployer non-SNP MA enrollees in 2018.

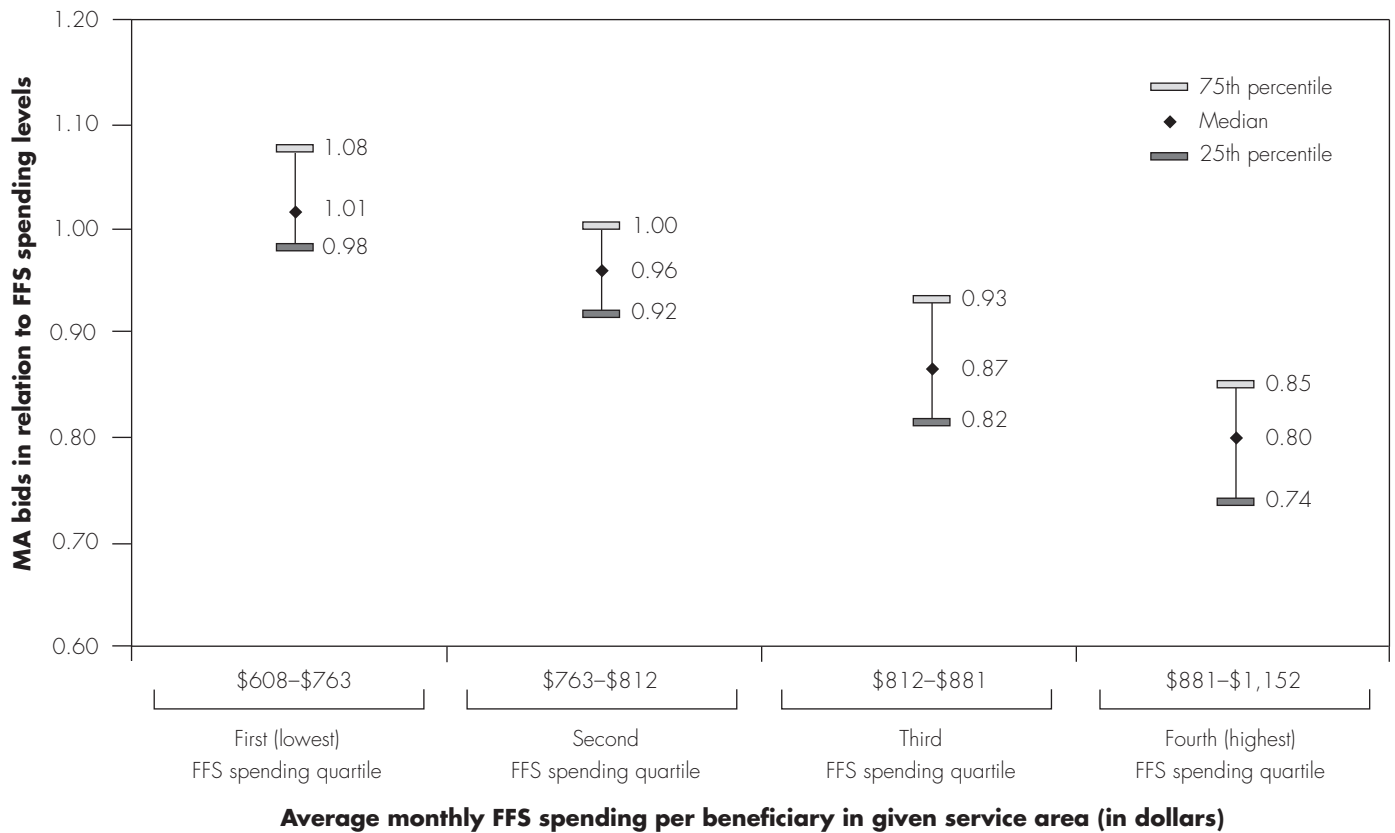
About 4 percent of MA enrollees, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 70 percent of FFS spending; 4 percent are also projected to enroll in plans that bid more than 110 percent of FFS spending.

Figure 13-3 shows how plans bid relative to FFS for service areas with different ranges of FFS spending. This figure is based on data from over 2,450 plan bids and excludes employer plans, SNPs, and plans in the territories. FFS spending ranges roughly correspond to FFS ranges in the payment quartiles for 2018. Each of the 4 FFS ranges covers the bids of at least 400 plans that include at least 2.9 million projected enrollees.

As expected, plans bid high (relative to FFS) in areas with relatively low FFS spending and bid low (relative to FFS) where FFS spending is relatively high. For example, plans bidding for service areas that average less than \$763 in monthly FFS spending are likely to bid more than FFS for 2018 (Figure 13-3). However, in plan service areas averaging more than \$763 per month in FFS spending, plans are likely to bid below (sometimes far below) the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. Ninety-eight percent of beneficiaries live in a county served by at least one plan that bid below its service area's average FFS spending for 2018. However, that does not mean that plans can bid lower than FFS in every county.

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. Overall, plan bids average 90 percent of expected FFS spending for beneficiaries with similar geographic and risk profiles in 2018, but because the benchmarks average 107 percent of FFS spending, Medicare pays an average of 101 percent of FFS for beneficiaries enrolled in MA (coding intensity differences are not considered in these numbers). Excluding quality bonuses, Medicare benchmarks average 103 percent of FFS, and Medicare payments would average 98 percent of FFS for MA enrollees.

The ratio of MA plan payments to FFS spending varies by plan type (Table 13-4, p. 364). For example, HMOs as a group bid an average of 88 percent of FFS spending,

**FIGURE
13-3****Medicare Advantage bids in relation to FFS spending levels, 2018**

Note: FFS (fee-for-service), MA (Medicare Advantage). Excludes employer group plans, special needs plans, and plans in the territories.

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

yet 2018 payments for HMO enrollees are estimated to average 100 percent of FFS spending because of benchmarks averaging 106 percent of FFS spending. Local PPOs' bids average 99 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 106 percent of FFS spending. Payments for beneficiaries enrolled in regional PPOs average 98 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, payments to SNPs and their bids tended to be slightly higher relative to FFS spending than payments to the other nonemployer

MA plans. This year in aggregate, however, SNP bids are slightly higher than other MA plans, but their payments are similar to the average plan because their benchmarks are slightly lower relative 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 nonemployer plans are submitted to compete for enrollment. (For more details on employer plans and our recommendation, see our March 2014 report to the Congress.) 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 like the payments to the nonemployer plans analyzed here.

**TABLE
13-7****Share of Medicare Advantage enrollment by parent organization, October 2017**

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.	25%	Humana Inc.	27%
Humana Inc.	16	UnitedHealth Group Inc.	27
Kaiser Foundation Health Plan	9	Aetna Inc.	7
Aetna Inc.	8	Blue Cross Blue Shield of MI	4
Anthem Inc.	4	Anthem Inc.	3
WellCare Health Plans Inc.	3	WellCare Health Plans Inc.	2
CIGNA	2	Highmark Health	2
Blue Cross Blue Shield of MI	2	BlueCross BlueShield of TN	2
Centene Corporation	2	CIGNA UPMC Health System	2
Highmark Health	2	UPMC Health System	2
Total, top 10 organizations	72	Total, top 10 organizations	77

Note: Includes only Medicare Advantage plans (coordinated care plans, private fee-for-service, and medical savings accounts 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. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS monthly enrollment reports, October 2017 (which excludes enrollment for contracts where an organization has fewer than 11 enrollees), and Census data on county designations.

MA margins

The growth in MA enrollment, the continued high level of access to plans, and the ability of plans to bid below benchmark levels are indicative of strong financial performance in the MA sector. As with other sectors, we have examined margin levels in MA. The most recent data available, from 2016, show that MA margins averaged 2.6 percent. This figure excludes Part D—for which we do not have 2016 data—and employer group plans, which are no longer included in the bid data on which we base our margin calculations. The 2016 margin of 2.6 compares with an average margin level of 1.4 percent in 2015.

Margins vary by plan type. In the 2016 data, nonprofit plans had a negative margin (–4.2 percent), while for-profit entities had a pretax margin of 4.9 percent. The large difference in margins between for-profit and nonprofit entities may reflect the extent to which employer group waiver plans (EGWPs) (plans available only to employer- or union-sponsored enrollees) are a more important market segment for nonprofit plans. Among nonprofit plans that are under contracts with 25 percent or more

EGWP enrollment (totaling 1.4 million enrollees in our 2016 margin data), the non-EGWP average margin was –8.6 percent. Among nonprofit MA plans with EGWP enrollment of 5 percent or less, the average margin was –1.8 percent (also with a total enrollment of 1.4 million). EGWP enrollment was a far smaller component of for-profit contracts in our 2016 margin data, with little difference in margins based on the level of EGWP enrollment. For-profit contracts with EGWP enrollment of 25 percent or more had an average margin of 4.4 percent, with 270,000 enrollees. For-profit contracts with EGWP enrollment of 5 percent or less had an average margin of 4.9 percent, with 7 million enrollees. In the 2016 data, EGWP margin data are not included because EGWPs were no longer required to submit bids after reforms to the manner in which EGWPs were paid. For prior years, when EGWP bids were included in the bid data, we found that EGWP margins were higher than non-EGWP margins, suggesting that EGWP margins can offset the losses that we see among nonprofit non-EGWP plans.

All categories of SNPs had positive margins: SNPs for Medicare–Medicaid dual-eligible beneficiaries (D–SNPs)

at 5.9 percent, SNPs for enrollees with chronic conditions (C-SNPs) at 9.7 percent, and SNPs for beneficiaries living in institutions (I-SNPs) at 14.1 percent. However, nonprofit D-SNPs had a negative margin (-2.3 percent). D-SNPs in Puerto Rico show relatively high margins, at 12.4 percent, but the Puerto Rico plans stated that extra funds were needed to subsidize their Medicaid line of business in serving D-SNP plan members.

Among D-SNPs, differences exist between CMS-designated fully integrated dual-eligible (FIDE) SNPs and other D-SNPs. FIDE-SNPs meet specified requirements regarding coverage of and coordination with Medicaid services. Some of the FIDE-SNPs can be eligible for additional payments that recognize higher frailty levels in the enrolled population (a payment adjustment available only to certain FIDE-SNPs and to PACE plans). In the margin data, only 16 plans are FIDE-SNPs. Among nonprofit plans, the data show that FIDE-SNPs with a frailty adjuster have higher margins than those without the frailty adjuster (0.9 percent vs. -0.4 percent), and the nonprofit FIDE-SNPs have higher margins than nonprofit D-SNPs that are not FIDE-SNPs (which have a margin of -4.4 percent). The relationship among types is different with for-profit plans. Two for-profit FIDE-SNPs with the frailty adjuster have a margin of 3.6 percent, compared with a margin of 7.2 percent for both of the other two categories, which do not have a frailty adjuster (for-profit D-SNPs that are FIDE-SNPs and those that are not). These data are limited and do not show a clear pattern. The data are thus inconclusive with respect to whether better integration between Medicare and Medicaid leads to lower costs and better profit margins. (Note that the margin data, based on bids that plans submit, do not contain information about the Medicare-Medicaid plans in the CMS financial alignment demonstration because such plans do not submit bids to CMS.)

We estimate that if we were to include Part D drug margins, doing so would raise the average MA plan margin by approximately 0.5 percent; if employer plan data were available, the margin would likely be higher—particularly in the case of nonprofit plans. Two additional factors affect this margin estimate: First, MA plans are subject to payment of the PPACA insurer fees applicable to most MA plans (which we estimate as representing 1.5 percent of plan revenue, but which have been suspended for 2017 through 2019). Second, as of 2014, plans are also subject to an 85 percent medical loss ratio (MLR) requirement, which could result in reduced margins (as evidenced by some plans returning funds to CMS for failure to meet the MLR requirement).

Market structure of the Medicare Advantage program

In the March 2016 report to the Congress, we provided information about the degree of concentration in the MA market (Medicare Payment Advisory Commission 2016). In 2007, the top 4 organizations had 45 percent of MA enrollment—with the top 2 having 41 percent—and the top 10 had 61 percent of total enrollment. At the beginning of 2011, the year before the effective date of PPACA payment changes, the shares remained essentially the same at 46 percent and 60 percent, respectively. The MA market has become more concentrated since then. In 2017, the top 4 organizations had 59 percent of the enrollment, and the top 10 organizations had 72 percent of total enrollment.

There are differences between metropolitan areas and nonmetropolitan areas (Table 13-7). In metropolitan areas, the top 2 organizations had over 40 percent of the 17 million MA enrollees in these areas. In nonmetropolitan areas, the top 2 organizations accounted for over half the enrollment (54 percent of the 2 million MA enrollees residing in these areas).

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. As was true in 2016, 87 percent of Medicare beneficiaries in 2017 resided in a county where at least three companies offered MA plans to individual Medicare beneficiaries (Table 13-8, p. 370). 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 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 status, and whether the original reason for Medicare entitlement was disability) 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

**TABLE
13-8**

Distribution of population by number of MA organizations operating in the county, October 2017

Number of MA organizations in county	As share of total Medicare population	As share of MA enrollment
None	1%	0.1%
1	3	1
2	8	5
3	10	7
4	12	12
5 or more	65	76

Note: MA (Medicare Advantage). Excludes plans offered only to employer group-sponsored retirees. Numbers may not sum due to rounding. The 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.

maximize its ability to predict annual medical expenditures for Medicare beneficiaries. 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 inappropriate manipulation or discretionary coding (Pope et al. 2004). To ensure the validity and reliability of the diagnostic data used in the model and to determine payment to MA plans, CMS applies additional eligibility criteria: Diagnoses must result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional, and diagnoses must be supported by evidence in the patient's medical record.⁶

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. In practice, the actual dollar amount a plan will receive for newly identifying a particular HCC for an enrollee depends on several additional factors, but for a simplified example of how coding additional HCCs increases payment to a plan, we consider amounts received by an MA plan that are approximately equal to average FFS Medicare spending.⁷ In this example, the annual Medicare payment to the MA organization in 2018 for an 84-year-old male who is not eligible for Medicaid (demographic component valued at \$5,707) with diabetes without complication (HCC 19, valued at \$1,058) would be \$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 is 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 for the first time in a given year is between \$1,000 and \$5,000, although some HCCs increase payment by \$10,000 or more.

MA plans submit diagnostic information to CMS in two ways. Through the Risk Adjustment Processing System (RAPS), plans submit the minimum information necessary to identify which HCCs apply to each enrollee. Since

2012, MA plans have also been submitting detailed information through the Encounter Data System (EDS) about each health care encounter an enrollee has with a Medicare provider. In 2016, CMS 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.⁸ Payment in 2016 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, 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. While both sources of risk score data are used for payment, MA plans need to submit data supporting each HCC through both RAPS and EDS in order to maintain consistent payment rates.

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. If certain diagnoses are not reported, the cost of treating those conditions is attributed to other components in the model, causing the coefficients to be inflated above their true value. If diagnoses were coded with the same intensity in FFS Medicare and MA, meaning that the proportion of all reported diagnoses was equal in the two programs, the impact of inflated coefficients would be offset between the two programs and there would be no payment inaccuracy. However, if MA plans submit more diagnoses for a particular beneficiary than would have been documented in FFS Medicare, the program spends more money for that beneficiary to be in MA. We have found that MA coding intensity is higher than FFS Medicare, and payments to MA plans are thus higher than intended.

The CMS–HCC model has always provided MA plans with a strong financial incentive to document all possible diagnoses. The following mechanisms increase plans’ access to diagnostic data and allow MA plans to submit more diagnoses.

Passive mechanisms:

- **Capitated contracts**—Some plans have capitated contracts with physician groups in which payment is

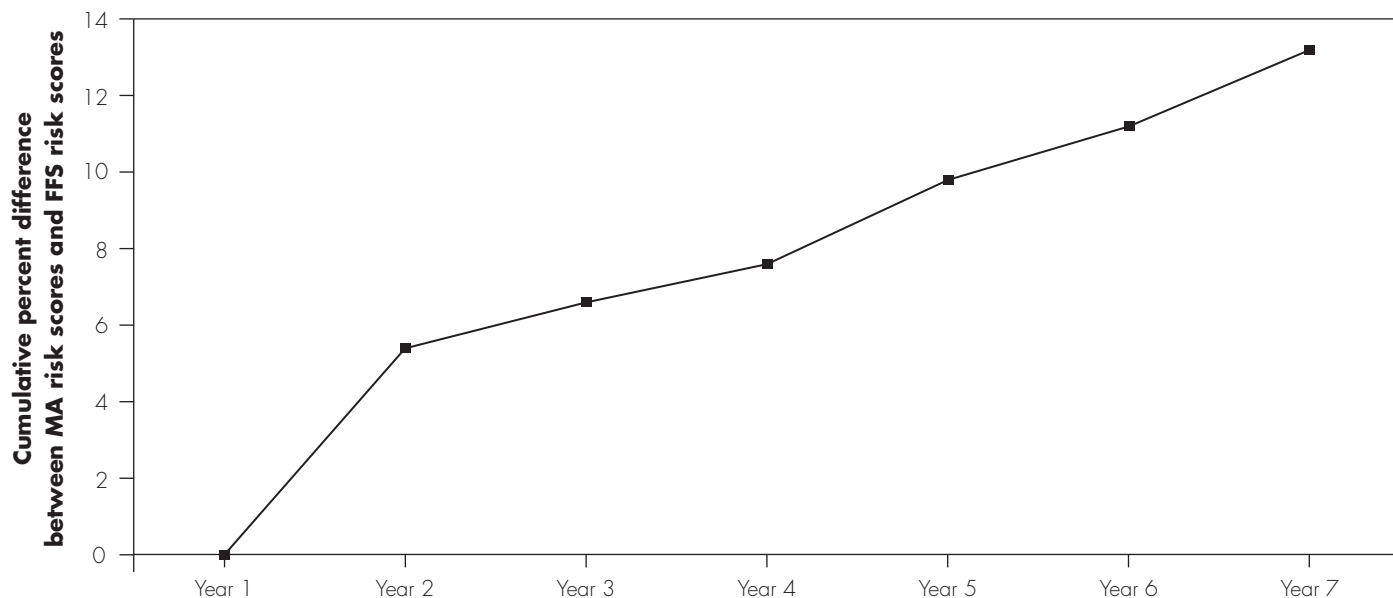
risk adjusted. These contracts pass diagnostic coding incentives on to physicians with direct access to the patient’s medical record and diagnostic information.

- **Data sharing with providers**—Plans have varying levels of access to providers’ electronic medical record (EMR) systems, which affects access to diagnostic data. For example, in staff-model HMOs, all providers use a single EMR that plan administrators can access. Other HMOs may have access to the EMR systems of some physician groups and hospitals but not others. PPO and PFFS plans have looser networks and are less likely to have access to EMR systems.

Plan-initiated mechanisms:

- **Health risk assessments (HRAs)**—HRAs assess an enrollee’s health status and document diagnoses as a first step to developing an enrollee’s care plan. HRAs can help enrollees engage in subsequent disease management, but generally treatment is not provided at the time of assessment. HRA diagnoses are used when calculating risk scores when conducted in person by a physician or other health care professional. With the help of consulting firms advertising revenue maximization, plans target HRAs to enrollees they suspect of having any undocumented diagnoses, often by sending a nurse to the enrollee’s home. Medicare’s annual wellness visit includes an HRA and is available in MA and FFS, but home visits are used almost exclusively in MA.
- **Chart reviews**—Plan staff visit providers’ offices to search medical records (“charts”) for diagnoses that were not included on the original claim submitted to the plan. Plans then submit additional diagnosis codes to CMS as an addendum to the original encounter.
- **Pay-for-coding programs**—For physicians who have an FFS contract with an MA plan (and do not share access to their EMR with the plan), there is no direct incentive to document diagnostic codes. In this situation, some plans inform physicians of potentially undocumented diagnoses and pay an additional amount if the physician submits a new diagnosis on a claim and includes documentation in the patient’s medical record.

Many of these actions serve multiple purposes. Some would argue that complete diagnostic information allows plans to more thoroughly identify enrollees who would benefit from preventive care or programs designed to

**FIGURE
13-4****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.

improve chronic condition management; the additional revenue that may result from higher MA coding intensity allows plans to fund such programs. However, some plans appear to have modified their approach to coding diagnoses to maximize revenue to the detriment of accurate reporting of diagnosis codes or consideration of patient needs. In recently unsealed lawsuits, whistleblowers alleged that plans ignored evidence of improper coding; used software that is incapable of deleting invalid diagnoses, or ignored the status of a diagnosis as valid or invalid; and focused clinical programs on patients with potential for coding a higher level of severity (e.g., diabetes without complications), but not on patients already coded with the highest level of severity for a condition (e.g., diabetes with complications) who might benefit the most from disease management.⁹

Policies to address the impact of coding differences

A series of congressional mandates have 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 required by law for 2014 through 2018, although larger reductions would have been allowed.

CMS has taken 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 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 by about 2.5 percent 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.

**TABLE
13-9**

Impact of diagnostic coding intensity on MA risk scores relative to FFS, 2013-2016

Risk score model	Cumulative change in MA risk scores relative to FFS risk scores			
	2013	2014	2015	2016
Old model	8%	9%	10%	N/A
Payment blend	8	7	10	8%
New model	N/A	7	8	8

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). Payments to MA plans are based in part on enrollee risk scores, where higher risk scores generate larger payments. All estimates account for any differences in age and sex between MA and FFS populations. "Old model" refers to the version of the CMS-hierarchical condition category (CMS-HCC) model used for payment through 2015. "New model" refers to the version of the CMS-HCC model introduced in payment year 2014. The payment blend was 75 percent new model / 25 percent old model in 2014 and 33 percent new model / 67 percent old model in 2015.

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

Impact of coding differences on payment to MA plans

Impact over time

For the past few years, the Commission has conducted its own analysis of coding differences between beneficiaries in FFS Medicare and those enrolled in MA plans. In our first year of 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 in FFS and spent all subsequent years through 2013 in the same program, either FFS or MA. For example, one cohort pair consisted of those beneficiaries who joined Medicare FFS 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 13-4 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.

While this analysis shows compelling evidence that a coding difference exists between beneficiaries in FFS Medicare and MA and that the difference grows over time, it does not tell us the overall impact of the coding difference on payments to MA plans in a given year.

Overall impact

To assess the overall impact of coding differences on payments to MA plans for a given year, we tracked current-year enrollees backward in time for as long as they were continuously enrolled in either MA or FFS, or through 2007. We used these retrospective cohorts of MA and FFS enrollees, accounting for differences in age and sex, to calculate the difference in risk score growth between the MA and FFS programs.

Table 13-9 shows the total differences in MA risk scores relative to FFS for payment years 2013 through 2016. The risk scores used to determine MA plan payments were based entirely on the old CMS-HCC model in 2013, on a blend of the old and new models in 2014 and 2015, and entirely on the new model in 2016. We found that MA risk scores for 2016 were about 8 percent higher than a comparable FFS population. From 2013 through 2015, MA risk scores for both the old model and new model grew faster than FFS scores by about 1 percentage point per year. However, from 2015 to 2016, MA and FFS risk scores based on the new model grew at the same pace, and the overall difference in MA and FFS risk scores held constant at 8 percentage points.

Our analysis of 2015 and 2016 data shows that MA risk scores continued to increase at about the same rate as in prior years, but FFS risk scores grew faster than before and roughly matched the MA risk score growth rate.¹⁰ Our estimate showing that MA risk scores for 2016 were about 8 percent higher than a comparable FFS population is lower than the previous year's estimate of a 10 percent difference. We find that the decrease is due to the full implementation of the new risk score model and an increase in the FFS risk score growth rate.

Relative to FFS Medicare, we found that MA risk score growth through 2016 was between 2 percent and 3 percent higher than CMS's adjustment for coding intensity (which was 5.41 percent in 2016). In other words, after accounting for all coding adjustments, payments to MA plans were between 2 percent and 3 percent higher than Medicare payments would have been if MA enrollees had been treated in FFS Medicare. The magnitude of these findings is similar to 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, Kronick and Welch 2014).

Impact of encounter data

The use of encounter data for risk adjustment can help improve risk adjustment accuracy and reduce MA and FFS coding differences. The process of submitting encounter data provides CMS the ability to ensure that the data represent valid encounters with health care providers and that submitted diagnoses meet risk adjustment eligibility criteria. Data for each encounter include the specific health care provider of a service, date of service, diagnoses identified, procedures conducted, and the cost of the services provided (when a capitated arrangement is not in place). The information on each encounter record is encoded in 154 to 202 data elements, depending on the type of provider, and CMS has developed a system of error and duplicate checks to ensure that duplicate encounters are not submitted and that data elements are in a valid format and logical range of values. In addition to checking the completeness and accuracy of each encounter record, CMS can ensure that submitted diagnoses meet risk adjustment eligibility criteria before payment is made to a plan. Over the past few years, CMS and plans have been working to refine this process. CMS has continually revised the feedback it gives to plans, which takes the form of error codes, reports detailing

the disposition of submitted encounters as accepted or rejected, and reports identifying the risk adjustment eligibility status of diagnoses from accepted encounters. CMS has disseminated guidance to plans through memos and has conducted user group calls to explain changes and allow for questions to be answered. However, submission of encounter data is a newer process, and government auditors note that CMS has yet to complete all validity assessments of the data (Government Accountability Office 2017). Because that process is ongoing and continues to require significant effort from plans, CMS has extended the deadlines for submitting encounter data affecting payment years 2016 and 2017, the first years that payment relies on encounter data.

Although the submission of encounter data may be onerous for plans as CMS continues to refine the submission and feedback processes, the use of encounter data significantly improves oversight and the opportunity to ensure the validity of payment data relative to RAPS data, which have been used as a basis for the majority of MA plan payments since 2004. Under RAPS, plans submit a limited set of data (including the type of provider, the date of service, diagnoses identified, and whether the diagnoses resulted from a risk assessment), and attest that the submitted data (1) are complete and accurate and (2) meet the risk adjustment eligibility criteria. Once plans attest to their RAPS data, no further assessment of data validity is conducted before payment is made to the plan.

Data submitted through either the encounter or RAPS processes are supposed to be audited to ensure that diagnoses are supported by the medical record through the risk adjustment data validation (RADV) audit process. Given the differences in the data submission processes and the fact that CMS does not review risk adjustment eligibility for RAPS data before payment, RADV audits are relied on significantly for assessing the validity of RAPS data. However, RADV audits have been limited so far, and early audits of RAPS data found diagnoses that did not meet risk adjustment eligibility criteria, resulting in significant overpayments to plans. So far, CMS has completed audits for only 2007, and the overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). These audits addressed data for a sample of 201 beneficiaries from each of 32 contracts (covering 6,432 beneficiaries) and recouped overpayments of \$13.7 million. For audits of 2011, 2012, and 2013, CMS has identified 30 contracts, or roughly 5 percent of all MA contracts, to audit in each year. For these audits, CMS will

recoup overpayments for the full enrollment of the contract by calculating, at the 99th percentile lower confidence interval, an error rate for each contract's sample of 201 beneficiaries, applying an FFS adjuster, and then applying this rate to the contract's total MA payments. In reviewing the RADV audit process, government analysts note that the audits are tasked with recouping billions of dollars in improper payments to MA plans based on RAPS data, but their report finds that significant improvements are needed for the audits to identify and recoup those overpayments (Government Accountability Office 2016).

While MA payment uses both RAPS and encounter-based risk scores, data supporting each HCC needs to be submitted through both RAPS and encounter processes for plans to maintain consistent payment rates. For the 2016 payment year, CMS extended the deadline for submitting the underlying encounter data (based on 2015 dates of service) beyond April 2018, allowing plans more than 27 months to finalize their encounter data submissions. Using encounter data submitted as of May 1, 2017, we found that 2016 risk scores based on encounter data were about 2 percent lower on average than risk scores based on RAPS data; however, we expect the 2 percent difference to shrink as more encounters are submitted. Looking at individual risk scores, we found that 91 percent of MA enrollees had 2016 risk scores based on RAPS and encounter data that were exactly the same, while about 7 percent had lower encounter-based scores and 2 percent had higher encounter-based scores. After accounting for the effect of using encounter-based risk scores, which was -0.2 percent when basing 10 percent of payment on encounter data, our estimate of the overall impact of coding differences remained at 8 percent.

CMS based 25 percent of payments in 2017 on encounter-based risk scores and has stated an intention to extend the deadline for encounter submissions. For 2018, CMS decreased the use of encounter data to 15 percent of payments. While we recognize that the submission of accurate encounter data has required significant effort from plans and that CMS has been diligent in working through submission issues with plans, we believe that reducing the use of encounter data for payment was a step backward for the validity of the data used to calculate the more than \$200 billion that Medicare pays to MA plans. MA plans have been submitting encounter data since 2012 and should now be held accountable for submitting valid data by relying more on encounter data for payments.

The Commission believes there is value for CMS in continuing to collect encounter data and to work with plans to submit complete and accurate encounter data. The use of encounter data allows risk adjustment eligibility to be ensured to a greater extent before payments are made to plans and provides a more substantial check on the submission of inaccurate or fraudulent data relative to RAPS data. Encounter data can improve program integrity by providing a more robust data source for risk adjustment and payment, allow for improvements in quality measurement in MA by incorporating claims-based measures, and be used to compare quality between MA and the FFS Medicare programs (for further discussion of quality, see text box on p. 391).

Variation in coding intensity across MA contracts

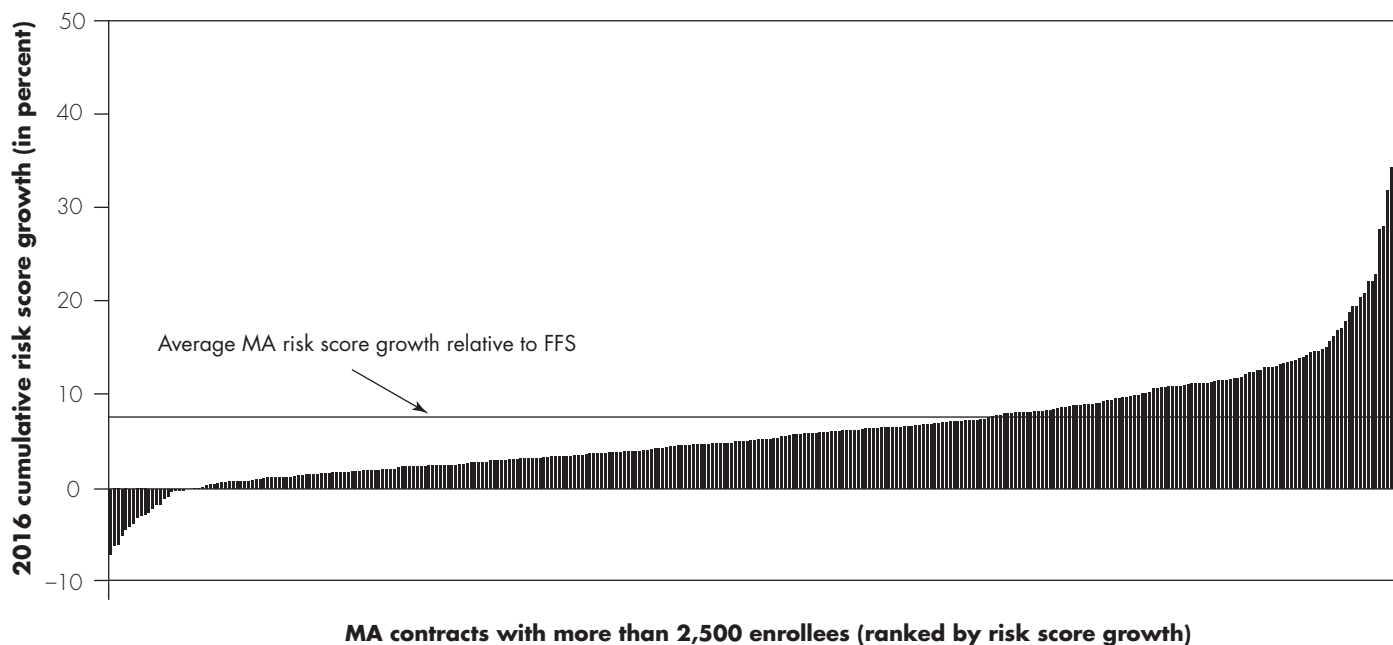
We continued to find wide variation in the impact of coding intensity for each MA contract in 2016. This finding is based on an analysis we conducted similar to our coding differences analysis, but the change in risk score for each MA beneficiary was attributed to the contract (excluding contracts for PACE and SNPs) in which the beneficiary was enrolled in 2016, thereby capturing the coding impact on 2016 payments to each contract. Figure 13-5 (p. 376) illustrates the variation across contracts with more than 2,500 enrollees in 2016 relative to FFS in their local service area. 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 the Medicare payment system should be neutral with respect to beneficiaries' choice of MA or FFS Medicare. Excess payments to MA plans allow them to offer additional benefits to enrollees, thus benefiting the MA program but costing taxpayers more than if MA beneficiaries had remained in FFS. Further, the additional payment to MA plans increases the Part B premium for all Medicare beneficiaries. The size of the Part B premium is based on total Part B spending, which for MA is calculated as a proportion of all MA spending.

**FIGURE
13-5**

Cumulative MA risk score growth varied across contracts relative to local FFS, 2016



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.

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 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 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 appears to adopt using two years of diagnostic data in MA risk adjustment by 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. In FFS, only about 6 percent of diagnoses documented on HRAs were not treated during the year.

Implementing these two policies would result in a more equitable adjustment across MA contracts than the current across-the-board adjustment because they more effectively target coding differences. 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 percent to 5 percent relative to Medicare FFS and thus would address roughly half of the impact of coding differences, reducing the need for the coding intensity adjustment described in the third part of the Commission’s 2016 recommendation.

The Commission has also discussed ways to implement the third part of the recommendation in a way that

improves equity across MA contracts. One way to implement the recommended coding intensity adjustment would be to 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 this grouping of contracts based on coding intensity when selecting MA contracts for RADV audits.¹¹ 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.

Quality in the Medicare Advantage program and the effect of contract consolidations

Each year, the Commission examines available quality indicators in MA to judge the quality of care beneficiaries receive and what changes there have been in quality indicators over time. However, our ability—and the ability of beneficiaries—to evaluate quality in MA is limited by contract consolidations, a practice that has been developing for several years whereby MA organizations consolidate MA contracts to obtain bonus payments under the MA quality bonus program. To date, over 4 million enrollees in MA—more than 20 percent of enrollees—have been moved among contracts to secure bonus payments that would not otherwise be payable.

Contract consolidations and quality ratings

In this section, we examine how the strategy to consolidate MA contracts has been implemented, whether the effect is only short lived, and what the consequences are for program expenditures and reporting data on health plan quality. On the basis of our findings, we make a new recommendation regarding bonus payments and star ratings and restate a recommendation first made in 2005 and called for again in 2010 regarding market areas for MA payment and quality reporting (Medicare Payment Advisory Commission 2010, Medicare Payment Advisory Commission 2005).

Interaction between MA plans and MA contracts under the star rating system

Medicare provides financial rewards in MA through a quality bonus program that has been in place since 2012. The concept of rewarding high quality is consistent

with the Commission's recommendations for MA and other sectors in Medicare. In 2004, the Commission recommended that the private plan sector of Medicare (now Medicare Advantage) incorporate a quality incentive program to reward and encourage high quality (Medicare Payment Advisory Commission 2004). The approach differs from the current quality bonus program in that the Commission recommended a budget-neutral approach to the determination of financial rewards. The 2004 recommendation would establish "a reward pool from a small percentage of current plan payments and redistribute it based on plans' performance attainment and improvement on quality indicators." High-performing plans would receive higher payments, and poorer performing plans would be penalized in the sense that they would receive lower payments than they would if there were no bonus program. An illustrative example was given whereby there would be a 1 percent withhold from all plans to be redistributed to high-performing plans. If half of plans qualified for bonuses, the high performers would have a payment level of 101 percent (retaining their 1 percent withhold and getting a 1 percent bonus), while the half of plans that were not eligible for bonuses would be paid at a 99 percent level. The approach of bonuses and penalties is the approach that Medicare currently uses in the hospital sector and others.

The current MA quality bonus program is not budget neutral and consists only of additional payments for higher quality plans with no penalty component. CMS currently uses 44 measures, assigned different weights, to determine a weighted average overall star rating of 1 to 5 stars. The bonus takes the form of an increase in benchmarks for MA contracts at 4 stars or higher. Contracts with a 5-star rating are able to enroll beneficiaries during every month of the year, rather than being limited to the October to December annual election period. The star rating also determines the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark. Star ratings are determined at the MA contract level, but bids are at the plan level. Under the contract-level rating system, the contract's star rating for quality determines the star rating for all of that contract's plans. (See the text box, pp. 378–379, for an explanation of terms associated with contract consolidation.)

The star rating system predates the quality bonus program. The rating system was introduced in 2006 as a 3-star rating system intended to provide information

Glossary of contract consolidation terms used in this report

- **Consolidation**

Consolidation refers to a Medicare Advantage (MA) organization’s combining of one or more MA contracts into a single surviving contract.

- **Consumed contract**

When an organization consolidates contracts, CMS uses the term *consumed contract* to refer to each contract that has been subsumed under another (surviving) contract.

- **Contract**

MA contract and *MA plan* are the two principal administrative designations in MA. As the terms suggest, the contract is the agreement entered into between an MA organization and CMS. Contracts are identified by an alphanumeric system; *H* designates a “local” contract, covering HMOs or local preferred provider organizations (PPOs), and *R* designates a contract for regional PPO plans. The letters are followed by four digits (e.g., H1234). Contracts for local plans are therefore sometimes referred to as “H-numbers.” An organization that has an MA contract can offer a single plan or multiple plans under the contract (see the definition of the term *plan*).

The contract is the administrative unit for various aspects of CMS’s administration of the MA program such as the collection and reporting of quality measures and the determination of network adequacy and for purposes of auditing and compliance. In contrast, MA bids are plan-level bids, and the statutory uniform benefit requirement—which requires that all enrollees in a given plan receive the same set of benefits—currently applies at the plan level, not the contract level.

- **Cross-walking**

In the late fall of each year, CMS publishes a file that “cross-walks” all current MA plans by listing their status in the current year and their status in the following year. All plans are shown in the cross-walk file, even if there are no changes to the plan (that is, if a plan continues to operate under

the same contract and there is no change in its service area, the plan is listed as unchanged). When there are changes, the types of changes include the contract consolidations discussed in this chapter and other changes such as termination of a contract or plan or expansions or reductions of service areas.

- **Deconsolidation**

Deconsolidation refers to the breaking up of a contract into separate contracts.

- **Plan or plan benefit package**

A contract can include multiple plans (also known as plan benefit packages). An MA organization can vary plans across geographic areas under one contract, and plans can be limited to a subset of Medicare beneficiaries—specifically, special needs beneficiaries (such as Medicare–Medicaid dually eligible beneficiaries), employer group enrollees, and, in the case of some organizations, residents of certain institutional facilities.

The statutory uniform benefit requirement currently applies at the plan level. For example, a bid for a special needs plan (SNP) would be different from the bids of other plans under the same contract in the same service area. Although quality measures are reported at the contract level, in the case of SNPs, a subset of quality measures is reported at the plan level, including four quality measures that apply only to SNPs.

If a company offers two or more plans in a county within the same category (such as two HMO options or two local PPO options), CMS currently requires that there be a “meaningful difference” between the products. Often, when a company has two plans in the same county under one contract, the distinction is that one includes drug coverage (an MA prescription drug (MA–PD) plan) and the other does not.

(continued next page)

Glossary of contract consolidation terms used in this report (cont.)

- **Reconsolidation**

For purposes of this report, *reconsolidation* refers to the practice of consolidating a contract that has already undergone one (or more) consolidations in a prior period.

- **Segment**

Within a plan covering multiple counties, an MA organization can depart from the uniform benefit package requirement by using *segments*. A segment would have different premium amounts and/or different cost sharing depending on the county served. CMS's recent proposed rulemaking would allow segments to be the equivalent of plans in terms of the benefit. (The regulatory change would be that, in addition to premiums and cost sharing, the package of extra benefits could vary by county, but bidding would still be at the plan level (Centers for Medicare & Medicaid Services 2017)).

- **Service area**

A *service area* is defined as one or more counties in which an MA organization will provide health care services to enrollees and in which the organization establishes that it meets network adequacy requirements. A Medicare beneficiary must reside in the MA organization's service area to enroll in one of the organization's plans. The regulations require that the CMS qualification of the service area be made at the contract level as part of the application process (new applications and service area expansion applications).

There is generally a “county integrity” requirement—meaning that service areas consist of an entire county, or whole counties, for local plans. On an exception basis, an MA organization can receive qualification for a portion of a county if it cannot ensure access to care throughout an entire county. The counties included in a contract do not need to be contiguous. Only regional PPOs have service areas that CMS specifies (covering entire states or multiple states with a uniform benefit package).

- **Surviving contract**

In a contract consolidation, the surviving contract is the one that remains after another contract, or other contracts, has been absorbed. Under current CMS policy, the star rating of the surviving contract determines the star rating for the “consumed” contracts for bonus purposes when bids are submitted (using a retrospective star rating that is current as of June of each year, when bids are due to CMS). For public reporting of updated star ratings published in October of each year for the annual election period, all subsumed contracts have the star rating of the surviving contract.

Generally, the identity of the consumed entities is not lost. Even though there is only one surviving contract, the consumed contracts can be identified because they have different plan numbers, bids, and service areas. ■

to Medicare beneficiaries about private health plans, as required by the Balanced Budget Act of 1997 (BBA). The BBA requires that beneficiaries be informed about health outcomes, disenrollment rates, member satisfaction, and a plan's compliance with program requirements—all of which are components of the current 5-star rating system. The BBA also requires that there be a comparison with the quality of care in FFS “in the area involved.” The MA quality bonus program was established by PPACA, effective for payments made in 2012 and thereafter, with the very brief statement that “the quality rating for a plan shall be determined according to a 5-star rating system

(based on the data collected under section 1852(e))” (the section of the law that requires MA organizations to submit data on “health outcomes and other indices of quality”). As we discuss the distortions that have arisen in the MA quality bonus program because of the financial incentives involved, it is important to keep in mind the original purpose of the MA star rating system. Its original primary purpose, and arguably its continuing primary purpose, is to provide Medicare beneficiaries with accurate comparative information about the quality of care they can expect to receive from a given MA plan when they

**TABLE
13-10****Consolidation activity, by contract type, 2013 to 2017**

	End of year					Totals	
	2013	2014	2015	2016	2017	All consolidations	Moved to bonus status
HMO	9	8	31	15	14	77	51
Local PPO	7	21	23	2	8	61	55
Regional PPO	0	0	0	2	0	2	2
Enrollees moved to bonus status through consolidation (in thousands)	120	1,050	900	700	1,400		4,170

Note: PPO (preferred provider organization). Each year's total enrollment figures are rounded. The total for the end of 2014 is greater than previously reported and includes the movement of 700,000 employer group-sponsored Medicare Advantage enrollees to bonus-status contracts. In addition to the consolidations raising a contract to 4 stars or better, there were (1) six cases of a contract being moved from 2.5 stars (at risk of termination) to a higher rating (four HMOs and two local PPOs) and (2) eight cases of HMO contracts being raised to 3.5 stars from a lower rating, which changes the rebate share from 50 percent to 65 percent of the difference between the bid and the benchmark. Data exclude cost-reimbursed plans and private fee-for-service plans.

Source: MedPAC analysis of CMS enrollment and cross-walk data.

are evaluating their Medicare health care options. The star rating system is intended to give information about the clinical quality, administrative capability, and patient experience results for MA plans. In addition, giving plans quality bonus payments enables plans to convey a price signal to beneficiaries whereby higher quality plans are able to provide more generous benefit packages (with lower premiums, lower cost sharing, and better benefits). Both the quality indicators and the price signals are now distorted because of contract consolidations.

For the past several years, the Commission's reports have called attention to the industry practice of consolidating MA contracts for the purpose of increasing bonus payments. Under this strategy, a contract with a rating below 4 stars is subsumed under a surviving contract rated at 4 stars or higher, thereby enabling a company to qualify for bonus payments for members of the "consumed" contract. Over the years, CMS has encouraged companies offering MA plans to consolidate contracts as a means of streamlining contract administration for the companies and CMS. For example, a company that in 2001 had 4 separate contracts in California across 31 counties combined all contracts into 1 statewide contract for 2002 and thereafter (with all contracts absorbed into the MA organization's oldest and largest contract). With the advent of the quality bonus program, CMS, which approves contract consolidations, has not discouraged the practice of contract

consolidation to achieve bonus status (including when smaller, newer contracts absorb larger, older contracts). At one point, CMS invited organizations with contracts at risk of termination because of low star ratings to merge such contracts with higher rated contracts to avoid termination (Centers for Medicare & Medicaid Services 2014).

Increased bonus payments through contract consolidation are possible because of timing issues in the MA contracting cycle. Companies can increase MA payments by assigning enrollees to contracts that are known to receive bonuses because, in a given contract year, a contract's bonus status is based on a star rating from a prior period. This retrospective approach to determining a contract's bonus status is viewed as necessary to determine benchmark payment levels when plans submit bids in June for the following contract year, but it also means that a company knows the bonus status of each of its contracts before the company makes decisions about consolidation.

The Commission first raised concerns about this issue in its March 2014 report to the Congress, noting that, at the end of 2013, consolidations to achieve bonus status affected a little over 120,000 enrollees (Table 13-10). The process continued thereafter, affecting over 1 million enrollees at the end of 2014; nearly 900,000 at the end of 2015; over 700,000 at the end of 2016; and 1.4 million in the current period (the end of 2017).¹² Over the years, the total number of beneficiaries who are in

4-star plans solely due to the consolidation strategy is about 4 million beneficiaries, representing over 20 percent of the enrollment in MA contracts participating in the bonus program and over 30 percent of the enrollment in contracts at or above 4 stars. Stated differently, while over 70 percent of enrollees in the 2018 contract year will be in bonus plans, excluding the 4 million enrollees moved through contract consolidation would mean that the actual share of enrollment in bonus plans would be lower, perhaps as low as 50 percent. In terms of the number of enrollees affected, nearly 90 percent of the consolidation activity to raise star ratings to bonus levels has occurred among the top two organizations in total MA enrollment.

The mechanics of contract consolidation

Three examples are helpful to illustrate:

- how the consolidation strategy works,
- whether the strategy is only a short-lived means of securing bonus payments, and
- what the direct and indirect consequences are of the strategy.

Consolidation The first example was included in the Commission’s March 2017 report and involves two large regional PPO contracts, each rated below 4 stars, being subsumed under a much smaller contract that had a 4-star rating (R7444). As a consequence of this action, UnitedHealth Group received bonus payments for 380,000 enrollees in plans that would not otherwise have been eligible for bonus payments. The contracts that included the 380,000 enrollees were consumed by a contract with 20,000 enrollees. The company capitalized on its first opportunity to consolidate regional PPOs to achieve bonus-level status since regional PPOs have generally not been able to achieve 4-star ratings.

Consolidation and reconsolidation The second example involves Humana contract H6609, which consumed 19 other contracts over the course of several years. In 2013, the H6609 service area included 250 counties in 9 states. At the end of 2013, the contract had 405,000 enrollees. In 2017, the contract served 955 counties in 35 states, with nearly 800,000 enrollees. One set of quality measures and one star rating applied to all 35 states under the contract. (See also the Commission’s 2014 report to the Congress, available at <http://www.medpac.gov>.)

The star rating for contract H6609 declined to 3.5 stars in the 2017 ratings released in October 2016. The 2017

star rating determines bonus eligibility for MA bids for the 2018 contract year (calendar year 2018). Having lost its bonus status, H6609 has now been “consumed” by a smaller 4-star contract, H5216, which served 91 counties in 4 states in 2017. The result is that, as of 2018, all enrollees of the former H6609 will be in a contract in bonus status (contract H5216). The new surviving H5216 will serve 38 states and 1,046 counties. H5216 initially had 50,000 enrollees in 2017 compared with the nearly 800,000 it added from contract H6609.

This example, involving a reconsolidation, illustrates how bonus status can be perpetuated. At first blush, it would appear that the strategy of using contract consolidation to increase bonus payments would be short lived if the combined memberships ended up having quality scores that were brought down because of the absorption of lower rated contracts. That is, the effect would be self-limiting—and perhaps less of a reason for concern—because poorer quality results would resurface under the consolidated contracts over time. However, as the example of H6609 shows us, if a surviving contract drops below 4 stars, there can be a subsequent consolidation in which a different contract that is at 4 stars or higher consumes the contract that fell below 4 stars. The H6609 reconsolidation (to H5216) is not the first instance of reconsolidation to maintain bonus status. Over the time we have been tracking this strategy, six contracts that were consumed and had an increase in star ratings to 4 stars or higher were in turn consumed by subsequent consolidations after falling below 4 stars. One contract underwent three rounds of consolidation.

Deconsolidation In the most recent contract cycle, there has been a deconsolidation. It is, to our knowledge, the first such instance: For 2018, a Humana regional PPO plan is breaking up a multi-region contract into separate contracts in each of the CMS-designated regional PPO regions covered under the original contract. Such a deconsolidation is beneficial in that it results in more accurate reporting of quality results in each region. When consolidated, each of the regional contract’s quality measures is a combined national result reported for all 23 states included in the contract, as illustrated in Table 13-11 (p. 382). When deconsolidated, reporting will be separate for each of the 14 regions involved.

If this regional plan had already deconsolidated for the 2016 Healthcare Effectiveness Data and Information Set[®] (HEDIS[®]) reporting year (the 2015 measurement year), rather than having a 3-star rating for the breast cancer

**TABLE
13-11**

HEDIS® breast cancer screening results for a multi-region contract

Region and states included	Breast cancer screening result	Star rating for screening result
All regions in the contract combined	66%	3
Result if the regions had been deconsolidated		
AR, MO	54	2
AZ	57	2
KS, OK	52	2
OH	61	2
PA, WV	60	2
TX	60	2
AL, TN	67	3
GA, SC	68	3
IL, WI	67	3
IN, KY	64	3
LA, MS	67	3
MI	65	3
NC, VA	68	3
FL	72	4

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®). Results are HEDIS breast cancer screening results for the 2015 measurement year. "Result" is the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.

Source: MedPAC analysis of HEDIS person-level data and CMS star cut points (which determine the star rating assigned to a given performance result).

screening measure that applied on a national, contract-wide basis, six of the regions would have been at 2 stars for this measure, seven would have been at 3 stars, and one region (Florida) would have received a 4-star rating for this measure. If the Florida region performs equally well for all other measures in the star rating system, it would achieve bonus status as a separate contract. Before the deconsolidation, the 3.5 overall star rating for this contract (not at a bonus level) applied to all its regions. (When deconsolidated, if the Florida region achieves 4-star status, it would be a candidate for consuming lower performing contracts.)

Deconsolidation is unusual in that one of the original reasons for allowing and encouraging contract consolidations was to streamline contract administration. A deconsolidation presumably has the opposite effect.

Areas of concern regarding consolidation

The practice of contract consolidation to achieve bonus status has a number of consequences related to program

expenditures as well as indirect consequences affecting the accuracy of information reported to beneficiaries and the integrity of data on MA quality. Several matters of concern are exemplified in the cases just discussed and in our earlier work on the issue of contract consolidation. In addition to increased program expenditures when bonuses are not warranted, the strategy results in:

- **Misrepresentation of information on quality.** The quality results reported to beneficiaries through the Medicare Plan Finder (MPF) website misrepresent the results for "consumed" contracts. Because CMS computes a star rating for consumed contracts in the first year of consolidation, that rating should be the star rating reported to beneficiaries, not the star rating of the surviving contract (which most often reflects performance in a different geographic area).
- **Inaccurate information on quality.** After consolidation, the population that is the basis for determining quality results is the population of the surviving contract, which includes all previously

independent contracts and generally encompasses a wider geographic area. Had the contracts not been consolidated, the star rating of the contracts that were consumed would have provided a more accurate measure of the quality in the geographic area served by the consumed contract.

- ***Erosion of the integrity and utility of the tools used to measure quality.*** In addition to the misinformation and inaccurate information at the market level, contract consolidations affect evaluations of overall quality in MA. The National Committee for Quality Assurance prepares an annual State of Health Care Quality report, which evaluates changes in MA quality over the years based on the average HEDIS results from year to year, separately reported for HMOs and PPOs. The averages are of contract-level results, which is how MA quality data are currently reported in CMS and other data. Similarly, the Commission’s yearly data book uses contract-level averages to track quality results over the years in MA. The Commission’s status report on MA, included in the March reports, has compared “same-store” results, looking only at contracts that report a result for two consecutive years.

Contract consolidations distort these usual methods of evaluating overall MA performance. Between 2013 and 2018, for example, the number of local PPOs with star ratings fell 42 percent (dropping from 124 to 72, with 7 of the 72 being contracts entered into after 2013) (data not shown). In 2013, 291 MA HMOs had star ratings. In 2018, that number dropped to 282, including 56 for contracts entered into after 2013—effectively a 23 percent reduction in the number of HMOs with star ratings that could be compared across years.

- ***Providing an undue competitive advantage.*** One way in which a company’s consolidation practices can affect unrelated companies is at the local market level. A high star rating is thought to encourage beneficiaries to choose a particular plan over one with a lower star rating. In our focus groups and discussions with brokers, we found that the star rating is less important in beneficiary decision making than the generosity of the benefit offerings. Since plans with ratings at or above 4 stars can provide richer benefits, a plan’s ability to provide extra benefits can be viewed as a proxy measure of quality—resulting in higher rated plans having a competitive advantage over lower

rated plans in a given market. However, a bonus-level star rating gained solely by contract consolidation is not a proxy measure of quality. A consumed contract gains an undue competitive advantage in relation to both plans in the same market that are not at a bonus level and bonus-level plans in the market area whose star ratings are based on their performance in the local market area. The plans that should have the competitive advantage are the plans at bonus levels because of the quality of care rendered in their market area, not those that have acquired their bonus status through a contract consolidation.

Methods of addressing the issue

To restore the integrity of the star rating system and improve MA quality reporting mechanisms, we propose an immediate action and a policy for future reporting. As an immediate action, for contract consolidations involving different geographic areas, CMS should freeze geographic reporting units based on preconsolidation configurations. MA organizations should continue to report quality data using the preconsolidation configuration, and CMS should continue to determine star ratings based on those configurations. While contracts can continue to be consolidated for administrative reasons, quality reporting and the determination of star ratings would continue as though the consolidation had not occurred. In the longer term, CMS should require MA organizations to report quality data by local market areas, and CMS should compute star ratings by local market areas. These steps would improve the accuracy of data reported to beneficiaries and would make the determination of star ratings fairer to MA organizations.

For contract consolidations involving different geographic areas, it is feasible to have MA organizations continue to report quality data based on preconsolidation configurations because the identity of the consumed contracts—in terms of the geographic areas they serve—is generally not lost.¹³ The concept of having a company report quality data at a subcontract level is also not unprecedented. For example, companies already separately report quality indicators for SNPs that are subunits of contracts. More relevant perhaps is a practice that CMS has used when there have been past consolidations, which is to have a company submit separate reports on quality indicators by geographic area. Kaiser Permanente did so in 2001, when it combined 4 separate contracts in California, serving 31 counties, into 1 statewide contract for 2002 and thereafter. Kaiser submitted two separate sets of quality

data for several years after the consolidation, with one reporting unit identified as the Southern California unit and the other as the Northern California unit (for northern and central California).

The first recommendation directs the Secretary to ensure that consolidations involving different geographic areas will not result in unwarranted bonus payments. Star ratings and eligibility for bonuses would be based on preconsolidation geographic configurations.

RECOMMENDATION 13-1

For Medicare Advantage contract consolidations involving different geographic areas, the Secretary should:

- **For any consolidations effective on or after January 1, 2018, require companies to report quality measures using the geographic reporting units and definitions as they existed prior to consolidation, and**
- **Determine star ratings as though the consolidations had not occurred, and maintain the pre-consolidation reporting units until new geographic reporting units are implemented per Recommendation 13-2.**

RATIONALE 13-1

Over the past five years, MA organizations have used the consolidation process to move about 20 percent of MA enrollees from contracts in nonbonus status to bonus status. This artificial means of raising star ratings has led to unwarranted increased program expenditures, inaccurate information provided to beneficiaries, and degradation of the ability to evaluate quality in the MA program. For future contract consolidations, the recommendation directs the Secretary to continue to use preconsolidation geographic configurations for quality reporting. This practice and the determination of star ratings would continue until the Secretary designs appropriate geographic reporting units that reflect the care delivery patterns of local health care market areas, as described in the second recommendation (p. 386).

The first part of Recommendation 13-1 specifies the effective date as on or after January 1, 2018, and the policy would apply to all consolidations going forward as well as the consolidations reflected in bids submitted in June 2017, which became effective January 1, 2018. The rationale for including consolidations occurring at the end of 2017 and effective on January 1, 2018, is that each contract consolidated at the end of 2017 has a current star rating that was determined based on preconsolidation data

on quality indicators. It is CMS's policy that any contract operating in October of a given year has a new star rating computed, regardless of whether the contract will continue to operate as a separate contract in the following year. When consolidations occur, even though separate updated star ratings are available, it is CMS's policy to immediately report the star rating of the surviving contract as the rating for all consumed contracts. For example, one consolidation occurring at the end of 2017 involved a surviving contract in Virginia being consolidated with a consumed contract operating in Missouri. Although both the Missouri and Virginia contracts had updated star ratings computed in October 2017, for residents of Missouri, the MPF in the October to December 2017 annual election period (AEP) immediately showed the Virginia contract's star rating as the rating applicable for beneficiaries deciding whether to enroll in a Missouri plan under this contract. For consolidations occurring at the end of 2017, the recommendation would require that CMS revert to the star ratings determined in October 2017 as the most accurate star rating for each geographic area affected by a consolidation. In the Virginia–Missouri example, for beneficiaries enrolling from January through September of 2018, the MPF would show the separate Virginia and Missouri star ratings rather than only the Virginia star rating.

The star ratings computed in October of each year serve two purposes. One is to update the public reporting in MPF and the other is their use in determining a contract's bonus status in the next round of MA bidding. Bids, which are submitted in June, use the preceding year's October star rating to determine bonus status. In the Virginia–Missouri example, based on current CMS policy, the October 2017 star rating of the Virginia contract (the surviving contract) will determine the bonus status of the Missouri contract (the consumed contract) for the June 2018 bids that determine 2019 payment rates. This outcome seems misguided since the Missouri contract had an October 2017 star rating that could be used as the basis for determining the bonus status of the Missouri plan(s) in the June 2018 bids for the 2019 payment year. The Commission's recommendation would require CMS to change its current policy and instead use the separate Virginia and Missouri star ratings to separately determine the bonus status of the plans in each of the two states.

With regard to new star ratings to be announced in October of 2018, it is our understanding that MA organizations are currently in the process of collecting and processing data for the 2017 measurement year, which are the data

that form the basis of the October 2018 star ratings. In our Virginia–Missouri example, the company is in the process of collecting and reporting on data for the combined service areas of the two states. If it is not possible to disaggregate the reported data so that separate updated star ratings can be computed for Virginia and Missouri in October 2018, CMS should continue to use the October 2017 star ratings for the separate geographic areas. The separate October 2017 Missouri and Virginia star ratings would be posted on MPF for the October to December 2018 AEP because they are more representative of the quality in each geographic area. If updated star ratings that would have been announced in October 2018 are not available in June 2019 for the separate geographic areas, CMS should also use the separate October 2017 star ratings of Virginia and Missouri to determine the bonus status of enrollees for bids submitted in June 2019 for the 2020 payment year. We recognize that this aspect of the recommendation represents a trade-off between having accurate but dated information about the quality of care a plan offers in a given market versus having a more up-to-date rating that is based on combined reporting, but which is not an accurate measure of quality at the local level.

The preconsolidation reporting units called for in the first recommendation would be in place until the Secretary designates appropriate geographic units for each local health care market, as described in the second recommendation (p. 386).

IMPLICATIONS 13-1

Spending

- Relative to current law, this recommendation would decrease Medicare spending by between \$250 million and \$750 million in 2019 and by between \$1 billion and \$5 billion over five years.

Beneficiary and plan

- For beneficiaries, the recommendation improves the accuracy of information on plan quality but results in a lower level of extra benefits in some plans. Some plans will see a reduction in bonus payments, but there will be a more level playing field for competing plans.

Other alternatives: Plan-level reporting, averaging

As we have seen with the wave of contract consolidations, the contract is no longer a valid reporting unit for quality. The plan, an already existing administrative unit, is a logical alternative to consider. Although CMS calculates star ratings at the contract level, the statute provides that, when there is a quality bonus payment, MA benchmarks

“shall be increased on a plan or contract level, as determined by the Secretary” (1853(o)(1) of the Social Security Act). The Bipartisan Budget Act of 2018 calls for the Secretary to determine the feasibility of reporting quality data at the plan level. Currently, SNPs report a subset of HEDIS measures and some additional measures at the plan level.

Plan reporting is feasible since each MA enrollee is in a unique plan that can be identified. The March 2010 report to the Congress examined the issues related to reporting at a unit smaller than the contract. The main issue is that, for HEDIS measures based on medical record sampling and for other measures collected through surveys, the sample sizes need to be increased to have valid results.

While plan reporting is feasible, using the plan as a reporting unit can result in the same issues that occur with the contract as a reporting unit. The defining features of a plan versus a contract are that a plan is the bidding unit, and the uniform benefit package rule applies at the plan level (though it may be applied at the county level, through the use of segments, under CMS’s proposed rule (Centers for Medicare & Medicaid Services 2017)). Like contracts, plans can span wide geographic areas. In 2017, there were 30 HMO plans with a service area of 10 or more metropolitan statistical areas (MSAs), and 35 local PPO plans served 10 or more MSAs. There is no requirement that plan service areas be contiguous. If the plan is the reporting unit for quality and the determination of stars, MA organizations could construct plans in such a way that the combination of counties under the plan maximizes star rating status for the greatest number of enrollees. In addition, allowing benefit-package variation by segment from county to county would facilitate the ability of MA organizations to design the most desirable geographic make-up of its plans for the purpose of maximizing star ratings.

An alternative way of measuring quality when contracts consolidate is to compute enrollment-weighted average results across combined contracts. CMS proposed this approach in its recent notice of proposed rulemaking (Centers for Medicare & Medicaid Services 2017), and it has now been enacted into law as a provision of the Bipartisan Budget Act of 2018. The Commission discussed issues with such an option in our March 2017 report to the Congress (Medicare Payment Advisory Commission 2017). The main concern is that the averaging method would give an accurate picture of quality in a given geographic area only if the two or more contracts

involved in a consolidation shared exactly the same service area or if the two or more contracts to be consolidated had the same level of performance in each contract for each quality measure. Otherwise, the averaging method distorts the quality information that is presented to beneficiaries. If two contracts of similar size are consolidated and one performs well and the other performs poorly, in the former case the performance is shown as worse than it actually is for the market area. In the poorly performing geographic area, MPF will indicate that the company has higher quality than is actually the case.

In the current cycle of contract consolidations (the end of 2017), there were 17 contract consolidations in which a contract below 4 stars was consumed by a contract at or above 4 stars. In only one of the cases was there any overlap of service areas (one company, which purchased another company, undertook a consolidation in which 3 of 13 counties were in the service areas of both contracts). Other combinations of service areas included state combinations such as Missouri and Virginia, Wisconsin and Kentucky, and Kentucky and New Hampshire. Given that the purpose of these consolidations was to substitute the higher quality rating of one geographic area for the lower rating in a different geographic area, an averaging approach would misrepresent the quality rating in both geographic areas—that of the consumed contract, where the averaging will raise the apparent performance level, and that of the surviving contract, where the averaging will lower the performance level below the actual performance level for the geographic area. MPF will show quality results that are lower than they should be in some areas and higher than they should be in other areas. Using the averaging method does a disservice to beneficiaries who should be provided with accurate information about plan performance in each geographic area where an MA organization operates.

In addition, the averaging method would continue to provide an incentive for organizations to use contract consolidation as a means of obtaining unwarranted bonus payments. For example, two contracts with equal enrollment, one with a 4.5-star rating and one with a 3.5-star rating, could be combined to result in what would likely be a 4-star rating of the consolidated contract. The averaging method forecloses certain types of combinations that have occurred in the past, but it does not fully address the concern about unwarranted program expenditures or inaccurate information provided to beneficiaries when there are consolidations.

The Commission's position on geographic areas for evaluating quality

The Commission has endorsed a different reporting unit for quality measures (Medicare Payment Advisory Commission 2010), based on work that was done primarily to examine the appropriate geographic units for payment purposes (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2005). In its June 2005 report, the Commission recommended the use of MA payment areas consisting of MSAs (as long as they did not cross state boundaries) and, for nonmetropolitan counties, “payment areas should be collections of counties in the same state that are accurate reflections of health care market areas, such as National Center for Health Statistics health service areas” (Medicare Payment Advisory Commission 2005). We also recommended that the Secretary update health service areas (HSAs) before using them as payment areas in MA and that the Secretary make periodic updates to HSAs to reflect changes in health care market areas that occur over time. The National Center for Health Statistics (NCHS) HSAs—which are determined for both metropolitan and nonmetropolitan areas—were developed in 1991 and were based on the patterns of care that Medicare beneficiaries received.

We stand by our 2005 recommendation that the Secretary designate areas that accurately reflect health care market areas and to update these designations periodically to account for changing patterns of care. While an update of the NCHS HSAs would be especially useful for designating geographic units in both metropolitan and nonmetropolitan areas for purposes of reporting on quality in MA and FFS, other sources of information about patterns of care could be used to inform the decision-making process, such as Primary Care Service Areas and the Dartmouth Atlas service area designations. The goal is to have geographic units that accurately reflect local patterns of health care delivery.

RECOMMENDATION 13-2

The Secretary should:

- **Establish geographic areas for Medicare Advantage quality reporting that accurately reflect health care market areas, and**
- **Calculate star ratings for each contract at that geographic level for public reporting and for the determination of quality bonuses.**

RATIONALE 13-2

One of the purposes of a rating system for MA plans is to give beneficiaries information about the quality of care across the options available in their geographic area. The Commission supports the concept of having interplan comparisons and comparisons between MA plans and FFS Medicare in a given geographic area. However, with quality measures reported and star ratings determined at the contract level, the current approach to star ratings often does not give beneficiaries accurate information about the quality of care among MA plans in their geographic areas. Contract consolidations have increasingly led to combinations of noncontiguous, disparate geographic areas. Quality should be evaluated at the local market area level for both MA and FFS.

IMPLICATIONS 13-2

Spending

- Relative to current law, the spending effect is uncertain and would depend on the distribution of star ratings under the reformed reporting system.

Beneficiary and plan

- For beneficiaries, the recommendation improves the accuracy of information on plan quality, and there will be a more level playing field for competing plans. Plans will also have an increased reporting burden for measures based on medical record sampling or member surveys.

Issues with smaller geographic reporting units

While Recommendation 13-1 has companies revert to, or continue to use, reporting units that had already been in use (for example, Virginia and Missouri had already been reporting on a separate basis), Recommendation 13-2 requires additional reporting efforts on the part of MA organizations if a contract includes more than one of the newly designated geographic reporting units. For example, a number of HEDIS measures are reported based on a review of a sample of medical records. If the number of geographic reporting units increases, there will be a concomitant increase in burden and cost to health plans for reporting such measures if each geographic unit must have a sufficient sample to compute a valid HEDIS rate. Similarly, survey-based measures such as the Consumer Assessment of Healthcare Providers and Systems[®] and the Health Outcomes Survey would have to have samples drawn from each geographic unit. However, we believe it is appropriate to impose this additional burden given the

substantial cost to Medicare of unwarranted quality bonus payments and because of the need to provide beneficiaries with accurate information regarding the quality of their Medicare options.

In some cases, there may be a small-numbers issue. There may be too few enrollees in a given geographic area for there to be valid quality results (in the same way that there are 13 contracts in the 2018 star ratings—all with small enrollment—that have a star rating indicated as “not enough data” for both Part C and Part D). In our March 2010 report, the Commission discussed this issue of how to evaluate quality in MA and how it compares with FFS. The report suggested that the Secretary could develop alternative ways to evaluate and report on quality, such as by using multiyear rolling averages or otherwise aggregating data.

Recent quality results in Medicare Advantage

In past years, the Commission has evaluated the state of health care quality in MA by examining year-to-year changes in quality indicators, using results reported at the contract level. To better gauge whether quality measures have improved or declined, we used the approach of making comparisons between contracts that existed in both years. This approach disregards results from new contracts (which tend to have lower performance); removes contracts that have left the program (which may also have had lower performance); and, at the measure level, does not include a contract that was unable to report a result in both of the two years examined. This approach gives a sense of whether, over time, MA organizations are able to improve their enrollees’ quality of care. However, because of the wave of contract consolidations, the two-year approach may no longer be suitable for assessing MA quality. Quality measures for a “surviving” contract with 5,000 enrollees that absorbs 700,000 enrollees from “consumed” contracts cannot be compared between the preconsolidation and postconsolidation periods.

Alternatives exist to the contract comparisons between years. One is to compare enrollment-weighted average results across all contracts. In this way, it is possible to glean useful information that gives a general picture of MA quality and changes from year to year because all enrollees are included in the data, even when there have been contract consolidations.

CMS publishes enrollment-weighted national average rates in the HEDIS public use files released in the late

**TABLE
13-12**

HEDIS® 2016 (measurement year 2015) results under different approaches

	Across the entire MA population or denominator for HEDIS measure	Contract enrollment-weighted average	Simple average
HEDIS measures not based on sampling (entire population reported by all plans for members to whom the measure applies)			
Breast cancer screening (ages 50–74)	76.9%	76.4%	72.6%
Osteoporosis management in women with fracture (ages 67–85)	42.7	44.2	38.5
MA HMOs	46.5	48.4	41.0
Local PPOs	35.8	38.8	31.9
HEDIS measures based on sampling for some contracts and the enrollee universe for others			
Colorectal cancer screening (ages 50–75)*	84.4	73.3	67.6
HEDIS measure requiring all contracts to use sampling			
Control of blood pressure among people with hypertension (ages 18–85)	66.9	74.9	68.8

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), MA (Medicare Advantage), PPO (preferred provider organization).
 *For the colorectal cancer screening measure in measurement year 2015, 8 contracts used administrative data (the universe of enrollees to whom the measure applied) to report a rate, while the remaining 468 contracts reported a rate using medical record sampling. The rate among contracts using administrative data was 88 percent, compared with 77 percent for contracts using medical record sampling. Contracts using administrative data represented 79 percent of the denominator for the measure but were 7 percent of total member months in the HEDIS data.

Source: MedPAC analysis of HEDIS person-level data and CMS star cut points (which determine the star rating assigned to a given performance result).

summer or fall of each year. Using the most recent data—the 2017 HEDIS data for the 2016 “measurement year”—CMS reported on 57 measures that can be compared between the two years (because the measure specifications did not have major changes over the years). Unlike the star ratings CMS releases in October, the HEDIS files include HEDIS results for contracts that are to be consolidated. For example, the 2017 HEDIS public use files include data for both Humana contract H6609 and contract H5216, which consumed the H6609 contract as of January 1, 2018. The 2017 HEDIS data are the basis for the 2018 star rating of H5216—a star rating that is also applied to the consumed H6609 in the MPF data published in October 2017.

Using CMS data on weighted average HEDIS results and comparing data from the most recent year with the prior year’s data, the results are mixed, with a greater number of measures showing improvement compared with the number declining. Of the 57 measures, 14 (about one-quarter) improved by over 3 percent (including 3 of a suite

of 8 asthma medication measures). Eight measures (14 percent of measures) declined by over 3 percent (including three of a set of four statin adherence measures). The most noteworthy change was the level of improvement in a measure introduced in 2015, medication reconciliation after discharge from an inpatient facility. For that measure, the enrollment-weighted average rate doubled between the HEDIS 2016 and 2017 data, from 27 percent to 58 percent. The measure is a star measure as of 2017 (that is, in the 2018 stars announced in October 2017). The level of improvement is typical for a new measure, and its inclusion as a star measure elevated its importance to MA organizations.

Another alternative to reporting quality is to use MA-wide results—that is, tabulating the results across all plans for each measure for the universe of MA enrollees. This method would involve using the HEDIS person-level data that collect all the numerators and denominators for each of the measures. Of the 21 measures we were able to compare on this basis between the 2015 and 2016 measurement years, four improved and four declined.

Table 13-12 shows results computed on an MA-wide basis for several HEDIS measures and compares the results with enrollment-weighted results (i.e., weighted by the number of enrollees in each contract) and simple averages (averages of contract-level results). The table shows three categories of measures for which there are different reporting practices. In the case of the table's first two measures, all plans report on the full universe of enrollees to whom the measure applies. Thus, the MA-wide breast cancer screening (BCS) result pertains to the 3 million women between the ages of 50 and 74 in the 2015 HEDIS measurement year data for 18.8 million MA enrollees. The number of enrollees to whom the osteoporosis management measure applied was 103,000 women between the ages of 67 and 85 across all MA plans reporting HEDIS data. The results differ depending on the method used. Enrollment-weighted averaging yields results similar to the MA-wide result for BCS. For the osteoporosis management measure, however, enrollment weighting yields a higher result. For HMOs, for example, the enrollment-weighted result of 48.4 percent is 4 percent better than the MA-wide rate of 46.5 percent. Among local PPOs, enrollment weighting yields a result that is 8 percent better than the MA-wide rate (and each result is far higher than the simple average).

Two of the categories of HEDIS measures shown in Table 13-12 illustrate why it is preferable not to use an MA-wide computation for HEDIS measures that are reported based on a sample of medical records (generally 411 medical records per contract, to achieve a sampling result with a 95 percent confidence level). For the last measure shown in the table (control of blood pressure among enrollees ages 18 to 85 with hypertension), all plans are required to use medical record sampling to report their HEDIS results. For such measures, the simple average would yield a result similar to the MA-wide result because each contract's result contributes equally to the MA-wide result (though some contracts have a sample that is slightly higher than 411, and some contracts report on the full universe of enrollees with hypertension if the number is below 411). For the colorectal cancer screening measure, the reporting is a mix of contracts that use medical record sampling and contracts that use the universe of enrollees to whom the measure applies. Thus, in an MA-wide result, the contracts using administrative data would have a much larger number of enrollees to whom the measure applied compared with a contract in which the measure is reported based on results for 411 enrollees (because sampling

is used). In the CMS star rating system, the results for 9 of the 13 HEDIS measures are reported exclusively or primarily based on medical record sampling. These include the more heavily weighted intermediate outcome measures of blood pressure control among beneficiaries with hypertension and blood sugar control among diabetics.

In addition to the medical record sampling issue affecting the MA-wide approach, both the MA-wide approach and the enrollment-weighted approach share a further shortcoming. Each of the HEDIS effectiveness of care measures is limited to a given age range and can be limited to specific conditions, diseases, or member characteristics. Enrollees' age ranges, conditions, and other characteristics can vary significantly across contracts. When using a weighted average, plans with the highest enrollment dominate the results. In using an MA-wide approach for measures not involving medical record review, weighting is not by enrollment but, rather, by the number of enrollees to whom the measure applies.

Table 13-13 (p. 390) shows the top 10 MA contracts by enrollment in the HEDIS data for measurement year 2015, their share of the overall enrollment, and their share of the denominator for two measures not reported based on sampling—BCS and osteoporosis management in women who had a fracture (OMW). Although we use the term *MA-wide result* as shorthand, the table illustrates that it is more accurate to say “the result across all MA plans for a given measure”—which does not take into account variations in the population make-up across contracts. For example, Contract 1 is disproportionately represented in the BCS measure. The contract has 9.2 percent of the enrollees qualifying for inclusion under the measure, but it has only 5.7 percent of the overall MA enrollment. If Contract 1's performance on the BCS measure is exceptionally high, the MA-wide result will be higher than it might otherwise have been because of the greater weight Contract 1 has in determining the MA-wide result for this measure. Enrollment weighting gives less weight to the contract for this measure even though the measure applies to more of this contract's enrollees. In the case of Contract 3, its exceptionally poor performance on both the BCS and OMW measures will have less influence on the MA-wide results because the contract is underrepresented in the denominators for both those measures. The case of Contract 7 shows that a contract can be overrepresented in one measure (BCS) but underrepresented in another (OMW). If that contract is the highest performing contract

**TABLE
13-13****Distribution of enrollment and HEDIS® denominators among the top 10 MA contracts, 2015 measurement year**

Contract	Share of all MA enrollment	Share in the BCS denominator	Share in the OMW denominator
1	5.7%	9.2%	6.2%
2	4.4	5.2	4.6
3	3.4	1.0	1.8
4	3.3	4.1	1.4
5	2.9	2.4	2.7
6	2.5	2.2	2.1
7	1.8	2.1	0.8
8	1.8	1.8	2.7
9	1.7	2.1	2.5
10	1.3	1.1	1.4
Total for the top 10 contracts	28.9	31.1	26.2

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), MA (Medicare Advantage), BCS (breast cancer screening), OMW (osteoporosis management in women who had a fracture).

Source: MedPAC analysis of HEDIS person-level data.

across all measures, it would raise the MA-wide result for BCS, but the MA program would appear to have poorer performance overall in the OMW measure. We also note that using an MA-wide result would not reveal much about intercontract variation in the measure results. (Intercontract variation can be substantial. For example, for the BCS results in HEDIS measurement year 2015, the enrollment-weighted 90th percentile value of contract-level results was 85.1 and the 10th percentile was 66.2.)

Other quality indicators

Another feature of past reports has been a table showing the distribution of overall contract star ratings by contract type (HMO, local PPO, etc.) with enrollment shares in each category. However, we continue to urge a degree of caution in interpreting overall star ratings as indicators of quality or as a basis for judging changes in the level of quality over the years. For example, the measures included in star rankings change over time, as do the relative weights; and the cut points for assignment into the five different star levels also change from year to year. For this year's report, given the extent of contract consolidation and its effect on star ratings, we do not see a value in presenting the star distributions. As noted, over 20 percent

of the enrollees in star-rated contracts are in a particular contract (the surviving contract) that is different from the individual's original contract at the time of enrollment (the consumed contract). A distribution of enrollment by star ratings would not give an accurate picture of the state of quality in MA.

Summary of the state of quality reporting in MA

The limitations of different approaches to reporting on quality in MA and the way in which contract consolidations have eroded the integrity of the star rating system underscore the need for quality data to be reported at the local market area level, as the Commission recommends. Reporting at the market level certainly has greater value for beneficiaries in choosing among plans and—when additional data on FFS quality become available—for beneficiaries comparing FFS with MA plans (see text box on comparing quality).¹⁴ If there are to be financial rewards for better performing plans, market-level reporting would allow payment of bonuses based on performance in relation to the level of performance in the market area. Currently, bonuses can be based on an engineered configuration of contracts that enables

Comparing quality among Medicare Advantage and other Medicare payment models

The Commission believes that quality measurement should be patient oriented, encourage coordination across providers and time, and promote change in the delivery system. Medicare quality programs should include population-based measures such as outcomes, patient experience, and value measures. Providers may choose to use more granular measures to manage their own quality improvement.

Medicare can use a small set of population-based measures to compare quality of care across its three payment models—fee-for-service (FFS) Medicare, Medicare Advantage (MA), and accountable care organizations within a local market area (Medicare Payment Advisory Commission 2015a, Medicare Payment Advisory Commission 2014). Medicare’s use of the same set of measures across payment models may also promote multipayer alignment, which can reduce the burden providers face in tracking a diverse number of quality measures across payers.

In its March 2010 report to the Congress and in response to a directive in the Medicare Improvements for Patients and Providers Act of 2008, the Commission made a set of interconnected

recommendations about how Medicare could compare quality across FFS Medicare and MA within a defined geographic area. The report acknowledged that the major limitation on calculating outcome measures such as potentially preventable admissions and readmission rates for MA plans was the lack of claims data. The report recommended that CMS move as quickly as feasible to gather the data needed to calculate a set of population-based outcome measures (Medicare Payment Advisory Commission 2010). Because MA plans have been reporting encounter data to CMS since 2012, there may now be opportunities for Medicare to calculate and compare quality results—for example, of low-value care—across MA plans and FFS in local areas. Some measures, however, may not be entirely comparable between the two sectors. For example, the vast majority of MA plans waive Medicare’s three-day hospital stay requirement for skilled nursing facility admissions, which can affect an FFS-to-MA comparison of hospital admission and readmission rates. For many measures, risk adjustment is necessary. Even when risk adjustment is done properly, it can be complicated by differences in coding practices between the two sectors. ■

bonus payments in geographic areas where they are not warranted.

Market-level information for both MA and FFS would provide a better basis for policymakers to evaluate the state of quality in the MA program. Instead of reporting on the level of quality in the MA program as a whole, the evaluation of quality in MA could be phrased in geographic terms: For example, “60 percent of the Medicare population resides in an area in which the quality indicators in MA plans are better than those of FFS Medicare, 20 percent where the quality is the same, and 20 percent where MA quality is worse than FFS.” Instead, nationwide assessments of MA performance mask variations in performance by health care markets, in which

plans in some markets perform better and in other markets worse relative to FFS. Better market-level information, currently incomplete for FFS or with measures that are not comparable with MA measures, would help identify the best practices in either MA or FFS that could be promoted to improve quality. ■

Endnotes

- 1 The analyses and figures in this chapter (except in the enrollment text box) do not include three other Medicare plan types that are not classified as MA plans: cost plans that are paid their reasonable costs under Section 1876 of the Social Security Act, Medicare–Medicaid Plans (MMPs) operating under the CMS financial alignment demonstration, and plans in the Program of All-Inclusive Care for the Elderly (PACE). None of these other plan types submits bids. MMPs and PACE plans have contracts with state Medicaid plans and provide both Medicare and Medicaid services. In November 2017, about 700,000 beneficiaries were enrolled in cost plans, about 400,000 were in MMPs, and about 40,000 were in PACE. Section 1876 cost plans arrange for the full range of Medicare services. Cost plans receive reasonable cost reimbursement for Part B physician and supplier services. However, the Medicare program directly pays providers for inpatient and outpatient institutional services. Enrollees of cost plans are not locked into the program. For example, an enrollee can use a non-network physician and the Medicare program will pay the physician under the physician fee schedule.
- 2 While all HMOs and PPOs have provider networks, PPOs cover out-of-network care while HMOs typically do not. Some HMOs offer a point-of-service option that covers some out-of-network care.
- 3 These plans are not available to most beneficiaries, do not submit bids, and are not classified as MA plans in law or in the rest of this chapter.
- 4 Previous Commission work has shown that partially dual-eligible beneficiaries are more likely to enroll in MA, but fully dual-eligible beneficiaries are less likely to do so. The Commission intends to further analyze these patterns in the future.
- 5 Cost plans currently serve substantial enrollment in Minnesota, North Dakota, and South Dakota. There are also some cost plans in other areas of the country. 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.
- 6 Other possible sources of diagnostic information—such as encounters for home health, skilled nursing, ambulatory surgery, durable medical equipment, and hospice services—are not used to determine payment through the risk adjustment model, either because adding diagnoses from these sources does not improve the model’s ability to predict medical expenditures or because of concerns about the reliability and manipulability of the diagnoses.
- 7 In practice, the actual dollar amount a plan will receive for coding a new HCC depends on which version of the HCC coefficient will be applied for a beneficiary and factors that affect a plan’s base rate. The dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan’s base rate, and a different version of the HCC coefficient will be applied depending on the beneficiary’s disability status and whether the beneficiary is partially, fully, or not eligible for Medicaid. Different versions of the HCC model also exist for beneficiaries who lack a full calendar year of diagnostic data, are institutionalized, or have end-stage renal disease. In addition, a plan’s base rate varies according to the plan’s bid and the benchmark for the local area.
- 8 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 they submitted to CMS.
- 9 Example cases include *United States v. Janke*, 2:09–cv–14044; *Sewell v. Freedom Health Inc. et al.*, 8:09–cv–01625; *United States ex rel. Swoben v. Secure Horizons et al.*, 09–5013; *United States of America ex rel. Benjamin Poehling v. UnitedHealth Group, Inc.*, No. 16–08697 (text online at <https://www.nytimes.com/interactive/2017/02/17/business/dealbook/document-Whistleblower-Lawsuit-Accuses-Insurer.html>).
- 10 FFS risk score growth matched MA risk score growth in 2016, which is the first occurrence of similar coding growth since the full implementation of the HCC model in 2007. If FFS and MA risk scores continue to increase at the same rate, MA risk scores will still be higher than FFS risk scores for comparable beneficiaries (because of prior differences in coding rates), but the overall difference between MA and FFS risk scores due to coding would be limited. To the extent that different types of FFS providers have open lines of communication about diagnostic information, more complete FFS coding could also be beneficial for managing FFS beneficiaries’ chronic conditions. CMS’s calculation of the risk score normalization factor, which functions to keep the average FFS risk score at 1.0 in each year, also showed evidence of faster FFS risk score growth in 2016 relative to prior years.
- 11 For risk adjustment data validation 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.

- 12 In one situation, nearly 700,000 additional enrollees of employer group plans were affected by the equivalent of a contract consolidation to achieve a higher star rating at the end of 2014. In 2015, UnitedHealth Group expanded a 4-star contract that had previously served 4 counties in Maine and had 5,500 enrollees at the end of 2014 (contract H2001). For 2015, United added 3,341 counties (all U.S. counties and the territories) to the contract service area as areas where United would enroll employer group-sponsored members. In January 2015, the contract had 298,000 members, consisting primarily of new members of the employer group plans under contract H2001. If United had started an entirely new contract for the nearly 300,000 employer group enrollees in H2001, the contract would have received the star rating that was the average of all of United's ratings at that time—3.5 stars—rather than the 4-star rating achieved by using the star rating of H2001. This particular strategy of securing a 4-star rating would not have been revealed in the CMS cross-walk files showing contract changes between one year and the next. Another strategy that United used in the same period involved moving about 375,000 employer group enrollees under contract H1509—rated 3.5 stars—to H2001 (the 4-star contract). While we were able to track the movement of 45,000 enrollees of H1509, which was consolidated at the end of 2015 with contract H2228 (a 4.5-star contract), 18 employer group plans under H1509 were shown as terminated at the end of 2015—suggesting that the beneficiaries were disenrolled. Instead, these employer group members had already been moved to contract H2001.
- 13 Thus, while there might be only one surviving contract after a consolidation, the consumed contracts can be identified because, in most cases, they have different plan numbers, bids, and service areas. For example, in the previously reported case of the consolidation of three regional contracts into one contract cited in the March 2017 report, the number of plans remained the same—eight plans under a single contract—with the geographic make-up of the plans unchanged. However, in some situations, a consolidation results in the blending of two enrolled populations, and the separate identities of the contracts involved are lost, which can occur when two companies serving one county decide to merge. In such a case, a contract consolidation is appropriate for administrative simplicity (though the company could decide to continue separate contracts); and an averaging or proportional determination of bonus eligibility would be appropriate if the contracts are consolidated. If one of the contracts was in bonus status and the other was not and if each contract had the same number of enrollees, for 2018 (assuming only one plan is offered), the bonus status would apply to one-half of the projected enrollment in the plan bid. Similarly, the new star rating for 2018 could be based on a weighted average of the results for each of the contracts. Averaging is the approach that CMS advocates in its recent proposed rule, but the rule would apply to averaging all types of consolidations, including those combining separate geographic areas (Centers for Medicare & Medicaid Services 2017).
- 14 A recent study has compared MA quality with that of FFS in three large states (California, Florida, and New York) using 2012 data (Timbie et al. 2017). Using MA HEDIS results, FFS claims data, Part D data, and CAHPS (survey-based patient experience measures) results for FFS and MA, the authors found that MA performed better than FFS on all 16 clinical quality measures examined, with large differences for HEDIS measures and smaller differences for Part D measures. MA HMOs performed better than PPOs, and PPO performance was sometimes below that of FFS. In CAHPS patient experience measures, MA enrollees reported better experiences with their plan except on the measure of getting needed care, and no significant difference in the care coordination measure. The HEDIS analysis included both measures reported using administrative data, which generally can be directly compared with FFS claims data, and measures for which HEDIS reporting involves medical record review. For the latter type of measures, as the Commission discussed in the March 2010 report to the Congress, MA rates and FFS rates cannot be directly compared using only FFS claims. However, the authors do point out that even for the measures requiring medical record review, if claims-based analyses indicate a widening gap over time between MA and FFS, it can be indicative of improvement in MA. Because the authors used 2012 data (the first year of the MA quality bonus program), replicating the analysis in subsequent years may show that the quality bonus program contributed to improvement in MA quality. However, the ability to replicate the findings in years after 2012 is affected by the contract consolidations that have resulted in large contracts that would yield smaller numbers for MA measures requiring medical record review (a sample of 411 members drawn from each of 19 contracts, for example, would be 411 for a single contract). The authors also found that the differences between MA and FFS narrowed with a contract-level analysis that compared MA results with FFS results in the geographic areas of each contract. The authors comment that this narrowing of differences suggests that the “overall results may be driven by a small number of high-performing plans.” The authors’ finding of a narrowing of differences at the local geographic level serves to emphasize the importance of our recommendation that quality should be measured at the local geographic level.

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