CHAPTER 11

The Medicare Advantage program: Status report

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Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2022, the MA program included 5,261 plan options offered by 182 organizations, enrolled about 29 million beneficiaries (49 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans $403 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 beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. We also provide updates on risk adjustment, risk coding practices, and the current state of quality reporting in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in the traditional FFS Medicare program, while others may prefer to seek the additional benefits and alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate—risk

In this chapter

adjusted per enrollee—rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and, for the seventh straight year, a historically high level of extra benefits financed by payments to plans through rebates. From 2018 to 2022, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 49 percent. All indications suggest that a majority of eligible Medicare beneficiaries will be enrolled in MA in 2023. In 2023, the average Medicare beneficiary has a choice of 41 plans (offered by an average of 8 organizations), and the average MA plan enrollee has access to over $2,350 in extra benefits annually that FFS enrollees cannot access without purchasing additional health insurance coverage or paying for the services on an out-of-pocket basis. Medicare payments for MA extra benefits have more than doubled since 2018. In this way, payments to MA plans have increasingly been used to provide an indirect subsidy to offer expanded benefits for MA enrollees. Medicare spending for these extra benefits (plus plan administrative fees and profit) accounts for 17 percent of payments to MA plans, yet we do not have reliable information about the extent to which beneficiaries use or value these benefits nor information about their value to beneficiaries.

The bids that MA plans submit to CMS suggest that plans continue to capitalize on their administrative flexibility and reduce their relative growth in health care costs year over year. Nearly all plan bids are below the projected cost of FFS Medicare. The average 2023 plan bid to provide Part A and Part B benefits was 17 percent less than FFS Medicare would be projected to spend for those enrollees under current payment policies.

The Commission remains concerned that the benefits from MA's lower cost relative to FFS spending are shared exclusively by the companies sponsoring MA plans (in the form of increased enrollment and revenues) and MA enrollees (in extra benefits). The taxpayers and FFS Medicare beneficiaries who help fund the MA program through Part B premiums do not realize any savings from MA plan efficiencies. Instead, Part B premiums are higher for all beneficiaries than they otherwise would be. Further, Medicare spends 6 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $27 billion in 2023. This amount would be even larger if the favorable selection of beneficiaries in MA plans were taken into account because beneficiaries who

choose to enroll in an MA plan tend to be more profitable than beneficiaries who remain in FFS Medicare.

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies relative to FFS with taxpayers. But private plans in the aggregate have never been paid less than FFS Medicare, due to policies that have explicitly elevated payments to MA above the FFS equivalent. As examples, MA benchmarks are set above FFS in many markets in part to encourage more uniform plan participation across the country, and quality payments (which the Commission has found do not meaningfully reflect plan quality, from the perspective of enrollees or the Medicare program) further inflate MA payments above FFS. Moreover, MA plans' diagnostic coding practices inflate payments and undermine the goal of plans competing to improve quality and reduce health care costs. All of these factors lead to government subsidization of increasingly higher levels of extra benefits for MA enrollees. In addition, the Commission finds that the plan-submitted data about beneficiaries' health care encounters are incomplete—or, in the case of many extra benefits, nonexistent—which prevents policymakers from understanding enrollees' use of services and plan efficiencies, limiting policymakers' ability to carry out program oversight. These policy flaws diminish the integrity of the program and generate waste from beneficiary premiums and taxpayer funds.

Although the additional benefits (including reductions in cost sharing and premiums for the basic Medicare benefit and for Part D coverage) are appealing to Medicare beneficiaries (as evidenced by the rapid enrollment growth), a major overhaul of MA policies is urgently needed to reduce the gap between MA and FFS payment for several reasons. First, the use and value of many supplemental benefits currently offered is unclear. Current supplemental benefits are well above historical levels, and the Commission has maintained that payments to plans could be reduced without substantial cuts to extra benefits that are highly valued by beneficiaries, such as lower premiums and cost sharing (indeed, these benefits likely would remain more generous than in the recent past). Second, the disparity between MA and FFS payment disadvantages beneficiaries who—due to medical reasons or personal preferences—do not want to enroll in MA plans that use tools like narrow networks or utilization management policies. Third, the payment-induced growth in MA will increasingly create challenges for benchmark

setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture. Finally, because of Medicare's fiscal situation, any expansions of benefits, if desired by policymakers, should be done deliberately, with attention to their value and in the most fiscally efficient manner. In the Commission's view, current policy does not meet that standard. Therefore, over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to address coding intensity, replace the quality bonus program, establish more equitable benchmarks, and improve the completeness of encounter data.

Plan payments—As noted above, total Medicare payments to MA plans in 2023 (including rebates that finance extra benefits) are projected to be $27 billion higher than if MA enrollees were enrolled in FFS Medicare. Payments to MA plans—including the impact of coding intensity but ignoring any favorable selection—average an estimated 106 percent of projected FFS spending. In addition, MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—continue to be well above projected FFS spending levels. In 2023, MA benchmarks averaged an estimated 109 percent of projected FFS spending (including quality bonuses but not accounting for MA coding), 1 percentage point above the level in 2022. Bids fell to 83 percent of projected FFS spending, a record low.

Risk adjustment and coding intensity—Medicare payments to MA plans are specific to each enrollee, 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. In FFS Medicare, most claims are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because those diagnoses raise an enrollee's risk score and result in higher payments to the plan.

Our analysis of 2021 data shows that higher diagnosis coding intensity resulted in MA risk scores that were about 10.8 percent higher than scores for similar FFS beneficiaries. By law, CMS reduces MA risk scores across the board to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2021, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores that were still about 4.9 percent higher than they would have

been if MA enrollees had been treated in FFS Medicare. In 2021, those higher scores resulted in $17 billion in excess payments to MA plans, and we project that the amount will reach $23 billion in 2023 (if MA coding remained the same as in 2021). We continue to find that coding intensity varies significantly across MA plans and that increasing diagnostic coding allows some plans to offer more extra benefits, thereby attracting more enrollees and undermining plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments (which rely on unverified enrollee-reported data), use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. We find that nearly two-thirds of MA coding intensity could be due to use of diagnoses from chart reviews and health risk assessments, and that these two mechanisms are a primary factor driving coding differences among MA plans.

Quality in MA—The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of MA quality of care. Beneficiaries lack good information on the quality of care provided by MA plans in their local market, limiting their ability to make informed choices among plans. Further, the 49 percent of eligible Medicare beneficiaries enrolled in MA do not know how their plan's quality compares with quality in FFS Medicare. MA and FFS quality comparisons are also necessary for policymakers to evaluate the quality of care that beneficiaries receive in all sectors. In its June 2020 report, the Commission recommended replacing the current quality bonus program, which is not achieving its intended purposes and is costly to Medicare, with a new value incentive program for MA.

The academic community has devoted growing attention to assessing MA quality and making comparisons with FFS. Notwithstanding the methodological and data issues that are present in many studies, that literature suggests that MA plans likely improve performance on some process measures. Findings are sufficiently mixed on patient experience and outcomes that the Commission cannot conclude that MA plans systematically provide better quality over FFS.

Mandated report: Historical comparison shows MA payments were consistently above FFS spending

The Consolidated Appropriations Act, 2023, mandated that the Commission submit a report by March 15, 2023, that compares MA and FFS per enrollee spending for at least the last five years for which data are available. The Act requests that the Commission's analysis use the FFS spending method

used to calculate MA benchmarks and to compare MA payments with beneficiaries enrolled in both Part A and Part B. We use our long-standing prospective method of comparing MA payments with FFS spending from 2004 through 2023 and supplement this analysis with a retrospective method using the available data on actual MA payments and FFS spending (both claims and nonclaims payments) from 2016 through 2019. Our prospective and retrospective methods yielded very similar results: Both found that MA payments were higher than FFS spending from 2016 through 2019. We note, however, that the retrospective and prospective methods likely would not yield similar results when estimating MA payments and FFS spending for 2020 because CMS's projection of FFS spending and MA bid and risk score projections were overestimated during the first year of the coronavirus pandemic. We will continue to update our retrospective comparison of MA payments relative to FFS spending as more recent data become available. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission strongly supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and the alternative delivery systems that private plans can provide. Unlike traditional FFS Medicare, MA plans typically have flexibility in payment methods, including the ability to negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery, and provide incentives for beneficiaries to seek care from more efficient providers. By contrast, traditional FFS Medicare has lower administrative costs, but it often lacks incentives to coordinate care and is limited in its ability to make care delivery more efficient.[1]

For beneficiaries, the primary trade-off in choosing between MA and FFS is access to the additional benefits that plans provide versus an almost unlimited choice of providers available under FFS. By statute, MA plans are required to offer an out-of-pocket spending limit that is not available in FFS Medicare. MA plans can offer integrated Part D benefits, provide supplemental benefits not covered by Medicare, and reduce cost-sharing liability. However, MA plan enrollees can be restricted to using providers in a plan's network or can face higher cost sharing to access providers out of a plan's network. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a choice between private MA plans and FFS Medicare that does not unduly favor one program component over the other.

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 the current state of quality in MA.

Types of MA plans

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

- ***Health maintenance organizations (HMOs) and local preferred provider organizations (PPOs)—*** These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- ***Regional PPOs—***These plans are required to offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.
- ***Private FFS (PFFS) plans—***These plans may or may not use provider networks, depending on where they operate, and generally do not manage care as efficiently as their HMO and PPO competitors. The Medicare Improvements for Patients and Providers Act of 2008 mandated that, in areas with two or more network MA plans, PFFS plans must have provider networks. As a result, PFFS plans are offered in only a small fraction of counties; by the end of 2022, only about 43,000 beneficiaries were enrolled in PFFS plans.
- ***Medicare Savings Account (MSA) plans—***MSA plans are a combination of a high-deductible plan and a medical savings account. The plan is paid the full MA benchmark and makes a deposit into the member's account that the member can use to help meet the plan deductible on Medicare services. In 2022, MSAs were available in 31 states with a total enrollment of about 11,000 beneficiaries. We do not include MSA plans in our analyses because their enrollment has been limited, beneficiaries dually eligible for Medicare and Medicaid are not eligible to enroll in MSA plans, and these plans do not bid on their enrollees' expected costs.

Two additional plan classifications cut across plan types: special needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific

populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Each SNP must be an HMO or PPO plan. 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. Employer plans do not submit bids, so they are not included in our access analyses. In contrast to prior years, we estimate payments for employer group plans and include them in our overall comparison of MA payments relative to FFS spending. (See the Commission's March 2015 report to the Congress for more detailed information on employer plans.)

How Medicare pays MA plans

In contrast to FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary, which is the product of a base rate and a risk score. Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are likely to have higher medical expenses and vice versa. (See "How Medicare calculates risk scores," p. 329.)

A plan's base rate is determined by the MA plan's bid and the benchmark for the county in which the beneficiary resides. The bid is intended to represent the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health. The benchmark is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.[2] (Medicare also pays plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process, and not all MA plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark. If a plan's normalized bid is above the normalized benchmark (after both have been adjusted to reflect a person of average risk), the plan's MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. For 2023, almost 100 percent of plans bid below their benchmarks. If a plan's bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings). For this computation, the comparison is between an individual plan's actual bid for its expected enrolled population and a plan-specific risk-adjusted average benchmark, weighted by the plan's projected enrollment from counties in its service area. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for paying the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans also devote some of the rebate to their administrative costs and profit. Plans can also choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.[3] (A more detailed description of the MA program payment system can be found in our Payment Basics series at https://www.medpac.gov/document-type/payment-basic/.)

How Medicare calculates MA benchmarks

Under the Affordable Care Act of 2010 (ACA), each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the county's beneficiaries.[4] Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans, and high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings, given the history of very low bids in such counties that reflect high FFS service use. Counties are assigned to quartiles based on average FFS spending; the highest-spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next-highest spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest-spending quartile has benchmarks set at 115 percent of local

FFS spending. U.S. territories are treated like counties in this lowest-spending quartile. Counties that move among quartiles from year to year receive a blended quartile factor. For example, a county that moved from the 100 percent quartile in 2022 to the 107.5 percent quartile in 2022 would have had a blended rate of 103.75 percent in 2023.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans awarded quality bonuses are 10 percent higher than the standard benchmarks.[5] Unlike nearly all of Medicare's FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars. The Commission's original conception of a quality incentive program for MA plans was a system that would be budget neutral and financed with a small share of plan payments (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004). A budget-neutral system is consistent with the Commission's principle of providing a level playing field between private MA plans and FFS Medicare and reflects the Commission's recommendation to the Congress in June 2020 (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019a).

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

CMS calculates risk scores with the CMS hierarchical condition category (CMS–HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Some conditions have more than one HCC, which differ by severity of the condition and are arrayed in a hierarchy. For example, the CMS–HCC model has three HCCs for diabetes: without complications, with chronic complications, and with acute complications. The "hierarchical" aspect of HCCs means that if a beneficiary's diagnoses map to more than one HCC in a condition hierarchy, CMS applies only the HCC that has the largest effect on the beneficiary's risk score—the highest-severity HCC.

CMS tracks beneficiary demographic information, but MA plans submit diagnostic information to CMS through encounter records, which contain basic information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee.[6] Diagnostic data collected from encounters in one calendar year are used to predict Medicare costs for the following calendar year.

CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for Medicare beneficiaries while also ensuring that the model's diagnostic categories were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS has two requirements to ensure the validity and reliability of the diagnostic data used in an enrollee's risk score: Diagnoses must (1) appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional; and (2) be supported by evidence in the patient's medical record.[7] Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio and video telecommunication that enables real-time communication with the beneficiary. To ensure that diagnoses are supported by evidence in the patient's medical record, CMS conducts risk-adjustment data validation (RADV) audits. RADV audits have been limited so far, but the available results show significant issues with medical record support for risk-adjustment diagnoses (see section on "Risk-adjustment data validation" later in this chapter).

Commission recommendations that have not been implemented would fix many flaws in MA payment policies

When risk-based payments for private plans were first incorporated into the Medicare program, policymakers expected that they would help to reduce Medicare

TABLE 11–1

Commission recommendations for changes to MA payment policy that have not been implemented

Recommendation
Fully account for MA coding intensity—*March 2016* The Congress should direct the Secretary to develop a risk-adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.
Improve encounter data accuracy and completeness—*June 2019* The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method starting in 2024, for MA organizations that fail to meet thresholds, or for all MA organizations if program-wide thresholds are not achieved.
Replace the quality bonus program—*June 2020*[a] The Congress should replace the current MA quality bonus program with a new MA value incentive program that scores a small set of population-based measures, evaluates quality at the local market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.
Establish more equitable benchmarks—*June 2021*[b] The Congress should replace the current MA benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local area FFS spending with price-standardized per capita national FFS spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and the Commission's prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre–Affordable Care Act cap on benchmarks.

Note: MA (Medicare Advantage), FFS (fee-for-service).
[a]The June 2020 quality recommendation incorporates the Commission's prior recommendations eliminating the doubling of the quality increases in specified counties (recommended in March 2016) and establishing a geographic basis for MA quality reporting that reflects health care market areas (June 2005, March 2010, and March 2018).
[b]The June 2021 benchmark recommendation incorporates the Commission's prior recommendations eliminating the cap on benchmark amounts implemented by the Affordable Care Act of 2010 (recommended in March 2016), basing benchmarks on FFS spending data only for beneficiaries with both Part A and Part B (recommended in March 2017), and establishing a geographic basis for MA payments that reflects health care market areas (recommended in June 2005, March 2010, and March 2018).

Source: Medicare Payment Advisory Commission 2021b, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2016.

spending. Indeed, under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments.[8] Without accounting for MA diagnostic coding intensity or favorable selection, MA plans continue to capitalize on their administrative flexibility and reduce their growth in spending relative to the projected FFS spending. For 2023, we estimate that the average plan will provide the Medicare Part A and Part B benefits for 17 percent less than FFS Medicare would spend for those enrollees, and nearly all plans will provide basic Medicare benefits for less than the cost of FFS Medicare (before accounting for MA coding intensity and favorable selection).

However, the benefits from these cost reductions are shared exclusively by the companies sponsoring MA plans and by MA enrollees, in the form of extra benefits. In a time of increasing financial stress for Medicare and its beneficiaries, the taxpayers and beneficiaries who fund the MA program (including those in FFS Medicare, who help finance MA through their Part B premiums) do not realize any savings from MA plan efficiencies. Instead, Medicare pays MA plans 6 percent more than it would spend if enrollees were covered under FFS Medicare, a program that already has inflated spending levels due to the volume-inducing incentives of FFS reimbursement, the widespread use of supplemental insurance that insulates beneficiaries from the financial impact of their service utilization, and inappropriate spending owing to fraud and waste. In fact, due to policies the Commission believes to be deeply flawed, private plans have never been paid less than FFS Medicare in aggregate.

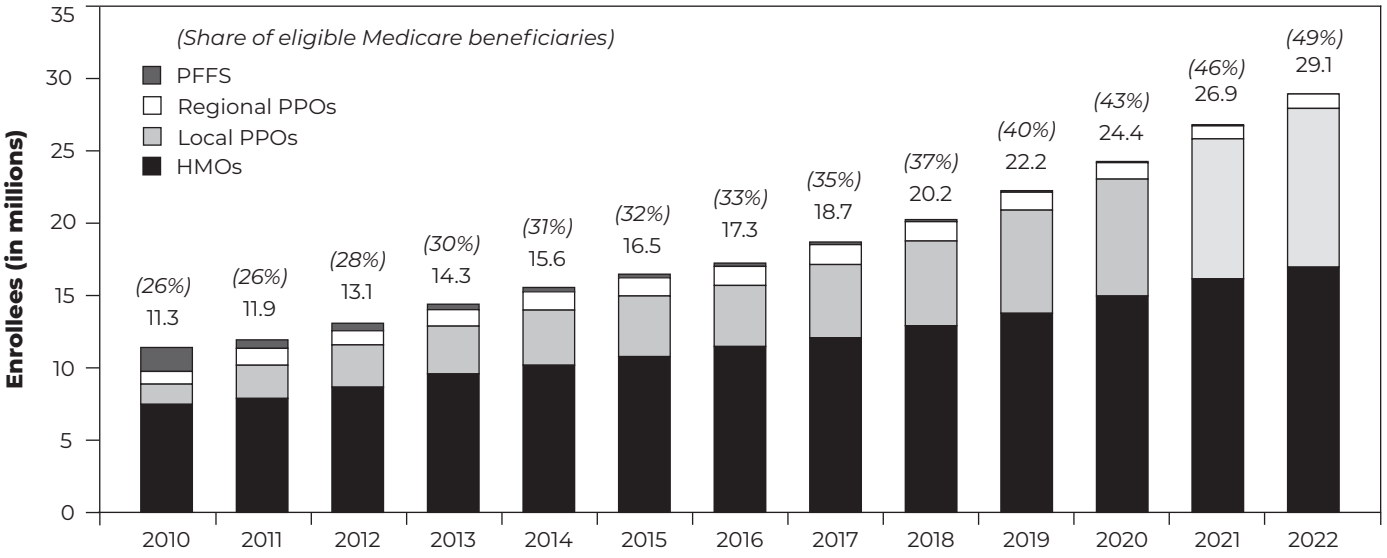
In particular, the Commission has found that CMS's coding intensity adjustment is inadequate to address inflated payments to MA plans. At the same time, the quality bonus program boosts plan payments for nearly all enrollees but does not provide beneficiaries with the necessary information to evaluate local quality. Further, plan benchmarks are set so high that the Medicare program (rather than plans) subsidizes extra benefits for MA enrollees. Arguably, the extra benefits funded by payments in excess of what Medicare would have spent under FFS fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.[9] The generosity of the additional benefits is appealing to beneficiaries, particularly for beneficiaries who are unable to afford a Medigap policy that would reduce cost sharing in FFS. But these policies undermine the goal of plans competing to improve quality and reduce health care costs, and the policies potentially generate waste from beneficiary premiums and taxpayer funds. Moreover, the Commission has found that plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to identify MA plan efficiencies, improve quality measurement, and provide more robust oversight of the MA program.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. But the rapid growth of MA enrollment and spending elevates the urgency and need for a major overhaul of MA policies. Medicare should not continue to overpay MA plans; in fact, as MA enrollment continues to grow, higher payments to plans will further worsen Medicare's fiscal sustainability. Overpaying MA plans also creates inequities among beneficiaries since beneficiaries in FFS Medicare help finance the overpayment that plans use to provide extra benefits for their enrollees (extra benefits that FFS beneficiaries do not enjoy). In addition, overpaying MA plans undermines incentives for efficiency in the delivery of care. To encourage efficiency, MA plans need to face appropriate financial pressure similar to what the Commission generally recommends for providers in the FFS program. Reducing payments to plans is therefore imperative. Past experience with reductions in MA payments under the ACA has demonstrated that such cuts can be enacted with little impact on plan participation and beneficiary enrollment.

Over the past few years, the Commission has developed four recommendations (some that incorporate and update prior recommendations) that would eliminate or lessen the effects of the most significant flaws in the MA program and reduce payments to MA plans. Table 11-1 summarizes the Commission's standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016); (2) ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with FFS Medicare (Medicare Payment Advisory Commission 2019a); (3) replace the quality bonus program with a market area–based, plan-financed reward program (Medicare Payment Advisory Commission 2020); and (4) establish more equitable MA benchmarks for the Medicare program (Medicare Payment Advisory Commission 2021b). Through reforms to the MA payment system, the Commission aims to improve the program for the beneficiaries it serves and to harness plan efficiency to strengthen Medicare's long-term financial sustainability.

FIGURE 11–1

Enrollment in MA has more than doubled since 2013



Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in the denominator of eligible Medicare beneficiaries.

Source: MedPAC analysis of CMS enrollment files, July 2010–2022.

Increasingly robust MA enrollment, plan availability, and rebates

Substantial growth in MA plan enrollment, availability, and rebates indicates an increasingly robust MA program. As of 2022, almost half of eligible Medicare beneficiaries are now in MA plans. For 2023, the average beneficiary has access to 41 plans sponsored by 8 organizations, and rebates that finance extra benefits are the highest in the program's history.

In 2022, MA plan enrollment grew by 8 percent; 49 percent of eligible Medicare beneficiaries are enrolled in MA plans

Between July 2021 and July 2022, enrollment in MA plans grew by 8 percent—or 2.3 million enrollees—to 29.1 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew only 2 percent and FFS enrollment declined about 4 percent. The growth in 2022 follows three consecutive years of 10 percent growth in MA enrollment. Between 2022 and 2023, MA enrollment rose from 46 percent to 49 percent of eligible Medicare beneficiaries (Figure 11-1).[10] Enrollment in MA has more than doubled since 2013. MA has increasingly become attractive to beneficiaries because plans provide cost-sharing reductions and a cap on out-of-pocket expenses at little or no premium. Many beneficiaries with care needs that are met within plan networks will likely have lower financial liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage.[11] In addition, while some MA enrollees with high care needs experience greater cost liabilities compared with beneficiaries in FFS (e.g., greater cost sharing for in-network and out-of-network services compared with the premiums for Medigap supplemental coverage), most of these MA enrollees

TABLE 11–2

MA plan enrollment continued rapid growth in 2022

	Enrollment (in millions)		Percent change in enrollment (2021–2022)
	July 2021	July 2022	
Total MA-eligible beneficiaries	**58.1**	**59.2**	**2%**
Total MA	**26.9**	**29.1**	**8**
Plan type			
HMO	16.2	17.1	6
Local PPO	9.7	11.2	16
Regional PPO	0.9	0.7	–23
PFFS	0.1	<0.05	–23
Restricted availability plans included in totals above			
SNPs*	4.1	4.9	20
Employer group*	5.0	5.2	4

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). "Total MA-eligible beneficiaries" excludes the 8 percent of Medicare beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. 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.

would likely have difficulty switching to FFS coverage because they could be denied a Medigap policy due to a preexisting condition.[12]

Among plan types, recent growth in MA enrollment has been disproportionately higher among local PPOs. Although HMOs continued to enroll the most beneficiaries (17 million) in 2022, enrollment in local PPOs grew faster (16 percent) than in HMOs (6 percent) (Table 11-2). In addition, between 2021 and 2022, enrollment in local PPOs grew by 1.5 million, accounting for two-thirds of the overall increase in MA enrollment. As MA rebates have risen, the resulting increase in extra benefits provided by local PPOs combined with less restrictive networks—relative to HMOs—has likely contributed to the recent enrollment increase among local PPOs.[13] Much of the increase in HMO enrollment resulted from enrollment in SNPs. In 2022, SNP enrollment grew by 20 percent. HMOs accounted for nearly two-thirds of the SNP enrollment growth (data not shown). While enrollment in non-SNP HMOs grew by 3 percent, enrollment in SNP HMOs grew by 18 percent (data not shown). Thus, in 2022, Medicare beneficiaries with special needs (e.g., dual-eligible for Medicaid) are increasingly enrolled in HMOs, and those without qualifying special needs are increasingly enrolled in PPOs (data not shown).

Enrollment patterns differ in urban and rural areas. The majority (51 percent) of eligible urban beneficiaries are enrolled in MA compared with 40 percent of eligible beneficiaries residing in rural counties.[14] However, the growth of MA plans in rural areas has been much faster in recent years. In 2022, MA enrollment in rural areas grew by 13 percent (compared with 7 percent growth in urban areas). The predominant plan type often differs between urban and rural areas. In 2022, 40 percent of rural MA enrollees were in HMO plans compared with

TABLE 11–3

MA enrollment share by top 3 parent organizations did not change nationally but declined at the county level, July 2018–2022

Top 3 parent organizations, by type of MA plan	Share of enrollment			Change in share	
	2018	2021	2022	2018–2022	2021–2022
All MA plans: Top 3 (national)	**51%**	**56%**	**56%**	**+5%**	**0%**
UnitedHealth Group Inc.	26	27	28	+2	+1
Humana Inc.	17	18	18	+1	–1
CVS Health Corporation	8	11	11	+3	0
Top open enrollment plans					
Top 3 nationwide	**51**	**55**	**54**	**+3**	**–1**
UnitedHealth Group Inc.	23	24	24	+1	0
Humana Inc.	21	21	20	–1	–1
CVS Health Corporation	8	9	10	+2	0
County level (weighted average)*					
Top organization	48	44	43	–5	–1
Top 2 organizations	72	68	67	–5	–1
Top 3 organizations	85	82	81	–4	–1

Note: MA (Medicare Advantage). Includes only Medicare Advantage plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Open enrollment plans exclude special needs plans and employer group plans, which have restricted availability. We present market shares of the top 3 open enrollment plans nationwide to help demonstrate the extent of market concentration. Market shares of the top 3 open enrollment plans at the county level demonstrate the extent of market concentration locally. The top 3 organizations in each county typically differ from the top 3 organizations nationally. Totals, differences, and market shares may not sum due to rounding.
*County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of CMS July 2018–2022 enrollment data.

about 62 percent of urban enrollees. By contrast, 54 percent of rural enrollees were in local PPOs compared with 36 percent of urban enrollees.

In many areas of the country, a majority of eligible Medicare beneficiaries are now enrolled in MA. In 26 states (including California, Florida, Michigan, New York, Pennsylvania, and Texas) and Puerto Rico, more than half of the eligible population was enrolled in an MA plan in 2022. In some metropolitan areas (e.g., Grand Rapids, MI; Greensboro, NC; El Paso, TX; Miami, FL; Pittsburgh, PA; Rochester, NY), more than 70 percent of eligible Medicare beneficiaries are enrolled in MA plans. MA benchmarks are computed at the county level, and in an increasing number of counties, most Medicare beneficiaries are enrolled in MA plans. In all counties in Puerto Rico and an additional 863 counties across 38 states, more than half of eligible Medicare beneficiaries were enrolled in MA plans in 2022. The increasing share of MA enrollees in some geographic areas raises questions about whether the local FFS population should continue to be the basis for MA payment benchmarks. Benchmarks can become biased if the FFS population is not representative of Medicare beneficiaries overall. When this disparity arises, the risk-adjustment model is less likely to capture differences between the local FFS and MA populations. For example, in some counties, a

disproportionate number of FFS beneficiaries have comprehensive supplemental coverage, which is generally unavailable in MA and induces higher demand for health care services.

The MA market is heavily concentrated, but slightly less so in 2022

Between 2021 and 2022, the national MA market continued to be concentrated, but—contrary to prior years—the largest organizations did not increase their combined market share. The top three organizations in 2022 had 56 percent of total MA enrollment, 5 percentage points higher relative to 2018 but unchanged from 2021 (Table 11-3).[15] Among open enrollment plans (plans available to all Medicare beneficiaries, thus excluding SNPs and employer plans), the top three organizations nationwide had 54 percent of enrollment in 2022, a decrease from 55 percent in 2021. In contrast, the national market for dual-eligible SNPs (D–SNPs) has been getting more concentrated; the largest three organizations nationally had 54 percent of total enrollment in D–SNPs, an increase from 51 percent in 2021 (data not shown).[16]

Another way of looking at the MA program's market structure is to examine competition at the county level (Table 11-3). Excluding employer plans and SNPs, in 2022, enrollment in the largest organization in each county accounted for 43 percent, on average, of all MA enrollment in the county (down from 44 percent in 2021). Enrollment in the top three organizations in each county accounted for 81 percent, on average, of all MA enrollment, which was down from 82 percent in 2021 and 85 percent in 2018. Similarly, under the Herfindahl–Hirschman Index (a common measure of market concentration), the share of MA enrollees living in counties with highly concentrated markets between 2021 and 2022 declined from 66 percent to 61 percent.[17] Thus, although local MA markets tend to be highly concentrated, the level of concentration has modestly trended downward in recent years. This trend suggests that insurers have entered new markets and are steadily gaining market share in areas that have historically been very concentrated. In addition, as illustrated in the next section, estimates in 2023 indicate that the average beneficiary will have access to many MA plans offered by a substantial number of organizations.

Access to MA plans remains high in 2023

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 2023, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2023. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in recent years (Table 11-4, p. 336). In 2023, 99 percent of Medicare beneficiaries have an HMO or local PPO plan (both are considered local CCPs) operating in their county of residence, nearly the same as in 2022.[18] Regional PPOs are available to 74 percent of eligible beneficiaries, similar to 2022. PFFS plans are available to 29 percent of beneficiaries, down from 35 percent in 2022.

The availability of SNPs continues to be high across the types of special needs populations served (Table 11-4, p. 336). In 2023, 94 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (nearly the same as in 2022), 66 percent live where SNPs serve beneficiaries with chronic conditions (up from 59 percent in 2022), and 77 percent live where SNPs serve institutionalized beneficiaries (up from 74 percent in 2022). Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

In 2023, 99 percent of eligible Medicare beneficiaries (compared with 98 percent in 2022) have access to at least one open enrollment MA plan (i.e., excluding SNPs and employer group plans) that includes Part D drug coverage and charges no Part C or Part D premium (enrollees still pay the Medicare Part B premium) (Table 11-4, p. 336).[19] About 74 percent of MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2023, 99 percent of beneficiaries (compared with 97 percent in 2022) have access to plans that offer some reduction in the Part B premium, but only 9 percent of 2023 enrollment was projected to be in these premium-reduction plans (data not shown).[20] Given the increasing number of plan choices, beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice.

In most counties, beneficiaries have access to a large number of MA plans. In 2023, the average number of

TABLE 11–4

Access to Medicare Advantage plans remains high

Type of plan	2019	2020	2021	2022	2023
Share of beneficiaries with access to at least one plan					
Any MA plan	99%	99%	99%	99%	>99.5%
Local CCP	97	98	98	99	99
Regional PPO	74	73	72	74	74
PFFS	38	36	34	35	29
Special needs plans					
Dual eligible	89	90	92	94	94
Chronic condition	47	52	57	59	66
Institutional	63	67	72	74	77
Zero-premium plan with drug coverage	90	93	96	98	99
Average number of choices					
County weighted	13	15	18	22	26
Beneficiary weighted	23	27	32	36	41

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. For 2018 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). For 2022, the share of Medicare beneficiaries only includes beneficiaries with both Part A and Part B coverage (i.e., includes MA-eligible beneficiaries). A "zero-premium plan with drug coverage" includes Part D coverage and has no premium beyond the Part B premium (including no Part D 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.

Source: MedPAC analysis of CMS bid and enrollment data.

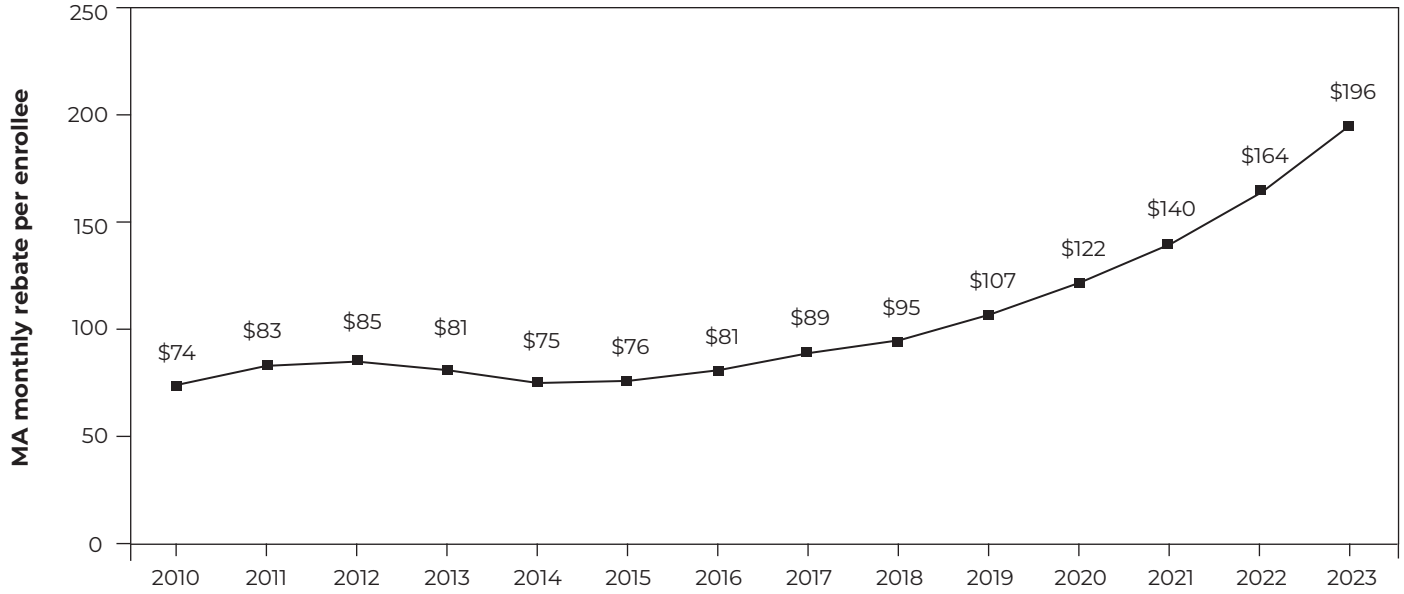
plans available in a county increased to 26 plans (from 22 plans in 2022) (Table 11-4). Plan availability can also be evaluated by number of plan choices available to the average beneficiary. Under that calculation, the average beneficiary in 2023 has 41 available plans, an increase from 36 plans in 2022, and can choose from plans sponsored by 8 organizations (organization data not shown); 98 percent of beneficiaries have access to MA plans sponsored by at least 3 different organizations, and 95 percent of beneficiaries can choose from plans sponsored by at least 4 different organizations.[21] Beneficiaries in 176 counties can choose from at least 20 plans offered by at least 10 distinct organizations. These counties include the major markets of Atlanta, Chicago, Cincinnati, Cleveland, Dallas, Houston, Los Angeles, Miami, New York City, and Phoenix. At the other end of the spectrum, 84 counties, representing less than half of 1 percent of beneficiaries, have no MA plans available (Medicare MSA plans and SNPs are not included in general availability measures).[22]

MA rebates in 2023 are a record high $196 per enrollee per month

As discussed above, a plan's base payment rate is determined by comparing the plan's bid (the dollar amount the plan estimates it needs in order to provide the Part A and Part B benefit package to a beneficiary of average health status) and the benchmark (the

FIGURE 11–2

MA rebates have more than doubled since 2018



Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free extra benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration.

Source: MedPAC analysis of data from CMS on plan bids.

applicable maximum amount set by Medicare for the county). If a plan's bid is below the benchmark, its payment rate is its bid plus a share of the difference between the plan's bid and the benchmark. This share (typically 65 percent) is somewhat dependent on a plan's quality rating and is referred to as the "rebate." Thus, rebates can increase through relative benchmark increases, relative bid decreases, and changes in a plan's quality rating.[23] Plans must use the rebate to provide extra benefits—such as lower cost sharing, lower premiums, or supplemental benefits not covered by Part A or Part B (such as vision, hearing, dental, and fitness benefits). Plans also use some of the rebate to cover their administrative costs and as profit. Although plans are required to submit encounter data for supplemental benefits, CMS does not have reliable information about enrollees' actual use of these benefits.[24]

For 2023, rebates for MA plans (excluding employer plans and SNPs) average $196 per enrollee per month (more than $2,350 annually per enrollee) and—for the seventh consecutive year—are the highest in the program's history (Figure 11-2).[25] These rebates account for 17 percent of plan payments, an increase from 15 percent in 2022. The average total rebate for 2023 is 19 percent higher than in 2022 ($32 higher per enrollee per month). The average MA rebate has more than doubled in the past five years, since 2018.

We assess plan rebates based on projected rebate allocations included in plans' bids, but we have no data about enrollees' actual use of extra benefits. In 2023, the share of plan rebates allocated toward cost-sharing reductions is projected to fall (Table 11-5, p. 338). Plans project that $76 per enrollee per month in rebates (39 percent of rebate dollars) will go toward reductions in cost sharing for Medicare services, 8 percent higher

TABLE 11–5

MA plans project that over a quarter of rebates will be allocated to non-Medicare supplemental benefits in 2023

	Rebate (per member per month)			Share of total rebate	
	2022	2023	2023 percent change	2022	2023
Total	$164	$196	19%	100%	100%
Extra benefit type					
Cost sharing	70	76	8	43	39
Non-Medicare supplemental	36	50	39	22	26
Part D supplemental	30	38	27	18	19
Part D premium	25	27	7	15	14
Part B premium	4	5	49	2	3

Note: MA (Medicare Advantage). Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. Amounts for cost sharing and non-Medicare supplemental benefits include plan costs for administration and profit. Cost sharing amounts include plan projections of their liability for the beneficiary out-of-pocket expenses cap. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. Totals, differences, and rebate shares may not sum due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

relative to 2022 but a drop in the share of rebate dollars (43 percent in 2022).[26,27] The rate of growth in the amount of rebates allocated to cost-sharing reductions is modestly higher than CMS's projected rate of growth for all Part A and Part B expenditures (6 percent; data not shown), suggesting that many MA plans have opted not to devote additional rebate dollars beyond medical inflation to this benefit. One reason is that doing so could induce greater service use among enrollees, as occurs among FFS beneficiaries with first-dollar Medigap coverage (Medicare Payment Advisory Commission 2012a).[28] Instead, plans report allocating an increasing share of plan rebates to non-Medicare-covered supplemental benefits.

In 2023, plans project that 26 percent of rebates (averaging $50 per enrollee per month) will be used for non-Medicare-covered supplemental benefits.[29] The Commission previously reported that while these benefits often include coverage for vision, hearing, or dental services, the non-Medicare supplemental benefits that plans most commonly offer appear to be tailored toward relatively healthy beneficiaries rather than populations that have the greatest social or medical needs (Medicare Payment Advisory Commission 2021b).[30] The lack of information about enrollees' use of supplemental benefits makes it difficult to determine whether the benefits improve beneficiaries' health. To the extent that plans' supplemental benefits are intended to address social determinants of health, it is not clear whether delivering those benefits through MA plans is more effective than direct financial assistance to beneficiaries would be.

Other uses of rebate dollars are for Part D supplemental benefits (19 percent of projected rebates), reductions in Part D premiums (14 percent of projected rebates), and reductions in Part B premiums (3 percent of projected rebates). MA plans cannot allocate administrative expenses or margin to Part B premium reductions.[31]

MA margins

The continued growth in MA enrollment, the substantial number of plans offered by several

organizations, and plans' ability to provide generous extra benefits point to continued strong financial health in the MA sector. We also analyze the margins that MA plans report in their bids as a potential indicator of plans' financial health. While these margins offer some insight, the data are limited in several ways. For example, the data do not include plans' expected costs and revenues for providing Part D (which nearly all MA plans offer) and do not include employer plans (18 percent of MA enrollment in 2021).[32] In addition, the increasing ownership of plans and providers under the same organization may overestimate plan medical expenses and underestimate plan margins. The degree to which provider revenues are shared with plans under these arrangements is unclear, but financial data suggest a substantial shifting of revenues and expenses for at least one large health plan (Frank and Milhaupt 2022). Moreover, the parent organizations of many MA plans have multiple lines of business, and understanding how MA revenues factor into their financial health is difficult. For example, MA gross profits tend to be higher than other lines of health insurance businesses (McDermott et al. 2020). Even if a parent organization has the same profit margin across its various insurance lines of business, the higher gross profits in MA may provide a financial advantage if the organization's fixed costs (e.g., rent, utilities, information technology infrastructure, and base salaries and benefits) are similar across the entire organization. Thus, MA margins may not be comparable with the margins of other health insurance lines of business within the same organization.

While analyses of MA margins are not indicative of the financial health of the MA sector, they can still be used as a partial indicator. Annual changes in plan-reported MA margins have been larger during the coronavirus public health emergency (PHE). From 2019 to 2020, plan-reported margins increased from 4.5 percent to 6.5 percent. Using the most recent data available, in 2021, MA plans reported margins that averaged 2.2 percent.[33,34] The increase in reported MA margins in 2020 was likely due to CMS overprojecting FFS spending in that year (due to the PHE), thus inflating MA benchmarks and plan revenues while plans incurred lower-than-expected medical expenses. The decrease in reported MA margins in 2021 likely coincides with lower-than-expected MA revenues from MA risk scores, which were based on beneficiary diagnoses in 2020. For 2023, plan bids indicate that plans' projected margins will be much closer to prepandemic levels (4.6 percent).

Margins vary by a plan's tax status and whether a plan is a SNP. In the 2021 data, nonprofit plans reported a margin of –0.9 percent; for-profit entities reported a pretax margin of 2.8 percent, both decreases relative to 2020.[35] In 2021, all categories of SNPs had overall positive margins. D–SNPs, for beneficiaries dually eligible for Medicare and Medicaid benefits, had margins of 6.4 percent. SNPs for enrollees with certain chronic conditions (C–SNPs) had margins of 4.6 percent. Institutional SNPs had margins of 4.0 percent. The 2021 profit margin among nonprofit D–SNPs was 1.2 percent.

Plans bid at record low levels in 2023, but payments remain above FFS spending

The growth and availability of MA plans has occurred without overall savings to the Medicare program. In 2023, MA plan payments (including rebates that finance extra benefits) remained above what Medicare would have paid for similar beneficiaries in FFS, continuing the trend of higher levels of payment throughout the history of Medicare managed care (see the mandated report section on Medicare payments to MA plans, pp. 342–351). Payments to MA plans are determined using a plan's bid—which is intended to represent the dollar amount that the plan estimates it will need to cover the Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides. The benchmark is based on CMS's projection of local FFS spending and is the maximum Medicare payment amount set by law for an MA plan to provide Part A and Part B benefits for beneficiaries in that county.

Before accounting for differences in diagnostic coding practices between MA and FFS, MA benchmarks (including quality bonuses) in 2023 are estimated to average 109 percent of projected FFS spending (Table 11-6, p. 340), up 1 percentage point from 2022.[36] In 2023, overall plan bids average an estimated 83 percent of FFS spending, a record low, down from 85 percent in 2022 (2022 data not shown).[37] When a plan bids below the benchmark, its payment rate is its bid plus a share of the difference between its bid and the benchmark. Overall, we estimate that—without any adjustments for

TABLE 11–6

Overall plan bids at record low levels in 2023, but plan payments remain above FFS spending due to coding

	Share of FFS spending in 2023		
Plan type	**Benchmarks**	**Bids**	**Payments**
All MA plans (after coding estimate)	**114%**	**87%**	**106%***
All MA plans (before coding estimate)	**109**	**83**	**101***
HMO	109	82	100
Local PPO	110	85	102
Regional PPO	95	82	91
PFFS	110	99	106
SNPs (included in totals above)	108	86	101

Note: FFS (fee-for-service), MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2023 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. To account for our most recent coding estimate of 4.9 percent, we estimated overall benchmarks, bids, and payments if coding differences between MA and FFS were fully reflected (i.e., if the risk-adjusted differences between MA and FFS did not include coding differences). We assume, conservatively, that the coding differences for 2023 are the same as for 2021 (the most recent year of data available). We did not estimate coding differences between MA and FFS by plan type. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the table includes all Part A and Part B spending. MA benchmarks, bids, and payments assume this level of FFS spending. Using data from 2017 to 2019 and adjusting spending for risk scores and beneficiaries with Medicare as a secondary payer, the Commission estimated that FFS spending for enrollees with both Part A and Part B was about 1 percent higher than spending for all FFS enrollees. All numbers in this table have been risk adjusted and reflect quality bonuses, but they have not been adjusted for favorable selection of beneficiaries in MA plans, and only aggregate numbers for all plans have been adjusted for coding intensity differences between MA and FFS.
*Payment values for "all MA plans" include employer plans. Payment values broken out by plan type do not include employer plans.

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

coding intensity or favorable selection (beneficiaries who choose to enroll in an MA plan tend to be more profitable for the plan than beneficiaries who remain in FFS Medicare)—Medicare payments to MA plans in 2023 would average 101 percent of projected FFS spending; however, uncorrected coding intensity (MA coding intensity in excess of the adjustment) increases payments to 106 percent of projected FFS spending. That difference translates into a projected $27 billion in 2023. The 2023 estimate does not adjust for the favorable selection of beneficiaries in MA plans but does incorporate our most recent estimate of MA coding intensity.[38] Before including quality bonuses, MA payments averaged 102 percent of FFS spending in 2023.

Because CMS does not pay employer plans based on their bids, employer plans are included only in our overall estimate of MA payments relative to FFS spending. In 2017 and 2018, CMS began paying employer plans based on a blend of the 2016 bidding behavior of employer plans and the other MA plans. Starting in 2019, CMS began paying employer plans based on the prior year's bidding behavior of nonemployer plans by plan type and payment quartile. Because employer plans are mostly PPOs, their payment in 2023 largely reflects the average bidding behavior of nonemployer PPOs in 2022. Using 2023 employer plan payment rates and recent employer plan enrollment and risk score trends, we estimate that MA payments to employer plans will average 102 percent of projected FFS spending in 2023.[39]

Prior to each payment year, CMS publishes plan benchmarks in April, and plans submit their bids in June. Benchmarks reflect projected FFS spending estimates using data available at the time the benchmarks were published (e.g., projected 2023 FFS spending estimates use data available just prior to the release of benchmarks in April 2022).[40] We use plans' projected enrollment, spending, and risk scores from their bids to estimate projected MA payments and compare that with CMS's projected FFS spending for a like set of FFS beneficiaries (by applying the MA enrollment and risk profile to CMS's projected spending of beneficiaries in FFS for each county). CMS's FFS spending estimates are the basis for MA benchmarks and therefore directly inform plan bids and payments.

Our method of using plan bids and CMS projections of FFS spending to compare MA and FFS spending does not fully account for the effects of favorable selection, which happens when MA plan payments (even after risk adjustment) are higher than actual costs. Because benchmarks are based on risk-standardized FFS spending, the underlying MA payment rates assume that standardized spending is equal between MA and FFS enrollees (prior to any coding differences between MA and FFS). However, bid data mask the favorable risk-adjusted spending that plans experience from beneficiaries who choose to enter MA and remain in MA. While the implementation of the CMS–HCC risk-adjustment model and policies that limited beneficiary plan switching during a year have reduced favorable selection for MA plans, research suggests that some favorable selection persists (Jacobson et al. 2019, McWilliams et al. 2012, Medicare Payment Advisory Commission 2012a, Newhouse et al. 2012). In preliminary work assessing favorable selection into MA, we have observed that the average risk-standardized FFS spending for beneficiaries who enrolled in MA in the next year was consistently lower than for beneficiaries who remained in FFS, suggesting that, on average, risk scores overpredict spending for beneficiaries who switch from FFS to MA. We also have found that this favorable selection persisted for years before those beneficiaries enrolled in MA, which suggests that the subsequent payments to MA plans for those enrollees, even after risk adjustment, were too high. Further, we have observed that MA enrollees with higher risk-standardized spending (which represents unfavorable selection for plans) are less likely to remain in MA and are more likely to either die or rejoin FFS. We will continue to evaluate favorable selection of MA enrollees and consider this analysis for inclusion in future comparisons of MA payments to FFS spending.

Variation in 2023 MA bids and payments

Without adjusting for coding intensity or favorable selection, the ratio of MA plan payments to projected FFS spending for 2023 varies by plan type (Table 11-6). For example, HMOs as a group bid an average of 82 percent of projected FFS spending, yet payments for HMO enrollees are estimated to average 100 percent of FFS spending because of benchmarks averaging 109 percent of FFS spending. Local PPOs' bids average 85 percent of projected FFS spending, yet payments for local PPO enrollees are estimated to be 102 percent of FFS spending. Payments for beneficiaries enrolled in regional PPOs average 91 percent of FFS because of the regional PPOs' relatively low benchmarks (which are blended with regional plans' bids). In addition, SNPs—HMOs and local PPOs available only to subpopulations of Medicare beneficiaries—bid an average of 86 percent of projected FFS spending, while payments are estimated to be 101 percent of projected FFS spending.

In 2023, 95 percent of MA plans (excluding SNPs) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend (prior to adjusting for coding intensity or favorable selection) to provide these benefits (Table 11-7, p. 342), an increase from 92 percent in 2022. Plans (including SNPs) that bid below FFS spending are projected to enroll about 97 percent of MA enrollees, excluding those in employer plans. About 6 percent of MA enrollees are projected to enroll in plans that bid lower than 70 percent of FFS spending (similar to 2022); less than 1 percent are projected to enroll in plans that bid more than 110 percent of FFS spending.

Although plan bids average less than projected FFS spending, payments for these plans' enrollees can exceed FFS spending because the benchmarks (including the quality bonuses) can be high relative to their area's FFS spending. Figure 11-3 (p. 343) shows how plans bid relative to FFS for service areas with different ranges of projected FFS spending.[41] As expected, plans bid higher (relative to FFS) in areas with relatively low FFS spending and bid lower (relative to FFS) where FFS spending is relatively high.

TABLE 11–7

Distribution of 2022 MA bids relative to FFS

Bids as a percent of FFS spending	Share of bids	Share of projected MA enrollment
Less than 70%	7%	6%
At least 70%, less than 80%	25	30
At least 80%, less than 90%	43	47
At least 90%, less than 100%	20	14
At least 100%, less than 110%	5	2
110% or more	1	<0.5

Note: MA (Medicare Advantage), FFS (fee-for-service). Employer group plans and special needs plans are not included. Results were similar when including special needs plans. Percentages do not account for unaddressed coding intensity differences or the favorable selection of beneficiaries who choose to enter and remain in MA. Totals may not sum to 100 percent due to rounding.

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

However, even in service areas in the lowest quartile of FFS spending, less than $977.24 per month on average, most plans bid less than the projected FFS spending level for 2023 (Figure 11-3). This finding suggests that, geographically, plan costs do not vary as much as FFS spending. After the ACA began lowering benchmarks in 2012, plans serving areas with benchmarks set at 115 percent of FFS spending (the lowest-spending quartile, corresponding to areas with benchmarks below $977.24 per month in 2023) began bidding below FFS far more frequently. The median bid for areas in this quartile declined between 2013 and 2023 from 111 percent to 89 percent of FFS. However, the increasing efficiency demonstrated by plan bids in these areas, which were presumed to be the most challenging for MA plans to compete in, have not translated into Medicare savings. For 2023, Medicare still pays an average of 110 percent of FFS spending in these areas, due to benchmarks that average 119 percent of FFS once quality bonuses are included.

Mandated report: Historical comparison shows MA payments consistently above FFS spending

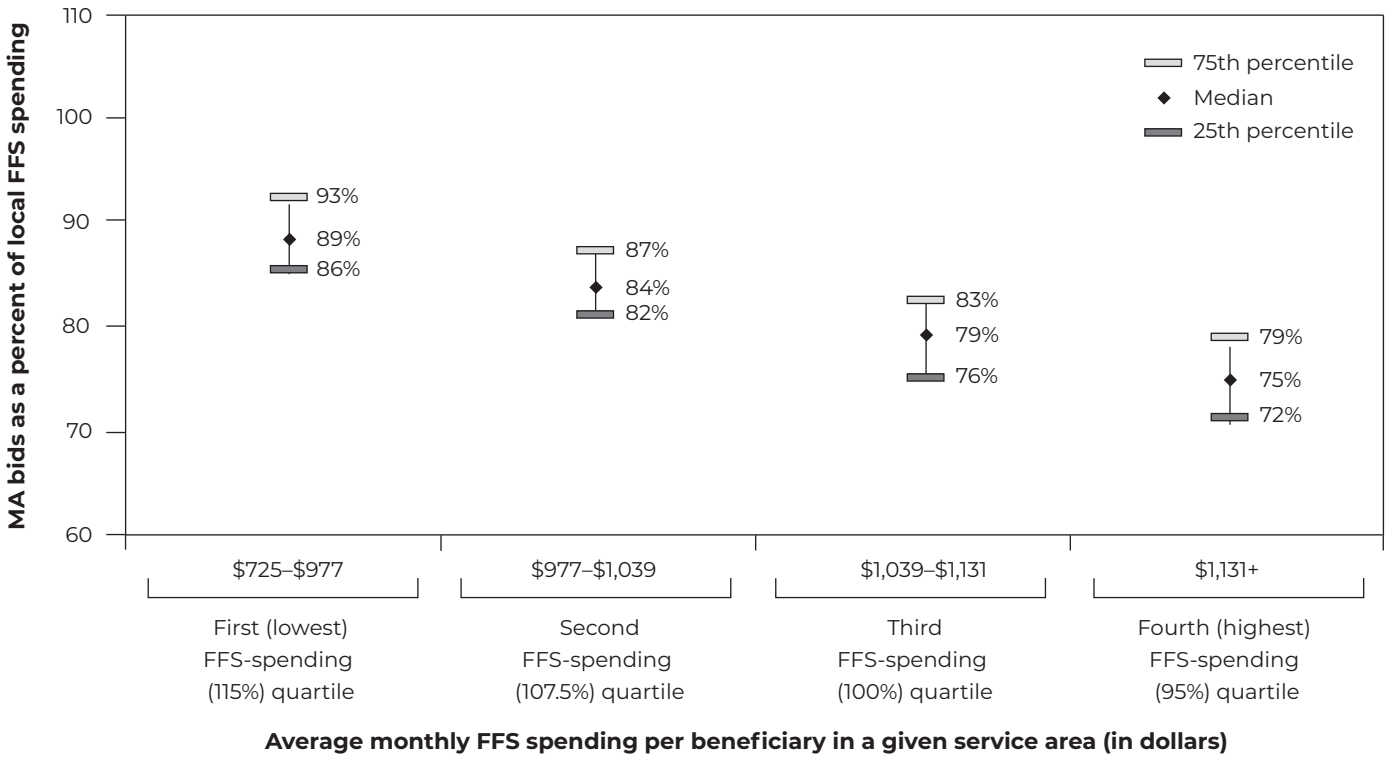
The Consolidated Appropriations Act, 2023, mandated that the Commission submit to the Congress by March 15, 2023, a comparison of MA and FFS per enrollee spending for at least the last five years for which data are available (see text box for the legislative language of the mandate, p. 345). The Act requires that the Commission analyze FFS spending calculated for MA benchmarks as well as spending for FFS beneficiaries enrolled in both Part A and Part B. In this section, we fulfill this mandate by describing our methods and results for two different analytic approaches to comparing MA and FFS spending:

- Our long-standing prospective method compares MA payments with FFS spending from 2004 through 2023 primarily using plan bid data and CMS's projections of FFS spending. This method analyzes both FFS spending as used to calculate MA benchmarks and FFS spending for beneficiaries enrolled in Part A and Part B.
- A new retrospective method compares actual MA payments and FFS spending from 2016 through 2019 primarily using actual plan payments reported by CMS, risk scores, and data on FFS claims and nonclaims payments. This method analyzes FFS spending for beneficiaries enrolled in both Part A and Part B.

Both our prospective and retrospective methods yield similar results and find that MA payments have been consistently higher than FFS spending. This finding

FIGURE 11–3

Medicare Advantage bids in relation to FFS spending levels, 2023



Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 4,308 plan bids and excludes employer group plans, special needs plans, and plans in the territories. Results were similar when including special needs plans. Percentages do not account for unaddressed coding intensity differences or the favorable selection of beneficiaries who choose to enter and remain in MA. The FFS spending denominator used in the figure includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B.

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

is consistent with previous Commission analyses that have found that private plans have never yielded aggregate savings for the Medicare program (Medicare Payment Advisory Commission 2022).[42]

Prospective method finds that aggregate Medicare payments to MA plans have never been lower than FFS Medicare spending

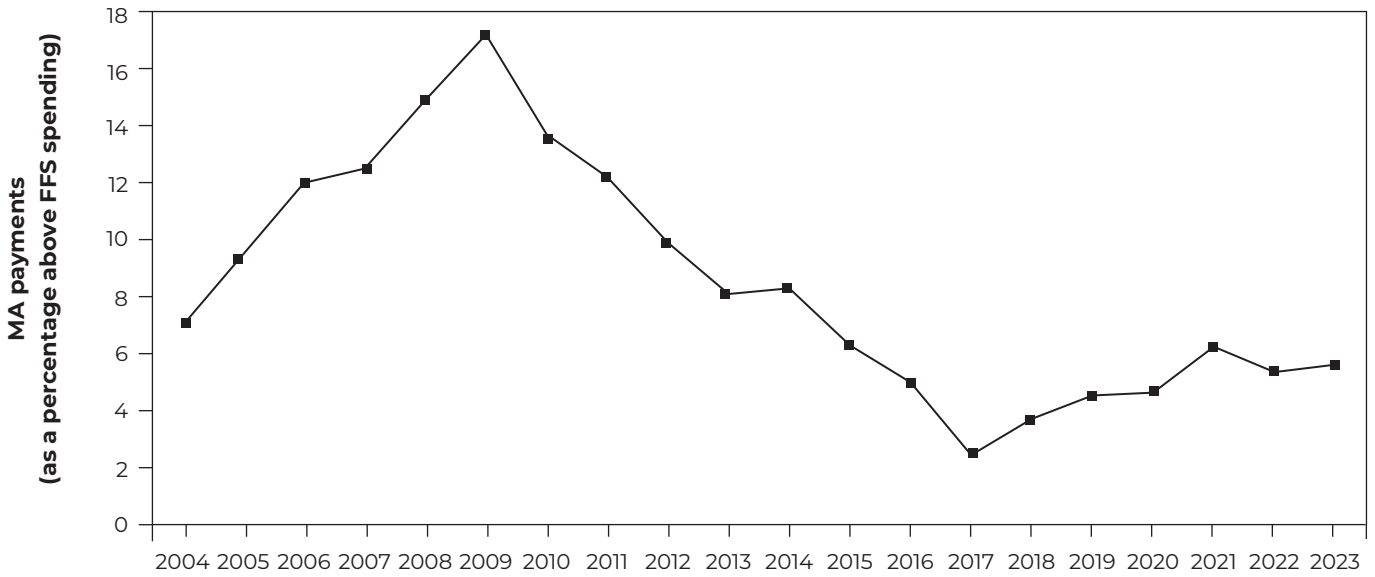
Since the introduction of bids and benchmarks in MA payment policy, the Commission has used the same general prospective method to compare plan benchmarks, plan bids, and the resulting payments to MA plans relative to projected FFS spending. The results for 2023 are shown in Table 11-6 (p. 340). Figure 11-4 (p. 344) shows that since 2004, estimated payments to MA plans continue to be above estimated FFS Medicare payments for similar beneficiaries. Our general approach compares the baseline spending of MA enrollees with a like set of FFS enrollees and then makes an adjustment for differences in diagnostic coding.

Prospective method step 1: Estimate base spending ratio

We compare how much Medicare spends on MA enrollees relative to how much Medicare would have spent on the same beneficiaries in the FFS program using a multi-part calculation. First, to estimate Medicare spending on the MA program, the Commission uses bid and benchmark data for all MA

FIGURE 11–4

Medicare spending on MA plans has been greater than FFS spending would have been for the same enrollees, 2004–2023



Note: MA (Medicare Advantage), FFS (fee-for-service). The estimates in the figure reflect the Commission's estimates of the impact of coding intensity, beginning in 2007; benchmark increases under the quality bonus demonstration from 2012 through 2014 and under the quality bonus program starting in 2015; and adjustments for MA enrollees with Medicare as a secondary payer starting in 2016. Estimates have not been adjusted for favorable selection of beneficiaries who choose to enroll in MA plans. We assume, conservatively, that the coding intensity impact for 2022 and 2023 is the same as for 2021 (the most recent year of data available). The Commission uses the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS spending figures are calculated by summing (1) risk-standardized Part A FFS monthly spending for all Part A enrollees and (2) risk-standardized Part B FFS monthly spending for all Part B enrollees. This method for calculating FFS spending includes all FFS beneficiaries, including those who are enrolled in only Part A or only Part B, and thus it is not perfectly comparable with the MA population. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in this figure includes all Part A and Part B spending. MA benchmarks, bids, and payments assume this level of FFS spending. We estimated that calculating FFS spending only for enrollees with both Part A and Part B would yield a result that is about 1 percentage point higher than the estimate of spending for all FFS enrollees.

Source: MedPAC reports to the Congress, 2006 through 2022, and MedPAC analysis of 2023 data from CMS on plan bids and FFS expenditures.

plans.[43] We calculate a payment rate for each plan that includes payments for Medicare-covered Part A and Part B services, plan rebates that fund extra benefits, and payments resulting from the quality bonus program. These MA payment rates reflect the projected MA enrollee risk scores in plan bid data. We then calculate total spending by multiplying each plan's estimated payment rate by the projected enrollment that plans also include in their bids.

Second, we estimate what Medicare would have spent had the same beneficiaries enrolled in the FFS program by using the county-level estimates of per beneficiary FFS spending that CMS produces to calculate the MA benchmarks (and publishes in the MA rate book). CMS generates these estimates by separately calculating per beneficiary FFS spending for Part A benefits (across all beneficiaries with Part A, including those who are not enrolled in Part B) and for Part B benefits (across all beneficiaries with Part B, including those who are not enrolled in Part A). CMS then risk standardizes the Part A and Part B estimates to reflect spending for an average beneficiary (with a 1.0 risk score) and sums the two amounts. CMS excludes spending for services that FFS provides but MA plans do not: hospice services, kidney acquisition costs, and graduate

Legislative language for the mandated report on spending

The applicable provision of the Consolidated Appropriations Act, 2023, is found under S8874 of the Senate congressional record and reads (in part):

DIVISION H—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2023 The explanatory statement accompanying this division is approved and indicates Congressional intent. Unless otherwise noted, the language set forth in House Report 117–403 carries the same weight as language included in this explanatory statement and should be complied with unless specifically addressed to the contrary in this explanatory statement. While some language is repeated for emphasis, it is not intended to negate the language referred to above unless expressly provided herein. In providing the operating plan required by section 516 of this Act, the departments and agencies funded in this Act are directed to include all programs, projects, and activities, including those in House Report 117–403 and this explanatory statement accompanying this Act. All such programs, projects, and activities are subject to the provisions of this Act. In cases where House Report 117–403 or this explanatory statement directs the submission of a report, that report is to be submitted to the Committees on Appropriations of the House of Representatives and the Senate.

House Report 117–403:

Report on Spending.—The Committee requests a report no later than the March 15th following the enactment of this Act comparing per enrollee spending on behalf of Medicare beneficiaries enrolled in the Medicare Advantage (MA) program and beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. In conducting such analysis, MedPAC shall evaluate at least the previous five plan years for which data is available. The analysis shall rely on data, as determined necessary, from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, MA bids, the Medicare Trustees, and any other sources to assess spending on the MA and FFS Medicare programs. MedPAC shall conduct this analysis using the method used by CMS in calculating spending on FFS for use in the calculation of MA benchmarks, as well as spending on FFS beneficiaries only enrolled in both Part A and Part B. MedPAC shall also provide a detailed description of their methodology for any spending comparison between FFS and MA, including, but not be limited to, a description of data sources used, inclusions or exclusions of populations or services, and any adjustments made to prices, utilization, or payments. ■

medical education (both direct and indirect).[44] We then calculate total spending by multiplying the county-level estimates of per beneficiary FFS spending by the projected MA enrollment in each county and the MA risk scores that plans include in their bids.

Third, we divide total MA spending by total FFS spending. For 2023, the base MA-to-FFS spending ratio is 1.007, which would indicate that—on a risk-adjusted basis—Medicare spends about 1 percent more on MA enrollees than it would spend to cover them in FFS, or MA payments (before coding estimates) are 101 percent of FFS spending (Table 11-6, p. 340). However, this base spending comparison does not account for the impact of diagnostic coding practices that inflate MA risk scores relative to FFS Medicare.

Prospective method step 2: Account for diagnostic coding differences

MA plans have a financial incentive to report all possible diagnoses for their enrollees, but providers in FFS generally do not.[45] The tendency of MA plans to

submit more diagnosis codes for their enrollees causes the risk scores for MA enrollees to be higher than the risk scores for FFS enrollees of similar health status. Higher MA risk scores for enrollees of equivalent health status has been well established by the Commission and by other researchers (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2012, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). In calculating the base MA and FFS spending estimates above, both estimates reflect MA risk score profiles; however, because of differences in diagnosis reporting, a 1.0 risk score in MA is not equivalent to a 1.0 risk score in FFS. Therefore, we adjust the MA-to-FFS Medicare base spending ratio to account for diagnostic coding differences.

The Commission has estimated the impact of differences in diagnostic coding on MA risk scores since 2007 (when the risk-adjustment model was implemented) and has found that MA risk scores generally have increased faster than FFS risk scores by about 1 percentage point per year.[46] MA risk scores in 2021 were about 10.8 percent higher than FFS risk scores due to coding differences. When determining plan payment rates, CMS historically has applied an adjustment that accounts for only a portion of this difference (e.g., 5.9 percentage points in 2021). The Commission and other researchers cited above all find that coding differences are larger than CMS's adjustment. The Commission's comparison of MA and FFS spending takes into account the remainder of the diagnostic coding difference (4.9 percent in 2021) by multiplying the MA-to-FFS base spending ratio by the ratio of MA-to-FFS coding differences (1.049). For example, in 2023, we multiply 1.007 by 1.049 to get an overall spending comparison showing that Medicare spending on MA is about 1.06, or 106 percent, of Medicare spending on FFS Medicare. Due to lags in data availability, our estimate of the impact of MA coding on MA payments is based on data that are two years old, and we conservatively assume that the impact of coding intensity did not change during that period (e.g., we used our estimate of coding intensity in 2021 in our analysis comparing MA payments with FFS spending in 2023).

The Commission's prospective comparison of MA to FFS spending accounts for differences in health status captured by risk scores (both spending estimates reflect the risk score profile in MA), geographic enrollment (both spending estimates reflect the geographic distribution of MA enrollment), covered services (both spending estimates exclude Medicare spending for hospice services, kidney acquisition costs, and direct and indirect graduate medical education), and diagnostic coding. As described in step 1, our comparison uses FFS spending as calculated by CMS for MA benchmarks, but the Commission also conducts a sensitivity analysis to estimate the effect of restricting CMS's FFS spending estimates to enrollees with both Part A and Part B.

Prospective method: Assess the impact of restricting FFS spending to enrollees with both Part A and Part B

We use CMS's county-level per beneficiary FFS spending amounts in our comparison because they are the basis for MA benchmarks and plans use benchmarks as the reference point for their bids. Hence, CMS's FFS estimates are the foundation of the MA plan payment rate calculation. Using a different method of calculating FFS spending would change benchmarks, and—in all likelihood—plans would alter their bids in response, leading to both different payment rates and a different estimate of MA aggregate spending. Thus, the Commission has used CMS's FFS spending estimates as calculated for benchmarks as the primary basis for comparing MA with FFS spending since the introduction of the current bidding system in 2004.

The method that CMS uses to produce its FFS estimates has been criticized because it includes beneficiaries who have Part A but not Part B, while MA enrollees are required to have both Part A and Part B. Part A–only beneficiaries have lower FFS spending than beneficiaries who have both Part A and Part B, so including them in the calculation results in lower FFS estimates. (The impact of Part B–only beneficiaries on the FFS spending estimate has been negligible.) The Commission has recognized this shortcoming in the CMS methodology and, in June 2017, recommended that CMS calculate MA benchmarks using FFS spending data only for beneficiaries with both Part A and Part B (Medicare Payment Advisory Commission 2017).

For 2017 through 2019, we used FFS claims data to estimate that risk-standardized, per beneficiary

FFS spending for beneficiaries with both Part A and Part B was roughly 1 percentage point higher than CMS's projection of FFS spending (as calculated for benchmarks). However, we do not apply this higher FFS spending estimate to our MA-to-FFS base spending ratio because we cannot accurately estimate how CMS's projections would have changed and what the resulting impact on MA spending would be. Specifically, higher FFS spending would increase MA benchmarks, and we cannot observe how plans would alter their bids in response to higher benchmarks. Instead, we present the impact of restricting FFS spending to beneficiaries with both Part A and Part B as a sensitivity analysis. Although the share of FFS beneficiaries who have Part A only has increased in recent years, Part A spending as a share of total FFS spending has declined more rapidly. As a result, the difference between FFS spending for beneficiaries with Part A and Part B and CMS's projected FFS spending for benchmarks has decreased slightly in recent years.

For our sensitivity analysis, we use historical claims data to (1) calculate the average risk-standardized Part A and Part B spending separately for beneficiaries with Part A and Part B coverage, Part A–only coverage, and Part B–only coverage by county, and to (2) make adjustments for beneficiaries with Medicare as a secondary payer. MA risk adjustment comprises a "full-risk" model that includes demographic characteristics and diagnoses and a "new-enrollee" model that includes demographic characteristics only. Beneficiaries with a full year of Part B coverage in the prior calendar year are assigned to the full-risk model, and all other beneficiaries are assigned to the new-enrollee model. CMS specifically designates Part A–only enrollees as new enrollees, and therefore Part A–only enrollees in FFS Medicare are used to calibrate the new-enrollee risk score model (Centers for Medicare & Medicaid Services 2021c, Pope et al. 2011). Thus, we risk standardize spending using the appropriate risk score—the full-risk score for beneficiaries with Part B in the prior year, and the new-enrollee score for Part A–only beneficiaries (reflecting that their average spending would be lower than the average beneficiary with both Part A and Part B coverage).

Beneficiaries with Medicare as a secondary payer (MSP) have lower Medicare spending because other health insurance generally pays for most of their health care services. CMS makes adjustments to plan bids and payments to plans with the intention of completely removing the effect of these beneficiaries having MSP. For FFS spending, we estimate the effect of MSP using two methods, and both methods produced nearly identical overall results. One method excludes beneficiaries with MSP, and the second method applies a weight factor to beneficiaries with MSP equal to the ratio of average spending for beneficiaries with MSP to average spending for beneficiaries with Medicare as primary payer. We estimate the effect of MSP separately for beneficiaries with Part A and Part B coverage, Part A–only coverage, and Part B–only coverage.

After risk standardizing and accounting for MSP, we calculate the percentage difference between the populations with Part A *or* Part B and the population with Part A *and* Part B, by county. We apply this factor to CMS's county-level projections of FFS spending. Because we do not know with certainty how CMS's projection of FFS spending (and consequently MA payments) would change if benchmarks were calculated using FFS spending for beneficiaries with both Part A and Part B, the degree to which MA payments exceed FFS spending for the MA-eligible population would be best understood through a retrospective analysis examining actual MA and FFS spending over multiple years.

Retrospective comparisons of actual MA and FFS spending are consistent with the Commission's prior prospective estimates

Our long-standing method of comparing MA payments with FFS spending has some limitations because it relies on projected estimates of MA and FFS spending, includes beneficiaries who are not eligible for MA enrollment, and uses an MA coding intensity estimate from two years prior. This year, we therefore conducted a retrospective analysis that compares actual MA plan payments from 2016 through 2019 with actual FFS spending for MA-eligible beneficiaries.[47] Our retrospective comparison of MA payments with FFS spending produced results that are consistent with our originally published prospective comparison of MA with FFS spending for those years.

In conducting our retrospective analysis of actual MA payments and FFS spending for 2016 through 2019, we restricted our analysis to beneficiaries who had both Part A and Part B coverage, had Medicare

TABLE 11–8

Retrospective comparisons of MA payments relative to FFS spending are consistent with the Commission's originally published estimates

	MA payments as percent of FFS spending			
	2016	**2017**	**2018**	**2019**
Before accounting for coding differences				
Prospective (as originally published)	102%[a]	100%[b]	101%[c]	100%[d]
Retrospective (MA-eligible beneficiaries)	103	101	100	101
After accounting for coding differences				
Prospective (as originally published with two-year lag)	*	104[b]	103[c]	102[d]
Retrospective (MA-eligible beneficiaries)	106	103	102	104

Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates have not been adjusted for favorable selection of beneficiaries who choose to enroll in MA plans (i.e., underlying differences in risk-standardized spending between the MA and FFS populations that are not captured by risk scores, which would increase MA payments relative to FFS spending). The table reflects the Commission's estimates of the impact of coding intensity in each year. Retrospective estimates include both claims and nonclaims FFS spending. Retrospective estimates are restricted to beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. Prospective estimates use the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS spending figures are calculated by summing (1) risk-standardized Part A FFS monthly spending for all Part A enrollees and (2) risk-standardized Part B FFS monthly spending for all Part B enrollees. In contrast with Figure 11-5, employer plans are not included in the results in the table. Our originally published prospective estimates did not include employer plans because, as of 2017, these plans stopped submitting bids. As shown in Figure 11-5, including employer plans would increase MA payments relative to FFS spending by about 1 percentage point in each year. Prospective estimates of coding are our most recent estimates (from two years prior) at the time of publication of the Commission's annual March report to the Congress. Retrospective estimates of coding differences reflect the actual coding estimate for each given year.
*In our March 2016 report, the Commission did not publish a 2016 estimate of the impact of coding intensity on MA payments relative to FFS spending.
[a]Table 12-4 of the Medicare Payment Advisory Commission's *Report to the Congress: Medicare payment policy*, 2016.
[b]Table 13-6 of the Medicare Payment Advisory Commission's *Report to the Congress: Medicare payment policy*, 2017.
[c]Table 13-4 of the Medicare Payment Advisory Commission's *Report to the Congress: Medicare payment policy*, 2018.
[d]Table 13-3 of the Medicare Payment Advisory Commission's *Report to the Congress: Medicare payment policy*, 2019.

Source: MedPAC analysis of data from CMS on risk scores, plan bids, plan payments, and FFS expenditures from 2016 through 2019.

as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia.[48] After applying these restrictions, our analysis included 89 percent of MA-eligible enrollees each year during the study period.[49]

For each MA plan, CMS publishes risk-standardized base payment rates (reconciled for actual county-level plan enrollment) and rebate amounts. To calculate total MA spending, we multiplied risk-standardized base payment rates by each beneficiary's final risk score and actual number of months of MA enrollment, then added rebate amounts multiplied by actual MA enrollment months. The sum of all base payments and rebates was reduced by 2 percent to reflect sequestration adjustments that occurred in all four years of the analysis. Finally, we added Medicare's supplemental payments to federally qualified health centers (FQHCs) for MA enrollees.[50]

To calculate actual FFS spending, we summed beneficiary spending from adjudicated claims for Part A and Part B services (removing hospice and medical education payments), provider settlement amounts (e.g., reconciled payments after cost reports are submitted), provider incentive payments (e.g., shared savings), and CMS's most recent estimate of FFS administrative claims costs.[51] We then risk standardized the average FFS spending within each county using final beneficiary risk scores.[52] Similar to our prospective method, we multiplied the risk-standardized county-level per beneficiary FFS spending by the actual MA enrollment and final MA risk scores in each county.

Finally, we estimated MA payments relative to FFS spending by dividing the sum of MA spending by the sum of FFS spending and then multiplied this ratio by our estimate of MA coding intensity for the respective year. Our retrospective method accounts for both geographic enrollment and risk score differences between MA and FFS.

Comparing prospective and retrospective method results

Our original prospective MA-to-FFS spending comparison results for 2017 through 2021 did not include employer plans because, as of 2017, these plans no longer submit bids, and the results prior to 2021 did not include an adjustment for plans' enrollees with MSP. Starting with our March 2022 report, we revised our prospective comparison method for 2022 to incorporate employer plans and to make an adjustment for MA enrollees with Medicare as a secondary payer.[53] At that time, we also revised estimates for 2016 to 2021 to account for Medicare as a secondary payer and revised estimates for 2017 to 2021 to incorporate employer plans.[54] For transparency, first we present a comparison of the results from our prospective method—as originally published—and the results from our retrospective method, and then we present a comparison of our revised prospective method and retrospective method. To align more closely with the two prospective methods, the retrospective analysis excluded employer plans when comparing with the original prospective method but included them when comparing with the revised prospective method. All results show that MA payments were higher than FFS spending from 2016 through 2019.

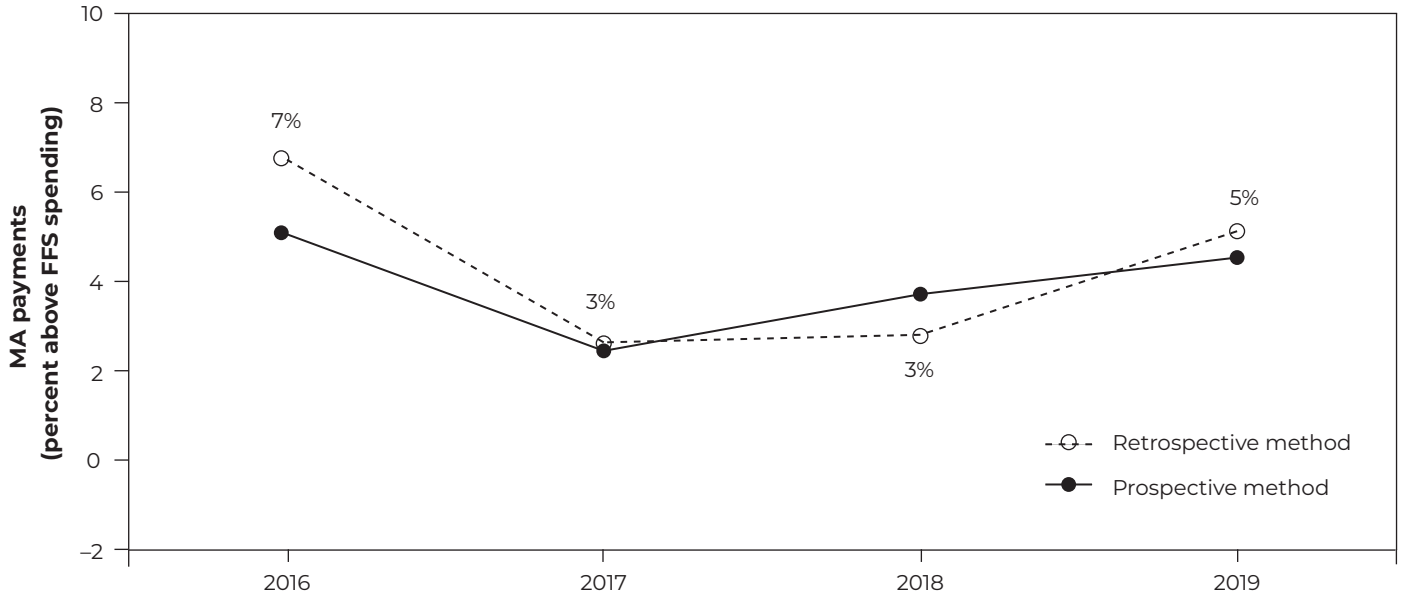
Comparing prospective (as originally published) and retrospective results Consistent with our originally published prospective analyses, a retrospective comparison shows that MA payments were higher than FFS spending from 2016 through 2019 (Table 11-8). These estimates confirm that our prospective estimates were reasonably accurate during the period. In fact, our retrospective estimates were nearly the same as the prospective estimates we originally published (Medicare Payment Advisory Commission 2019b, Medicare Payment Advisory Commission 2018c, Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016). We note that when originally published, our MA-to-FFS comparison did not include employer plans (2017 through 2019), and our FFS spending estimate did not make an adjustment for the risk scores of MA enrollees with Medicare as a secondary payer (2016 through 2019). Therefore, the retrospective results shown in Table 11-8 exclude employer plans to match our original method more closely. (It was not possible to account for Medicare as a secondary payer in the retrospective analysis in a way that is consistent with the original prospective method.) In addition, our original prospective estimates assumed that the level of coding intensity in MA plans would be the same as it had been two years before the payment year (due to data availability constraints). The retrospective analysis incorporates the actual impact of coding differences in the payment year.

Comparing revised prospective and retrospective results A more precise comparison of MA and FFS spending from 2016 through 2019 includes employer plans and incorporates an adjustment for Medicare as a secondary payer, which we have implemented in both our revised prospective analysis and retrospective analysis shown in Figure 11-5 (p. 350). Using this method, MA payments were higher than FFS spending for all years from 2016 through 2019 (Figure 11-5).[55] Under the revised prospective method, MA payments relative to FFS spending increased by about 1 percentage point in each year compared with the original prospective method. For example, actual 2018 MA payments relative to actual FFS spending were 102 percent (including coding intensity) using our original method, and they were 103 percent after including employer plans. In general, the revised prospective method matches the retrospective method more closely than the original method. Without taking into account the favorable risk-adjusted mix of beneficiaries in MA plans, the estimates in Figure 11-5 represent our best estimate of MA payments relative to FFS spending during the period.

While our retrospective and prospective estimates were very similar during this period, this pattern would likely not hold for the years during the coronavirus PHE. CMS's projection of FFS spending and MA bid and risk score projections were likely overestimated during the PHE. We will continue to update our retrospective comparison of MA payments relative to FFS spending as more recent data become available.

FIGURE 11–5

Revised prospective and retrospective comparisons show MA payments consistently higher than FFS spending, 2016–2019



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates have not been adjusted for favorable selection of beneficiaries who choose to enroll in MA plans (i.e., underlying differences in risk-standardized spending between the MA and FFS populations that are not captured by risk scores, which would increase MA payments relative to FFS spending). The figure reflects the Commission's estimates of the impact of coding intensity in each year. Retrospective estimates include both claims and nonclaims FFS spending. Retrospective estimates are restricted to beneficiaries who had both Part A and Part B coverage, had Medicare as their primary payer, did not have end-stage renal disease, and resided in the 50 states and the District of Columbia. In contrast with Table 11-8, retrospective estimates include payments to employer plans. In addition, prospective estimates are revised to reflect payments to employer plans and adjustments for MA enrollees with Medicare as a secondary payer. Prospective estimates use the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS spending figures are calculated by summing (1) risk-standardized Part A FFS monthly spending for all Part A enrollees and (2) risk-standardized Part B FFS monthly spending for all Part B enrollees.

Source: MedPAC analysis of data from CMS on risk scores, plan bids, plan payments, and FFS expenditures from 2016 through 2019.

Additional considerations for comparing MA and FFS spending

Administrative expenses

We do not make a separate adjustment for administrative expenses when comparing MA and FFS spending in the prospective method. In MA, plans incorporate administrative expenses in their bid, including claims costs and other costs necessary for plan operations and plan profits. In FFS, the costs of processing and adjudicating FFS claims (including operations by the Medicare administrative contractors) are already included in the FFS spending estimate. The retrospective method matches this approach by adding CMS's estimate of administrative claims processing costs to the FFS spending estimate.

Our FFS spending estimate does not include Medicare's nonclaims administrative costs because doing so would erroneously add administrative expenses to the FFS Medicare spending estimate that are unrelated to FFS Medicare spending (such as costs for maintaining the MA program; costs to cover the Part B premium for eligible Medicaid enrollees; costs for fraud and abuse oversight by the Department of Health and Human Services, Office of Inspector General (OIG), the Department of Justice (DOJ), and the Federal Bureau of Investigation across the entire Medicare program; and funding for a host of other projects and agencies that are not related to spending within the FFS program).[56] The Commission's estimates include only the costs necessary to directly pay for services in each program.

Favorable risk selection

The risk scores of MA and FFS enrollees are not completely comparable in part because beneficiaries who choose to enroll in an MA plan tend to be more profitable for the plan than beneficiaries who remain in FFS Medicare (due to costs that are much lower than predicted by their risk scores). Favorable risk selection bias has been found in studies showing that FFS beneficiaries who chose to switch to MA had lower-than-average risk-adjusted FFS spending before entering MA (Jacobson et al. 2019, Medicare Payment Advisory Commission 2012a). The favorable selection that MA plans experience is separate from effects of higher MA coding intensity, and the effects of the two phenomena are additive. In our analysis, we account for overall diagnostic coding differences between MA and FFS but not favorable selection in MA. Thus, risk-adjusted MA baseline spending is likely higher than we estimated and the difference between MA and FFS spending is likely greater. As we have recently observed that beneficiaries who enroll in an MA plan had lower-than-average risk-adjusted FFS spending in all years prior to joining the plan, we hope to estimate the magnitude of the favorable mix of beneficiaries who enter and remain in MA plans in a future analysis.

Coding differences increased payments to MA plans by $17 billion in 2021 and generated rebate inequity across plans

Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. Risk scores are based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing plans' monthly payments and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans.

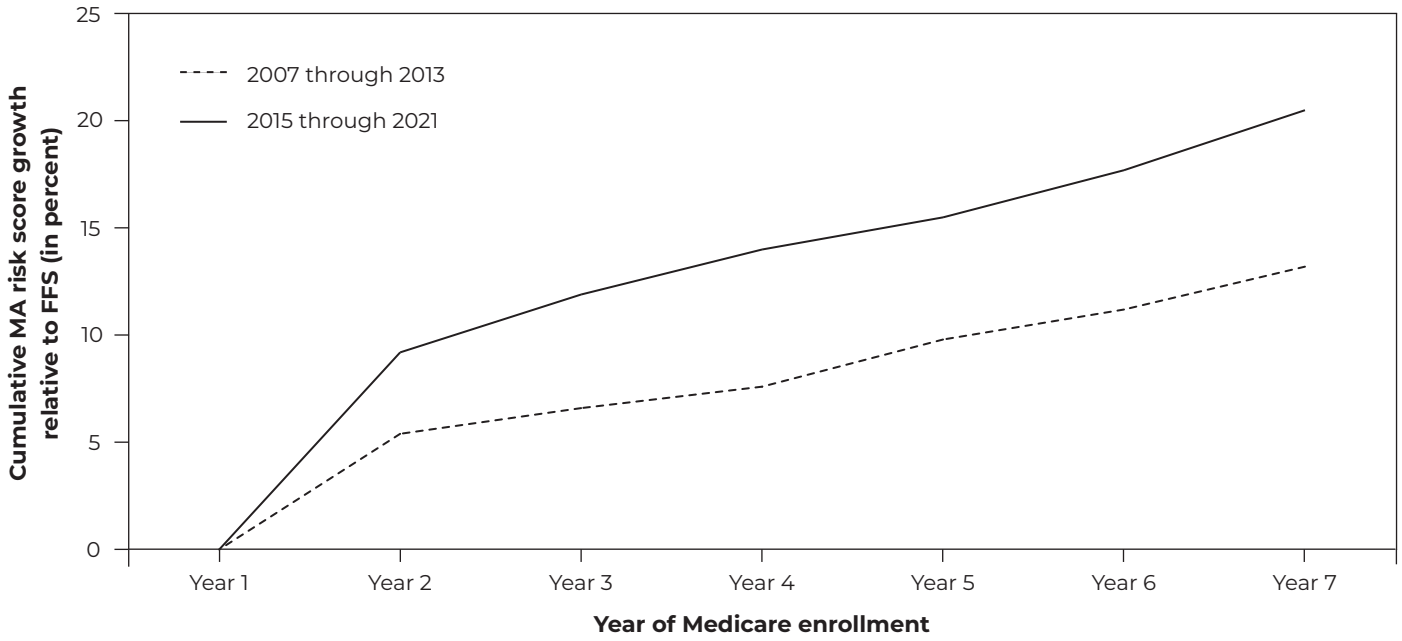
Documenting more diagnosis codes increases payments to plans

Among the 20 most common HCCs in MA—which have reimbursement amounts ranging from roughly $1,000 to $5,500—the average additional payment per HCC is about $3,400 per year. Documenting each additional HCC for an enrollee can thus significantly increase Medicare payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan using average FFS Medicare spending.[57] For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at $6,726) with diabetes without complication (HCC 19, valued at $1,284) would have been $8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at $3,620), the Medicare annual payment to the MA organization would increase to $11,630.

Because the CMS–HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported on physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses for FFS beneficiaries. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have been if the diagnoses had been reported. For MA payments to be accurate, diagnoses must be coded with the same intensity in FFS Medicare and MA. When MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS. Because of the increased financial incentives for MA plans to code as many diagnoses as possible and the additional tools that MA plans use to capture diagnoses—which are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended. Although Medicare's accountable care organization (ACO) programs and some other alternative payment models (APMs) offer incentives to increase diagnostic coding intensity in FFS Medicare, we have yet to see a measurable impact on the difference between MA and FFS coding intensity overall. The tools that ACOs and APMs have available are far less effective than those in MA; notably,

FIGURE 11–6

In the first year of MA enrollment, beneficiaries' average risk scores relative to those in FFS increased sharply, and they continued to rise in subsequent years



Note: MA (Medicare Advantage), FFS (fee-for-service). Analysis of 2007 through 2013 includes six MA and FFS cohort pairs starting in 2007 through 2012 and ending in 2013. Analysis of 2015 through 2021 includes six MA and FFS cohort pairs starting in 2015 through 2020 and ending in 2021.

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

chart reviews, in-home health risk assessments, and subcapitation to medical groups are used only in MA. Thus we expect that FFS coding will continue to identify fewer diagnosis codes than MA coding.

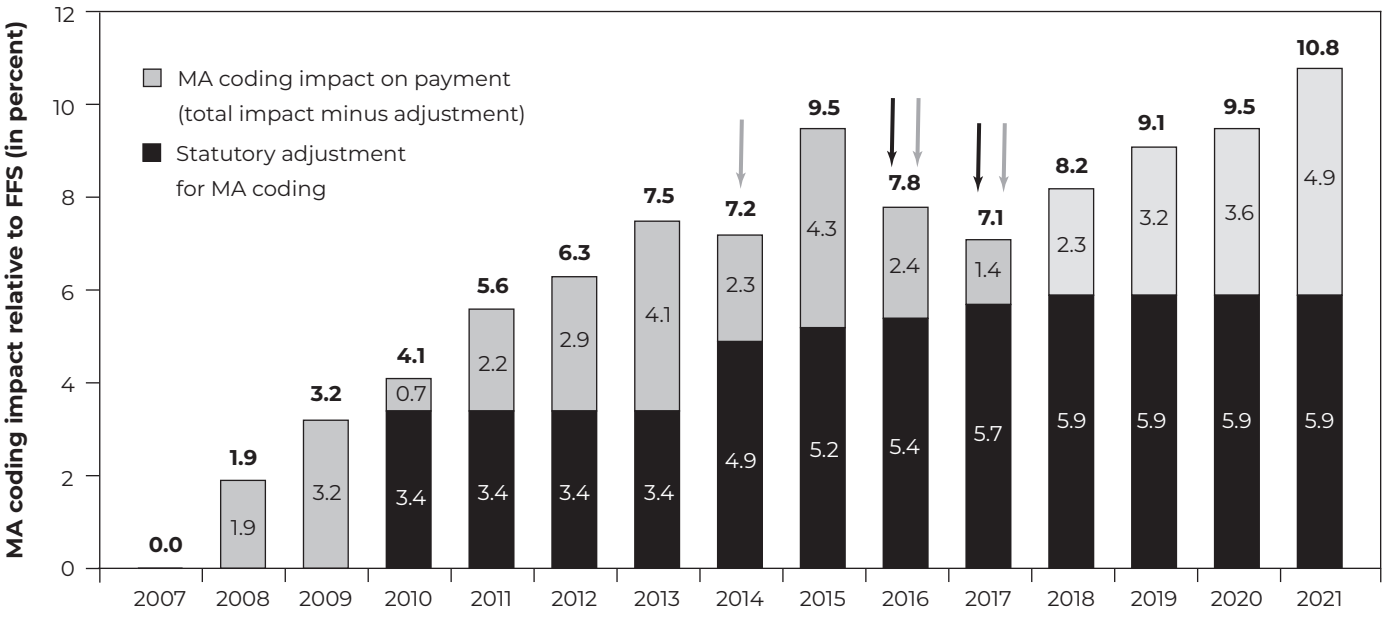
We analyzed enrollment cohorts from 2007 through 2013 to test whether beneficiary risk scores grew faster in MA than in FFS. Among a cohort of beneficiaries who enrolled in FFS Medicare and whose first full year of Medicare enrollment was 2007, we compared beneficiaries who remained in FFS through 2013 with those who switched to MA in their second year and remained in MA through 2013.[58] In the first year after switching to MA (year 1 to year 2), average MA risk scores increased by about 6 percent more than FFS scores across all cohorts (Figure 11-6). For each subsequent year in MA, average MA risk scores continued to increase more than FFS scores by about 1.5 percent across all cohorts.

We repeated this analysis for enrollment cohorts from 2015 through 2021, defining FFS and MA cohort pairs the same way as in the 2007 through 2013 analysis. The results of our second analysis show that differences in MA and FFS coding practices across all cohorts have continued to diverge, with MA risk scores increasing about 9 percent more than FFS scores in the first year and increasing by about 2.3 percent more than FFS scores in each subsequent year.

MA plans are reacting to financial incentives to document all of an enrollee's diagnoses that are accurate and properly supported by medical evidence. MA plans that report inaccurate diagnoses for the purpose of receiving unwarranted payments risk financial penalty if inaccurate diagnoses are discovered during risk-adjustment data validation audits (see "Risk-adjustment data validation," p. 362).

FIGURE 11–7

Impact of coding intensity on MA risk scores was larger than coding adjustment, 2007–2021



MA coding intensity increased MA risk scores by 1 percentage point annually but was offset by new risk-adjustment model versions in 2014, 2016, and 2017 (gray arrows) and by increased FFS coding in 2016 and 2017 (black arrows).

Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age and sex between MA and FFS populations. Annual adjustment for MA coding began in 2010.

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

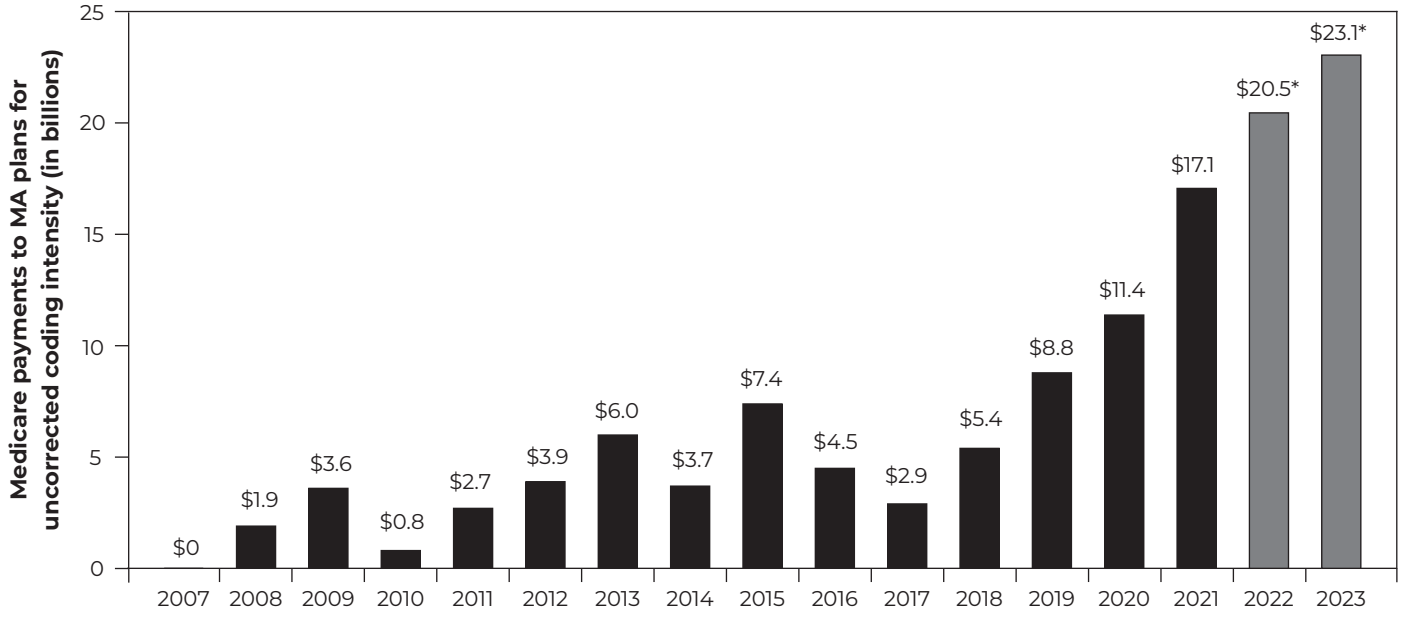
In 2021, coding differences increased payments to MA plans by $17 billion

Inflated MA payments due to coding differences have been under scrutiny for more than a decade. Starting in 2010, a series of congressional mandates required CMS to reduce MA risk scores to address the impact of MA and FFS coding differences on payments to MA plans. Because of these mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to about 5.9 percent in 2018, where it will remain until the Secretary of Health and Human Services implements risk adjustment using MA diagnostic, cost, and use data. Although larger reductions are allowed under the legislation, CMS reduced MA risk scores by only the minimum amount required by law for 2014 through 2023.[59] In 2023, CMS will reduce MA risk scores by 5.9 percent.

Figure 11-7 shows, for 2007 through 2021, the impact of differences in coding intensity on MA risk scores relative to FFS and the size of the coding intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity).[60] During that period, coding intensity consistently increased MA risk scores by about 1 percentage point or more annually; however, the underlying trend was offset in 2014, 2016, and 2017 by the introduction of new versions of the risk-adjustment model and by more intensive FFS coding. The coding intensity adjustment has never fully

FIGURE 11–8

Uncorrected MA coding intensity has generated $80 billion in payments to plans through 2021 and is projected to generate nearly $44 billion more in 2022 and 2023



Note: MA (Medicare Advantage). Estimates for 2007 through 2021 are based on the Commission's estimate of uncorrected coding intensity and Medicare spending for MA plans from the Medicare Trustees' reports.
*The 2022 and 2023 estimates incorporate the conservative assumption that uncorrected coding intensity will be the same as in 2021 (4.9 percent, although all evidence suggests that it will be larger) and are based on projected Medicare spending for MA plans from the 2022 Medicare Trustees' report.

Source: MedPAC analysis of CMS enrollment and risk score files, and Medicare Trustees' reports, 2017 and 2022.

accounted for the impact of coding intensity on MA risk scores, resulting in continued excess payments to MA plans relative to FFS spending for similar enrollees.

For 2021, MA risk scores were 10.8 percent above FFS risk scores, and this difference was only partially offset by the coding intensity adjustment that reduced MA risk scores by 5.9 percent. The net effect was a 4.9 percent increase in MA risk scores, leading to $17 billion in excess payments to MA plans. The magnitude of these findings is consistent with most other research showing that the impact of coding differences on MA risk scores is larger than CMS's adjustment for coding (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Kronick and Welch 2014). One analysis using a unique method found that coding intensity resulted in MA risk scores that were 20 percent above FFS risk scores in 2019 (Kronick and Chua 2021).

Expressed as a trend, MA coding intensity increases MA risk scores by 1 percentage point per year more than the FFS risk score trend (the trend was about 1.25 percentage points per year higher from 2007 through 2013 and about 1 percentage point per year higher from 2017 through 2021). However, Figure 11-7 (p. 353) shows deviations from this trend in 2014, 2016, and 2017, which we attribute to two factors: (1) new versions of the risk-adjustment model that were less susceptible to MA and FFS diagnostic coding differences were introduced in 2014, 2016, and 2017; and (2) FFS risk scores grew faster in 2016 and 2017 than in prior and subsequent years

(matching or nearly matching MA risk score growth rates), likely due to Medicare's transition from using International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes in October 2015. See our March 2021 MA chapter for a more detailed explanation of these factors (Medicare Payment Advisory Commission 2021c).

Between 2007 and 2023, we estimate that MA coding intensity will have caused nearly $124 billion in aggregate excess payments to MA plans (Figure 11-8). Between 2007 and 2021, MA coding intensity resulted in $80 billion in excess payments to MA plans. Conservatively assuming that uncorrected coding intensity (coding intensity in excess of the adjustment) will remain the same in 2022 and 2023 as in 2021 (4.9 percent, although all evidence suggests that it will be larger), uncorrected coding intensity in 2022 and 2023 will add another $20 billion and $23 billion, respectively. (We noted earlier that, in 2023, Medicare will pay MA plans a total of $27 billion more than it would spend if those beneficiaries were enrolled in FFS Medicare; $23 billion of that total is due to MA coding intensity.)

Documenting additional diagnosis codes increases plan rebates and can undermine competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more extra benefits than if fewer diagnostic codes had been documented for the same set of enrollees. For a plan submitting a bid below its benchmark (nearly all plans in 2022), the plan's rebate is based on the difference between the plan's bid for its expected enrollee population and the plan's risk-adjusted benchmark, which is the standard benchmark (for a beneficiary of average risk, with a 1.0 risk score) multiplied by the plan's expected average risk score. Raising a plan's average risk score raises the plan's risk-adjusted benchmark and widens the difference between the plan's bid and risk-adjusted benchmark, thereby increasing the plan's rebate amount and ability to offer more extra benefits. In sum, plans can translate greater coding effort into the ability to offer more extra benefits than their competitors and can gain a competitive advantage in attracting enrollees.

MA payment policies use the ability to offer more extra benefits as an incentive for plans to lower spending and improve quality. By reducing health care costs, plans can reduce their bids, increasing their rebate and extra benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase in their benchmark or with an increase in the rebate percentage (the percentage of the bid and benchmark difference that determines the rebate amount). These policies are supposed to benefit beneficiaries through improved quality, more extra benefits, and reduced premiums, and the policies are intended to lower taxpayer funding for the Medicare program. Greater MA coding intensity, however, undermines these incentives by allowing plans to offer more extra benefits without reducing health care costs or improving quality.

Table 11-9 (p. 356) illustrates the relationship between coding intensity and rebate amounts using a hypothetical example of three plans covering the same set of enrollees for whom the expected cost of care is the same, at $900 per member per month. Plans A and Z have an expected risk score of 0.97, and Plan B has an expected risk score of 1.03 due to more aggressive diagnostic coding. All three plans have bids below the risk-adjusted benchmark and must provide extra benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's rebate ($52 per month vs. $15 per month), so it can offer enrollees more extra benefits. Plan B's aggressive diagnostic coding effort has therefore given it an unfair competitive advantage over Plan A.

In addition, aggressive coding can result in greater extra benefits than the effect of MA quality bonuses. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z, which has 5 stars: Plan B's rebate amount is higher than Plan Z's ($52 per month vs. $49 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer more extra benefits than that provided through quality bonuses.

The plans illustrated in Table 11-9 (p. 356) have a risk score difference of 6 percentage points, reflecting different coding practices. We analyzed MA contracts (MA organizations can offer one or more plans under each contract with Medicare) and found much greater variation in coding for 2021.[61] Figure 11-9 (p. 357) shows contract-level coding intensity relative to FFS coding in the same counties served by the contract, excluding contracts in the Program of All-Inclusive Care for the

TABLE 11–9

Illustrative example: A plan that codes diagnoses more aggressively can offer its enrollees more extra benefits

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	Monthly MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted monthly benchmark (benchmark multiplied by risk score)	Difference in risk-adjusted benchmark and plan bid	Monthly value of extra benefits (rebate amount)*
Nonbonus plans						
Plan A (3.5 stars)	$900	0.97	$952	$923	$23	$15
Plan B (3.5 stars)	900	1.03	952	981	81	52
Bonus plan						
Plan Z (5 stars)	900	0.97	1,000	970	70	49

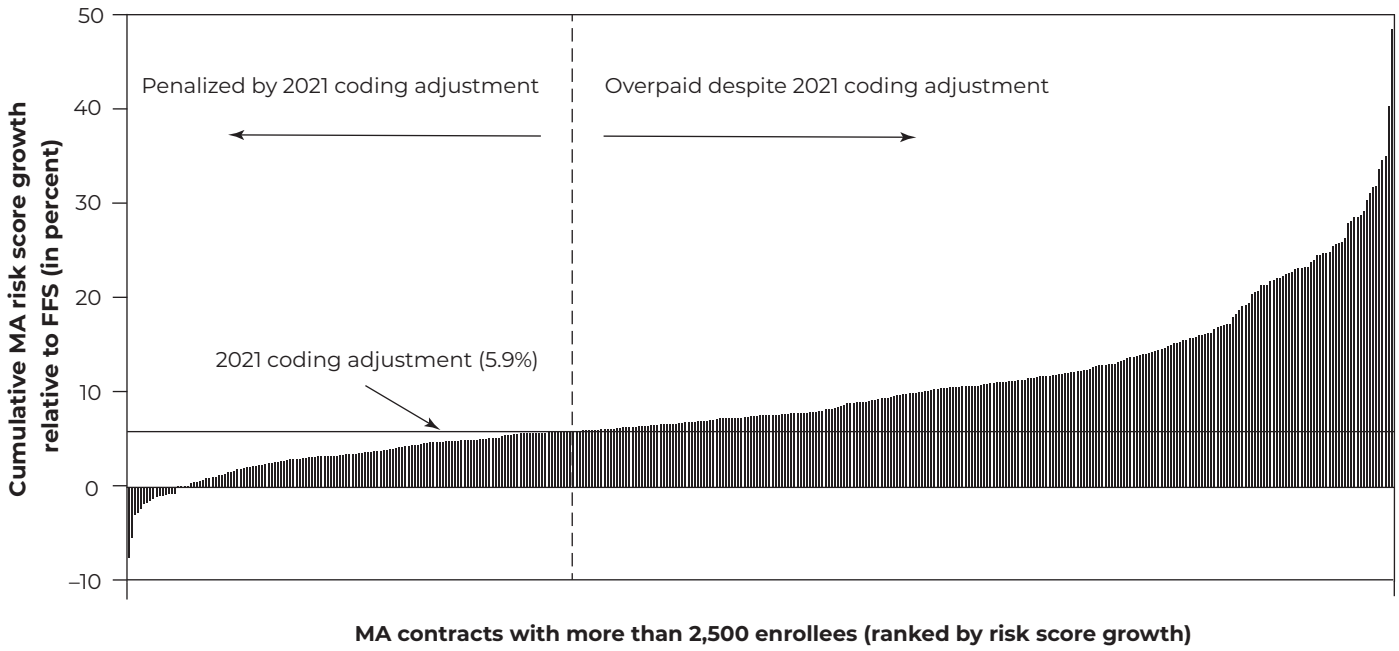
Note: MA (Medicare Advantage). Under the MA quality bonus program, plans with a star rating of 4 or more stars, "bonus plans," receive a bonus increase to their benchmark. Plans with fewer than 4 stars are referred to as "nonbonus plans." An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is $900 monthly for each of the three plans and that the plans serve the same beneficiaries. Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.
*Plans A and B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

Elderly, special needs plans, and contracts with fewer than 2,500 enrollees.

Consistent with prior years, nearly all MA contracts had coding intensity greater than FFS, and the share of MA contracts that are overpaid after accounting for the coding adjustment continues to increase. To illustrate the relative advantage for higher-coding plans, we note that the difference between the MA contracts at the 25th and 75th percentile is more than 7 percentage points, and the difference between contracts in the 10th and 90th percentile is more than 19 percentage points. Our finding that coding intensity varies across MA contracts is consistent with other research and is consistent with the Office of Inspector General's (OIG's) findings that use of chart reviews and health risk assessments—accounting for nearly two-thirds of MA coding intensity, by our estimate—varies widely across MA organizations (Geruso and Layton 2015, Kronick and Welch 2014, Office of Inspector General 2021). These differences are large enough to give contracts with higher coding intensity a significant competitive advantage by inflating the size of plan rebates and helping them to attract more enrollees. In addition, different coding intensity levels demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by reducing net revenue (coding intensity–based payments minus CMS's coding intensity adjustment) for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

We also analyzed whether such coding differences exist across MA organizations (which can have multiple contracts with Medicare) and found that some companies offering MA plans have a significant competitive advantage over others. Figure 11-10 (p. 358) shows that among the eight largest MA organizations (covering 77 percent of MA enrollees), there is a more than 9 percentage point difference in average coding intensity, with average coding intensity of about 15 percent above FFS levels for three of the organizations, and average coding intensity between 6 percent and 10 percent above FFS for the other five large organizations. All eight of these organizations had greater coding intensity than the 5.9 percent coding adjustment and therefore received excess payment due to aggressive coding practices.

FIGURE 11–9 **Cumulative MA risk score growth varied across contracts relative to local FFS, 2021**



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and contracts with enrollment of less than 2,500. Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007.

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

MA plans have several ways to code more diagnoses than their FFS counterparts

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. They can identify enrollees likely to have an HCC that has not yet been documented using data the plan already has: an enrollee's historical claims, risk score data, and prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Of all the mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews as major sources of plan revenue from coding intensity.

Pay-for-coding programs and patient assessment forms

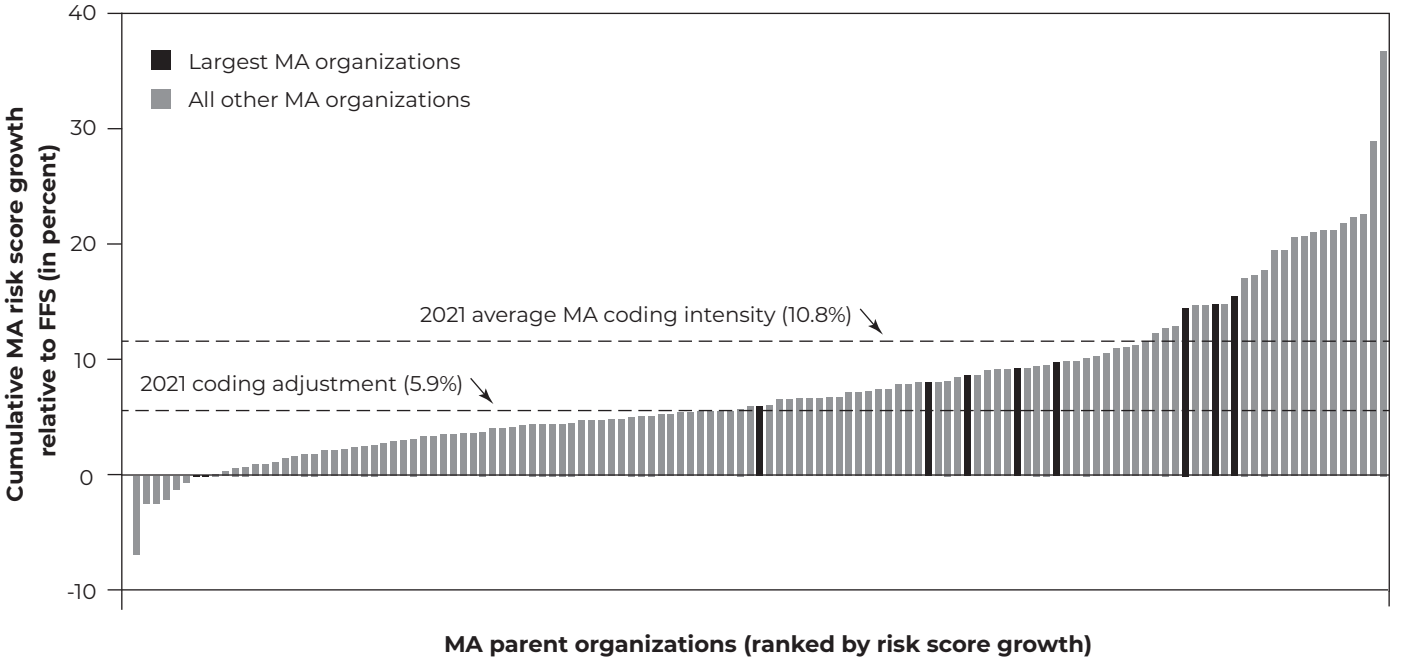
Some plans try to ensure that providers submit all possible diagnoses for their enrollees through pay-for-coding programs in which plans send physicians a patient assessment form that includes diagnosis codes that the plan has identified for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Plans pay physicians based on completing the form or as a dollar amount per diagnosis code submitted, and some plans include a bonus payment for submitting every code that the plan identifies for a beneficiary.

Capitated arrangements in California and Florida tend to exacerbate coding intensity

In the course of reviewing our coding intensity estimates by MA organization, we found that several organizations with the highest diagnostic coding relative to FFS are located in California and Florida. Hence, we identified 23 MA organizations offering plans

FIGURE 11–10

Cumulative MA risk score growth varied across the 8 largest MA organizations relative to local FFS, 2021



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and parent organizations with enrollment below 2,500. Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007.

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

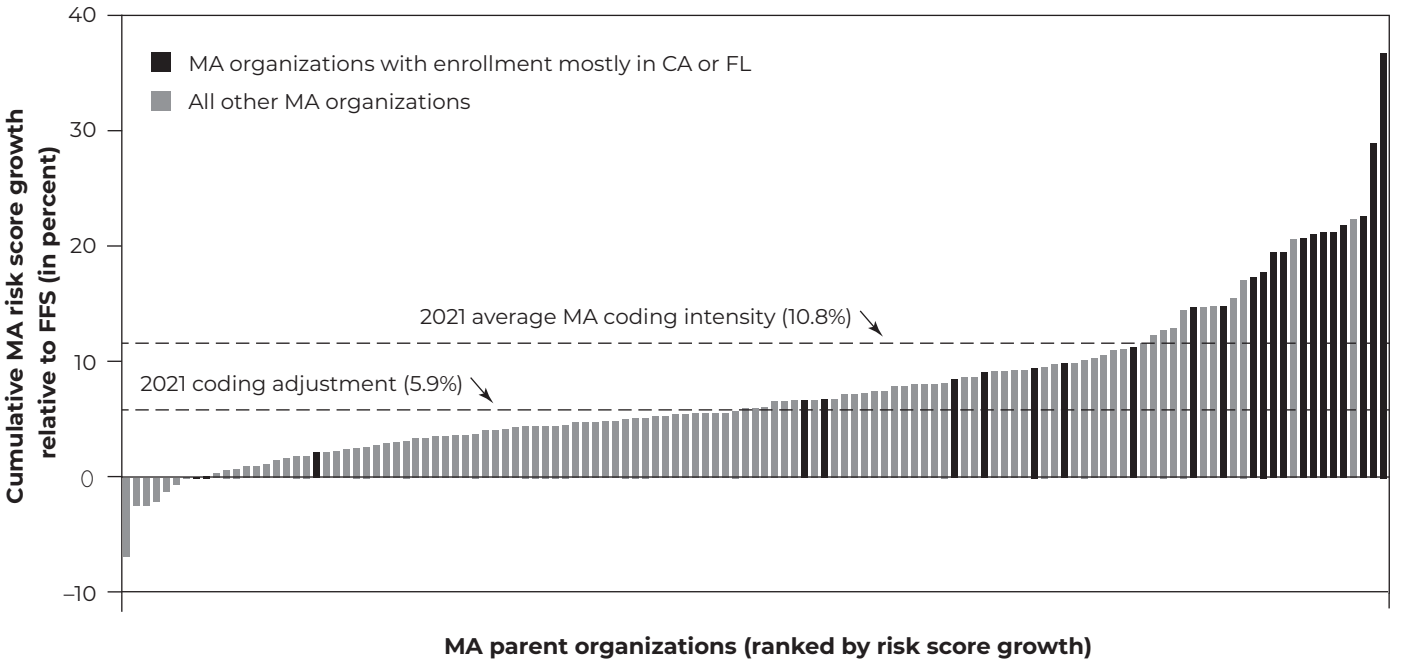
primarily in California and Florida (i.e., organizations with a majority of their enrollment in California or Florida, excluding the eight largest MA organizations) and found that many have among the highest levels of coding intensity of all MA organizations. Twelve of the 14 organizations with the highest coding intensity offer plans primarily in California and Florida (Figure 11-11).

To address why these California- and Florida-focused organizations account for so many of the highest-coding organizations, we considered that health plans in California and (to a somewhat lesser extent) Florida have long participated in a form of capitated payment for providers known as the "delegated model." Under the delegated model, the responsibility for health care delivery and associated financial risk are delegated by the plan to a medical group or independent physician association. Typically, a plan pays a medical group a risk-adjusted sum per enrollee, which is often calculated as a share of a plan's total Medicare revenue. Because a plan's revenue increases when more diagnoses are documented, the capitated payments to providers (determined as a percentage of the plan's revenue) increase proportionately. In these arrangements, the financial incentive to document more diagnoses is passed on to the medical group, which has direct access to an enrollee's medical records and diagnostic information.

Although we could not confirm that the plans offered by the 12 highest-coding California and Florida organizations use the delegated model, we found that for the 5 organizations with the highest

FIGURE 11–11

MA organizations offering plans primarily in California or Florida account for many of the organizations with the highest coding intensity



Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes special needs plans, contracts for the Program of All-Inclusive Care for the Elderly, and parent organizations with enrollment below 2,500. Analysis is based on retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007. The eight largest MA organizations identified in Figure 11-10 were excluded from the organizations identified as having enrollment mostly in CA or FL.

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

coding intensity, provider payments are almost entirely capitated. For the next four highest-coding organizations, between 50 percent and 75 percent of provider payments are capitated, and for the remaining three organizations, between 20 percent and 35 percent of provider payments are capitated. For context, across all MA plans, about two-thirds of contracts use some capitation, and the average share of capitated payments among those contracts is about 40 percent. Based on our results, it appears that some capitated providers in California and Florida have responded to financial incentives and dramatically increased risk scores for MA plan enrollees. Finally, we note that the alignment of clinical and financial accountability under the delegated model theoretically provides a number of beneficial incentives to constrain costs, avoid low-value care, and coordinate care. However, these potential benefits do not justify excess payments due to coding intensity, and such payments are not necessary to sustain the model's incentives.

MA plans' use of health risk assessments to increase diagnosis coding

In a recent study, OIG found that in 2017, health risk assessments and chart reviews accounted for $9.6 billion in payments to MA plans (Office of Inspector General 2021). Based on their findings, we estimate that health risk assessments and chart reviews generated 4.6 percent of total payments to plans and were responsible for 64 percent of MA coding

intensity in 2017. Our prior work closely examined MA plans' use of health risk assessments to document additional diagnosis codes (Medicare Payment Advisory Commission 2016). Some MA plans spend significant resources calling enrollees, offering incentives to have them participate in health risk assessments, and sending nurses to enrollees' homes to ask directly about their health. We estimate that diagnoses supported only by a health risk assessment—where no treatment was provided during the year—accounted for about 1 percentage point to 2 percentage points of overall MA coding intensity impact. OIG found that in 2017, diagnoses supported only by a health risk assessment—80 percent of which were the result of in-home health risk assessments—accounted for payments to MA plans of $2.6 billion (Office of Inspector General 2020). In 2017, this amount is about 1.2 percent of payments to MA plans.

The DOJ recently joined a whistleblower lawsuit against Cigna for submitting false and invalid diagnosis codes that were collected through its "360 Comprehensive Assessment" program for in-home health risk assessments. Cigna's internal documentation stated that vendor-company nurses conducting the assessments *were prohibited from providing actual patient treatment or care* and that "[t]he primary goal of a 360 visit is administrative code capture and not chronic care or acute care management" (Department of Justice 2022). According to the DOJ, Cigna targeted plan members who were likely to yield the greatest risk score increase; many diagnoses documented during a 360 visit were not documented during any other health care visit in the year; nurses did not perform specific testing or imaging that is required to reliably diagnose conditions documented during the visit; and many diagnoses did not conform to the ICD Office Guidelines for Coding and Reporting as required by federal regulations (plans submit diagnoses to CMS using ICD–10 codes) (Department of Justice 2022). The DOJ alleges that, over nine months in 2014, Cigna spent $2.13 million on in-home visits that generated an additional $14 million in Medicare payments, for a return on investment (ROI) of nearly seven to one. The allegations in this case demonstrate how health risk assessments can be used to increase MA risk scores and highlight the risks some plans take to submit more diagnosis codes by submitting false or invalid codes or otherwise violating federal regulations.

MA plans' use of chart reviews to increase diagnosis coding

Some MA plans devote significant effort to conducting chart reviews to increase MA payments.[62] Because chart reviews are not used in FFS Medicare, all diagnoses newly documented through chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to excess payments to MA plans. Chart reviews document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): Sometimes the diagnoses are not reported on the provider's claim that is sent to the MA plan, and sometimes the MA plan does not submit a record of the encounter to CMS. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record, medical record reviews are a logical way for plans to identify diagnoses not captured through provider claims or on plan encounter data. However, chart review programs are used exclusively in MA (there is no incentive to undertake chart reviews in FFS Medicare) and thereby exacerbate Medicare's failure to sufficiently account for differences in MA and FFS diagnostic coding.

Like health risk assessments, some MA plans treat chart review programs as an independent revenue stream that yields a positive ROI because the additional Medicare payments from newly documented diagnoses far exceed the costs of paying nurses and medical assistants to review medical charts.[63] Ongoing lawsuits allege that MA plans use chart reviews to identify new diagnosis codes but not to verify the accuracy of already submitted codes, even when the MA organization is aware that some diagnoses that have been submitted are not supported by the medical chart (violating Medicare's rules governing the reporting of diagnoses). Documentation from these whistleblower lawsuits sheds light on the profitability of chart reviews. In 2005 and 2006, just one year after the CMS–HCC model began to be phased in, one plan sponsor contracted with a chart review vendor to conduct three batches of chart reviews, yielding ROIs ranging from 22:1 to 30:1 (United States of America ex rel. James M. Swoben v. Secure Horizons 2017). Between 2010 and 2015, a large insurer obtained over $3 billion in additional MA payments from its

chart review program (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016). In 2015, a different MA plan sponsor spent about $19 million conducting over 500,000 chart reviews and was able to net over $94 million in profits, yielding an ROI of 6:1 (United States of America v. Anthem 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and use artificial intelligence to more accurately identify likely revenue-producing charts (Optum 2020). One vendor claims that its clients have received ROIs between 6:1 and 12:1 (Blue Health Intelligence 2020). While the financial return is clearly worth plan sponsors' effort and financial investment, chart review programs offer questionable benefits for plan enrollees and are detrimental for the taxpayers and beneficiaries funding the Medicare program.

Medicare accepts chart reviews as evidence of a diagnosis for risk adjustment. Plans submit encounter records of chart reviews along with records of encounters with health care providers. Some chart review records are linked to a specific provider encounter, but CMS also allows plans to submit "unlinked chart review records," in which the provider encounter that is the subject of the chart review is not specified. Some chart review records provide evidence of provider encounters for which the plan has not submitted an encounter record. For use in risk adjustment, CMS uses both encounter records and chart review records from hospital and physician visits as the source of diagnostic data.

OIG analyzed 2016 encounter data and found that 80 percent of MA contracts submitted at least one chart review and that plans submitted a total of 52.6 million chart reviews during the year (Office of Inspector General 2019). Of those chart reviews, 17 million contained diagnoses that were not documented on any health care encounter record. Although plans can use chart reviews to add or delete diagnoses from encounters, OIG found that less than 1 percent of chart reviews were used to delete diagnoses, lowering payments by $196.5 million. Chart reviews adding diagnoses raised payments to MA plans by $6.9 billion (resulting in a net payment increase of $6.7 billion). In 2017, this amount was about 3.2 percent of payments to MA plans. Chart reviews that were not linked to a specific provider encounter accounted for $2.7 billion of the increased payments. Although chart reviews are common in MA, the use of chart reviews varied across contracts or plan sponsors. OIG found that 10 MA contracts accounted for one-third of the additional payments, and that 10 of 137 parent organizations accounted for 79 percent of the increased payments to MA plans.

The Commission's prior recommendation on coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality. The Commission's approach to addressing MA coding intensity has been to address the underlying causes first (e.g., remove health risk assessments and reduce year-to-year coding variations) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach.

The recommendation, which would replace the existing mandatory minimum coding intensity adjustment (which was 5.9 percent beginning in 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- apply a coding adjustment that fully 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 diagnostic information and would reduce year-to-year variation in documentation. However, CMS did not take this step, even though the agency was given the authority to do so in the 21st Century Cures Act. Removing diagnoses documented only through health risk assessments would mean that a diagnosis, to be counted in risk-

adjustment calculations, would have to have been the subject of a medical encounter. Diagnoses that were both documented on an assessment and associated with a medical encounter would continue to count toward risk adjustment. However, about 30 percent of the HCCs documented through health risk assessments for MA enrollees were not treated during the year, compared with about 6 percent of diagnoses that were documented through these assessments for FFS enrollees.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart review data from risk adjustment (consistent with the Commission's approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. As noted earlier, health risk assessments and chart reviews alone account for almost two-thirds of MA coding intensity.

Adjusting for any remaining coding intensity differences could also improve equity across MA contracts. Under one approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding intensity adjustment would be applied based on each tier's average level of coding intensity. CMS has used a similar approach to select MA contracts for risk-adjustment data validation audits.[64] While this policy would leave some unevenness within each group of contracts, overall inequity would be reduced relative to a single across-the-board adjustment. CMS could consider using a greater number of tiers to further refine the equity of the overall adjustment.

Risk-adjustment data validation

Medicare payments to MA plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. MA plan leadership signs an attestation stating that risk-adjustment criteria have been applied correctly and that the submitted data are accurate. CMS conducts risk-adjustment data validation (RADV) audits after payments have been made to the plan to check whether plan-submitted diagnoses are supported by the medical record as required by Medicare. If diagnoses do not meet requirements, plans are required to return payments to Medicare.[65] Overpayments for diagnoses that do not meet program requirements are not the same as overpayments for uncorrected MA coding intensity; however, there is an unknown amount of overlap between the two types of overpayments.

CMS audits roughly 5 percent of MA contracts per year (about 30 contracts in early audit years) and, for each contract, uses a sample of 201 enrollees who are eligible for the audit population because they had at least 1 HCC reported and met certain other criteria.[66] The sample includes 67 randomly selected enrollees from each of three strata of beneficiaries' risk scores (low, medium, and high). For each beneficiary, the audit calculates a payment error rate, defined as the portion of the beneficiary's HCC-based payment that was not based on valid data. Beneficiary payment error rates can be offset if any additional HCCs are found that were not submitted for payment but were supported by the beneficiary's medical record.[67] In the initial round of audits of 2007 data, CMS recovered overpayments only for beneficiaries in the sample of 201 enrollees. For subsequent audits, in 2018 CMS proposed (but has not implemented) recovering overpayments for all audit-eligible enrollees in the contract by extrapolating from the lower 99th percent confidence interval around the average payment error rate for the sampled enrollees.[68] Using the lower 99th percent confidence interval ensures that CMS recovers only overpayment amounts that are identified with a very high degree of confidence.

RADV audits of MA contracts have been limited, and their results are largely unreported. Audits of 2007 risk-adjustment data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS recovered $13.7 million in overpayments from audits of 37 contracts, based on overpayments for only the 7,437 beneficiaries included in the audit sample (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008, 2009, or 2010. Kaiser Health News obtained through a Freedom of

TABLE 11–10

Risk-adjustment data validation audits have been limited, and results are largely unreported

Audit status	2007[a]	2011[b]	2012[b]	2013[b]	2014	2015	2016	2017	2018	2019
Recovery complete	$13.7 million									
Audit complete, no results		X	X	X						
Audits in progress					X	X				
Audits not started							X	X	X	X

Note: No audits were conducted from 2008 through 2010.
[a]The RADV audits conducted in 2007 attempted to recoup payments for only the beneficiaries and diagnoses associated with the overpayments identified in the audit data, a small fraction of all plan payment data.
[b]CMS has completed audits of 2011, 2012, and 2013 data and stated that it expects to recoup $650 million in overpayments through an overpayment recovery method that extrapolates sampled audit data to all plan payments, but the agency will not release results of those audits until the extrapolation method is finalized.

Source: Department of Health and Human Services financial annual reports and CMS MA risk-adjustment data validation audits fact sheet, June 1, 2017.

Information Act request summaries of the preliminary results for 90 audits completed during 2011, 2012, and 2013 and found that 71 audits uncovered net overpayments, with 23 audits finding overpayments of $1,000 or more per beneficiary (Schulte and Hacker 2022). CMS stated that it expects to recoup about $650 million in overpayments using the extrapolation method for audits conducted on data for 2011 through 2013 (Centers for Medicare & Medicaid Services 2018). However, CMS will not release the results of those audits until its extrapolation method is finalized (Centers for Medicare & Medicaid Services 2019).

CMS has proposed additional RADV audits focused on certain HCCs rather than on whole contracts; however, CMS has not identified the scope of such audits or stated when they would begin. Audits of 2014 and 2015 data are still in progress in part due to delays related to the coronavirus PHE. Table 11-10 summarizes the history of RADV audits and results.

In reviewing the RADV audit process, the Government Accountability Office (GAO) noted that RADV audits are tasked with recouping billions of dollars in improper payments to MA plans based on risk-adjustment data. However, GAO found a number of shortcomings with the audits and recommended targeting them at contracts with a higher likelihood of overpayments (Government Accountability Office 2016). Although CMS has released the final results only for the RADV audits of 2007 data, OIG has been conducting compliance audits (independent of CMS's RADV audits) for many MA contracts (see text box on OIG's audits of specific diagnosis codes, p. 364).

Quality in MA is difficult to evaluate

By statute, since 2012, Medicare uses a quality bonus program (QBP) that rates MA plans based on a 5-star system and provides bonuses to plans rated 4 stars or higher. The 5-star system, which predates the QBP, is also the basis of information that beneficiaries receive about MA plan quality through the medicare.gov Plan Finder website. Over the years, the Commission has determined that the QBP is flawed and does not provide a reliable basis for evaluating quality across MA plans in meaningful ways; plans have also received unwarranted bonus payments under the QBP system

Office of Inspector General's compliance audits of specific diagnosis codes

The Department of Health and Human Services Office of Inspector General (OIG) has broad authority to conduct oversight of CMS's operations. During 2021 and 2022, OIG audited the diagnostic data of 20 Medicare Advantage (MA) contracts and made recommendations for overpayment recovery by CMS.[69] OIG then tracked and reported on CMS's overpayment recoveries in the aggregate. Although we do not know the status of overpayment recovery amounts based on OIG's audits and recommendations, the audit findings show significant discordance between plan-submitted data used for payment and program rules requiring that diagnoses be supported in a patient's medical record.

Three audits focused on all diagnoses submitted by the contract for a single payment year and found overpayment amounts representing between 1 percent and 7 percent of the payments in the audit sample. Although the overpayment rates were relatively low, for two of the audits OIG recommended recovering an overpayment amount based on payments for the entire contract, resulting in the largest overpayment recovery recommendations of $198 million and $54 million.

The other 17 audits focused on codes for "high-risk conditions" that were identified as being more likely to be miscoded. These audits generally evaluated two years of diagnostic data. Audits of high-risk conditions found overpayment amounts representing between 54 percent and 78 percent of the payments under audit, except for one audit of high-risk conditions in which OIG found a 5 percent overpayment rate. Overpayment recovery amounts were based on payments for the entire contract, except one audit for which the recommended overpayment recovery amount was based only on overpayments identified in the audit sample. For overpayment recoveries for entire contracts, OIG recommended recovering between $1.8 million and $9.2 million in overpayments for 14 audits, $14.5 million for one audit, and $34.4 million for another audit. ■

(Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of the quality of care across MA plans. Under the coronavirus PHE, CMS relaxed quality reporting rules for 2020, boosting 2022 star ratings for many plans and generating a windfall for some plans. Star ratings subsequently dropped in 2023 when quality reporting returned to pre-PHE rules (see text box on quality bonuses under the coronavirus PHE, p. 365).

Comparative assessments could help in evaluating MA performance and changes in performance over time, in evaluating payment policy in MA, and in determining the adequacy and appropriateness of the standards applied to MA plans (for example, by using quality results as an indirect measure of network adequacy in MA plans). The ability to compare MA and FFS quality, and to compare quality across MA plans, is important for beneficiaries. Choosing between MA and FFS is a threshold choice that beneficiaries make before getting to the step of deciding among available MA plans (see text box on comparisons of MA and FFS quality and outcomes, pp. 366–368). Unfortunately, star ratings for most plans are based on data from geographically dispersed areas and therefore do not provide meaningful information about the quality of care providers furnish in beneficiaries' local areas.

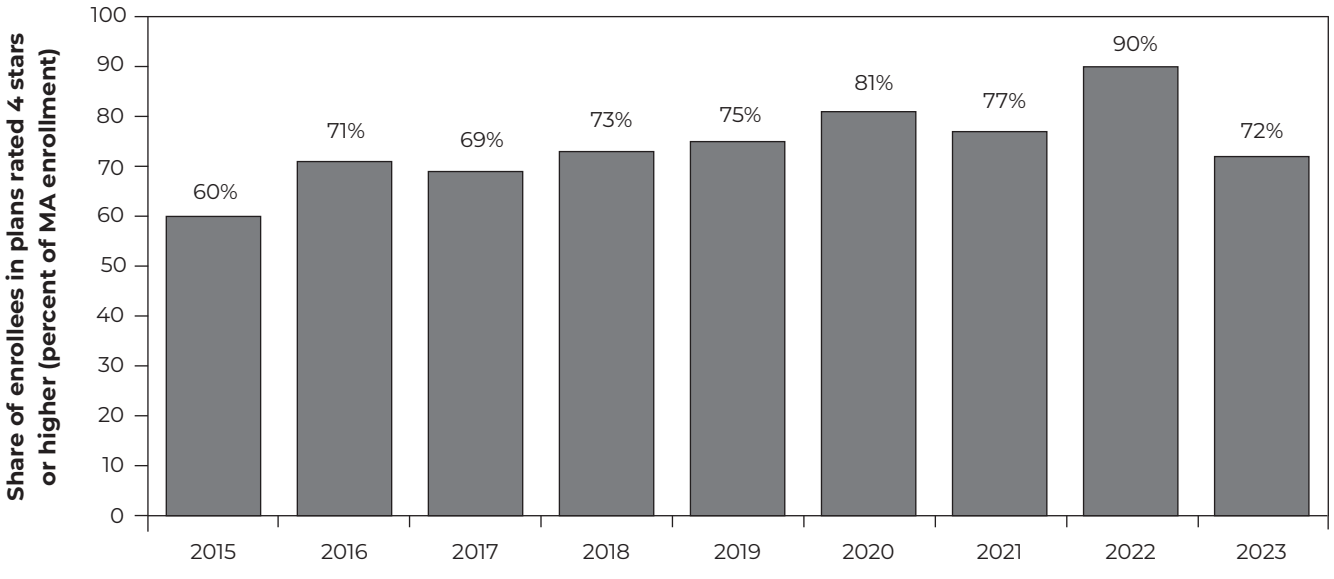
One recent study assessed plan performance on nine claims-based measures and compared changes for MA plans before and after the introduction of the QBP with changes for commercial plans (plans covering the employer group and other markets that are not eligible to participate in the Medicare QBP). The authors found

Quality bonuses under the coronavirus public health emergency (PHE)

Despite the substantial flaws in the quality bonus program, the program significantly boosts payments to Medicare Advantage (MA) plans each year. Our prior analyses have shown that these increases in plan revenue did not result in dollar-for-dollar increases in extra benefits. In fact, most of the extra dollars from quality bonus payments were not used to provide extra benefits to MA enrollees (Medicare Payment Advisory Commission 2020). Figure 11-12 shows that the share of MA enrollees in plans receiving a bonus benchmark (by achieving a star rating of 4 stars or higher) has increased since the start of the program in 2015. Although the Congress limited plans' incentive to use contract consolidations to artificially increase star ratings, the Commission has reported that contract consolidations are responsible for many of the star rating increases over the period shown in Figure 11-12 (Medicare Payment Advisory Commission 2020). In the first year of the coronavirus public health emergency, CMS relaxed quality reporting rules for 2020, allowing plans to apply the higher of 2019 or 2020 quality results for measures making up about 40 percent of 2022 star ratings (Health Management Associates 2021). The 2022 star ratings were used by Medicare beneficiaries to make their coverage decisions for 2022 and have been used in the calculation of 2023 payment rates. The reporting flexibility resulted in an unprecedented 90 percent of MA enrollees being enrolled in an MA plan that received a bonus benchmark increase. Although many of these plans would have received a quality bonus without the reporting flexibility, a number of plans appear to have achieved a quality bonus only because of the relaxed reporting rules, and these plans are receiving a windfall in 2023. The prior rules for quality reporting were reinstated for 2023 star ratings (which will be used for 2024 payments), and the share of MA enrollees in a 4-star or higher plan fell to 72 percent, lower than in the previous five years.■

FIGURE 11–12

In 2022, the share of MA enrollees in plans rated 4 stars or higher reached about 90 percent due to reporting flexibility during the PHE



Note: MA (Medicare Advantage), PHE (public health emergency). Before 2020, many MA plans used contract consolidations to artificially increase star ratings. Flexible reporting rules were allowed during the first year of the coronavirus pandemic, boosting 2022 star ratings, but reporting rules returned to normal in 2023. Star ratings are applied to plan payments in the subsequent year. For example, 2023 star ratings are used in the calculation of 2024 payment rates.

Source: MedPAC analysis of CMS star rating fact sheets for 2015 through 2023.

Mixed findings on comparisons of FFS and MA quality and outcomes

Good information on the quality of care that Medicare Advantage (MA) enrollees (49 percent of eligible Medicare beneficiaries) receive and how that quality compares with quality in fee-for-service (FFS) Medicare, including in accountable care organizations, is necessary for beneficiaries and policymakers to properly evaluate the program and plan options. MA plans have a number of management tools that are not available in FFS but permit plans to improve the quality of care for their enrollees—tools such as selective contracting, care management, information systems shared across providers, and utilization management that can prevent overuse of potentially harmful care. These tools give MA the potential to improve quality relative to FFS, but methodological challenges and a lack of sufficient data severely limit any definitive comparisons between MA and FFS Medicare.

There are several challenges that policymakers and researchers face in measuring the quality of care and outcomes of beneficiaries enrolled in either MA or FFS. First, many of the currently available clinical process or intermediate outcome measures (e.g., colorectal cancer screening, controlling high blood pressure) that MA plans report to CMS as a part of the 5-star rating system require plans to use clinical data to calculate results. The Medicare program cannot currently access this level of clinical information from FFS providers, so FFS and MA comparisons are limited.

Second, Medicare can calculate some quality outcome measures (e.g., hospital readmissions, mortality) using FFS administrative claims data; however, plan-submitted data about beneficiaries' health care encounters are incomplete, which results in less reliable MA plan outcome calculations. For example, MA inpatient admissions captured in Medicare Provider Analysis and Review (MedPAR) and encounter data incompletely overlap, so neither data source is complete. Also, most plans' reporting of office visits, emergency department visits, and inpatient admissions in patient-level Health Effectiveness Data Information Set® (HEDIS®) data does not match their reporting through encounter records.[70] In 2015, only 27 percent of MA plans reported a total number of inpatient stays for their enrollees in HEDIS data that was within 10 percent of the number reported in encounter data (Medicare Payment Advisory Commission 2019a).

Third, favorable selection of beneficiaries who choose to either switch from FFS to MA or vice versa may create bias in analysis comparing MA and FFS quality and outcomes. As mentioned earlier in the chapter (p. 351), the Commission will continue to study the effects of selection bias when evaluating MA.

Finally, greater diagnostic coding intensity among MA plans can make MA enrollees appear sicker than they would under FFS Medicare coding practices, thus making MA plans appear unduly better on quality measures that use diagnosis codes to risk adjust outcomes or to identify populations eligible for quality measurement.

Simple comparisons that do not control for unobserved differences between MA and FFS populations will be misleading. Yet, even after controlling for sources of variation such as patient characteristics and health status, unobserved confounding may still be present. More advanced statistical methods could help address some concerns about confounding, but these methods have other limitations. Perhaps more importantly, MA plans may vary in the quality of care they provide, and that quality may change over time. So even if all the statistical (and data) concerns could be addressed, definitive comparisons of the quality of care under MA and FFS may remain elusive.

Notwithstanding the limitations in addressing these challenges, researchers have used a variety of data sources, methods, and measures of quality and outcomes to try to compare MA with FFS. The results are mixed. Three systematic reviews of the literature comparing MA and FFS quality and other

(continued next page)

Mixed findings on comparisons of FFS and MA quality and outcomes (cont.)

areas such as spending and health care disparities were published in recent years (Agarwal et al. 2021, DuGoff et al. 2021, Ochieng and Fuglesten Biniek 2022). Although there are some differences in the methodologies and literature highlighted among the three studies, the high-level findings are generally consistent: The results of MA and FFS quality and outcomes comparisons are heterogeneous. In particular, research comparing hospital readmissions, mortality, and patient experience measures did not show a consistent pattern or trend of better performance in MA plans than traditional (FFS) Medicare.[71]

- ***Clinical process measures:*** Two of the literature reviews analyzed studies that compared clinical process quality measures between MA and traditional Medicare. They generally find that MA plans perform better on these measures. Specifically, Agarwal and colleagues identified nine studies that compared MA and FFS performance on clinical process measures focused on preventive care and other screenings (Agarwal et al. 2021). Two-thirds of those studies demonstrated better performance by MA relative to FFS on most of the measures. For example, three studies found that MA performed significantly better than FFS on breast cancer screening (Ayanian et al. 2013a, Ayanian et al. 2013b, Hung et al. 2016). Another study found that MA outperformed FFS on several clinical process measures, including breast cancer screening, diabetic eye examinations, diabetic cholesterol tests, and cholesterol screening for patients with cardiac care (Timbie et al. 2017). Similarly, Ochieng and Fuglesten Biniek identified seven studies comparing receipt of preventive care among beneficiaries in MA and traditional Medicare, and MA enrollees generally reported higher rates of preventive screening services. For example, in three studies, a larger share of MA enrollees than traditional Medicare beneficiaries reported colorectal and breast cancer screenings and blood pressure screening (Johnston et al. 2021, Park et al. 2020, Timbie et al. 2017).

- ***Hospital readmissions:*** All three literature reviews analyzed studies that examined rates of hospital readmissions between MA and FFS. The authors came to slightly different conclusions, but a finding across all the reviews is that the literature did not show a consistent pattern or trend of better performance in MA plans than traditional Medicare.

  Agarwal and colleagues identified 11 studies that compared readmission rates for MA and traditional Medicare beneficiaries (Agarwal et al. 2021). Five studies showed lower readmission rates for MA compared with FFS, two studies found higher readmission rates for MA, and four of the studies found no differences in readmission rates. Ochieng and Fuglesten Biniek's review included 12 studies that compared hospital readmission rates (Ochieng and Fuglesten Biniek 2022). Seven of these studies generally found lower rates in MA than traditional Medicare. Four studies that were more limited in scope found similar rates of readmission between traditional Medicare and MA. DuGoff and colleagues reviewed 7 studies using 38 analyses to compare readmission rates in MA and traditional Medicare (DuGoff et al. 2021). Twelve of the 38 analyses found a statistically significant relationship in favor of MA; however, 22 analyses did not find any statistically significant difference. All the literature reviews highlighted a study that used administrative data along with HEDIS beneficiary-level data and found that MA beneficiaries had higher risk-adjusted 30-day readmission rates than traditional Medicare beneficiaries for three common medical conditions (Panagiotou et al. 2019).

- ***Mortality:*** Two of the literature reviews analyzed and summarized the small number of studies they identified as comparing mortality in MA and traditional Medicare populations (Agarwal et al. 2021, DuGoff et al. 2021). Beveridge and colleagues showed that beneficiaries in MA were less likely to die than would be predicted had those

(continued next page)

Mixed findings on comparisons of FFS and MA quality and outcomes (cont.)

beneficiaries enrolled in traditional Medicare (Beveridge et al. 2017). An earlier study not included in these literature reviews also found this result (Afendulis et al. 2013). Another study found that the adjusted mortality rate of a cohort newly enrolled in MA was initially well below that of a cohort newly enrolled in traditional Medicare, but the difference had diminished markedly, though not completely, after five years (Newhouse et al. 2019).

Similar to the Newhouse study (Newhouse et al. 2019), a study released after the three literature reviews were published found that enrollment in MA was associated with modestly lower rates of 30-day mortality following acute myocardial infarction in 2009, but the rates converged and were no longer statistically significant by 2018 (Landon et al. 2022). This finding could thus suggest that mortality differences observed by earlier studies may also have diminished over time (at least for this one condition).[72]

- ***Patient experience:*** Two of the literature reviews included studies that examined aspects of beneficiaries' experiences with MA and traditional Medicare, including satisfaction with care. Agarwal and colleagues reviewed six studies that compared the experiences of beneficiaries in MA and traditional Medicare and concluded that the evidence on experience of care did not show a trend of better performance for MA plans than traditional Medicare (Agarwal et al. 2021). Ochieng and Fuglesten Biniek reviewed 16 studies that examined various aspects of beneficiaries' experiences, including satisfaction with care, access to care, and care coordination (Ochieng and Fuglesten Biniek 2022). Overall, MA enrollees and traditional Medicare beneficiaries reported similar levels of satisfaction with care. Ochieng and Fuglesten Biniek also reported inconsistent findings among studies that examined the share of MA enrollees and traditional Medicare beneficiaries who reported difficulty getting needed health care. MA enrollees and traditional Medicare beneficiaries reported similar experiences on measures of care coordination overall.

We have described the literature reviews and the studies they examined as they are reported in the health services research literature. We report their conclusions at face value, whether the findings suggest MA performs better, FFS performs better, or the results are mixed. However, these studies have some of the data and methodological limitations noted earlier, which tend to introduce bias in favor of MA. Therefore, the Commission has taken the position that we cannot yet make rigorous comparisons of quality and outcomes between MA and FFS given these limitations, and we continue to have concerns about the MA quality bonus program that we have discussed at length in prior reports (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019a). ■

no overall differences in quality between the MA and commercial plans and observed little evidence that the QBP was associated with improvements in quality performance for MA enrollees (Markovitz et al. 2021).

A new MA value incentive program

In our June 2019 report to the Congress, the Commission discussed ways to apply our quality principles to the MA program through a value incentive program (Medicare Payment Advisory Commission 2019a). In the June 2020 report to the Congress, the Commission recommended replacing the quality bonus program with a value incentive program that incorporates the following key features:

- Use of a small set of population-based outcome and patient/enrollee experience measures that, where practical, align across all Medicare-accountable entities and providers, including MA plans and

ACOs. To avoid undue burden on providers, measures should be calculated or administered largely by CMS, preferably with data that are already reported, such as claims and encounter data.

- Evaluation of health care quality at the local market level to provide beneficiaries with information about quality in their local area and provide MA plans with incentives to improve quality in every geographic area.
- Quality measurement against a continuous scale of performance that clearly provides the incentive to improve quality at every level.
- Accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of beneficiaries with similar social risk profiles so that plans with higher shares of these enrollees are not disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care are not masked.
- Application of budget-neutral financing so that the MA quality system is more consistent with Medicare's FFS quality payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020). ■

Endnotes

1 CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.14 percent of FFS spending (Centers for Medicare & Medicaid Services 2021a). Expenses for FFS-claim administration are included in our comparison of FFS spending with MA payments and differ from the expenses found in Medicare's Trustees' report, which include the administration and oversight of the MA program and the enrollment of all Medicare providers (which is required for contracting with MA plans). The Medicare Trustees reported that administrative expenses (including those for MA enrollees) accounted for 1.04 percent of CMS's total Medicare benefit costs in 2020 (Boards of Trustees 2021).

2 Payments described here do not apply to the relatively small number of enrollees with end-stage renal disease (ESRD). How Medicare pays MA plans for enrollees with ESRD is described in the Commission's March 2021 report under "Medicare payments to MA plans differ for ESRD and non-ESRD enrollees" (Medicare Payment Advisory Commission 2021c).

3 Plans' benefits may include a premium for mandatory supplemental benefits that cover all enrollees. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits. In addition, optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.

4 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only those beneficiaries with both Part A and Part B coverage (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017). This change would make the assumptions about FFS spending in the calculation of MA benchmarks and payments more reflective of the MA-eligible population.

5 The ACA caps any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor, or (2) 100 percent of its estimated FFS spending in the current year. 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).

6 Before 2022, MA plans also submitted diagnostic information through the Risk Adjustment Processing System (RAPS). The use of RAPS data was phased out from 2016 through 2021, except for contracts in the Program of All-Inclusive Care for the Elderly, which continue to use pooled RAPS and encounter data as the source of diagnostic data for risk scores.

7 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk-adjustment model for several reasons: (1) adding diagnoses from these sources does not improve the model's ability to predict medical expenditures; (2) concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers); and (3) a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis.

8 Although Medicare has contracted with private plans since 1966, prior to 1985 nearly all contracts used cost-based payment rates or used risk-based payment but were administered through a demonstration project. We identify the 1985 enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) as the introduction of private plan contracting in Medicare with payment rates set on a full risk basis (Zarabozo 2000).

9 One study found that additional benefits and limits on out-of-pocket spending were the two leading reasons that MA enrollees chose an MA plan (Leonard et al. 2022).

10 The Commission's previous work suggests that, although some beneficiaries enroll in MA immediately upon becoming eligible, most MA enrollees initially enroll in FFS Medicare and subsequently move to MA. For more on enrollment patterns, see our March 2015 report (Medicare Payment Advisory Commission 2015).

11 In 2018, most beneficiaries who purchased Medigap supplemental insurance chose the most comprehensive supplemental coverage options, which generally have the highest premiums. For more information on Medigap enrollment, see our July 2021 data book (Medicare Payment Advisory Commission 2021a).

12 Beneficiaries are guaranteed access to a Medigap supplemental insurance policy with no underwriting, even if they have a preexisting condition, if they purchase it during

the 6-month Medigap open-enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Beneficiaries have only one Medigap open enrollment period. Except for in limited circumstances, access to a Medigap policy is not guaranteed in most states after the Medigap open-enrollment period ends. Only four states require guaranteed-issue protections for aged (65 and over) beneficiaries in traditional Medicare, regardless of medical history. Under these protections, insurers cannot deny a Medigap policy to applicants based on preexisting conditions (Boccuti et al. 2018).

13 The availability of zero-premium local PPOs may have contributed to the increase in local PPO enrollment in 2022. For example, 87 percent of Medicare beneficiaries had an available zero-premium local PPO in 2022, up from 82 percent in 2021.

14 In 2022, 14 percent of MA enrollees and 21 percent of FFS enrollees resided in rural areas.

15 The top three organizations nationally also had the highest market share within both urban areas and rural areas in 2022. In urban areas, the top three organizations covered 55 percent of the MA enrollees (unchanged from 2021). In rural areas, the top three organizations accounted for 64 percent of the MA enrollees (unchanged from 2021).

16 In 2022, 15 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D–SNPs). While the national D–SNP market is more concentrated than the overall MA market (the three largest D–SNPs had 63 percent of enrollment), only two of the three largest national MA organizations were also among the top three D–SNP organizations.

17 The Herfindahl–Hirschman Index is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size; the index reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Under Department of Justice guidelines, markets with an index below 1,500 are considered unconcentrated; those with an index between 1,500 and 2,500 are considered moderately concentrated; and those above 2,500 are considered highly concentrated (Department of Justice and the Federal Trade Commission 2010).

18 Our measurement of beneficiary access to plans uses 2023 plan bids and July 2022 county-level enrollment for the Medicare population with both Part A and Part B coverage.

19 The increasing availability of zero-premium plans in recent years has largely been driven by the availability of zero-premium local PPOs. Between 2019 and 2023, the availability of zero-premium local PPOs increased from 69 percent of Medicare beneficiaries to 96 percent, and the availability of zero-premium HMOs increased from 86 percent to 98 percent.

20 In 2023, MA plans (excluding SNP and employer group plans) project that the average enrollee will have a Part B premium reduction of about $5. Among the 9 percent of enrollees projected to be in a plan with any Part B premium reduction, Part B premiums will be reduced by an average of $75. About 5 percent of enrollees in these plans will have the entire base amount of their Part B premium covered (the maximum possible Part B premium reduction). Compared with plans that did not offer any Part B premium reduction, per enrollee rebates will be about 25 percent higher in 2023 for plans that offered any Part B premium reductions, and per enrollee non-Medicare supplemental benefits will be about 5 percent higher.

21 Despite the large availability of MA plans, concerns have been raised about whether beneficiaries understand or are aware of their array of choices. One analysis of online plan insurance agents across five markets found that, on average, agents offered less than half of available MA plans to beneficiaries (Ali et al. 2021).

22 Beneficiaries in some parts of the country have access to Section 1876 cost-reimbursed HMOs. Such plans arrange for the full range of Medicare services. They receive reasonable cost reimbursement for Part B physician and supplier services, but the Medicare program pays providers directly for inpatient and outpatient institutional services. Enrollees in cost plans are not locked into the plan and can receive any out-of-network services, which Medicare pays for. By statute, cost plans cannot operate in areas where there are at least two competing MA CCPs that meet a minimum enrollment requirement.

23 A plan's benchmark can change based on factors such as changes in a plan's average quartile adjustment, quality rating, and coding intensity.

24 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR § 422.310(b)), including items and services provided through supplemental benefits; however, CMS's Encounter Data Submission and Processing guidance limits that requirement to supplemental services for which the plan has sufficient data to populate an encounter record. In addition, CMS systems are able to accept "professional" and "institutional" claim formats, which allow for the collection of some supplemental services, but CMS is not equipped

to accept dental claims. Further, reimbursement for many supplemental benefits does not use any claim format (e.g., fitness, meals, transportation, pest control), meaning there is no standard way for plans to submit information about the use of such benefits.

25 Among all nonemployer plans (including SNPs and plans that do not offer prescription drug coverage), 2023 rebates are projected to average $206 per enrollee per month.

26 In 2023, plans project that 13 percent of the rebate dollars used for cost-sharing reductions will be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 17 percent of the plan-projected rebate dollars used for cost-sharing reductions is projected to be allocated for plan administrative costs and profit.

27 CMS generally expects MA plans to use their rebate dollars to cover the beneficiary cap on out-of-pocket expenses. Thus, the plan liability for the out-of-pocket cap would be part of the cost-sharing reductions category. In 2023, plans project that their liability for the out-of-pocket cap will be $12 per enrollee per month—equivalent to 6 percent of rebates and 1 percent of projected plan payments. The plan liability for the out-of-pocket cap is generally not comparable with FFS spending because most beneficiaries in FFS have supplemental insurance and are unlikely to have cost-sharing expenses that exceed the out-of-pocket cap for MA enrollees. In addition, MA enrollees are prohibited from purchasing Medigap coverage, and MA plans are expected to provide supplemental benefits in lieu of Medigap coverage.

28 In 2019, 77 percent of Medigap enrollees had either first-dollar coverage or first-dollar coverage after the $185 Part B deductible.

29 In 2023, open enrollment MA plans (excluding employer plans and SNPs) project that 14 percent of the rebate dollars used for non-Medicare-covered supplemental benefits will be allocated for plan administrative costs and profit. Among all nonemployer plans (including SNPs), 16 percent of the plan-projected rebate dollars used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 17 percent of the plan-projected rebate dollars used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit.

30 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional and psychological impact of injuries or health conditions, and reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general use purposes or to address social determinants of health. The degree of projected spending for new types of supplemental benefits is not available in plan bid data.

31 When submitting Part C bids, MA plans do not allocate administrative expenses or margins for Part D premium buydowns or Part D supplemental benefits. However, plans may allocate administrative expenses and margin for these benefits when including these rebates as Part D revenues in their Part D bids.

32 In prior years, when employer plan bids were included in the bid data, we found that employer plan margins were higher than the margins of other MA plans (Medicare Payment Advisory Commission 2016).

33 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. As in prior years, we removed contracts that reported medical expenses equal to or greater than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and any administrative expenses). We identified these outliers at the contract level to account for plans that other MA plans could be subsidizing (i.e., product pairing) within the same service area. CMS requires MA plans with negative margins to submit a business plan to achieve profitability and expects MA plans to meet or exceed the year-by-year margin targets in the business plan.

34 MA plans annually report their medical loss ratios (MLRs) to CMS, which differ from our MLR estimate because plans can include quality improvement and fraud reduction activities as medical expenses when submitting their MLRs. Plans are subject to financial and other penalties for failure to meet the statutory requirement that they have an MLR of at least 85 percent. For contract year 2021, plans submitted MLRs to CMS in December 2022, and CMS will begin subtracting amounts from regular monthly plan payments in July 2023 to recoup any revenue difference between a plan's actual MLR and the 85 percent minimum MLR.

35 As noted in our March 2018 report to the Congress, the large difference in margins between for-profit and nonprofit entities could be because the bid data do not include employer group plans (Medicare Payment Advisory Commission 2018c).

36 The 1 percentage point increase in benchmarks relative to FFS spending from 2022 to 2023 is somewhat attributable to an increase in the share of MA enrollees who are projected

to be in a plan that received a quality bonus increase to their benchmarks. Although the share of enrollees in plans receiving a quality bonus increased by 13 percentage points between 2022 and 2023, the overall impact on benchmarks was small. In 2024, the share of MA enrollees in a quality bonus plan is projected to decrease to levels somewhat below those in 2022.

37 Apart from plan efficiencies relative to expected FFS spending, part of the drop in bids relative to FFS spending reflects MA's higher coding of diagnoses. In addition, as MA plans enroll a greater share of enrollees, these beneficiaries could have lower expected spending relative to their risk score. Furthermore, FFS alternative payment model incentive payments are a very small but increasing part of benchmarks. Although Medicare's financial targets for accountable care organizations do not include shared savings payments, these payments are included in MA benchmarks. The Medicare program effectively pays shared savings to both accountable care organizations and MA plans (through higher benchmarks).

38 To account for coding differences in 2023, we conservatively assume that the impact of coding intensity in 2023 is the same as in 2021. The coding intensity trend from 2017 to 2021 suggests that the impact in 2023 may be higher than in 2021. We will continue to evaluate this trend. Our estimate of MA payments relative to FFS spending does not account for other potential factors that are more difficult to measure with certainty, including how benchmark quartiles and plan bids and payments would have changed if calculating FFS spending using only beneficiaries with both Part A and Part B. In addition, we have observed a potentially large risk-adjusted spending effect from favorable selection of beneficiaries who choose to either switch from FFS to MA or exit MA. We will continue to evaluate this issue and consider it for inclusion in future analyses. Furthermore, our analysis does not include secondary effects with far less certainty, such as the potential spillover of provider behavior that can occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of MA and FFS improper payments found retrospectively.

39 Consistent with our analysis in 2022, we conservatively assumed employer plan enrollment growth of 3.5 percent from 2022 to 2023, which is lower than the enrollment growth of employer plans in most recent years. In addition, we calculated the overall risk score ratio of employer plans to other MA plans in 2020 (reflecting diagnoses documented in 2019), and we applied this ratio to the average risk score in 2023 MA bids.

40 CMS projects the average risk-standardized spending for all non-ESRD FFS beneficiaries in each county—including beneficiaries who are not eligible to enroll in an MA plan (i.e., beneficiaries with only Part A or Part B coverage). Along with claims payments, FFS spending estimates include provider settlements (e.g., cost report settlements) and alternative payment model incentive payments (e.g., shared savings for accountable care organizations).

41 Each of the 4 FFS ranges covers the bids of at least 700 plans that include at least 4.3 million projected enrollees.

42 Our review of private plan payments suggests that over a 38-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in FFS Medicare (Medicare Payment Advisory Commission 2022).

43 MA bid data are generally not available to nongovernment entities, causing other estimates of MA spending to rely on samples of MA data based on availability and convenience.

44 While statute limits the amount of indirect medical education payments that can be removed from MA rates (affecting two counties in 2023), we incorporate CMS's entire estimate of indirect medical education payments in the MA rate book.

45 Inpatient hospital, outpatient hospital, and physician claims are used in risk adjustment. Most diagnoses that are eligible for risk adjustment are documented on physician claims, which in FFS Medicare rely on procedure codes rather than diagnostic codes to determine payment amounts.

46 The Commission's estimate of the impact of coding differences accounts for differences in age, sex, enrollment type, and length of enrollment in both Medicare Part A and Part B.

47 The complete set of data sources necessary for the retrospective analysis is available only for 2016 through 2019. Provider settlement data are not available before 2016, and the most recent MA plan payment data are for 2019.

48 We required the analytic population to meet all criteria for all months in each year. We excluded enrollee months and spending occurring after an MA enrollee elected hospice and had to disenroll from their plan.

49 Measured by the number of months enrolled, our analysis included 88 percent of the MA population and 89 percent of the FFS population.

50 When an MA plan's contracted rate for an FQHC is less than the Medicare prospective payment system rate, Medicare

pays the FQHC the difference, less any cost-sharing amounts owed by the MA enrollee.

51 CMS reports provider settlement amounts on a national basis, and CMS reports provider incentive payments and medical education payments on a county basis. To estimate provider settlements at the county level, we distributed national settlement amounts using the county distribution of Part A and Part B spending for our study population. In addition, we excluded provider settlement amounts and alternative payment model incentive payments that would have been made for beneficiaries with Part A only, Part B only, ESRD, or Medicare as a secondary payer. Also, we removed medical education payments using CMS's county-level medical education payment file and similarly adjusted the amount to remove payments for beneficiaries with Part A only, Part B only, ESRD, or Medicare as a secondary payer. Further, we used CMS's most recent estimate of administrative claims cost, which is 0.14 percent of FFS spending during the year.

52 For counties with fewer than 12,000 FFS months, we applied a credibility adjustment similar to CMS's method when calculating FFS spending for MA benchmarks. For urban counties with fewer than 12,000 FFS months, we blended county spending with the average risk-standardized spending of the county's metropolitan statistical area. For nonurban counties with fewer than 12,000 FFS months, we blended county spending with the average risk-standardized spending of the county's health service area (as defined by the National Center for Health Statistics). This broader market definition is consistent with the Commission's recent MA analyses (Medicare Payment Advisory Commission 2021b, Medicare Payment Advisory Commission 2020).

53 We first reported 2022 results using the updated method in Table 12-6 of MedPAC's March 2022 report. Under the revised prospective method, we include employer plans using actual employer plan payment rates, actual enrollment from the prior year (updated to the payment year by assuming a 3.5 percent growth in enrollment), and we multiply the actual historical risk ratio of employer plans to other MA plans by the average risk score in MA bids. Under the revised method, we incorporate plans' secondary payer adjustment to their risk scores when calculating our FFS spending estimate. In our original published analyses, this adjustment was applied to MA payments but not to risk-standardized FFS spending.

54 The revised estimates increased the MA-to-FFS spending ratio by about 1 percentage point in each year and first appeared in Figure 12-3 of the March 2022 report.

55 One study comparing 2019 MA payments with FFS spending for MA-eligible beneficiaries (those with both Part A and Part B coverage) found that MA payments were approximately 103 percent of spending per person for comparable beneficiaries in FFS (Fuglesten Biniek et al. 2021).

56 For more detail about administrative expenses that are not clearly attributable to FFS Medicare spending, see the line items under "Administrative expenses" in the 2019 Medicare Trustees Report, p. 44 for the Hospital Insurance Trust Fund and p. 76 for the Supplementary Medical Insurance Trust Fund (Boards of Trustees 2019).

57 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied to a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have end-stage renal disease. A plan's base rate varies according to the plan's bid and the local area's benchmark.

58 We also examined six similar pairs of cohorts for beneficiaries whose first full years in Medicare were 2007 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.

59 CMS has made adjustments to the risk-adjustment model to better align FFS and MA risk scores. Between 2014 and 2016, CMS phased in a new risk-adjustment model that reduced MA coding intensity by about 2 percentage points to 2.5 percentage points relative to FFS by removing some diagnoses that were found to be coded more aggressively in MA. In 2017, CMS began accounting for Medicaid benefit eligibility more accurately (full, partial, or no benefits status by month), which reduced MA risk scores by about 1 percentage point, eliminating the amount that MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status.

60 To assess the overall impact of coding differences on payments to MA plans, we built retrospective cohorts of beneficiaries enrolled in either FFS or MA for all of 2021. We tracked each beneficiary backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007, the first year that payment to MA plans was based entirely on CMS–HCC risk scores. Our analysis calculated differences in risk score growth by comparing FFS and MA cohorts with the same years of enrollment (e.g., 2007 through 2021, 2008 through 2021), adjusting for differences in age and sex between each FFS and MA cohort.

61 Similar to our overall estimate of coding differences, this contract-level analysis uses retrospective cohorts of 2021 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007. The change in risk score for each MA beneficiary, however, is attributed to the MA contract in which the beneficiary was enrolled in 2021, and the comparison population consists of the FFS beneficiaries who live in the counties served by the MA contract. The analysis captures the impact of coding intensity on each contract's 2021 payments.

62 Plans also use chart reviews to submit additional diagnoses when the number of diagnoses identified during an encounter exceeds the number of diagnosis fields on an encounter record.

63 This statement is supported by the legal complaints cited in this section. One complaint includes exhibits of plan documents that detail the financial performance of the plan's chart review program (United States of America v. Anthem 2020).

64 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.

65 MA plans are also required to report and return self-identified overpayments. This requirement was suspended while under legal challenge but is now a program requirement again. The most recent data show that MA plans have remitted a relatively small share of estimated MA overpayments. In 2019, the most recent information available, MA plans self-reported and returned a tiny fraction—0.5 percent (amounting to $44.6 million)—of CMS's estimated MA overpayments that year (Department of Health and Human Services 2019).

66 Other criteria include Part B enrollment for the full data collection year, continuous enrollment in the contract for the full data collection year and January of the payment year, and no end-stage renal disease or hospice status.

67 HCCs newly discovered during the audit that were not submitted for payment offset beneficiary payment error rates but do not result in additional payments to the MA plan because the data were not submitted for payment during the required time period.

68 CMS proposed this method of determining overpayment recovery amounts in 2018 but had not issued a final rule at the time this report was produced (Centers for Medicare & Medicaid Services 2022, Centers for Medicare & Medicaid Services 2021b, Centers for Medicare & Medicaid Services 2018).

69 See the HHS OIG's Office of Audit Services reports and publications website for the 18 audit reports published during 2021 and 2022 identified as MA compliance audits of diagnosis codes. The audits summarized here are for contracts offered by the following organizations: BlueCross BlueShield of Michigan (H9572), Humana (H1036, R5826), Anthem now Elevance Health (H3655), Coventry Health of Missouri / CVS Health (H2663), UPMC (H3907), HealthFirst (H3359), SCAN (H5425), Tufts Health Plan now Point32Health (H2256), People's Health / UnitedHealth Group (H1961), Cariten / Humana (H4461), Cigna HealthSpring of Florida (H5410), WellCare of Florida / Centene (H1032), Regence BlueCross BlueShield of Oregon (H3817), InterValley Health Plan now defunct (H0545), BlueCross BlueShield of Tennessee (H7917), Highmark (H3916), California Physician's Service (H0504), BlueCross BlueShield of Rhode Island (H4152), and Cigna HealthSpring of Tennessee (H4454).

70 HEDIS® is a registered trademark of the National Committee for Quality Assurance.

71 The Commission's principles for quality measurement encourage the use of outcome measures (e.g., readmissions, mortality) as well as patient experience in Medicare quality programs (Medicare Payment Advisory Commission 2018b).

72 One recent study of cancer patients in California found that, from 2000 to 2020, enrollment in MA was associated with higher rates of 30-day mortality following stomach, pancreas, or liver surgery (Raoof et al. 2022).

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