# The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans

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## Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2021, the MA program included 4,778 plan options offered by 186 organizations, enrolled nearly 27 million beneficiaries (46 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated $350 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and 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 traditional 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, including the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans have greater incentives

## In this chapter

- Increasingly robust MA enrollment, plan availability, and rebates financed by higher payments relative to FFS spending

- Risk adjustment: Coding intensity inflates payments to MA plans

- Quality in MA is difficult to evaluate

- Mandated report: Comparing the performance of D–SNPs and other plans that serve dual-eligible beneficiaries

than FFS providers to innovate and use care management techniques to deliver more efficient care.

For the past two years, the coronavirus public health emergency has had a significant and tragic impact on beneficiaries. Policymakers have been concerned that the disruption in service utilization and plan administrative activities could impact payments in unexpected ways. However, because Medicare payments to MA plans are established before the start of each calendar year based on prior years' data, overall plan revenues in 2020 remained at prepandemic levels while service use declined, resulting in increased profitability for most MA plans. Although utilization remained below prepandemic levels and most publicly traded insurers reported profitability in 2021, some plans are concerned that lower utilization in 2020 limited their ability to document diagnoses, resulting in smaller risk adjustments and lower plan revenues in 2021. The effect of risk adjustments on 2021 revenues is not yet known and likely varies across the industry. In 2022, Medicare payments to MA plans are increased because of the expectation that deferred care will raise utilization above prepandemic levels. We do not anticipate that the pandemic will have a deleterious impact on overall plan revenues.

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and, for the sixth straight year, a historically high level of extra benefits financed by payments to plans through rebates. In 2022, the average Medicare beneficiary has a choice of 36 plans, and the average MA plan enrollee has access to nearly $2,000 in extra benefits annually that Medicare FFS enrollees cannot access without purchasing additional health insurance coverage. Medicare payments for MA extra benefits have increased by 53 percent since 2019. 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 15 percent of payments to MA plans, yet we have no data about their use nor information about their value. From 2018 to 2021, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 46 percent. If the trend continues, a majority of eligible Medicare beneficiaries will be enrolled in MA by 2023.

MA plans continue to capitalize on their administrative flexibility and reduce their relative growth in health care costs year over year. For 2022, the average plan bid to provide Medicare Part A and Part B benefits was 15 percent less

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than FFS Medicare would spend for those enrollees, and nearly all plan bids are below the cost of FFS Medicare.

However, these efficiencies are shared exclusively by the companies sponsoring MA plans and MA enrollees, in the form of extra benefits. The taxpayers and FFS Medicare beneficiaries who help fund the MA program (nearly all Medicare beneficiaries with Part B coverage pay a Part B premium, although for some that payment is made by a state Medicaid agency) do not realize any savings from MA plan efficiencies. Instead, Medicare spends 4 percent more for MA enrollees than it would spend if those enrollees remained in FFS Medicare. The MA program has been expected to reduce Medicare spending since its inception—under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments—but private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.

In particular, coding intensity inflates payments to MA plans and undermines the goal of plans competing to improve quality and reduce health care costs; the quality bonus program boosts plan payments for nearly all enrollees but does not meaningfully reflect plan quality, from the perspective of enrollees or the Medicare program; and MA benchmarks are set at an abundantly high level such that the government subsidizes MA plans' substantial and ever-higher levels of extra benefits for MA enrollees. Apart from payments, the Commission finds that the plan-submitted data about beneficiaries' health care encounters are incomplete, preventing policymakers from understanding plan efficiencies or implementing program oversight. These policy flaws diminish the integrity of the program and generate waste from beneficiary premiums and taxpayer funds. A major overhaul of MA policies is therefore urgently needed.

Over the past few years, the Commission has made recommendations to address coding intensity, improve the completeness of encounter data, replace the quality bonus program, and establish more equitable benchmarks. 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. Beneficiaries clearly find Medicare Advantage to be an attractive option through which to receive their Medicare benefits, as evidenced by robust trends in year-over-year enrollment growth. However, this does not

mean that Medicare should continue to overpay MA plans; in fact, under current policies, as MA enrollment continues to grow, it will further worsen Medicare's fiscal sustainability. It is imperative that the Congress and the Secretary make policy improvements. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for providers in the traditional FFS program.

*Enrollment—*For the third consecutive year, enrollment in MA plans grew by 10 percent. Between July 2020 and July 2021, MA enrollment grew by 2.5 million enrollees—to 26.9 million enrollees. In 2021, about 46 percent of MA-eligible beneficiaries (i.e., Medicare beneficiaries with both Part A and Part B coverage) were enrolled in MA plans, up from 43 percent in 2020. Among plan types, health maintenance organizations (HMOs) continued to enroll the most beneficiaries (16 million, or 60 percent of MA enrollees and 28 percent of MA-eligible beneficiaries). Compared with 2020, enrollment in local preferred provider organizations (PPOs) grew by 19 percent, regional PPO enrollment fell by 19 percent, and private fee-for-service enrollment dropped by 29 percent. Special needs plan enrollment grew by 17 percent, and employer group enrollment grew by 6 percent.

*Plan availability—*In 2022, access to MA plans remains high, with 99 percent of Medicare beneficiaries having access to at least one plan. Almost all eligible beneficiaries have had access to some MA plan type since 2006, and HMOs and local PPOs have become more widely available in the past few years. Nearly all MA-eligible beneficiaries (99 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 74 percent of beneficiaries. The average beneficiary has 36 available plans sponsored by 8 different parent organizations, both of which are increases relative to 2021.

*Plan rebates—*In 2022, rebates that are used to provide additional benefits to enrollees are at a historic high of $164 per enrollee per month. The average total rebates are 17 percent higher than in 2020 ($24 higher per enrollee per month). Plans can devote the rebate (including plans' allocation of administrative costs and profit) to lower cost sharing, lower premiums, or supplemental benefits. In 2022, 43 percent of projected plan rebates were allocated for lower cost sharing, down from 46 percent in 2021.

*Plan payments—*In 2022, plan payments remain higher than FFS spending levels. Total Medicare payments to MA plans (including rebates that finance extra benefits) average an estimated 104 percent of FFS spending, similar

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to the percentage of FFS spending in 2021. The 2022 estimate incorporates about 3.6 percentage points of uncorrected coding intensity. Relative to FFS spending for Part A and Part B benefits, quality bonuses in MA account for 3 percentage points of MA payments. Using plan bid data for 2022, and ignoring the impact of coding intensity, we estimate that MA payments are 100 percent of 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 FFS spending levels. In 2022, MA benchmarks averaged an estimated 108 percent of FFS spending (including quality bonuses), about the same level as in 2021. Bids fell to 85 percent of FFS, a record low.

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

A Commission analysis of 2020 data shows that higher diagnosis coding intensity resulted in MA risk scores that were about 9.5 percent higher than scores for similar FFS beneficiaries. By law, CMS makes an across-the-board reduction to MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a larger reduction than the minimum required by law, the agency has never done so. In 2020, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores that were about 3.6 percent higher than they would have been if MA enrollees had been treated in FFS Medicare, translating to $12 billion in excess payments to MA plans. 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 the goal of plans competing on the basis of quality and costs.

The Commission previously recommended changes to MA risk adjustment that 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. These changes were intended to improve equity across plans and eliminate the

impact of differences between MA and FFS coding intensity. Recent reports from the Office of Inspector General highlight the impact of MA plans' use of medical chart reviews (a coding practice that does not exist in FFS Medicare) and of health risk assessments to increase risk scores. We find that nearly two-thirds of MA coding intensity could be due to 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 the quality of care in MA. With 46 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care that MA enrollees receive and how that quality compares with quality in FFS Medicare is necessary for beneficiaries and policymakers to compare MA and FFS quality and to compare quality among MA plans. In its June 2020 report, the Commission, recognizing that the current quality program is not achieving its intended purposes and is costly to Medicare, recommended a new value incentive program for MA that would replace the current quality bonus program.

### Mandated report: Comparing the performance of D–SNPs and other plans that serve dual-eligible beneficiaries

Dual-eligible special needs plans (D–SNPs) are specialized MA plans that limit their enrollment to beneficiaries who receive both Medicare and Medicaid. The Bipartisan Budget Act (BBA) of 2018 permanently authorized D–SNPs and, starting in 2021, requires them to meet new standards for integrating the delivery of Medicare and Medicaid services. The BBA of 2018 mandated that the Commission periodically compare the performance of different types of D–SNPs and other plans that serve dual-eligible beneficiaries. This chapter includes our first report under the mandate, which we are required to submit to the Congress by March 15, 2022. We find that the performance data that MA plans report as part of the Healthcare Effectiveness Data and Information Set® provide limited insight on the relative performance of D–SNPs.[1] This finding is consistent with previous Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans. ∎

## Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2021, the MA program included 4,778 plan options offered by 186 organizations, enrolled nearly 27 million beneficiaries (46 percent of Medicare beneficiaries with Part A and Part B coverage), and paid MA plans an estimated $350 billion (not including Part D drug plan payments). 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 (e.g., programs focused on preventing avoidable hospital readmissions), and develop robust information systems that provide timely feedback to providers. In addition to a mandatory out-of-pocket spending limit, plans can provide incentives for beneficiaries to seek care from more efficient providers, offer integrated Part D benefits, and give beneficiaries more predictable cost sharing; one trade-off is that the choice of providers in plan networks is more limited than in FFS Medicare.

By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it often lacks incentives to coordinate care and is limited in its ability to make care delivery more efficient.[2] Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a choice between private MA plans and traditional FFS Medicare that does not unduly favor one 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.

For the past two years, the coronavirus public health emergency has had a significant and tragic impact on beneficiaries. Policymakers have been concerned that the disruption in service utilization and plan administrative activities could impact payments in unexpected ways. Because Medicare payments to MA plans are established before the start of each calendar year based on prior years' data, overall plan revenues in 2020 remained at prepandemic levels while service use declined, resulting in increased profitability for most MA plans. Although utilization remained below prepandemic levels and most publicly traded insurers reported profitability in 2021, plans are concerned that lower utilization in 2020 limited their ability to document diagnoses, resulting in smaller risk adjustments and lower plan revenues in 2021. The effect of risk adjustments on 2021 revenues likely varies across the industry. In 2022, Medicare payments to MA plans are increased because of the expectation that deferred care would raise utilization above prepandemic levels. We do not anticipate that the pandemic will have a deleterious impact on overall plan revenues. (See the text box about the effect of the coronavirus pandemic on our 2022 estimates, p. 416.)

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and, for the sixth straight year, a historically high level of extra benefits. The average Medicare beneficiary has a choice of 36 plans, and the average MA plan enrollee has access to nearly $2,000 in extra benefits annually that Medicare FFS enrollees cannot access without purchasing additional coverage. Medicare spending for these extra benefits accounts for 15 percent of payments to MA plans, but we have no data about their use nor information about their value. From 2018 to 2021, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 46 percent. If the trend continues, a majority of eligible Medicare beneficiaries will be enrolled in MA by 2023.

For 2022, the average plan is expected to provide the Medicare Part A and Part B benefits for 15 percent less than FFS Medicare would spend for those enrollees, and nearly all plans are expected to provide Medicare benefits for less than the cost of FFS Medicare. MA

## The impact of the coronavirus pandemic on 2022 benchmarks, bids, and payments relative to FFS spending

Since early 2020, the ongoing coronavirus pandemic and associated public health emergency have had tragic effects on beneficiaries. They have also affected providers' patient volume and costs. Overall utilization of health care services dropped sharply beginning in March 2020 but by summer had returned to near-normal levels for many types of services. Despite the pandemic's varied impact on utilization by type of service and geographic region, aggregate utilization was reduced through 2020 due to delaying or forgoing elective treatments and was only partially offset by use of health care services related to treatment of COVID-19. For Medicare Advantage (MA) plans and other payers of medical services, the pandemic temporarily lowered overall medical expenditures. In financial reports, public MA insurers reported medical expenses as a share of revenue (or medical loss ratios) at or near record lows during the second quarter of 2020 (April through June). Meanwhile, because Medicare payments to MA plans are established before the start of each calendar year based on prior years' data, plan revenues in 2020 remained at normal levels, resulting in higher profitability for many plans during the pandemic (McDermott et al. 2020).

Preliminary Medicare fee-for-service (FFS) data indicate that in 2021, utilization in many sectors returned much closer to prepandemic levels but was still below what would have likely been assumed when 2021 MA payment rates were prospectively set (using data through 2019). However, plans are concerned that lower utilization in 2020 limited plans' ability to document diagnoses, resulting in smaller risk adjustments and lower plan revenues in 2021. The effect of risk adjustments on 2021 revenues

likely varies across the industry. Insurers are also concerned about delayed care rebounding as the pandemic ebbs, boosting future medical expenses above normal levels; that scenario had not been borne out in the aggregate as of December 2021. In addition, beginning in 2021, MA plans are no longer subject to the Affordable Care Act of 2010 (ACA) insurer fee, which was equivalent to 1.4 percent of plan revenues in 2020. The repeal of the ACA insurer fee combined with preliminary FFS utilization data suggest that most MA plans could maintain their prepandemic profitability in 2021.

We do not anticipate the pandemic having a substantial impact on MA payments in 2022. In our analysis, we use CMS's estimate of 2022 FFS spending, which uses data through 2020 as the basis for 2022 MA benchmarks, bids, and payments. This estimate also represents the FFS spending levels that were increased by the Office of the Actuary to account for the expectation that deferred care due to the pandemic would increase FFS spending in 2022. These higher FFS spending estimates are the basis for 2022 MA plan bids submitted in June 2021. We do not yet know the full effect of the pandemic on beneficiary spending in 2022 and on 2022 risk scores based on service use in 2021. However, the record level of plan rebates in 2022 and the wider availability of zero-premium plans indicate that plans anticipate continued ability to offer bids far below payment benchmarks. We also note that MA coding intensity raised 2020 MA risk scores and payments by about 3.6 percentage points and continues to raise MA risk scores and payments each year. We will continue to monitor the impact of the coronavirus pandemic on plan availability and MA payments. ∎

plans continue to capitalize on their administrative flexibility and reduce health care costs year over year.

However, these efficiencies are shared exclusively by the companies sponsoring MA plans and 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 (all Medicare beneficiaries pay a Part B premium) do not realize any savings from MA plan efficiencies. Instead, Medicare spends 4 percent more on MA than it would spend on FFS Medicare, a program with

spending levels that are already inflated by the volume-inducing incentives of FFS reimbursement, Medigap's effect of insulating beneficiaries from the financial impact of their service utilization, and inappropriate spending owing to fraud and waste. The MA program has been expected to reduce Medicare spending since its inception: Under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments. However, private plans in the aggregate have never reduced Medicare spending.

MA payments do not align with the level of plan efficiencies. In some parts of the country, payments to MA plans are low enough to produce savings for the Medicare program but high enough, given plan efficiencies, to allow plans to offer a relatively high level of extra benefits to plan enrollees residing in those areas. In other parts of the country, payments to MA plans are far more than what Medicare would pay if enrollees remained in FFS and result in greater subsidies for MA plans to offer more extra benefits. These inconsistencies, along with the misalignment of MA payment with plan efficiencies, demonstrate that the policies governing payment rates to MA plans are deeply flawed.

In particular, the Commission has found that (1) coding intensity inflates payments to MA plans and undermines the goal of plans competing to improve quality and reduce health care costs; (2) the quality bonus program boosts plan payments for nearly all enrollees but does not provide beneficiaries with the necessary information to evaluate local quality; and (3) plan benchmarks are set so high that the Medicare program (rather than plans) subsidizes extra benefits for MA enrollees. Apart from payment policies, the Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to understand MA plan efficiencies, improve quality measurement, and provide oversight of the MA program. These policy flaws diminish the integrity of the program and generate waste from beneficiary premiums and taxpayer funds. The rapid growth of MA enrollment and spending elevates the urgency and need for a major overhaul of MA policies.

Over the past few years, the Commission has developed four recommendations, incorporating and updating

prior recommendations where appropriate, that would eliminate or reduce the effects of the most significant current policy flaws in the MA program. Table 12-1 (p. 418) 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-based, plan-financed reward program (Medicare Payment Advisory Commission 2020a); 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 better focus the program on the beneficiaries it serves and to harness plan efficiency to improve Medicare's long-term financial sustainability.

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. Beneficiaries clearly find MA an attractive option through which to receive their Medicare benefits, as evidenced by robust trends in year-over-year enrollment growth. However, the potential appeal of MA does not mean that Medicare should continue to overpay MA plans; in fact, as MA enrollment continues to grow, it will further worsen Medicare's fiscal sustainability. It is imperative that the Congress and the Secretary make policy improvements. A decade ago, the Affordable Care Act of 2010 (ACA) enacted payment reforms that reduced MA program payments, causing some concern about whether MA would continue to grow and attract Medicare beneficiaries. However, those reforms did not have the negative effect that some had predicted. Instead, MA enrollment has grown and per capita costs in relation to FFS spending have fallen across the country. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for providers in the traditional FFS program.

TABLE
12–1

**Commission recommendations for changes to MA payment policy that have not been implemented and the approximate impact on MA payments**

| Recommendation | Approximate impact on MA payments |
|---|---|
| **Fully account for MA coding intensity**—*March 2016*<br>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. | –2% |
| **Improve encounter data accuracy and completeness**—*June 2019*<br>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. | 0 |
| **Replace the quality bonus program**—*June 2020\**<br>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. | –2 |
| **Establish benchmarks that align with MA efficiencies**—*June 2021\*\**<br>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. | –2 |

Note: MA (Medicare Advantage), FFS (fee-for-service). The approximate impact on MA payments was estimated at the time of the recommendation and may be subject to behavioral responses.

*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).

**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, 2020a, 2019a, 2016.

## Types of MA plans

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

- *HMOs and local preferred provider organizations (PPOs)*—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve

and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).

• *Regional PPOs*—These plans are required to offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.

• *Private FFS (PFFS) plans*—These plans may or may not use provider networks, depending on where they operate. The Medicare Improvements for Patients and Providers Act of 2008 mandated that, in areas with two or more network MA plans, PFFS plans have provider networks. Therefore, PFFS plans have to either locate in areas with fewer than two network plans or operate as network-based PFFS plans. The Congress anticipated that the legislation would reduce the availability of and enrollment in these plans that did not manage care as efficiently as their HMO and PPO competitors. In 2021, only about 57,000 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 places a deposit into the member's account that the member can use to help meet the plan deductible on Medicare services. In 2021, MSAs were available in 30 states with a total enrollment of about 10,000 beneficiaries. However, 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 (those beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are

included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. (See the Commission's March 2013 report to the Congress, available at http://www.medpac.gov, for more detailed information on SNPs.) As we recommended in an earlier report, employer plans no longer submit bids (since 2017). Therefore, 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 traditional FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by the MA plan bid—which 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 status—and the benchmark for the county in which the beneficiary resides, which is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.[3] (Medicare also pays plans for providing the Part D drug benefit, but Medicare's Part D payments are determined through the Part D bidding process, and not all plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark. If a plan's normalized bid is above the normalized benchmark (that is, a benchmark for 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. If a plan's bid is below the benchmark, its payment rate is its bid plus a share (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings) of the difference between the plan's bid and the benchmark. 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

**TABLE
12–2**

### MA plan enrollment continued rapid growth in 2021

| | MA enrollment (in millions) | | Percent change in enrollment | 2021 MA enrollment as a share of total Medicare |
|---|---|---|---|---|
| | July 2020 | July 2021 | | |
| Total | 24.4 | 26.9 | 10% | 46% |
| Plan type | | | | |
| CCP | 24.3 | 26.8 | 10 | 46 |
| HMO | 15.0 | 16.2 | 8 | 28 |
| Local PPO | 8.1 | 9.7 | 19 | 17 |
| Regional PPO | 1.1 | 0.9 | –19 | 2 |
| PFFS | 0.1 | 0.1 | –29 | <1 |
| Restricted availability plans included in totals above | | | | |
| SNPs* | 3.5 | 4.1 | 17 | 7 |
| Employer group* | 4.7 | 5.0 | 6 | 9 |
| | | | | **Share of Medicare population in MA** |
| Urban/rural | | | | |
| Urban | 21.2 | 23.2 | 9 | 48 |
| Rural | 3.2 | 3.7 | 16 | 36 |

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). CCPs include HMO, local PPO, and regional PPO plans. Unlike prior years, the total Medicare population used to calculate enrollment shares in this table excludes the 9 percent of beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. Urban/rural designations have been updated from prior years and use the core-based statistical area codes delineated by the Office of Management and Budget (OMB) in 2020. Urban areas are those designated as metropolitan by OMB. Rural areas include counties designated as micropolitan and counties that are neither metropolitan nor micropolitan. 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.

Part B premium and may pay premiums to the plan for additional benefits). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can also devote some of the rebate to administration costs and margins. Plans may also choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages

and charge premiums to cover those additional benefits.[4] (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 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.[5] Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending. Each quartile contains 785 or 786 counties. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans, and high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings, given the history of very low bids in such counties that reflect high FFS service use. Counties (excluding the territories) are assigned to quartiles based on average FFS spending; the highest spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next highest spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest spending quartile has benchmarks set at 115 percent of local FFS spending. (U.S. territories are treated like counties in this low-spending quartile.) Counties can move among quartiles from year to year and in doing so receive a blended quartile factor; for example, a county moving from the 100 percent quartile in 2021 to the 107.5 percent quartile in 2022 would have a blended rate of 103.75 percent.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans awarded quality bonuses are 10 percent higher than the standard benchmarks.[6] Unlike nearly all of Medicare's FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars. 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 traditional FFS Medicare and reflects the Commission's recommendation to the Congress in June 2020 (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019a).

## Increasingly robust MA enrollment, plan availability, and rebates financed by higher payments relative to FFS spending

Substantial growth in MA plan enrollment, availability, and rebates indicates an increasingly robust MA program, financed by MA payments that continue to be above FFS levels. In 2021, for the third consecutive year, MA plan enrollment grew by 10 percent; 46 percent of eligible Medicare beneficiaries are now in MA plans, compared with 43 percent in 2020. The increasing share of MA enrollees in some geographic areas raises questions about the long-term feasibility of using the local FFS population to calculate MA payment benchmarks. For 2022, the average beneficiary now has access to 36 plans sponsored by 8 organizations, and rebates that finance extra benefits are the highest in the program's history. At the same time, however, the robust growth and availability of MA plans has occurred without overall savings to the Medicare program. In 2022, MA bids average 85 percent of FFS spending, but payment benchmarks average 108 percent of FFS—resulting in MA payments that are 100 percent of FFS and an estimated 104 percent of FFS spending after accounting for differences in coding practices between MA and FFS.[7]

### In 2021, 10 percent growth in MA plan enrollment; MA enrollment now 46 percent of eligible Medicare beneficiaries

Between July 2020 and July 2021, enrollment in MA plans grew by 10 percent—or 2.5 million enrollees—to 26.9 million enrollees (compared with a 2 percent growth in the same period for the total eligible Medicare population ("eligible" meaning beneficiaries with both Part A and Part B coverage) and about a 4 percent decline in eligible FFS enrollment). The 10 percent growth is among the highest in the last 10 years, equaling growth in 2012, 2019, and 2020. During this period, MA enrollment rose from 43 percent (data not shown) to 46 percent of eligible Medicare beneficiaries (Table 12-2).[8] Enrollment in MA has more than doubled since 2010 (Figure 12-1, p. 422).[9] MA has increasingly become attractive to beneficiaries because of MA plans' coverage of cost-sharing reductions at little to no premium and a mandatory cap on out-of-pocket expenses. Many beneficiaries with average

**FIGURE**
**12–1**

### Enrollment in Medicare Advantage has more than doubled over the last 10 years
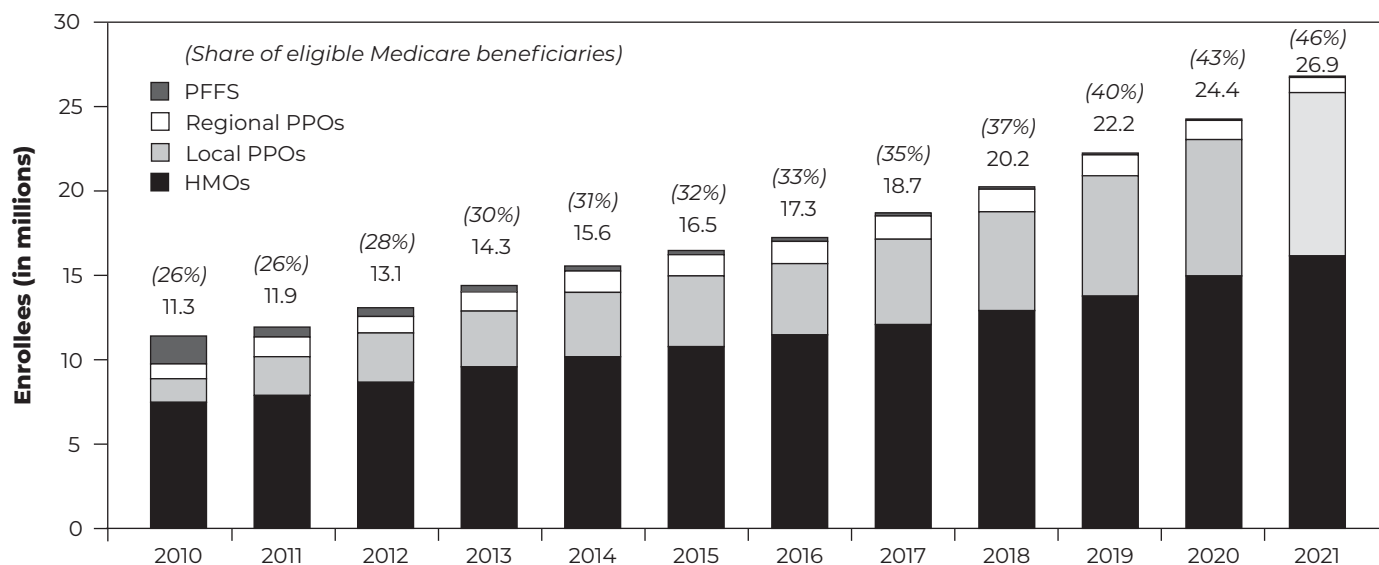


Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to be eligible for enrollment in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not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

Source: MedPAC analysis of CMS enrollment files, July 2011–2021.

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.[10] In addition, while some MA enrollees with high care needs may experience greater cost liabilities compared with beneficiaries in FFS, most of these MA enrollees would likely have difficulty switching to FFS coverage because they may be denied a Medigap policy due to a preexisting condition.[11,12]

Among plan types, although enrollment grew more slowly in HMOs (8 percent) than in local PPOs (19 percent), HMOs continued to enroll the most beneficiaries (16 million) in 2021, with 28 percent of eligible Medicare beneficiaries in HMOs (Table 12-2, p. 420). Between 2020 and 2021, enrollment in regional PPOs and PFFS plans dropped by 19 percent and 29 percent, respectively. In 2021, SNP enrollment grew by 17 percent, and employer group enrollment grew by 6 percent.

Enrollment patterns differ in urban and rural areas. Over 48 percent of eligible urban beneficiaries are enrolled in MA compared with 36 percent of eligible beneficiaries residing in rural counties (Table 12-2, p. 420). In 2021, 39 percent of rural MA enrollees were in HMO plans compared with about 63 percent of urban enrollees (data not shown). By contrast, 51 percent of rural enrollees were in local PPOs compared with 35 percent of urban enrollees.

In many areas of the country, a majority of eligible Medicare beneficiaries are now enrolled in MA.[13] In 15 states (including California, New York, Florida, Michigan, and Pennsylvania) and Puerto Rico, more than half of the eligible population is enrolled in an MA plan in 2021. In some metropolitan areas (e.g., Miami, FL; Pittsburgh, PA; Rochester, NY; Grand Rapids, MI; Portland, OR; El Paso, TX; New Orleans, LA), more than two-thirds of eligible Medicare beneficiaries enrolled in MA plans. MA benchmarks are computed at the county level, and an increasing number of counties had most Medicare

beneficiaries enrolled in MA plans. In all counties in Puerto Rico and an additional 621 counties across 36 states, more than half of eligible Medicare beneficiaries enrolled in MA plans. The increasing share of MA enrollees in some geographic areas raises questions about the long-term feasibility of using the local FFS population to calculate MA payment benchmarks. As the share of FFS beneficiaries in these counties decreases, 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 a county's FFS beneficiaries have comprehensive supplemental coverage, which is unavailable in MA and induces higher demand for service use. In addition, a larger share of beneficiaries remaining in FFS may rely on care from volume-inducing providers who are outside of most MA plan networks.[14]

## Access to MA plans remains high in 2022

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 2022, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2022. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 12-3, p. 424). In 2022, 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 2021. Regional PPOs are available to 74 percent of eligible beneficiaries, similar to 2021. PFFS plans are available to 35 percent of beneficiaries, nearly the same as in 2021.

The availability of SNPs improved across types of special needs populations served (Table 12-3, p. 424). In 2022, 94 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 92 percent in 2021), 59 percent live where SNPs serve beneficiaries with chronic conditions (up from 57 percent in 2021), and 74 percent live where SNPs serve institutionalized beneficiaries (up from 72 percent in 2021). Overall, 98 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

In 2022, 98 percent of eligible Medicare beneficiaries (compared with 96 percent in 2021) have access to at least one nonemployer, non-SNP MA plan that includes Part D drug coverage and charges no Part C or Part D premium (beyond the Medicare Part B premium) (Table 12-3, p. 424). About 69 percent of nonemployer, non-SNP MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2022, 97 percent of beneficiaries (compared with 89 percent in 2021) have access to plans that offer some reduction in the Part B premium, but only 7 percent of 2022 enrollment was projected to be in these premium-reduction plans (data not shown). Given the increasing number of plan choices, beneficiaries may find it difficult to discern differences in plan benefit packages and make an optimal choice.

In most counties, many MA plans sponsored by a robust number of organizations are available to beneficiaries. In 2022, the average number of plans available in a county increased. On average, in 2022, 22 plans (vs. 18 plans in 2021) are available in each county (Table 12-3, p. 424). Plan availability can also be calculated by weighting the number of a county's eligible beneficiaries to give a sense of the number of plan choices available to the average beneficiary. Under that calculation, the average beneficiary in 2022 has 36 available plans, an increase from 32 plans in 2021, and can choose from plans sponsored by 8 organizations (organization data not shown); 96 percent of beneficiaries have available MA plans sponsored by at least three different organizations.[15] Beneficiaries in 126 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, 152 counties, representing 1 percent of beneficiaries, have no MA plans available (medical savings account plans and SNPs are not included in general availability measures); however, some of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).[16]

## Largest organizations slightly increase MA market share

In 2021, the national MA market continued to grow slightly more concentrated. The top 2 organizations

TABLE
12–3

**Access to Medicare Advantage plans remains high**

**Share of Medicare beneficiaries with access to at least one MA plan, by type**

| Type of plan | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| Any MA plan | 99% | 99% | 99% | 99% | 99% |
| Local CCP | 96 | 97 | 98 | 98 | 99 |
| Regional PPO | 74 | 74 | 73 | 72 | 74 |
| PFFS | 41 | 38 | 36 | 34 | 35 |
| Special needs plans | | | | | |
| Dual eligible | 86 | 89 | 90 | 92 | 94 |
| Chronic condition | 47 | 47 | 52 | 57 | 59 |
| Institutional | 56 | 63 | 67 | 72 | 74 |
| Zero-premium plan with drug coverage | 84 | 90 | 93 | 96 | 98 |
| Average number of choices | | | | | |
| County weighted | 10 | 13 | 15 | 18 | 22 |
| Beneficiary weighted | 20 | 23 | 27 | 32 | 36 |
| Average monthly rebate for nonemployer, non-SNP plans | $95 | $107 | $122 | $140 | $164 |

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 the 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. The plan rebate is the per beneficiary per month amount that the plan is offering as premium-free extra benefits and excludes plans that do not offer Part D coverage.

Source: MedPAC analysis of CMS bid and enrollment data.

had 46 percent of enrollment (Table 12-4) (vs. 45 percent in 2020; data not shown), and the top 10 organizations had 79 percent of enrollment (vs. 78 percent in 2020; data not shown). Market concentration differed between urban areas (23.2 million MA enrollees) and rural areas (3.7 million enrollees). In urban areas, the top two organizations had 44 percent of the MA enrollees residing in these areas (Table 12-4) (vs. 43 percent in 2020; 2020 data not shown). In rural areas, the top two organizations accounted for 54 percent of the MA enrollees residing in these areas (unchanged from 2020; 2020 data not shown).

Another way of looking at the MA program's market structure is to examine market competition at the county level. Excluding employer plans and SNPs, in 2021, 66 percent of MA enrollees (down from 69 percent in 2020) resided in a highly concentrated county as measured by the Herfindahl–Hirschman Index.[17] In 2021, enrollment in the top organization in each county accounted for 44 percent of all MA enrollment (down from 45 percent in 2020). Enrollment in the top two organizations in each county accounted for 68 percent of all MA enrollment (down from 69 percent in 2020). Thus, although the MA market is

**TABLE**
**12–4**

**Share of Medicare Advantage enrollment by parent organization, July 2021**

| Urban areas | | Rural areas | |
|---|---|---|---|
| **Parent organization** | **Share of total MA enrollment in urban counties** | **Parent organization** | **Share of total MA enrollment in rural counties** |
| UnitedHealth Group Inc. | 27% | UnitedHealth Group Inc. | 28% |
| Humana Inc. | 17 | Humana Inc. | 26 |
| CVS Health Corporation | 11 | CVS Health Corporation | 10 |
| Kaiser Foundation Health Plan Inc. | 8 | Anthem Inc. | 6 |
| Anthem Inc. | 6 | Centene Corporation | 4 |
| Centene Corporation | 4 | Blue Cross Blue Shield of Michigan | 4 |
| CIGNA | 2 | Spectrum Health System | 2 |
| Blue Cross Blue Shield of Michigan | 2 | BlueCross BlueShield of Tennessee | 1 |
| Summit Master Company LLC | 1 | Highmark Health | 1 |
| Highmark Health | 1 | CIGNA | 1 |
| **Total, top 10 organizations** | **79** | **Total, top 10 organizations** | **84** |

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. Urban/rural designations use the 2020 delineations by the Office of Management and Budget (OMB). Urban areas are those designated as metropolitan by OMB. Rural areas include counties designated as micropolitan and counties that are neither metropolitan nor micropolitan. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS July 2021 enrollment data and OMB 2020 delineations.

highly concentrated, the level of concentration is not increasing locally. In tandem, national MA market concentration modestly rose, but local MA market concentration modestly fell, suggesting that the largest national plans continue to gain MA market share in areas where they do not have a large presence. Nevertheless, as illustrated in the section entitled "Access to MA plans remains high in 2022" (p. 423), the average beneficiary has access to many MA plans offered by a robust number of organizations.

### MA rebates in 2022 are a record high $164 per enrollee per month

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. For 2022, rebates for MA plans (excluding employer plans and SNPs) average $164 per enrollee per month (nearly

$2,000 annually per enrollee) and are the highest in the program's history (accounting for 15 percent of plan payment). The average total rebates are 17 percent higher than in 2021 ($24 higher per enrollee per month) (Table 12-5, p. 426). MA rebates have increased by 53 percent since 2019. Plans can devote the rebate (which includes plan allocations for administrative costs and profit) to lower cost sharing, lower premiums, or supplemental benefits. In 2022, the share of plan rebates allocated toward cost-sharing reductions is projected to fall. Plans project that $70 per enrollee per month in rebates (43 percent of rebate dollars) goes toward reductions in cost sharing for Medicare services, 10 percent higher relative to 2021 but a drop in the share of rebate dollars (46 percent in 2021).[18,19] The growth rate of cost-sharing reductions is above but relatively similar to CMS's projected growth rate of all Part A and Part B expenditures (8.5 percent; data not

TABLE
12–5

**A smaller share of plan rebates is allocated to cost sharing in 2022**

| | Rebate (per member per month) | | | Share of total rebate | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2022 percent change** | **2021** | **2022** |
| Total | $140 | $164 | 17% | 100% | 100% |
| Extra benefit type | | | | | |
| Cost sharing | 64 | 70 | 10 | 46 | 43 |
| Non-Medicare supplemental | 29 | 36 | 24 | 21 | 22 |
| Part D supplemental | 24 | 30 | 23 | 17 | 18 |
| Part D premium | 20 | 25 | 21 | 15 | 15 |
| Part B premium | 2 | 4 | 55 | 2 | 2 |

Note:    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. Totals, differences, and rebate shares may not sum due to rounding.

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

shown), suggesting that many MA plans do not need or want to devote additional rebate dollars to this benefit beyond medical inflation. Indeed, plans may find that additional rebate allocations toward reductions in cost sharing may induce greater service use, such as the induced service use that occurs in FFS for beneficiaries with first-dollar Medigap coverage (Medicare Payment Advisory Commission 2012a).[20] Plans project that $36 per enrollee per month (22 percent) of rebates will be used for non-Medicare-covered supplemental benefits. The Commission recently 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).[21,22] For example, in 2021, the five most commonly offered benefits—worldwide emergency care, routine eye exam, worldwide urgent care, fitness benefits, and an annual physical exam—were offered to more than 90 percent of plan enrollees, while most enrollees were not in plans that offer benefits targeted to individuals who are high needs

or who have certain chronic illnesses. In addition, utilization of these benefits lacks transparency—making it unclear whether Medicare payments for these supplemental benefits better address social determinants of health compared with direct financial assistance.[23] Three other uses of rebate dollars are for Part D supplemental benefits (18 percent of projected rebates), reductions in Part D premiums (15 percent of projected rebates), and reductions in Part B premiums (2 percent of projected rebates). MA plans cannot allocate administrative expenses or margin to these three categories of benefits.[24]

**Plans bid at record low levels in 2022, but payments remain above FFS spending**

In 2022, 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 text box on Medicare payments to MA plans, p. 431). 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

TABLE
12–6

**Overall plan bids at record low levels in 2022, but plan payments remain above FFS spending due to coding**

| | Share of FFS spending in 2022 | | |
| Plan type | Benchmarks | Bids | Payments |
| --- | --- | --- | --- |
| **All MA plans (after coding estimate)** | **112%** | **88%** | **104%*** |
| **All MA plans (before coding estimate)** | **108** | **85** | **100*** |
| HMO | 108 | 84 | 100 |
| Local PPO | 109 | 89 | 102 |
| Regional PPO | 97 | 84 | 92 |
| PFFS | 106 | 98 | 103 |
| Restricted availability plans (SNPs) included in totals above | 107 | 87 | 100 |

***Values include employer plans.**

Note:    FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2022 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 3.6 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 2022 are the same as for 2020 (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. Comparing payments with spending for FFS enrollees with both Part A and Part B would decrease the overall MA payments relative to FFS in the table by about 1 percentage point.

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

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

the Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides. The benchmark is based on 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. In the early years of MA, benchmarks were set high in order to attract plan participation. In 2010, MA benchmarks averaged 112 percent of FFS spending, bids averaged 100 percent of FFS, and payments averaged 109 percent of FFS. After implementation of the ACA, reductions in benchmarks began lowering Medicare payments to plans. However, with ACA policies fully implemented and in place since 2017, benchmarks and payments

remain above FFS spending levels. We estimate that in 2022, MA benchmarks (including quality bonuses) average 108 percent of FFS spending (before adjusting fully for coding intensity; see Table 12-6). Similarly, benchmarks in 2021 averaged 108 percent of FFS (data not shown), while MA plans bid at record low levels. Overall plan bids average an estimated 85 percent of FFS spending in 2022, down from 87 percent of FFS in 2021 (latter data not shown).[25] 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 Medicare payments to MA plans would average 100 percent of FFS spending in 2022; however, uncorrected coding intensity increases

| TABLE 12–7 | 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% | 8% | 7% |
| At least 70%, less than 80% | 19 | 22 |
| At least 80%, less than 90% | 38 | 43 |
| At least 90%, less than 100% | 27 | 23 |
| At least 100%, less than 110% | 7 | 4 |
| 110% or more | 1 | 1 |

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

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

payments to 104 percent of FFS spending. The 2022 estimate incorporates about 3.6 percentage points of uncorrected coding intensity. Relative to FFS spending for Part A and Part B benefits, quality bonuses in MA account for 3 percentage points of MA payments. MA payments also averaged 104 percent relative to similar beneficiaries in FFS in 2021.

Our estimates of the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending are calculated using plans' bid projections to compare projected MA spending with projected FFS spending on a like set of FFS beneficiaries. Benchmarks are set each April for the following year. Plans submit their bids in June and incorporate the recently released benchmarks. Benchmarks reflect FFS spending estimates for 2022 made by CMS actuaries at the time the benchmarks were published in April 2021. The bid data mask the impact of differences in MA and FFS diagnostic coding. Accounting for these differences would increase overall bids, benchmarks, and payments to MA plans by about 3.6 percentage points. However, using the bid data allows for subgroup comparisons, such as by MA plan type, shown in Table 12-6 (p. 427).

The ratio of MA plan payments to FFS spending for 2022 varies by plan type, excluding employer plans,

which do not submit bids but are separately discussed in a subsequent paragraph (Table 12-6, p. 427). For example, HMOs as a group bid an average of 84 percent of FFS spending, yet payments for HMO enrollees are estimated to average 100 percent of FFS spending because of benchmarks averaging 108 percent of FFS spending. Local PPOs' bids average 89 percent of FFS spending, and PFFS plans have average bids of 98 percent of FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 102 percent and 103 percent of FFS spending, respectively. Payments for beneficiaries enrolled in regional PPOs average 92 percent of FFS because of the regional PPOs' relatively low benchmarks (which are a blend of regional plans' bids and FFS spending).

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

In 2014, we recommended that CMS pay employer plans differently because the employer bids were not

usually submitted for a competitive purpose, while the bids for other plans are submitted to compete for enrollment. (For more details on employer plans and our recommendation, see our March 2014 report to the Congress, available at http://www.medpac. gov.) As we recommended, CMS no longer pays the employer plans based on their bids. In 2017 and 2018, CMS began paying employer plans based on a blend of the 2016 bidding behavior of nonemployer plans and employer 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.[26] Because employer plans are mostly PPOs, their payment in 2022 largely reflects the average bidding behavior of nonemployer PPOs in 2021. Using 2022 employer plan payment rates and recent employer plan enrollment trends, we estimate that MA payments to employer plans will average 102 percent of FFS spending in 2022. After including payments to employer plans, overall MA payments remained at 100 percent of FFS spending before accounting for coding differences.

### Variation in 2022 MA bids and payments

About 92 percent of plans bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits (Table 12-7), an increase from 87 percent in 2021. These plans are projected to enroll about 96 percent of MA enrollees, excluding those in employer group and special needs plans. About 7 percent of MA enrollees are projected to enroll in plans that bid lower than 70 percent of FFS spending (nearly double the share relative to 2021); 1 percent are projected to enroll in plans that bid more than 110 percent of FFS spending.

Although plan bids average less than FFS spending, payments for these plans' enrollees can exceed FFS spending because the benchmarks (including the quality bonuses) can be high relative to their area's FFS spending. Figure 12-2 (p. 430) shows how plans bid relative to FFS for service areas with different ranges of FFS spending. Each of the four FFS ranges covers the bids of at least 601 plans that include at least 3.8 million projected enrollees. As expected, plans bid higher (relative to FFS) in areas with relatively low FFS spending and bid lower (relative to FFS) where FFS spending is relatively high. However, even in service areas within the lowest quartile of FFS spending, less

than $940.76 per month on average, most plans bid less than the FFS spending level for 2022 (Figure 12-2). In plan service areas averaging $940.90 or more per month in FFS spending, most plans are likely to bid far below the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. 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 $940.76 per month in 2022) began bidding below FFS far more frequently. The median bid for areas in this quartile declined between 2013 and 2022 from 111 percent to 92 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 to Medicare savings. For 2022, Medicare is still paying an average of 109 percent of FFS spending in these areas because the benchmarks average 118 percent of FFS when quality bonuses are included.

### MA margins

The continued growth in MA enrollment, the ability of MA plans to bid well below FFS expenditure levels, and plans' ability to provide generous extra benefits point to continued strong financial health in the MA sector. Margins for MA sponsors have remained stable. The most recent data available, from 2020, show that MA plans reported margins that averaged 6.5 percent.[28,29] This figure excludes Part D—for which we do not have 2020 data—and the following plan categories that do not submit bids: employer group plans, the Medicare–Medicaid demonstration plans, cost-reimbursed plans, Program of All-Inclusive Care for the Elderly, and medical savings account plans. In addition, the 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.

Our estimate does not include Part D drug margins, and if employer plan data were available, the margin levels might be higher. The absence of data on employer plans—19 percent of MA enrollment in 2020—limits our ability to determine the average margin in the MA sector. In prior years, when employer plan bids

FIGURE
12–2

**Medicare Advantage bids in relation to FFS spending levels, 2022**



Average monthly FFS spending per beneficiary in a given service area (in dollars)
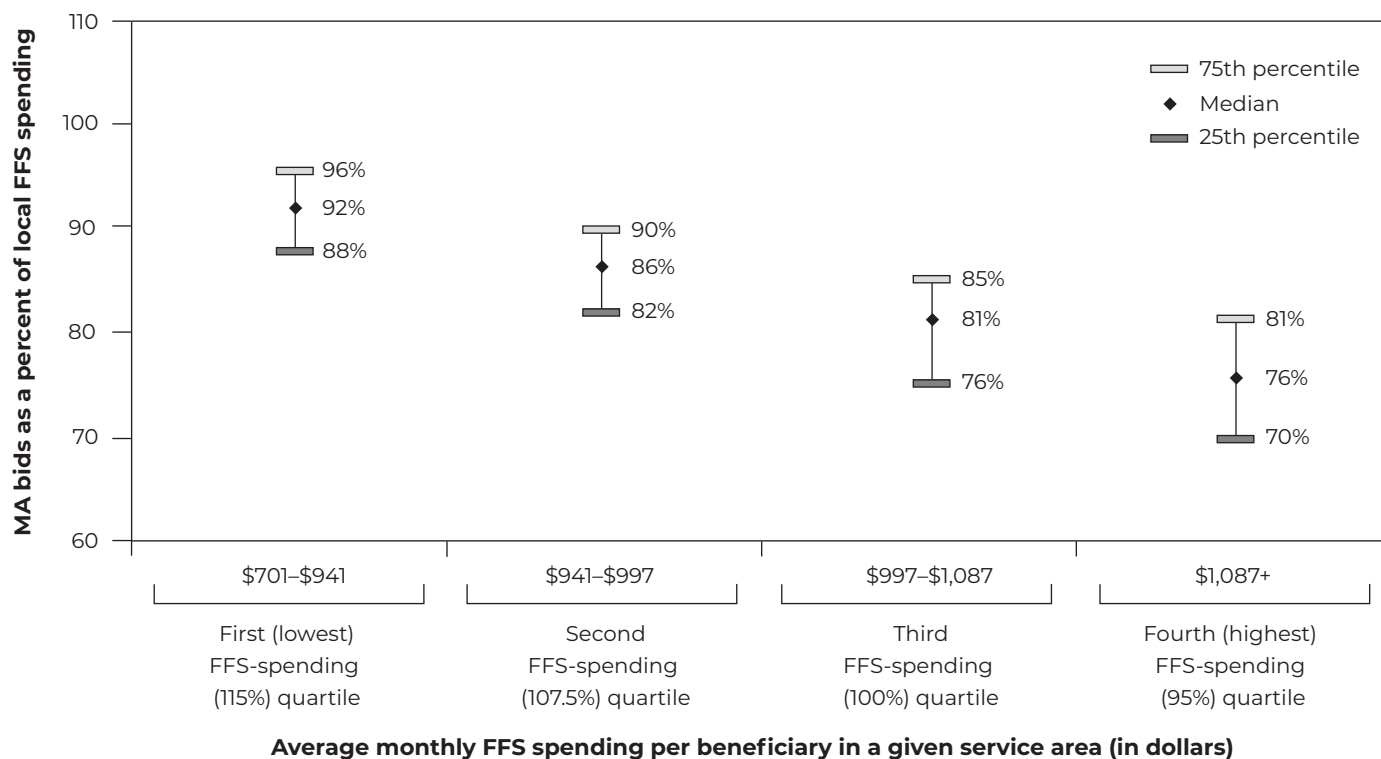
Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 4,087 plan bids and excludes employer group plans, special needs plans, and plans in the territories. Percentages do not account for unaddressed coding intensity differences. The FFS spending denominator used in the figure includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. Comparing bids with spending for FFS enrollees with both Part A and Part B would decrease overall MA bids relative to FFS spending by about 1 percentage point.

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

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).

Margins vary by plan tax status. In the 2020 data, nonprofit plans reported a margin of 4.6 percent; for-profit entities reported a pretax margin of 6.9 percent, both reflecting robust increases relative to 2019. As noted in our March 2018 report to the Congress, the large difference in margins (2.3 percentage points) between for-profit and nonprofit entities could be because the bid data do not include employer group plans (Medicare Payment Advisory Commission 2018c). Given the relatively high margins of employer group plans in prior years, including these plans would at

least modestly increase MA margins for nonprofit plans whose overall MA business is disproportionately more reliant on employer group plans. In addition, many nonprofit plans are sponsored by providers, and this relationship can obscure plan margins. Further, for-profit entities' MA plan margins were substantially higher in 2020 despite MA plans being subject to payment of the ACA insurer fees in 2020 but not 2019.[30] In 2020, the insurer fees represented about 1.4 percent of total revenue.

In 2020, all categories of SNPs had overall positive margins. Dual-eligible SNPs (D–SNPs), for beneficiaries dually eligible for Medicare and Medicaid benefits, had margins of 10.7 percent. SNPs for enrollees with

## Aggregate Medicare payments to Medicare Advantage plans have never been lower than FFS Medicare spending

Our review of private plan payments suggests that over a 37-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program.[27] 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 fee-for-service (FFS) Medicare. Evaluations of private plan payment rates under Medicare demonstrations occurring before 1985 found that payment rates were 15 percent to 33 percent higher than FFS

Medicare spending (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and led to private plan payments that were, in the late 1980s and through the mid-1990s, 5 percent to 7 percent higher than FFS Medicare spending (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996). Figure 12-3 shows that since 2004, payments to MA plans continue to be above the amount FFS Medicare would have spent for the same beneficiaries. ■

### FIGURE 12–3

**Medicare has paid more to MA plans than FFS Medicare spending would have been for the same enrollees, 2004–2022**
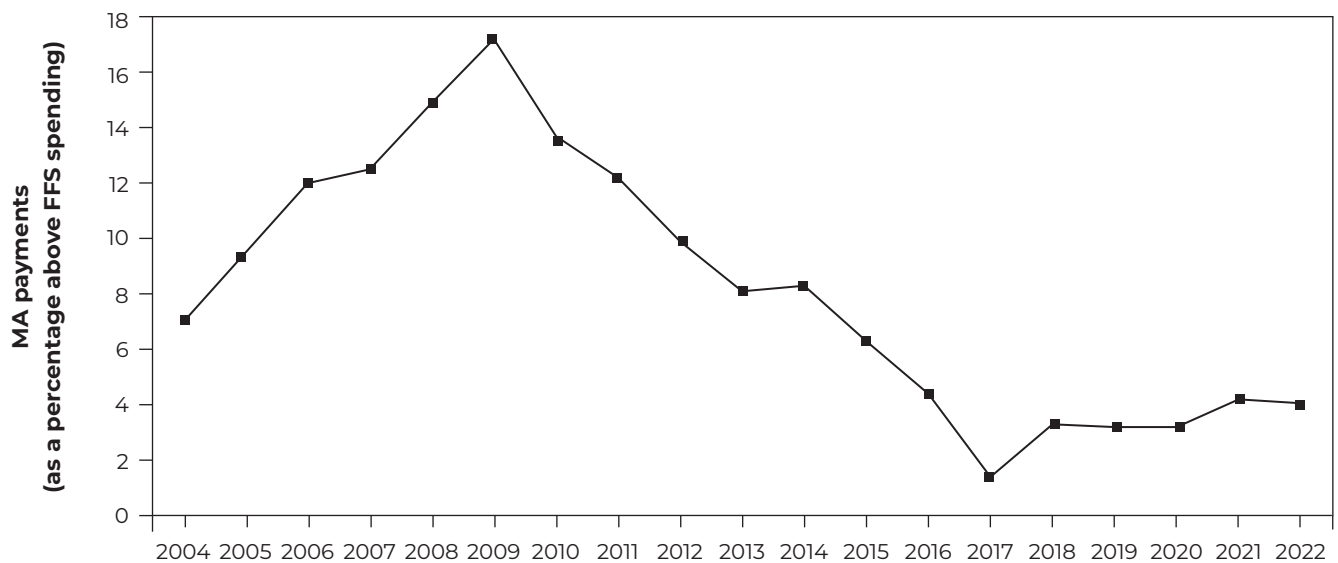


Note:    MA (Medicare Advantage), FFS (fee-for-service). Benchmark increases under the quality bonus demonstration applied from 2012 through 2014 and under the quality bonus program applied starting in 2015. The figure reflects the Commission's estimates of the impact of coding intensity, beginning in 2007. Estimates are updated from prior years to reflect payments to employer plans after 2016 and adjustments for MA enrollees with Medicare as a secondary payer. We assume, conservatively, that the coding intensity impact for 2021 and 2022 is the same as for 2020 (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 only in Part A or only in Part B, and thus 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 the table 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. Assuming that an increase to FFS spending (and benchmarks) would not increase plan bids, comparing MA payments with spending for FFS enrollees with both Part A and Part B would lower the spending estimate about 1 percentage point.

Source:  MedPAC reports to the Congress 2006 through 2021, MedPAC analysis of 2022 data from CMS on plan bids and FFS expenditures.

certain chronic conditions (C–SNPs) had margins of 11.2 percent. Institutional SNPs (I–SNPs) had margins of 2.8 percent, which was notably lower than the 12.1 percent margins of I–SNPs in 2019 and may have resulted from the pandemic's disproportionate impact on institutionalized beneficiaries. The 2020 profit margin among nonprofit D–SNPs was 6.4 percent.

## Risk adjustment: Coding intensity inflates payments to MA plans

Medicare payments to MA plans are adjusted to account for differences in expected beneficiary medical costs. The purpose of risk adjustment is to ensure that plans are adequately and fairly compensated for treating all categories of enrollees—those with high medical costs as well as those with less health care utilization. If the risk-adjustment system is flawed, misaligned incentives could result in "favorable selection," in which plans have an incentive to attract certain types of beneficiaries and avoid enrolling others. Plans can achieve unwarranted profits if the risk-adjustment system overpays for some enrollees and underpays for others.

Medicare payments to private plans in the early years of the program were not sufficiently risk adjusted. By avoiding counties with high hospital spending and by marketing to healthy beneficiaries, plans were able to disproportionately attract profitable enrollees. Other factors contributed to favorable selection for plans: Beneficiaries could choose to enroll in or disenroll from a plan on a monthly basis, and sicker beneficiaries preferred FFS Medicare (Medicare Payment Advisory Commission 2000, Newhouse et al. 1989). Research demonstrated that favorable selection of enrollees led to Medicare spending on private plans that was 5.7 percent higher in 1989 and 7 percent higher in the mid-1990s than spending would have been under FFS Medicare (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996).

The Balanced Budget Act of 1997 required Medicare to improve risk adjustment for private plan payments and mandated the collection of diagnoses from inpatient claims. Initially, a small share of payment to plans was based on a new risk-adjustment model using principal inpatient diagnoses. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded risk adjustment to include the use of diagnoses from ambulatory settings. From 2004 through 2006, Medicare phased in the CMS hierarchical condition category (CMS–HCC) model, which uses diagnoses collected from hospital visits (both inpatient and outpatient) and physician office visits in addition to beneficiary demographic information.

The CMS–HCC risk-adjustment model, coupled with policies requiring plans to enroll all eligible Medicare beneficiaries who elect a plan and locking in MA enrollees for the calendar year (with limited exceptions), has generally reduced favorable selection for MA plans. However, some favorable selection likely persists as beneficiaries who use more services could be wary of plans' limits on provider choice and thus less likely to enroll in MA; those high service users who enroll in MA could be more likely to disenroll and return to FFS than beneficiaries who use fewer services (Jacobson et al. 2019, McWilliams et al. 2012, Newhouse et al. 2012). In particular, Medicare beneficiaries who are eligible for Medicaid have multiple opportunities to change coverage options during the calendar year. Although policies have reduced favorable selection, the CMS–HCC model's reliance on diagnosis codes creates a financial incentive for MA plans to document diagnosis codes more thoroughly than in FFS Medicare, so as to boost monthly payments to plans and increase extra benefits for enrollees. In 2020, differences in diagnostic coding caused Medicare to pay MA plans $12 billion more than it would have spent if the same beneficiaries had been enrolled in FFS Medicare.

### The CMS–HCC risk-adjustment model

The risk-adjustment model uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Higher risk scores generate higher payments because beneficiaries with high risk scores are expected to have higher expenditures and vice versa. CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for Medicare beneficiaries, with some constraints. In developing

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the model, CMS used statistical analyses to select certain HCCs for inclusion in the model based on an HCC's ability to predict annual Medicare expenditures, 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 applies additional criteria to ensure the validity and reliability of the model's diagnostic data. To be used in determining payment to MA plans, 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 (including real-time audio and video telehealth visits), and (2) be supported by evidence in the patient's medical record.[31] 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.

Diagnostic data in the CMS–HCC model are used prospectively, meaning that diagnoses collected during one calendar year are used to predict Medicare costs for the following calendar year. HCCs are counted toward an enrollee's risk score if any of the underlying diagnosis codes are submitted on a hospital or physician claim at any time during the data collection year. Multiple submissions of the same diagnosis code and submissions of different diagnosis codes that are grouped in the same HCC do not affect an enrollee's risk score.

MA plans submit diagnostic information to CMS in two ways: (1) through the Risk Adjustment Processing System (RAPS), to which plans submit the minimum information necessary to identify which HCCs apply to each enrollee, and (2) through the encounter data system (EDS), to which MA plans submit detailed information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee. CMS initially used only RAPS to calculate risk scores, but from 2016 through 2021, CMS phased in the use of encounters as the source of diagnostic information by generating two risk scores, one based on RAPS data and one based on EDS data.[32] Figure 12-4 (p. 434) shows the use of encounter data for risk adjustment since 2016. In that year, payment was based on a blend of the RAPS risk score (90 percent) and the EDS risk score

(10 percent). In 2017, CMS increased the portion of the payment based on EDS risk scores to 25 percent. Facing opposition from plans, CMS reduced the portion of the payment based on EDS risk scores to 15 percent in 2018, and in 2019 began pooling EDS data with inpatient RAPS data and basing the remainder of risk scores on RAPS data alone.[33]

In 2020, the share of risk scores based on pooled EDS and inpatient RAPS data increased to 50 percent and to 75 percent in 2021; for 2022, CMS will base risk scores entirely on encounter data with no use of RAPS data.[34] The Commission has strongly supported basing MA risk scores entirely on encounter data and urges CMS to increase incentives for plans to submit complete encounter data, which could serve multiple purposes.[35] For example, using encounter data as the basis for measuring MA plan quality would allow for more consistent quality measurement between MA and FFS and would provide an additional incentive for MA plans to submit complete encounter data.

## The incentive to code diagnoses more thoroughly in MA

Documenting additional diagnosis codes raises enrollees' risk scores, generating two distinct benefits for MA plans: (1) It boosts the monthly payment amount a plan receives, and (2) it increases the rebate amount a plan uses to provide extra benefits to enrollees, thereby giving plans that document relatively more diagnosis codes a competitive advantage over other plans.

### Documenting more diagnosis codes increases payments to plans

Each demographic and HCC component in the risk-adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated using FFS Medicare claims data such that all Medicare spending in a year is distributed among the model components. Medicare payment for an MA enrollee is approximately equal to the sum of the dollar-value coefficients for all components identified for that enrollee. Although the actual dollar amount a plan will receive for newly identifying an HCC depends on several additional factors, we consider a simplified example using average FFS Medicare spending to show how coding additional HCCs increases payment to a plan.[36] To illustrate, in 2018, the annual Medicare payment to an

**FIGURE
12–4**

**Risk scores were based partially on encounter data beginning
in 2016 and by 2022 were 100 percent based on encounter data**
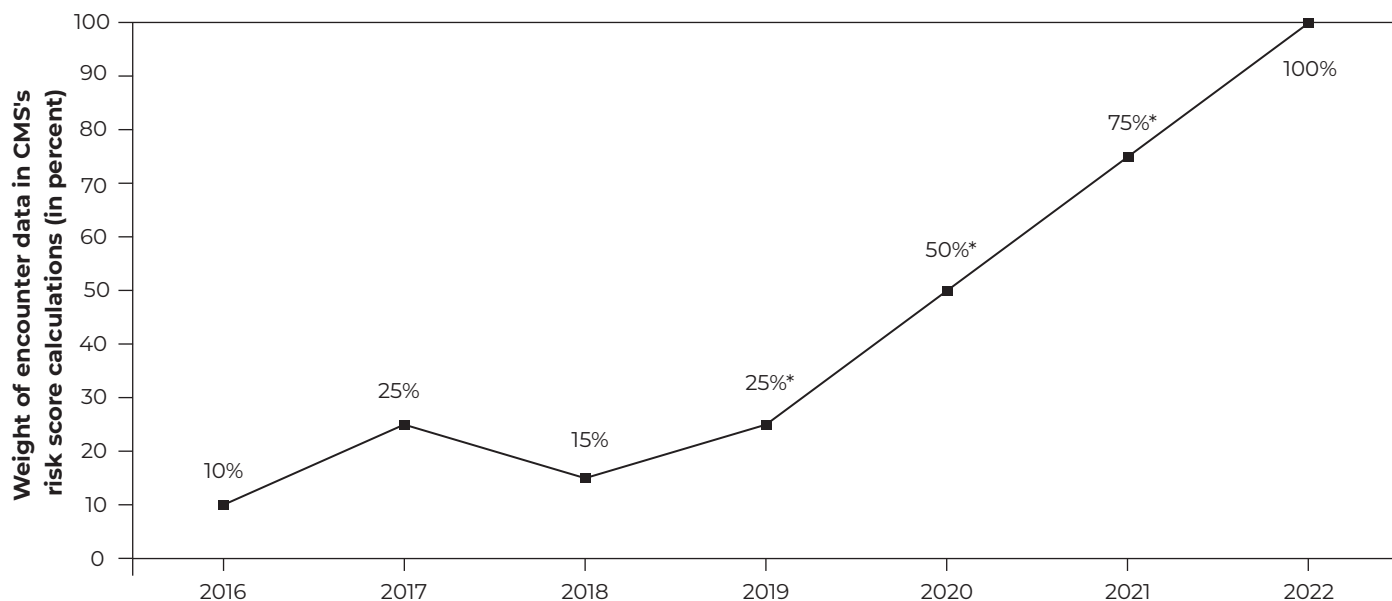


Note:    MA (Medicare Advantage). MA plans are required to submit to CMS detailed information about each Medicare-covered encounter an enrollee
has with a health care provider and each Medicare-covered item provided to the enrollee. From 2016 through 2021, CMS phased in the use of this
encounter data as the source of the diagnostic information used to calculate MA enrollee risk scores.
*For 2019, 2020, and 2021, CMS added inpatient Risk Adjustment Processing System data to encounter data, making the true proportion of risk
scores based on encounter data less than the percentage noted in the figure.

Source: CMS announcement of MA rates for 2016 through 2022.

MA organization for an 84-year-old male who was not
eligible for Medicaid (demographic component valued
at $5,707) with diabetes without complication (HCC 19,
valued at $1,058) would have been $6,765, the sum of
the two model components.

Documenting each additional HCC for an enrollee can
significantly increase the Medicare payment. If the
same 84-year-old male with diabetes were also found
to have vascular disease (HCC 108, valued at $3,031),
the Medicare annual payment to the MA organization
would increase from $6,765 to $9,796. The payment
per MA enrollee for most HCCs is between $1,000
and $5,000 per year, although some HCCs increase
payment by $10,000 or more.

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. However, 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 financial
incentives for MA plans to code as many diagnoses as
possible, coding intensity is higher in MA than in FFS

**FIGURE
12–5**

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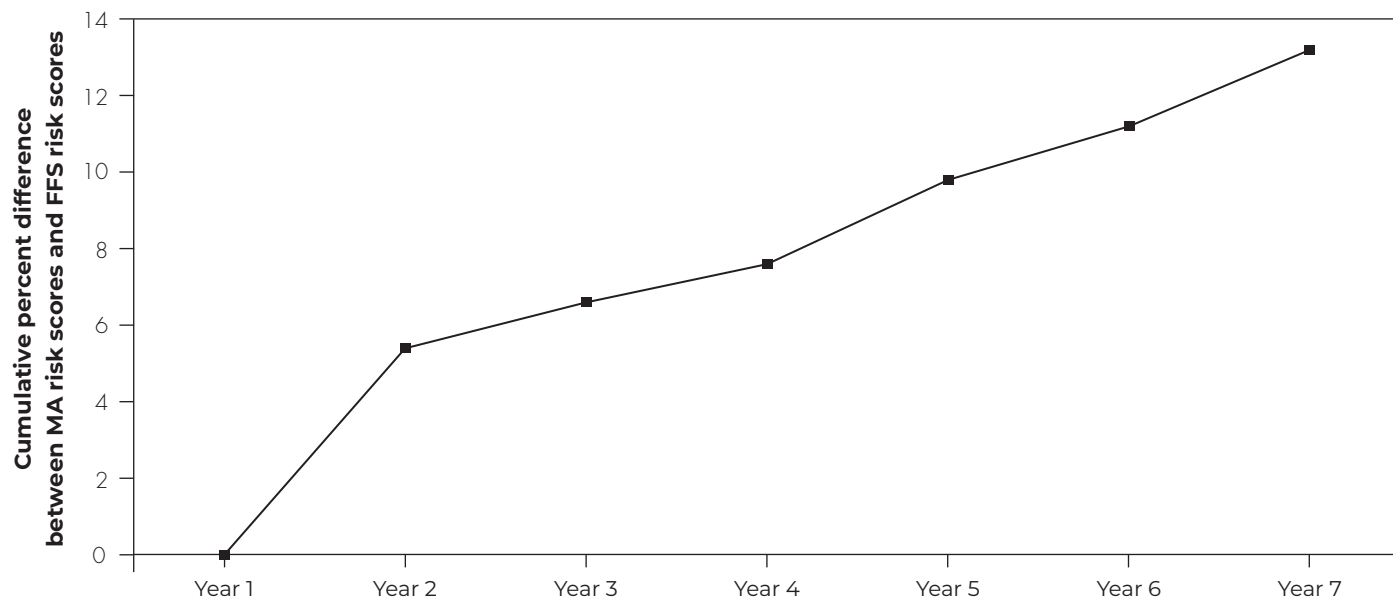


Note:    MA (Medicare Advantage), FFS (fee-for-service). Analysis includes six MA and FFS cohort pairs ending in 2013 and starting in 2007 through 2012.

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

Medicare, whose structure lacks such incentives, and payments to MA plans are thus higher than intended. Notably, the Next Gen accountable care organization (ACO) program and some alternative payment models (APMs) offer incentives to increase diagnostic coding intensity in FFS Medicare. Although the share of FFS Medicare payments that flow through ACOs and APMs is growing, we have yet to see a significant effect on FFS coding intensity overall.

We used data from 2007 through 2013 to test whether beneficiary risk scores grew faster in MA than in FFS. We built cohorts of beneficiaries who spent their first full calendar year of Medicare enrollment and subsequent years through 2013 in the same program, either FFS or MA. For example, one cohort pair consisted of beneficiaries who joined FFS Medicare in 2006 and then either (1) remained exclusively in FFS through 2013 or (2) switched into MA in January 2007 and remained in MA through 2013. We also examined

five similar pairs of cohorts for beneficiaries whose first full years in Medicare were 2008 through 2012. Beneficiaries were assessed starting with their first full year of Medicare enrollment, so that the subsequent differences in the risk score growth between the cohort pairs could be attributed to differences in coding.

From year 1 to year 2, average MA risk scores increased by about 6 percent more than FFS scores across all cohorts (Figure 12-5). For each subsequent year, average MA risk scores continued to increase more than FFS scores by about 1.5 percent across all cohorts.

Higher payments to MA plans due to differences in coding intensity between MA and FFS Medicare are the result of a failure in risk-adjustment policy, violating the assumption that diagnoses are documented with the same intensity in FFS Medicare (where less incentive exists) and in MA (where significant incentive

**TABLE**
**12–8**

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

| Plan | Bid: Monthly cost of care for expected population | Risk score of expected population | 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 (4 stars) | 900 | 0.97 | 1,000 | 970 | 70 | 46 |

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is $900 monthly for each of the three plans and that Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.
*All plans in this table have a rebate percentage of 65 percent based on their star ratings.

exists). MA plans that document an enrollee's additional diagnoses 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" section on pp. 443–444.)

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

Documenting as many diagnostic codes as possible results in bigger rebates for MA plans, which in turn allows a plan to offer their enrollees more extra benefits than if fewer diagnostic codes had been documented for the same set of enrollees. Plans offering more extra benefits than their competitor plans gain a competitive advantage in attracting 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, thereby widening the difference between the plan's bid and risk-adjusted benchmark, increasing the plan's rebate amount and ability to offer more extra benefits. In sum, plans can translate greater coding effort into a competitive advantage over other plans.

MA payment policies strive to create incentives for plans to lower spending and improve quality by offering more extra benefits and the potential to attract additional enrollees. By reducing health care costs, plans can reduce their bids, thereby increasing their rebate and extra benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase to 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 benefit beneficiaries through improved quality, more extra benefits, and reduced premiums and lower taxpayer funding for the Medicare program. However, these polices are undermined by diagnostic coding intensity, which

allows plans to offer more extra benefits without reducing health care costs or improving quality.

Table 12-8 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 below 1.0 (at 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, differences in coding can more than offset the effect of MA quality bonuses on the total value of extra benefits plans can offer and directly increase payment rates to plans, as described in the previous section. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z, which has 4 stars: Plan B's rebate amount is higher than Plan Z's ($52 per month vs. $46 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer a level of extra benefits that is of more value than that provided through quality bonuses.

The plans illustrated in Table 12-8 have a risk score difference of 6 percentage points that reflects only coding practices. The Commission's analysis of MA coding practices suggests that there is a far wider range of coding variation, with several contracts having risk scores inflated by 15 percent or 20 percent above FFS due to coding practices (see Figure 12-7, p. 442).

## Mechanisms of coding more diagnoses in MA

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. Diagnoses documented through these mechanisms generate higher coding intensity compared with FFS Medicare, resulting in excess payments to MA plans.

MA plans often identify enrollees with additional HCCs by using an enrollee's historical information (e.g., electronic health records, claims, or risk score data),

when it is available, or by identifying likely diagnoses in data that are not used in MA risk adjustment, such as prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Plans then need to ensure that all diagnoses are appropriately documented in the current year to count toward MA payment. This documentation can be facilitated by greater sharing of diagnostic information. For example, providers can give plans access to electronic medical records and, under capitated arrangements, pay physicians a risk-adjusted sum per enrollee, thereby passing the financial incentives to document more diagnoses on to physicians with direct access to medical records and diagnostic information. In addition, plans actively collect diagnoses through health risk assessments, chart reviews of earlier provider encounters, and pay-for-coding programs. In some pay-for-coding programs, plans send physicians a patient assessment form that includes diagnosis codes that the plan identifies for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Payment to the physician may be based on completing the form or paid as a dollar amount per diagnosis code submitted, and may include a bonus payment for submitting every code that the plan identifies for a beneficiary. While these efforts can be used to improve care management, some companies offering services to help plans collect diagnostic information use language that targets enrollees based on lack of documentation rather than clinical need.

Of all mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews. In a recent study, the Office of Inspector General (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 2021f). 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. (For 2017, we estimated that MA risk scores were about 7.1 percent higher than FFS risk scores before applying the mandatory coding adjustment.)

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

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 conduct health risk assessments. We calculated 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). We note that this amount is about 1.2 percent of payments to MA plans in 2017. Medicare should not reimburse MA plans for medical conditions that were not treated. At least one plan sponsor is alleged to have used its health risk assessment program to submit invalid and unsupported diagnosis codes to CMS with the knowledge of plan officials (United States of America ex rel. Robert A. Cutler v. Cigna Corp. 2020).

## MA plans' use of chart reviews to increase diagnosis coding

Some MA plans devote significant effort to chart reviews to increase MA payments. 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.

Some MA plans treat chart review programs as an independent revenue stream that yields a positive return on investment (ROI) by generating additional Medicare payments from newly documented diagnoses that exceed the costs of paying nurses and medical assistants to review medical charts.[37] 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 plan sponsor 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). Although 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 the beneficiaries funding the Medicare program.

Medicare accepts chart reviews as evidence of a diagnosis for risk adjustment. In RAPS data, plans do not identify the source of the information—provider claims or chart reviews—submitted for risk adjustment. For encounter data, plans submit 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). We note that this amount is about 3.2 percent of payments to MA plans in 2017. 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.

## Policies to address the impact of coding differences

A series of congressional mandates has 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 implements risk adjustment using MA diagnostic, cost, and use data. Although larger reductions are allowed under the legislation, CMS reduced MA risk scores by the minimum amount

required by law for 2014 through 2022. CMS took an additional step to help control MA's increased coding intensity by phasing in a new CMS–HCC model that removed some diagnoses suspected of being more aggressively coded by MA plans (e.g., lower-severity kidney disease and polyneuropathy). Our analysis suggests that the new CMS–HCC model made MA risk scores more similar to FFS scores by reducing them 2 percentage points to 2.5 percentage points relative to the old model. The new model was phased in during 2014 and 2015, and MA payments were based entirely on the new model starting in 2016.

Before 2017, the HCC model accounted for dual enrollment in Medicare and Medicaid with a set of variables that increased payment for such enrollees. This approach treated MA enrollees who qualify for full Medicaid benefits and those who qualify for partial Medicaid benefits as a single group, even though enrollees with full Medicaid benefits have significantly higher Medicare spending than enrollees with partial Medicaid benefits. As a result, risk scores under the old model were systematically too low for full-benefit dual enrollees and too high for partial-benefit dual enrollees.[38] Partial-benefit dual enrollees make up a larger share of MA dual enrollees compared with the share in FFS Medicare, causing the risk scores for MA enrollees with Medicaid benefits to be inflated under the old model. CMS began differentiating between MA enrollees with full Medicaid and partial Medicaid benefits in 2017 by using separate models that more accurately determine the risk scores of these two groups.[39] We found that the model introduced in 2017 reduced MA risk scores by almost 1 percentage point by more accurately determining risk scores for full-benefit and partial-benefit dual enrollees, among other subgroups.

## Coding differences increased payments to MA plans by $12 billion in 2020

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 2020. 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

FIGURE
12–6

**Impact of coding intensity on MA risk scores
was larger than coding adjustment, 2007–2020**
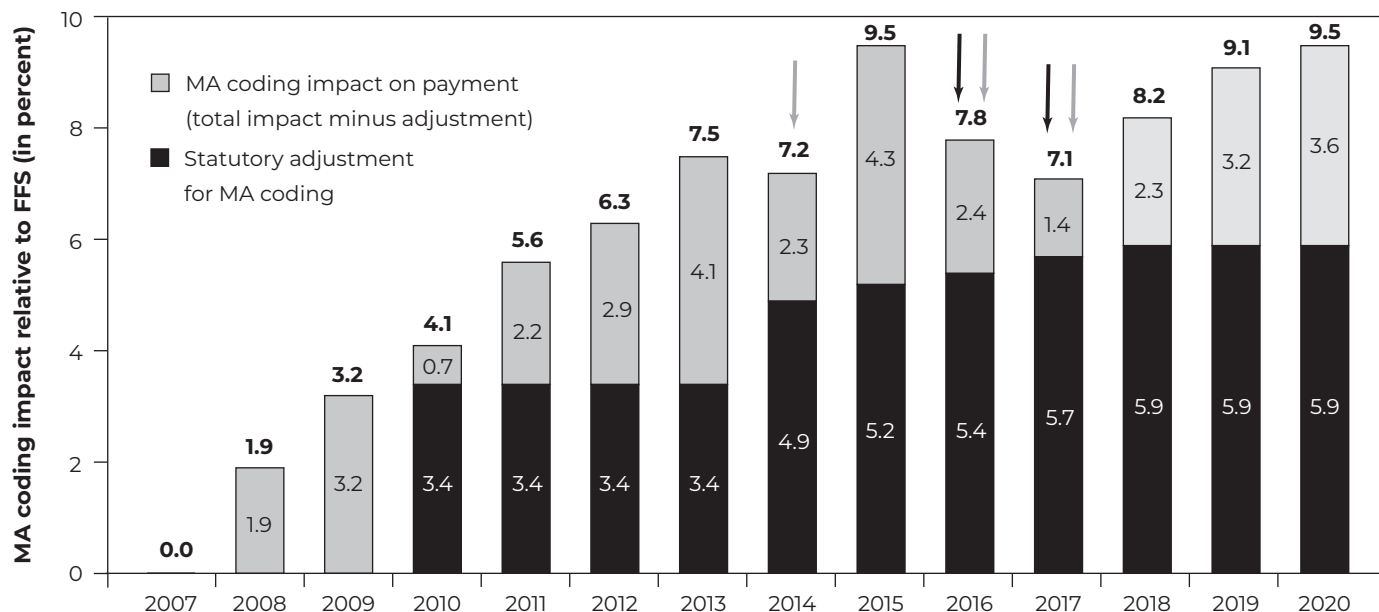


*MA coding intensity increased MA risk scores by 1 percentage point annually but was offset by new risk-adjustment
model versions in 2014, 2016, and 2017 (gray arrows) and by increased FFS coding in 2016 and 2017 (black arrows).*

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.

MA cohorts with the same years of enrollment (e.g.,
2007 through 2020, 2008 through 2020), adjusting for
differences in age and sex.

Figure 12-6 shows, for payment years 2007 through
2020, 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). 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 more intensive FFS coding. The coding
intensity adjustment has never fully accounted for

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

For 2020, MA risk scores were 9.5 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 3.6
percent increase in MA risk scores, leading to nearly $12
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

MedPAC

and Burns 2018, Kronick and Welch 2014). One recent analysis using a unique method has found that coding intensity could increase MA risk scores by much more than our estimate (Kronick and Chua 2021).

Expressed as a trend, MA coding intensity results in an increase in MA risk scores of about 1 percentage point per year relative to the FFS risk score trend (the trend was about 1.25 percentage points per year higher from 2004 through 2013 and about 1 percentage point per year higher from 2017 through 2019). However, Figure 12-6 shows deviations from this trend in 2014, 2016, and 2017, which we attribute to two factors:

- *Changes in the risk-adjustment model:* MA coding intensity fell in 2014, 2016, and 2017 due to the introduction of model versions that were less susceptible to MA and FFS diagnostic coding differences.

- *Changes in the relative growth rates of FFS and MA risk scores:* In 2016 and 2017, MA risk scores grew at about the same rate as in prior years, but FFS risk scores grew at a faster rate, likely caused by Medicare's transition from using International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes in October 2015.[40]

See our March 2021 MA chapter for a more detailed explanation of these two factors (Medicare Payment Advisory Commission 2021c).[41]

Between 2019 and 2020, the somewhat smaller increase in MA coding intensity (a 0.4 percentage point increase) was due to slower MA risk score growth, while FFS risk score growth remained about the same between the 2017 to 2019 period and the 2019 to 2020 period.

### Variation in coding intensity across MA contracts

For 2020, we continued to find that nearly all MA contracts had risk scores that were higher than FFS scores and that the impact of coding intensity across MA contracts varied widely. This finding is based on a similar analysis we conducted of average coding differences (using retrospective cohorts of 2020 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 first year that payment to MA plans was based entirely on CMS–HCC-model risk scores), but the change in risk score for each MA

beneficiary was attributed to the contract (excluding contracts in the Program of All-Inclusive Care for the Elderly and SNPs) in which the beneficiary was enrolled in 2020, thereby capturing the coding impact for each contract's 2020 payments. Figure 12-7 (p. 442) illustrates the variation across contracts with more than 2,500 enrollees in 2020 (less than 1 percent of MA enrollees were in contracts with fewer than 2,500 enrollees) relative to risk scores for FFS in their local service area.

Our finding that coding intensity varies across MA contracts is consistent with other research and is consistent with 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 plan sponsors (Geruso and Layton 2015, Kronick and Welch 2014, Office of Inspector General 2021f). Given this variation, CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by (1) reducing net coding intensity 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; and (2) undermining the competition-driven incentives for plans to lower costs and improve quality.
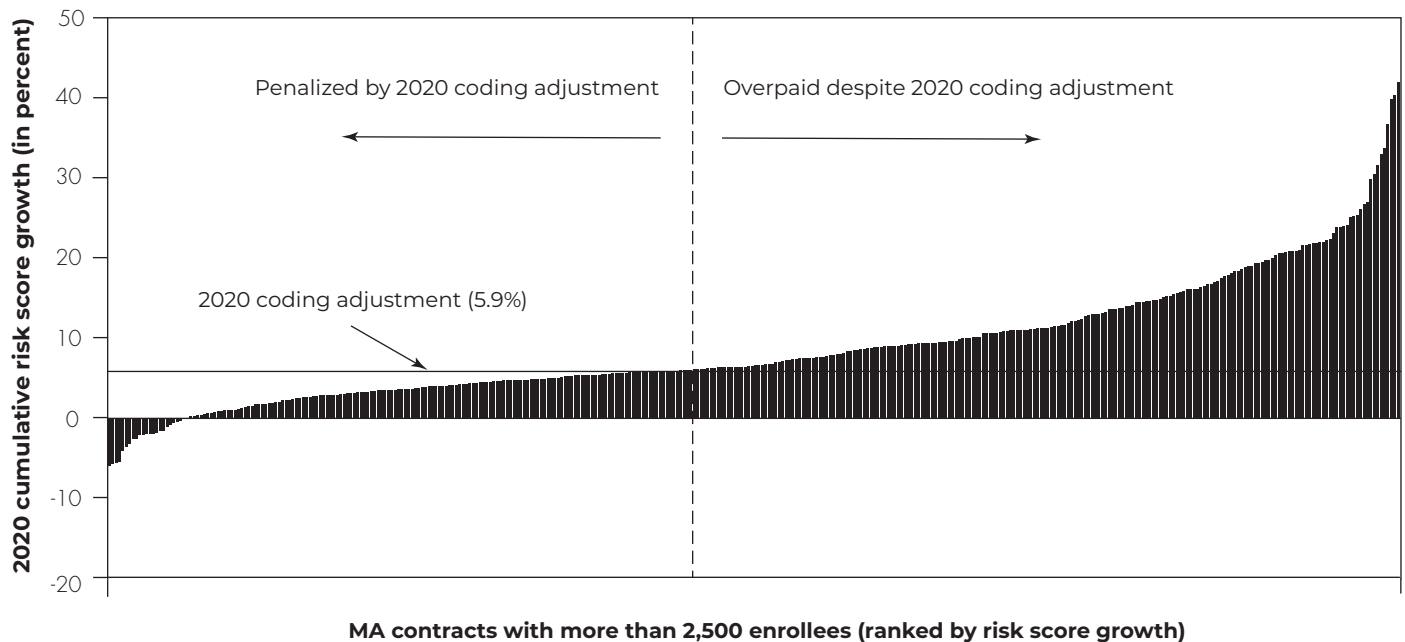
### The Commission's prior recommendation on coding intensity

The Commission's long-standing position is that Medicare payment policies should not unduly favor MA or FFS Medicare. Excess payments to MA plans may benefit enrollees in the MA program (when used to increase the value of extra benefits offered rather than increase profits) but cost taxpayers more than if these enrollees were covered in FFS Medicare. Further, excess payments to MA plans increase fiscal pressure on the Hospital Insurance (Part A) Trust Fund as well as on the taxpayers, beneficiaries, and state Medicaid programs that pay premiums to finance the Part B program.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, would improve the equity of the adjustment across MA contracts, and would increase the competitively driven incentives to reduce costs

FIGURE
12–7

**Cumulative MA risk score growth varied across contracts relative to local FFS, 2020**



Penalized by 2020 coding adjustment

Overpaid despite 2020 coding adjustment

2020 coding adjustment (5.9%)

**MA contracts with more than 2,500 enrollees (ranked by risk score growth)**

Note:    MA (Medicare Advantage), FFS (fee-for-service). Excludes MA contracts with enrollment below 2,500 (representing less than 1 percent of total MA enrollment), contracts for the Program of All-Inclusive Care for the Elderly, and special needs plans. Analysis is based on retrospective cohorts of 2020 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.

and improve quality. 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. The 21st Century Cures Act (the

Cures Act) codifies the Secretary's authority to use two years of diagnostic data in MA risk adjustment, stating that, for 2019 and subsequent years, "the Secretary may use at least two years of diagnosis data." However, CMS did not take this step in any of the rulemaking that implemented the Cures Act provisions. Removing diagnoses documented through only health risk assessments would mean that a diagnosis, to be counted in risk-adjustment calculations, would have to have been the subject of medical treatment. Diagnoses that were both documented on an assessment and associated with medical treatment 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—would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. We estimated that these policies' combined effect would reduce MA risk scores by roughly 3 percentage points to 5 percentage points relative to FFS Medicare and thus would address roughly half of the impact of coding differences.

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 (RADV) audits.[42] While this policy would leave some unevenness within each group of contracts, overall inequity would be reduced relative to an across-the-board adjustment. CMS could consider using a greater number of tiers to further refine the equity of the overall adjustment.

The Commission's recommendation does not address the use of chart reviews to increase MA risk scores and payments since data were not available in 2016. Recent analysis from OIG indicates that chart reviews are a significant driver of both MA coding intensity and the variation in coding intensity across MA contracts. The Commission's approach to addressing MA coding intensity has been to tackle the underlying causes (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. Eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach and would reduce the need for an across-the-board or tiered 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 covering both RAPS and encounter data that risk-adjustment criteria are applied correctly and submitted data are accurate, but only for encounter data is a more thorough review conducted in which CMS independently verifies that diagnoses are generated in the appropriate health care setting (hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional). The use of encounter data significantly improves oversight of payment data and offers the opportunity to ensure their validity before payments are made to MA plans. CMS must conduct RADV audits of both encounter and RAPS data to ensure that diagnoses are supported by the medical record, but RADV audits of RAPS data must also check whether diagnoses are made during an encounter with an appropriate type of provider.

RADV audits determine whether an MA plan was overpaid due to invalid data and are the basis for calculating an overpayment amount to recover from the plan.[43] 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 had at least 1 HCC reported and met certain other criteria.[44] 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.[45] For 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 recovering overpayments for the entire contract (of eligible enrollees) by extrapolating from the payment error rates for the sampled enrollees.[46]

RADV audits of MA contracts have been limited and their results are largely unreported. Audits of 2007 RAPS data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most

TABLE
12–9

**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.

contracts under audit (Schulte 2016). CMS recovered $13.7 million in overpayments from audits of 37 contracts, based on overpayments only for the 7,437 beneficiaries included in the audit sample (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008 through 2010. For audits of 2011, 2012, and 2013 payment years, CMS stated that it expects to recoup about $650 million in overpayments based on the extrapolation method (Centers for Medicare & Medicaid Services 2018). 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 due to delays related to the public health emergency. Table 12-9 summarizes the history of RADV audits and results.

In reviewing the RADV audit process, the Government Accountability Office noted that RADV audits are tasked with recouping billions of dollars in improper payments to MA plans based on RAPS data but 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 only the results of the RADV audits of 2007 data, OIG recently released the results of compliance audits for six MA contracts (see text box).

## 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 discussed the flaws in the 5-star system and the QBP and the continuing erosion in reliability of data used

Over the past year, the Office of Inspector General (OIG) reported its findings from audits of specific diagnosis codes for six Medicare Advantage (MA) contracts. These audits check whether diagnosis codes are supported by an enrollee's medical record as required by Medicare program rules. One of the audits found that $584,852 of the $701,593 that Medicare paid to one contract for certain diagnosis codes from 2014 through 2016 was not properly documented and recommended that the plan sponsor return the overpayment of $584,852 (Office of Inspector General 2021d). For the other five audits, OIG sampled beneficiaries with one or more hierarchical condition categories (HCCs) for the diagnosis codes under audit and extrapolated the error rate to the total payments to the plan for those HCCs. Using this method, OIG concluded that the MA organizations sponsoring these five contracts should return net overpayments of $3.5 million, $5.2 million, $6.4 million, $14.5 million, and $197.7 million (Office of Inspector General 2022, Office of Inspector General 2021a, Office of Inspector General 2021b, Office of Inspector General 2021c, Office of Inspector General 2021e). ∎

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to assess the quality of MA plans (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 in MA. The Commission's March 2019 report to the Congress contains a detailed discussion of the difficulty of evaluating the quality of care within the MA sector and changes in MA quality from one year to the next (Medicare Payment Advisory Commission 2019b). During the coronavirus public health emergency, CMS has relaxed quality reporting rules, boosting star ratings for many plans and generating a windfall for plans in 2023 (see text box on quality bonuses, p. 446).

Good information on the quality of care that MA enrollees (46 percent of eligible Medicare beneficiaries) receive and how that quality compares with quality in FFS Medicare, including in ACOs, 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 a lack of sufficient data severely limits any definitive comparisons between MA and FFS Medicare.

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. 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 area.

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 to changes for commercial plans (plans covering the employer group and non-group markets that are not eligible to participate in the Medicare QBP).

## Quality bonuses under the coronavirus public health emergency

Despite the substantial flaws in the quality bonus program, the program significantly boosts payments to Medicare Advantage (MA) plans each year. Our prior analyses showed 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 2020a). Figure 12-8 shows that the share of MA enrollees in plans receiving a bonus benchmark has increased (by achieving a star rating of 4 stars or higher) 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 12-8 (Medicare

Payment Advisory Commission 2020a). Under the coronavirus public health emergency (PHE), CMS relaxed quality reporting rules, essentially allowing plans to apply the higher of 2019 or 2020 quality measure results for measures making up about 40 percent of 2022 star ratings (Health Management Associates 2021). The 2022 star ratings are used by Medicare beneficiaries to make their coverage decisions for 2022 and are used in the calculation of 2023 payment rates. The reporting flexibility during the PHE 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 will receive a windfall in 2023. ∎

**FIGURE
12–8**

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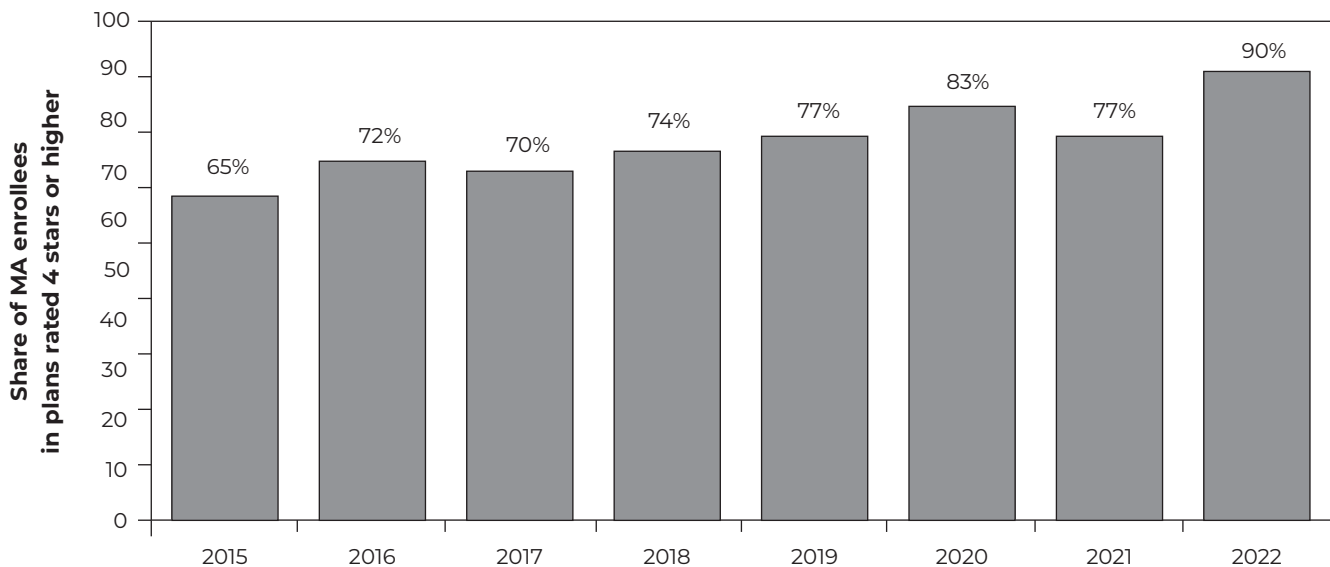


Note: MA (Medicare Advantage), PHE (public health emergency). Before 2020, many MA plans used contract consolidations to artificially increase star ratings. For 2022 star ratings, flexible reporting rules were allowed under the PHE.

Source: MedPAC analysis of CMS enrollment and star rating reports for 2015 through 2022.

The authors found 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 the Commission's 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 2020a).

## Mandated report: Comparing the performance of D–SNPs and other plans that serve dual-eligible beneficiaries

Dual-eligible special needs plans (D–SNPs) are specialized MA plans that limit their enrollment to beneficiaries who receive both Medicare and Medicaid. The Bipartisan Budget Act (BBA) of 2018 permanently authorized D–SNPs and, starting in 2021, required them to meet new standards for integrating the delivery of Medicare and Medicaid services. The BBA of 2018 mandated that the Commission periodically compare the performance of different types of D–SNPs and other plans that serve dual-eligible beneficiaries. This analysis constitutes our first report under the mandate, which we are required to submit to the Congress by March 15, 2022. We find that the performance data that MA plans report as part of the Healthcare Effectiveness Data and Information Set® (HEDIS®) provide limited insight on the relative performance of D–SNPs. This finding is consistent with previous Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

### D–SNP integration requirements

Dual-eligible beneficiaries, as a group, are often in poor health and may have trouble obtaining well-coordinated care because they receive services from two separate programs. D–SNPs are based on the rationale that this population will receive better care from a specialized MA plan that is tailored to meet their distinct care needs than they would from a traditional MA plan.

The extent to which D–SNPs must integrate the delivery of Medicare and Medicaid services has evolved over time. When D–SNPs were first authorized in 2003, they did not have to meet any specific requirements for integration. The Congress enacted the first requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Since 2010, MIPPA has required D–SNPs to have Medicaid contracts that meet certain minimum requirements, such as specifying the plan's service area, the Medicaid services the plan provides (if any), and its responsibility to coordinate the delivery of Medicaid services for its enrollees. Later in 2010, with the Affordable Care Act of 2010, the Congress added requirements for plans to qualify as a *fully integrated dual-eligible* SNP (FIDE–SNP). These plans must be offered by an entity

**TABLE
12–10**

**In 2021, most D–SNP enrollees were in plans with a low level of integration**

| Type of plan | Plans | | Enrollment (in thousands) | |
|---|---|---|---|---|
| | Number | Share | Number | Share |
| Coordination-only D–SNP | 338 | 59% | 1,904 | 57% |
| HIDE–SNP or FIDE–SNP without exclusively aligned enrollment | 164 | 28 | 1,150 | 35 |
| HIDE–SNP or FIDE–SNP with exclusively aligned enrollment | 72 | 13 | 260 | 8 |
| Total, all D–SNPs | 573* | 100 | 3,313 | 100 |

Note: D–SNP (dual-eligible special needs plan), HIDE–SNP (highly integrated dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan). We counted the number of plans using unique combinations of contract number and plan number. Figures are based on July 2021 enrollment and do not include plans in the U.S. territories. Components may not sum to totals because of rounding.
*In 2021, one D–SNP operated in both North Carolina and Virginia but met different integration standards in the two states (coordination-only in North Carolina and HIDE–SNP without exclusively aligned enrollment in Virginia). We included that plan in the plan count for each integration standard, so the unduplicated number of D–SNPs was 573 rather than 574.

Source: MedPAC analysis of CMS enrollment and D–SNP integration data.

that has a capitated Medicaid contract to provide both institutional and community-based long-term services and supports (LTSS) and can receive higher Medicare payments if their enrollees have high levels of functional impairment.

The BBA of 2018 made the authorization for D–SNPs permanent—previously, it had been temporary—and built on the MIPPA standards by requiring D–SNPs, starting in 2021, to meet one of three additional criteria for integration:

- The plan meets a minimum set of requirements, determined by the Secretary, to coordinate the delivery of LTSS, behavioral health, or both for plan enrollees. CMS specified through regulation that these plans must notify the state about admissions to inpatient hospitals and skilled nursing facilities for at least one group of "high-risk" full-benefit dual eligibles, which is defined by the state. CMS refers to these plans as *coordination-only D–SNPs*; they have the lowest level of integration because they do not have to provide any Medicaid services (plan enrollees instead receive those services through a Medicaid FFS program or a separate Medicaid managed care plan).

- The plan qualifies as a FIDE–SNP or as a *highly integrated dual-eligible* SNP (HIDE–SNP) by having a capitated Medicaid contract to provide LTSS, behavioral health, or both. FIDE–SNPs have the highest level of integration because they provide a broad range of Medicaid services, including substantial LTSS coverage. HIDE–SNPs fall somewhere in the middle: They are more integrated than coordination-only plans because they provide some Medicaid services, but less integrated than FIDE–SNPs because their Medicaid contracts are not as extensive and they can use a wider variety of contracting arrangements with states.

- The plan assumes "clinical and financial responsibility" for both Medicare and Medicaid benefits provided to its enrollees. CMS has defined these plans as HIDE–SNPs or FIDE–SNPs that have exclusively aligned enrollment, which means that enrollment in the D–SNP is limited to dual eligibles who receive their Medicare and Medicaid benefits from the same parent company. Under a separate BBA of 2018 provision, these plans must have a unified process for handling appeals and grievances

Section 50311(b)(1) of the Bipartisan Budget Act of 2018 reads (in part):

(E) STUDY AND REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than March 15, 2022, and, subject to clause (iii), biennially thereafter through 2032, the Medicare Payment Advisory Commission established under section 1805 … shall conduct (and submit to the Secretary and the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on) a study to determine how specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) perform among each other based on data from Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, reported on the plan level, as required under section 1852(e)(3) (or such other measures or data sources that are available and appropriate, such as encounter data and Consumer Assessment of Healthcare Providers and Systems data, as specified . . . as enabling an accurate evaluation under this subparagraph). Such study shall include, as feasible, the following comparison groups of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii):

(I) A comparison group of such plans that are described in subparagraph (D)(i)(I).

(II) A comparison group of such plans that are described in subparagraph (D)(i)(II).

(III) A comparison group of such plans operating within the Financial Alignment Initiative demonstration for the period for which such plan is so operating and the demonstration is in effect, and, in the case that an integration option that is not with respect to specialized MA plans for special needs individuals is established after the conclusion of the demonstration involved.

(IV) A comparison group of such plans that are described in subparagraph (D)(i)(III).

(V) A comparison group of MA plans, as feasible, not described in a previous subclause of this clause, with respect to the performance of such plans for enrollees who are special needs individuals described in subsection (b)(6)(B)(ii).

(ii) ADDITIONAL REPORTS.—Beginning with 2033 and every five years thereafter, the Medicare Payment Advisory Commission … shall conduct a study described in clause (i). ∎

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(instead of separate processes for Medicare-covered and Medicaid-covered services).

This year, D–SNPs are available in 45 states and the District of Columbia (including South Dakota and Wyoming, which had never had D–SNPs before). The only states without them are Alaska, Illinois, New Hampshire, North Dakota, and Vermont.

In 2021, about 3.3 million dual-eligible beneficiaries were enrolled in D–SNPs (Table 12-10). More than half of those beneficiaries (57 percent) were enrolled in coordination-only D–SNPs, which have the lowest level of integration. Another 35 percent were enrolled in HIDE–SNPs or FIDE–SNPs that did not have aligned enrollment, and 8 percent were enrolled in HIDE-SNPs or FIDE–SNPs with aligned enrollment. Although HIDE–SNPs and FIDE–SNPs may meet either the second or third integration criteria, depending on their use of aligned enrollment, HIDE–SNPs account for 95 percent of the enrollment for plans meeting the second criterion and FIDE–SNPs account for 87 percent of the enrollment for plans meeting the third criterion (figures not shown in table).

## Mandated report

The BBA of 2018 directs the Commission to periodically examine how D–SNPs "perform among each other" using HEDIS quality measures or other data sources, such as plan encounter data or the Consumer Assessment of Healthcare Providers and Systems beneficiary survey, as appropriate (see text box for the

legislative language of the mandate, p. 449). The first mandated report is due by March 15, 2022, and must be updated every two years through 2032. After that, the schedule changes, with another report due in 2033 and updates required every five years.

To the extent feasible, these reports must compare five types of plans that serve dual-eligible beneficiaries: three types of D–SNPs (divided based on the BBA of 2018's integration criteria), Medicare-Medicaid Plans (MMPs) (which operate under CMS's financial alignment demonstration), and other MA plans (but looking only at the dual eligibles enrolled in those plans).

For this report, we analyzed person-level HEDIS data for measurement year 2020, the most recent available. HEDIS is a set of quality measures that has been developed by the National Committee for Quality Assurance to evaluate health plans. CMS requires both MA plans and MMPs to collect and report data annually for a subset of HEDIS measures.

The person-level HEDIS data have both beneficiary and plan identifiers, which we used to identify beneficiaries enrolled in D–SNPs, MMPs, and other MA plans and to determine which beneficiaries in other MA plans were dual-eligible beneficiaries. In 2020, about 53 percent of all dual eligibles were enrolled in Medicare's FFS program, 24 percent were enrolled in a D–SNP, 19 percent were enrolled in some other type of MA plan, and 3 percent were enrolled in an MMP. We divided the D–SNP enrollees into three groups based on the BBA of 2018's integration criteria that each plan met in 2021.

CMS typically requires plan sponsors to collect and report HEDIS data at the contract level, but the BBA of 2018 mandate directs the Commission to use data reported at the plan level. The distinction between contract-level and plan-level data is important for certain measures. Plan sponsors rely exclusively on administrative data (such as encounter data) as the source for many measures, but there are some "hybrid" measures for which sponsors can or must use both administrative data and data collected from a sample of enrollee medical records. When sponsors rely entirely on administrative data for a measure, they report HEDIS data for every enrollee under a given contract, which makes it feasible to calculate scores for either the entire contract or any individual plan offered under that contract.

In contrast, when sponsors report data for hybrid measures, they collect data for a random sample of 411 enrollees, which is chosen at the contract level. Since most contracts have multiple plans, this sample is too small to generate reliable plan-level estimates. CMS requires MA plan sponsors to report plan-level data for a subset of HEDIS measures for all types of special needs plans, including D–SNPs. That subset includes some hybrid measures, but sponsors are not required to collect any additional data for them, so the plan-level scores for them are not reliable. As a result, our analysis excludes four hybrid measures—colorectal cancer screening, controlling high blood pressure, comprehensive diabetes care, and transitions of care. CMS may want to consider requiring plan sponsors that collect data from medical records to use large enough samples (411 enrollees at the plan level) to generate reliable estimates for SNPs.

For each comparison group, we calculated scores for 22 HEDIS measures that had a total of 35 associated rates (Table 12-11, pp. 452–453). Some measures have more than one associated rate: For example, the measure on follow-up after an emergency department visit for mental illness has two rates, one for 7-day follow-up and one for 30-day follow-up.

The results from this analysis are mixed—each plan type performed relatively well on some measures and relatively poorly on others—and do not clearly favor one plan type over the others. Drawing broader conclusions from this analysis is challenging due to underlying differences in the five comparison groups. Although each comparison group represents a plan type that serves dual-eligible beneficiaries, they nonetheless differ in ways that make it difficult to compare their HEDIS scores. For example, the groups differ in the following three areas:

- *Geographic distribution of enrollment.* Most beneficiaries have access to MA plans—this year, 99 percent live in counties where at least one plan is available and 94 percent live in counties where at least one D–SNP is available—but the share who are enrolled in plans nonetheless varies geographically. This variation is particularly pronounced for the more highly integrated plans, which are not as widely available. For example, in 2021, FIDE–SNPs and MMPs were available in only 12 states and 9 states, respectively, and about 85 percent of the

enrollment in each plan type was in just 5 states. This variation means that differences in HEDIS scores across the five comparison groups could be influenced by factors such as regional differences in disease prevalence, access to care, and physician practice patterns.

- *Type of dual-eligible beneficiaries enrolled.* Depending on their circumstances, dual eligibles may qualify for full benefits, which can include important wraparound services such as LTSS and behavioral health, or partial benefits, which are limited to assistance with Medicare premiums and cost sharing. As a group, partial-benefit dual eligibles tend to have somewhat better health and lower costs than full-benefit dual eligibles (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018). The share of enrollees who qualify for full or partial benefits varies significantly across the five plan types. For example, in 2020, partial-benefit dual eligibles accounted for 55 percent of the dual-eligible beneficiaries enrolled in other MA plans and 28 percent of D–SNP enrollees, but only 2 percent of FIDE–SNP enrollees and less than 1 percent of MMP enrollees. Even if the analysis were limited to full-benefit dual eligibles, the differences in HEDIS scores could be partly due to differences in the geographic distribution of enrollment across the comparison groups and variation in state Medicaid eligibility requirements.

- *Structural differences between MMPs and MA plans.* MMPs are demonstration plans and thus distinct from MA plans. The two plan types differ in many ways, and differences in their enrollment models and quality incentives could affect their relative performance on HEDIS measures. In MA, almost all beneficiaries enroll voluntarily, while in MMPs, many beneficiaries have been passively enrolled by states. MMPs might have more difficulty engaging with passive enrollees, which could contribute to their poor performance on some measures. Both types of plans have quality incentives, but the incentive for MA plans is structured as a bonus (higher payments for plans with a rating of 4 stars or better) while the incentive for MMPs is structured as a quality

withhold (lower payments for plans that do not meet performance thresholds), and they are not evaluated on the same measures. Three HEDIS measures (statin therapy for cardiovascular patients, osteoporosis management in women who had a fracture, and breast cancer screening) are used in the MA star ratings but not the MMP quality withhold, and MA plans performed better than MMPs on all three. Conversely, one measure (follow-up after hospitalization for mental illness) is used in the MMP quality withhold but not the MA star ratings, and MMPs performed better on that measure. Some of the differences in HEDIS scores may thus reflect differences in the financial incentives that plans have to focus on certain measures over others.

The challenges of using HEDIS measures to assess performance also reflect larger difficulties in assessing the quality and performance of MA plans (both in terms of how well individual plans perform compared with each other and how well MA plans perform compared with the FFS program). Most HEDIS measures are process measures that are not tied to clinical outcomes, but the Commission holds that measures tied to clinical outcomes and patient experience are more suitable for assessing quality (Medicare Payment Advisory Commission 2018b). CMS includes some process measures in the calculation of the MA star ratings, accounting for about 30 percent of a plan's overall star rating, but gives more weight to outcomes and patient experience measures (Medicare Payment Advisory Commission 2020a).

In 2020, the Commission recommended replacing the MA quality bonus program with a new MA value incentive program (MA–VIP) that uses a small set of measures tied to clinical outcomes and patient experience to evaluate plan performance (Medicare Payment Advisory Commission 2020a). We developed a set of potential MA–VIP measures to illustrate how our recommendation would work, but it included just four HEDIS measures—breast cancer screening, colorectal cancer screening, controlling high blood pressure, and hemoglobin A1c control for diabetics. Although we consider these four to be among the more meaningful HEDIS measures, we had to exclude three of them from our analysis because they are hybrid measures that may be based on data that plan sponsors collect by sampling medical records, and those samples do not produce reliable plan-level estimates.

TABLE
12–11

## HEDIS® scores for measurement year 2020, by plan type

| Measure | Coordination-only D–SNPs | Unaligned HIDE–SNPs and FIDE–SNPs | Aligned HIDE–SNPs and FIDE–SNPs | MMPs | Other MA plans |
|---|---|---|---|---|---|
| **Access/availability of care** | | | | | |
| Adults' access to preventive/ambulatory health services | 95.7% | 95.6% | 96.8% | 90.3% | 95.4% |
| Initiation and engagement of alcohol and other drug abuse or dependence treatment | | | | | |
| Initiation | 37.8 | 27.0 | 32.7 | 37.1 | 33.1 |
| Engagement | 6.8 | 4.3 | 5.5 | 7.1 | 5.0 |
| **Effectiveness of care: Behavioral health** | | | | | |
| Antidepressant medication management | | | | | |
| Effective acute phase treatment | 73.8 | 76.2 | 80.6 | 74.4 | 78.5 |
| Effective continuation phase treatment | 57.2 | 58.6 | 67.4 | 59.1 | 62.7 |
| Follow-up after emergency department visit for alcohol and other drug abuse or dependence | | | | | |
| 7-day follow-up | 10.5 | 9.7 | 11.5 | 14.1 | 10.6 |
| 30-day follow-up | 15.2 | 13.9 | 17.8 | 21.0 | 15.5 |
| Follow-up after hospitalization for mental illness | | | | | |
| 7-day follow-up | 28.3 | 31.2 | 31.3 | 42.0 | 26.2 |
| 30-day follow-up | 48.9 | 50.6 | 53.0 | 62.5 | 44.9 |
| Follow-up after emergency department visit for mental illness | | | | | |
| 7-day follow-up | 32.8 | 32.3 | 51.9 | 52.8 | 31.0 |
| 30-day follow-up | 48.7 | 50.1 | 65.4 | 68.0 | 46.2 |
| Adherence to antipsychotic medications for individuals with schizophrenia | 74.3 | 77.4 | 82.2 | 79.5 | 77.0 |
| **Effectiveness of care: Cardiovascular conditions** | | | | | |
| Persistence of beta-blocker treatment after a heart attack | 88.2 | 88.2 | 90.4 | 90.7 | 90.1 |
| Statin therapy for patients with cardiovascular disease | | | | | |
| Received statin therapy | 83.9 | 84.2 | 83.9 | 83.2 | 84.6 |
| Statin adherence 80% | 82.9 | 83.9 | 86.5 | 82.2 | 84.5 |
| **Effectiveness of care: Diabetes** | | | | | |
| Kidney health evaluation for patients with diabetes | 40.0 | 50.3 | 40.4 | 39.7 | 44.4 |
| Statin therapy for patients with diabetes | | | | | |
| Received statin therapy | 78.9 | 79.7 | 82.0 | 77.1 | 79.2 |
| Statin adherence 80% | 82.2 | 82.6 | 86.2 | 81.6 | 82.9 |

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| Measure | Coordination-only D–SNPs | Unaligned HIDE–SNPs and FIDE–SNPs | Aligned HIDE–SNPs and FIDE–SNPs | MMPs | Other MA plans |
|---|---|---|---|---|---|
| **Effectiveness of care: Medication management and care coordination** | | | | | |
| Follow-up after emergency department visit for people with multiple high-risk chronic conditions | 55.8 | 57.9 | 60.6 | 58.2 | 55.2 |
| **Effectiveness of care: Musculoskeletal conditions** | | | | | |
| Disease-modifying antirheumatic drug therapy for rheumatoid arthritis | 76.8 | 77.8 | 79.3 | 76.9 | 78.6 |
| Osteoporosis management in women who had a fracture | 41.1 | 42.0 | 30.5 | 19.3 | 39.7 |
| **Effectiveness of care: Overuse/appropriateness (lower scores indicate better performance)** | | | | | |
| Use of high-risk medications in older adults | | | | | |
|   At least 1 dispensing event | 17.5 | 17.3 | 18.0 | 14.5 | 15.0 |
|   At least 2 dispensing events | 5.3 | 6.4 | 6.7 | 4.7 | 6.6 |
| Potentially harmful drug-disease interactions in older adults | | | | | |
|   History of falls | 40.8 | 39.9 | 39.3 | 36.3 | 39.4 |
|   Dementia | 42.9 | 46.7 | 42.8 | 41.5 | 42.2 |
|   Chronic kidney disease | 13.5 | 15.5 | 12.8 | 13.9 | 10.6 |
| Use of opioids at high dosage | 6.0 | 8.6 | 7.0 | 4.5 | 6.9 |
| Nonrecommended PSA-based screening in older men | 24.7 | 29.5 | 21.8 | 22.3 | 25.9 |
| Use of opioids from multiple providers | | | | | |
|   Multiple pharmacies | 2.5 | 2.2 | 2.5 | 2.4 | 1.9 |
|   Multiple prescribers | 15.8 | 13.1 | 14.3 | 15.2 | 13.6 |
|   Multiple prescribers and pharmacies | 1.2 | 1.0 | 1.0 | 1.3 | 0.9 |
| **Effectiveness of care: Prevention and screening** | | | | | |
| Breast cancer screening | 71.5 | 72.9 | 69.9 | 60.1 | 69.8 |
| **Effectiveness of care: Respiratory conditions** | | | | | |
| Pharmacotherapy management of COPD exacerbation | | | | | |
|   Systemic corticosteroid | 72.4 | 70.1 | 71.5 | 73.5 | 71.7 |
|   Bronchodilator | 85.4 | 85.1 | 88.8 | 88.3 | 83.6 |
| Use of spirometry testing in the assessment and diagnosis of COPD | 29.9 | 31.0 | 29.1 | 21.7 | 26.4 |

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), D–SNP (dual-eligible special needs plan), HIDE–SNP (highly integrated dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan), MA (Medicare Advantage), PSA (prostate-specific antigen), COPD (chronic obstructive pulmonary disease). Figures do not include plans in the U.S. territories.

Source: MedPAC analysis of HEDIS person-level data for measurement year 2020 and D–SNP integration data for 2021.

In 2019, the Commission examined the completeness and accuracy of MA encounter data. We believe that encounter data could be a rich source of information about the services that MA enrollees use, but we found that the encounter data that have been collected to date are not complete enough to accurately compare utilization among different MA plans or between MA and FFS (Medicare Payment Advisory Commission 2019a). ∎

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# Endnotes

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

2   CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.1 percent of FFS spending (Centers for Medicare & Medicaid Services 2021a). FFS-claim administrative expenses are included in our comparison of FFS spending with MA payments and differ from those reported 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).

3   Payments described here are for enrollees without end-stage renal disease (ESRD), representing the vast majority of MA enrollees. 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).

4   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.

5   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 (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.

6   ACA payment formulations include an administratively determined cap on each county's benchmark. The law included a provision that 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).

7   To account for coding differences in 2022, we conservatively assume that the impact of coding intensity in 2022 is the same as in 2020. The coding intensity trend from 2017 to 2020 suggests that the impact in 2022 may be higher than in 2020. We will continue to evaluate this trend. Our estimate of MA payments relative to FFS spending does not account for other potential factors that we cannot 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, potential favorable selection of beneficiaries who choose to either switch from FFS to MA or exit MA, 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.

8   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).

9   As of June 2020, Medicare beneficiaries with Medicaid benefits who have full dual eligibility—that is, those who have Medicaid coverage for their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports—are less likely to enroll in MA plans than beneficiaries with "partial" dual eligibility.

10  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).

11  MA enrollees with hospital stays greater than five days typically have greater cost sharing for those stays compared with beneficiaries in FFS with no supplemental coverage (Freed et al. 2020).

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   By contrast, in some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans. For example, in Anchorage, AK, where only employer group plans are available, 1 percent of beneficiaries were enrolled in MA in 2021.

14   The Commission has also found that the risk-adjustment model tends to underpredict spending for beneficiaries with no medical conditions (Medicare Payment Advisory Commission 2020a). If a disproportionate share of a county's FFS beneficiaries had no medical conditions, the risk-adjusted average FFS spending estimate would be too high.

15   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).

16   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 of cost plans are not locked into the plan and can receive any out-of-network services, which Medicare pays for. The statute calls for the phasing out of cost plans in areas in which there are at least two competing MA CCPs that meet a minimum enrollment requirement. The cost plans are expected to transition to MA plans, and some have already begun the transition.

17   Market concentration is traditionally computed using the Herfindahl–Hirschman Index. The 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 and 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. Using 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   Plans estimate administrative expenses and margins separately for cost-sharing reductions. The allocated $70 per enrollee per month for cost sharing includes administrative expenses of 10 percent and a margin of 1 percent.

19   CMS estimates that the 2021 monthly actuarial value of Medicare deductibles and coinsurance for a beneficiary without end-stage renal disease is $178.37 (Centers for Medicare & Medicaid Services 2021a). The Commission has previously summarized the evidence on the effects of cost sharing on Medicare spending, recommended an additional charge on supplemental insurance (Medicare Payment Advisory Commission 2012a), and found (in a commissioned study) higher Medicare spending for beneficiaries with Medigap coverage (Hogan 2009).

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

21   Plans estimate administrative expenses and margins separately for supplemental benefits. The allocated $36 per enrollee per month for supplemental benefits includes administrative expenses of 11 percent and a margin of 3 percent.

22   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.

23   One study of the 2018 Medicare Current Beneficiary Survey found that Medicare beneficiaries enrolled in MA plans were somewhat more likely to experience cost-related problems with accessing health care (Fuglesten Biniek et al. 2021b).

24 When submitting Part D bids, plans may allocate administrative expenses and margin toward the Part D revenue that results from projected Part C (i.e., MA) rebates.

25 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 new 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. For example, 2022 MA benchmarks use shared savings payments to accountable care organizations through 2019. From 2018 to 2019, these payments rose from $1.2 to $1.9 billion (a 60 percent increase). 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).

26 Payment rates for employer plans are calculated based on the bid to benchmark ratios of MA plans in the prior year. CMS separately calculates the bid to benchmark ratios for each plan type (i.e., PPO, HMO) and quartile. The final county payment rates for employer plans are calculated by weighting each plan type within each quartile by the employer plan enrollment in each of those respective plan types and quartiles.

27 An analysis 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. 2021a). This finding is similar in magnitude to the Commission's 2019 estimate of MA payments relative to FFS spending for MA-eligible beneficiaries.

28 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 outliers (13 contracts accounting for 5 percent of reported plan revenues) 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 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. Most of the outlier contracts we identified reported negative margins in the bid data for consecutive years— indicating that these contracts are reporting unreliable data. Specifically, 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.

29 MA plans annually report their medical loss ratios (MLRs) to CMS, which differs 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 2020, plans submitted MLRs to CMS in December 2021, and CMS will begin subtracting amounts from regular monthly plan payments in July 2022 to recoup any revenue difference between a plan's actual MLR and the 85 percent minimum MLR.

30 The ACA insurer fee was in effect in 2020 but is entirely repealed in all subsequent years.

31 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 the diagnosis.

32 In 2015, CMS combined RAPS data and encounter data for risk adjustment, meaning that plans were paid for HCCs identified through at least one of the two data sources submitted to CMS.

33 CMS pooled inpatient RAPS data with encounter data because the agency found that inpatient encounter record submissions were low relative to inpatient RAPS submissions, implying that some inpatient encounter records were missing and inpatient RAPS data were needed in their place. Our analysis concluded that the RAPS data were faulty (specifically, the provider type was indicated to be inpatient hospital when the provider was likely an outpatient hospital or physician), and in comment letters we stated that RAPS inpatient data should not be pooled with encounter data. Our analysis leading to this conclusion is more thoroughly described in the March 2019 report to the Congress (Medicare Payment Advisory Commission 2019b).

34 Program of All-Inclusive Care for the Elderly contracts are an exception, which will continue to use pooled RAPS and encounter data as the basis for risk scores.

35 The Commission previously assessed the completeness of encounter data by comparing the data with other sources of MA utilization information. The Commission recommended that the Secretary establish thresholds for encounter data completeness, evaluate plans' submitted data, apply a payment withhold based on data completeness, and allow providers to submit records through the Medicare administrative contractors (Medicare Payment Advisory Commission 2019a). The Commission's most recent evaluation is summarized in our March 2020 report to the Congress (Medicare Payment Advisory Commission 2020b).

36 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied for a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. 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.

37 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).

38 Partial Medicaid enrollment generally provides coverage of Medicare premiums and, for some categories, cost-sharing assistance for Medicare benefits, while full Medicaid enrollment includes premium and cost-sharing assistance and covers additional services not covered in the Medicare benefit.

39 The 2017 model also determines Medicaid enrollment status on a monthly basis during the payment year, which improves the accuracy of payment for these enrollees. The model has separate segments based on aged or disabled status, combined with no, partial, or full Medicaid enrollment status.

40 FFS risk score growth matched MA risk score growth between 2015 and 2016 for the first time since the full implementation of the HCC model in 2007. Between 2016 and 2017, FFS risk score growth slowed somewhat relative to MA risk score growth, and after 2017, the FFS rate was roughly equivalent to pre-2015 growth rates.

41 We also considered the impact of encounter data as a source of diagnostic information, but we do not think encounter data had a significant impact on MA risk scores or payments to plans due to the blending of RAPS and encounter data, a process completed in 2021 (see Figure 12-4, p. 434), and the shrinking difference between encounter-based and RAPS-based risk scores over time. Our analysis found that encounter-based and RAPS-based risk scores were the same for about 92 percent of MA enrollees in 2016, 93 percent in 2017, and 95 percent in 2018, and that average encounter-based risk scores were about 2 percent lower than RAPS-based risk scores in 2016 and about 1 percent lower in 2018.

42 For RADV audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.

43 While MA plans are required to report and return self-identified overpayments, MA plans remit a relatively small and decreasing share of estimated MA overpayments. In 2019, MA plans self-reported and returned only $44.6 million (0.5 percent of CMS's estimated MA overpayments that year) (Department of Health and Human Services 2019).

44 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.

45 Additional HCCs that were not submitted for payment but were supported in one of up to five medical records submitted through the audit can offset beneficiary payment error rates but will not result in additional payments to the MA plan. MA plans are required to submit diagnoses for payment.

46 CMS proposed this method of determining overpayment recovery amounts in 2018 but has not yet issued a final rule (Centers for Medicare & Medicaid Services 2021b, Centers for Medicare & Medicaid Services 2018). For extrapolation, a contract's payment error rate would be set at the lower 99th percent confidence interval of beneficiary-level error rates in the sample. For contract payment error rates greater than zero, the overpayment recovery amount would be the payment error rate at that confidence interval multiplied by the total payment for eligible enrollees in the contract.

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