

CHAPTER

12

**The Medicare Advantage
program: Status report**

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2020, the MA program included over 4,000 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$317 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 than FFS providers to innovate and use care-management techniques to deliver more efficient care.

In this chapter

- Increasingly robust MA enrollment, plan availability, and rebates financed by higher payments relative to FFS spending
- Medicare Advantage risk adjustment and coding intensity
- Quality in Medicare Advantage is difficult to evaluate
- Payment and access for enrollees with end-stage renal disease
- Future direction of MA payment policy

The Commission has emphasized the importance of encouraging all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which subsidized MA plans by providing payments substantially above FFS rates. The phase-in of MA payment policies from the Affordable Care Act reduced the difference in Medicare spending between MA and FFS on a national average basis. However, aggregate plan payments under the ACA were similar to FFS levels for only one year before rising above FFS due to higher risk coding, an increasing share of MA enrollees in areas with payments above FFS spending, and quality bonus rules. Notwithstanding, over the past few years, plan bids have fallen in relation to FFS spending while MA enrollment continues to grow. Plans have improved efficiencies, leading to more competitive bids that enable MA plans to continue to increase enrollment by offering extra benefits that beneficiaries find attractive. The clear, strong trend suggests an opportunity for the Medicare program to share in MA efficiencies.

Enrollment—Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 24.4 million enrollees. About 43 percent of Medicare beneficiaries with Part A and Part B coverage (39 percent of all Medicare beneficiaries) were enrolled in MA plans in 2020, up from 40 percent with Part A and Part B coverage in 2019. Among plan types, HMOs continued to enroll the most beneficiaries (15 million), with 24 percent of all Medicare beneficiaries in HMOs in 2020. During this period, enrollment in local preferred provider organizations (PPOs) grew by 15 percent, regional PPO enrollment decreased by 7 percent, and private fee-for-service enrollment decreased by 27 percent. Special needs plan enrollment grew by 14 percent, and employer group enrollment grew by 5 percent.

Plan availability—Access to MA plans remains high in 2021, with 99 percent of Medicare beneficiaries having access to at least one plan. Almost all beneficiaries have had access to some type of MA plan since 2006, and HMOs and local PPOs have become more widely available in the past few years. Nearly all Medicare beneficiaries (98 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 72 percent of beneficiaries. The average beneficiary in 2021 has 32 available plans sponsored by 7 different parent organizations.

Plan rebates—In 2021, rebates used to provide additional benefits to enrollees are at a historic high of \$140 per enrollee per month. The average total rebates are 14 percent higher than in 2020 (\$17 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 2021, a smaller share of projected plan rebates—46 percent compared with 49 percent in 2020—was allocated for lower cost sharing.

Plan payments—In 2021, 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, an increase of 1 to 2 percentage points compared with 2020. The 2021 estimate incorporates about 3 percentage points of uncorrected coding intensity. Relative to FFS spending for Part A and Part B benefits, quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021. Using plan bid data for 2021, and ignoring the impact of coding intensity, we estimate that MA payments would be 101 percent of FFS spending. Bid data also show that MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—are slightly higher relative to FFS than they were in recent years. MA benchmarks in 2021 averaged an estimated 108 percent of FFS spending (including quality bonuses), compared with 107 percent in 2020. Bids slightly decreased to 87 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: Higher enrollee risk scores result in higher payments to the plan.

Our updated analysis for 2019 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar FFS beneficiaries. This estimate is higher than the prior year due to faster MA risk score growth relative to FFS risk score growth, which, except for 2016 and 2017, has been the norm since 2007. By law, CMS makes 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 2019, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores and payments that were more than 3 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. The minimum adjustment for coding intensity will remain at 5.9 percent until risk adjustment incorporates MA diagnostic, cost, and use data. The Commission previously recommended that MA risk adjustment exclude diagnoses

collected from health risk assessments, use two years of diagnostic data, and apply an adjustment for any residual impact of coding intensity in order to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity. This year we highlight the impact of MA plans' use of medical chart reviews to increase risk scores (a coding practice that does not exist in FFS). Recent reports from the Office of Inspector General indicate that the majority of MA coding intensity may be due to chart reviews and health risk assessments.

Quality in MA—The Commission has previously reported its concerns with the MA star rating system and recommended improvements. The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA. With 43 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare is necessary for proper evaluation. The ability to compare MA and FFS quality and to compare quality among MA plans is also important for beneficiaries. Recognizing that the current quality program is not achieving its intended purposes and is costly to Medicare, in its June 2020 report the Commission recommended a new value incentive program for MA that would replace the current quality bonus program.

Future direction of MA payment policy—As in the past several years, many indicators continue to point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and historically high extra benefits. However, some policies are deeply flawed and are in need of immediate improvement. The Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program.

Despite the relative efficiency of MA plans in providing Part A and Part B benefits, aggregate MA payments (including rebates that finance extra benefits) are about 4 percent higher than expected FFS expenditures for similar beneficiaries, an increase of more than 1 percentage point from last year. In setting payment policy in the FFS sector, the Commission consistently strives to encourage providers to deliver care efficiently while maintaining beneficiary access to good quality care. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS Medicare, which are compounded by Medigap's effect of insulating beneficiaries from true health care costs, and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare in

1982, in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, Medicare may be able to share in some of those efficiencies. ■

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 2020, the MA program included 4,234 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with Part A and Part B coverage), and paid MA plans an estimated \$317 billion (not including Part D drug plan payments). The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and the alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions), and develop robust information systems that can potentially provide timely feedback to providers. Plans also can provide incentives for beneficiaries to seek care from more efficient providers and give beneficiaries more predictable cost sharing; one trade-off is that 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. 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 through Medicare's payment systems or its monitoring and enforcement efforts.

Efficient MA plans can capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in those plans by providing extra benefits without exceeding FFS spending levels. However, in some parts of the country, MA plans offer higher levels of extra benefits to their enrollees because they receive payments that are higher relative to what would have been paid under FFS Medicare for similar beneficiaries. Thus, some of those benefits are subsidized by higher government spending and higher beneficiary Part B premiums (including the premiums for enrollees in traditional FFS Medicare) at

a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for providers in the traditional FFS program. One method of achieving equal financial pressure is to link private plans' payments more closely to FFS Medicare costs within the same market. The Commission will continue to monitor plan payments and performance and begin to develop policies to further improve the efficiencies of MA.

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

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 2020, only about 80,000 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 2020, they were available in 25 states with a total enrollment of about 8,000 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.

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 and payment analyses. (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 beneficiary who has chosen to enroll. Plan payment rates are determined by the MA plan bid—which represents the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which is

the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.¹ (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 (between 50 percent and 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 payment of the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can also devote some of the rebate to administration costs and margins. Plans may also choose to include additional supplemental benefits that are not financed by the rebate in their packages and charge premiums to cover those additional benefits.² (A more detailed description of the MA program payment system can be found at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ma_final_sec.pdf?sfvrsn=0.)

How Medicare calculates MA benchmarks

Under the Affordable Care Act (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.³ 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 2019 to the 107.5 percent quartile in 2020 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.⁴ 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 2020c, 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. For the second consecutive year, MA plan enrollment in 2020 grew by 10 percent; 43 percent of all eligible Medicare beneficiaries are now in MA plans, compared with 40 percent in 2019. 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 2021, the average beneficiary now has access to 32 plans sponsored by 7 organizations, and rebates that finance extra benefits are the highest in the program’s history. However, the robust growth and availability of MA plans has occurred without overall savings to the Medicare program. In 2021, MA bids average 87 percent of FFS spending, but payment benchmarks average 108 percent of FFS—resulting in MA payments that are 101 percent of FFS and an estimated 104 percent of FFS spending after accounting for differences in coding practices between MA and FFS.⁵

Ten percent growth in MA plan enrollment in 2020; MA enrollment now 43 percent of all eligible Medicare beneficiaries

Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 24.4 million enrollees (compared with a 2 percent growth in the same period for the total Medicare population and about a 2 percent decline in FFS enrollment). The 10 percent growth is among the highest in the last 10 years, equaling the 10 percent growth in 2012 and 2019. During this period, MA enrollment rose from 36 percent (data not shown) to 39 percent of all Medicare beneficiaries (Table 12-1, p. 362).⁶ Beneficiary eligibility to join an MA plan requires enrollment in both Part A and Part B. Because 9 percent of Medicare beneficiaries do not meet this requirement, we also examined MA enrollment as a share of the Medicare population with both Part A and Part B coverage. Between July 2019 and July 2020, MA enrollment increased from 40 percent to 43 percent of all Medicare beneficiaries with Part A and Part B coverage. (See the text box, pp. 363, for an explanation of updates to our enrollment methodology.) Enrollment in MA has more than doubled since 2010 (Figure 12-2, p. 364). 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 care needs that are met within plan networks will likely have lower financial liability (premiums and cost sharing) compared

**TABLE
12-1**

MA plan enrollment continued rapid growth in 2020

| | MA enrollment (in millions) | | Percent change in enrollment | 2020 MA enrollment as a share of total Medicare |
|--|-----------------------------|-----------|------------------------------|---|
| | July 2019 | July 2020 | | |
| Total | 22.2 | 24.4 | 10% | 39% |
| Plan type | | | | |
| CCP | 22.1 | 24.3 | 10 | 39 |
| HMO | 13.8 | 15.0 | 8 | 24 |
| Local PPO | 7.0 | 8.1 | 15 | 13 |
| Regional PPO | 1.2 | 1.1 | -7 | 2 |
| PFFS | 0.1 | 0.1 | -27 | <1 |
| Restricted availability plans included in totals above | | | | |
| SNPs* | 3.1 | 3.5 | 14 | 6 |
| Employer group* | 4.5 | 4.7 | 5 | 8 |
| Urban/rural | | | | Share of Medicare population in MA |
| Urban | 17.5 | 19.0 | 8 | 42 |
| Rural | 4.7 | 5.4 | 14 | 31 |

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. The total Medicare population used to calculate enrollment shares in this table includes 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. In 2020, 43 percent of eligible beneficiaries were enrolled in an MA plan. Urban/rural designations use the Urban Influence Codes delineated by the Office of Management and Budget (OMB). These codes were last updated in 2013 and are updated every 10 years. 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.

with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage.⁷

Among plan types, although enrollment grew more slowly in HMOs (8 percent) than in local PPOs (15 percent), HMOs continued to enroll the most beneficiaries (15 million) in 2020, with 24 percent of all Medicare beneficiaries in HMOs (Table 12-1). Between 2019 and 2020, enrollment in regional PPOs and PFFS plans dropped by 7 percent and 27 percent, respectively. In 2020, SNP enrollment grew by 14 percent, and employer group enrollment grew by 5 percent.

Enrollment patterns differ in urban and rural areas. Over 40 percent of urban beneficiaries are enrolled in MA compared with less than one-third of beneficiaries

residing in rural counties. In 2020, 41 percent of rural MA enrollees were in HMO plans compared with about 67 percent of urban enrollees (not shown in Table 12-1). By contrast, 48 percent of rural enrollees were in local PPOs compared with 29 percent of urban enrollees.

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. In fact, many areas now have a majority of their Medicare beneficiaries enrolled in MA.⁸ In three states (Florida, Hawaii, and Oregon) and Puerto Rico, more than half of the MA-eligible population enrolled in MA plans in 2020. In some metropolitan areas (e.g., Miami, FL; Pittsburgh, PA; Rochester, NY; Grand Rapids, MI; Portland, OR; El Paso, TX), 60 percent or

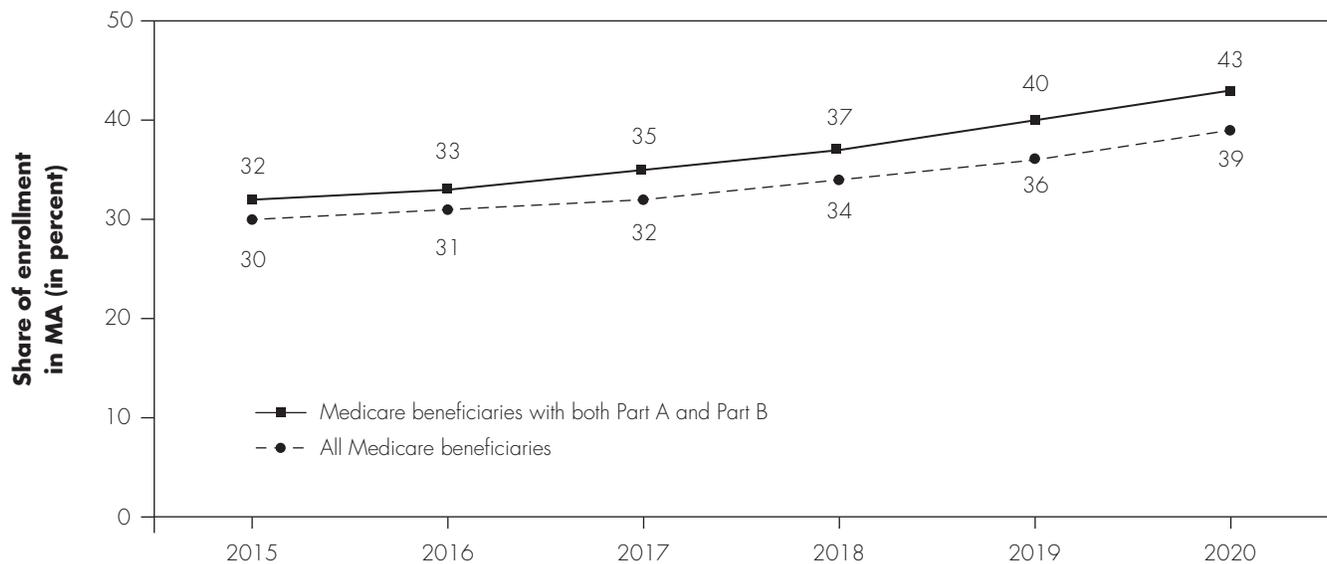
The share of Medicare beneficiaries enrolled in MA

Historically, the Commission has used information on “Medicare-eligible individuals” from CMS’s Medicare Advantage (MA) penetration files as the denominator in calculating the share of Medicare beneficiaries enrolled in MA. However, “Medicare-eligible individuals” include people previously, but no longer, covered by Medicare and people within 5 months of their 65th birthday. In addition, CMS has identified an issue with the Medicare-eligible individuals number in recent years, in which the program double counted fee-for-service beneficiaries with multiple addresses. We now have data from the CMS enrollment dashboard that allows us to calculate MA enrollment as a share of Medicare beneficiaries with either Part A or Part B coverage and thus can calculate a more accurate MA

enrollment percentage. At the national level, these data also allow the Commission to calculate MA enrollment as a share of the Medicare population with both Part A and Part B coverage. Because having both Part A and Part B coverage is required for MA enrollment, this information is particularly valuable. Furthermore, we now report enrollment as of July since it is the month most representative of average annual (and person-year) enrollment. The percentages published here for the years shown supersede all of the Commission’s prior estimates of the share of Medicare beneficiaries enrolled in MA. That share has increased rapidly in recent years (Figure 12-1). Between 2015 and 2020, MA enrollment increased from 32 percent to 43 percent of all Medicare beneficiaries with Part A and Part B coverage. ■

FIGURE 12-1

Rapid increase in the share of eligible Medicare beneficiaries enrolled in MA, 2015–2020

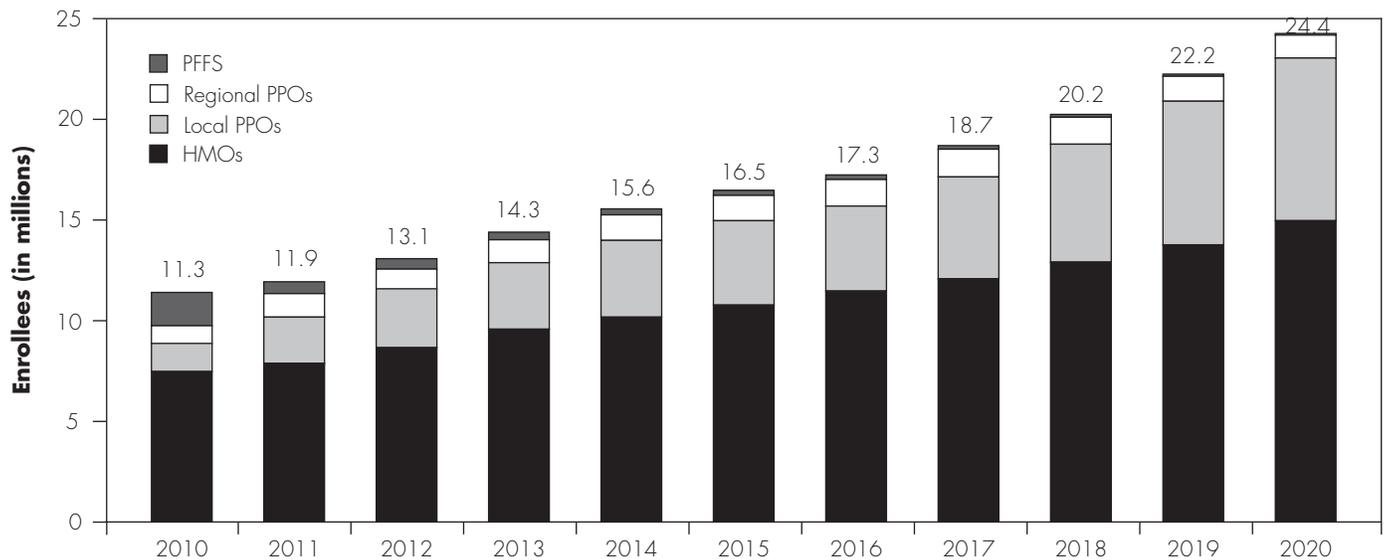


Note: MA (Medicare Advantage). Medicare beneficiaries must have both Part A and Part B coverage to enroll in an MA plan. In 2020, 9 percent of Medicare beneficiaries were not eligible to enroll in an MA plan because they did not have both Part A and Part B coverage.

Source: MedPAC analysis of CMS enrollment files, July 2015–2020.

more of all 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 241 counties across 29 states, more than half of all Medicare beneficiaries enrolled in MA plans. Thus, as the share of FFS beneficiaries in these counties decreases, benchmarks can

**FIGURE
12-2****Medicare Advantage enrollment, 2010–2020**

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

Source: MedPAC analysis of CMS enrollment files, July 2010–2020.

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, a disproportionate number of a county's FFS beneficiaries may 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.⁹

Access to MA plans remains high in 2021

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 2021, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2021. 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 12-2). In 2021, 98

percent of Medicare beneficiaries have an HMO or local PPO plan (both are considered local CCPs) operating in their county of residence, the same as in 2020. Regional PPOs are available to 72 percent of beneficiaries in 2021, nearly the same as in 2020. Access to PFFS plans in 2021 is lower, available to 34 percent of beneficiaries, down from 36 percent in 2020. Overall, 99 percent of Medicare beneficiaries have access to an MA plan, and 99 percent have access to a CCP (total CCP data not shown in Table 12-2), similar to 2020.

The availability of SNPs improved across types of special needs population served. In 2021, 92 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 90 percent in 2020), 57 percent live where SNPs serve beneficiaries with chronic conditions (up from 52 percent in 2020), and 72 percent live where SNPs serve institutionalized beneficiaries (up from 67 percent in 2020). Overall, 96 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

**TABLE
12-2****Access to Medicare Advantage plans remains high****Share of Medicare beneficiaries with access to at least one MA plan, by type**

| Type of plan | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|------|------|-------|-------|-------|
| Any MA plan | 99% | 99% | 99% | 99% | 99% |
| Local CCP | 95 | 96 | 97 | 98 | 98 |
| Regional PPO | 74 | 74 | 74 | 73 | 72 |
| PFFS | 45 | 41 | 38 | 36 | 34 |
| Special needs plans | | | | | |
| Dual eligible | 86 | 86 | 89 | 90 | 92 |
| Chronic condition | 44 | 47 | 47 | 52 | 57 |
| Institutional | 52 | 56 | 63 | 67 | 72 |
| Zero-premium plan with drug coverage | 81 | 84 | 90 | 93 | 96 |
| Average number of choices | | | | | |
| County weighted | 10 | 10 | 13 | 15 | 18 |
| Beneficiary weighted | 18 | 20 | 23 | 27 | 32 |
| Average monthly rebate for nonemployer, non-SNP plans | \$89 | \$95 | \$107 | \$122 | \$140 |

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. "Share of Medicare beneficiaries" includes beneficiaries that do not have both Part A and Part B coverage (i.e., all Medicare beneficiaries). A zero-premium plan with drug coverage includes Part D coverage and has no premium (including the Part D premium) beyond the Part B premium. "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county. The plan rebate is the per beneficiary per month amount that the plan is offering as premium-free extra benefits and excludes plans that do not offer Part D coverage.

Source: MedPAC analysis of CMS bid and enrollment data.

In 2021, 96 percent of Medicare beneficiaries (compared with 93 percent in 2020) 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 12-2). About 64 percent of nonemployer, non-SNP MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2021, 89 percent of beneficiaries (compared with 79 percent in 2020) have access to plans that offer some reduction in the Part B premium, but only 4 percent of 2021 enrollment was projected to be in these premium-reduction plans (data not shown).

In most counties, a large number of MA plans sponsored by a robust number of organizations are available to beneficiaries. In 2021, the average number of plans

available in a county increased. On average, 18 plans (vs. 15 plans in 2020) are available in each county in 2021 (Table 12-2). Plan availability can also be calculated by weighting the number of beneficiaries living in the county to give a sense of the number of plan choices available to the average beneficiary. Under that calculation, the average beneficiary in 2021 has 32 available plans, an increase from 27 plans in 2020. The average beneficiary in 2021 can choose from plans sponsored by seven organizations (data not shown). In 2021, 95 percent of beneficiaries will have available MA plans sponsored by at least three different organizations. In 2021, beneficiaries in 70 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

**TABLE
12-3**

Share of Medicare Advantage enrollment by parent organization, July 2020

| 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. | 26% | UnitedHealth Group Inc. | 27% |
| Humana Inc. | 17 | Humana Inc. | 25 |
| CVS Health Corporation | 11 | CVS Health Corporation | 10 |
| Kaiser Foundation Health Plan Inc. | 9 | Anthem Inc. | 5 |
| Anthem Inc. | 6 | Blue Cross Blue Shield of Michigan | 4 |
| Centene Corporation | 4 | Centene Corporation | 3 |
| CIGNA | 2 | Highmark Health | 1 |
| Blue Cross Blue Shield of Michigan | 2 | CIGNA | 1 |
| SCAN Health Plan | 1 | Spectrum Health System | 1 |
| Summit Master Company LLC | 1 | BlueCross BlueShield of Tennessee | 1 |
| Total, top 10 organizations | 78 | Total, top 10 organizations | 79 |

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 Urban Influence Codes delineated by the Office of Management and Budget (OMB). These codes were last updated in 2013 and are updated every 10 years. 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 2020 enrollment data and OMB Urban Influence Codes.

Phoenix. At the other end of the spectrum, 211 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).¹⁰

Largest organizations slightly increase MA market share

The national MA market has become slightly more concentrated in recent years, and that trend continued in 2020. In 2020, the top 3 organizations had 56 percent of enrollment (vs. 55 percent in 2019; data not shown), and the top 10 organizations had 78 percent of total enrollment (vs. 76 percent in 2019; data not shown). Market concentration differed between urban areas (19.0 million MA enrollees) and rural areas (5.4 million enrollees) (Table 12-3). In urban areas in 2020, the top three organizations had 53 percent of the MA enrollees residing in these areas (unchanged from 2019; 2019 data

not shown). In rural areas, the top three organizations accounted for 62 percent of the MA enrollees residing in these areas (unchanged from 2019; 2019 data not shown).

Another way of looking at the market structure in the MA program is to examine market competition at the county level. Excluding employer plans and SNPs, in 2020, 69 percent of MA enrollees (down from 71 percent in 2019) resided in a highly concentrated county as measured by the Herfindahl–Hirschman Index.¹¹ In 2020, enrollment in the top organization in each county accounted for 45 percent of all MA enrollment (down from 47 percent in 2019). Enrollment in the top two organizations in each county accounted for 69 percent of all MA enrollment (down from 71 percent in 2019). Thus, although the MA market is 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 are slightly gaining MA market share in areas where they do not have a large presence. Nevertheless, as

**TABLE
12-4**

A smaller share of plan rebates are allocated to cost sharing in 2021

| | Rebate (per member per month) | | 2021 percent change | Share of total rebate | |
|---------------------------|----------------------------------|-------|------------------------|-----------------------|------|
| | 2020 | 2021 | | 2020 | 2021 |
| Total | \$122 | \$140 | 14% | 100% | 100% |
| Extra benefit type | | | | | |
| Cost sharing | 60 | 64 | 5 | 49 | 46 |
| Non-Medicare supplemental | 22 | 29 | 33 | 18 | 21 |
| Part D supplemental | 22 | 24 | 9 | 18 | 17 |
| Part D premium | 16 | 20 | 26 | 13 | 15 |
| Part B premium | 2 | 2 | 12 | 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 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.

illustrated in the section on plan availability in 2021 (pp. 364–365), the average beneficiary has access to many MA plans offered by a robust number of organizations.

MA rebates in 2021 are a record high \$140 per enrollee per month

For 2021, rebates for nonemployer, non-SNP plans average \$140 per enrollee per month (nearly \$1,700 annually per enrollee) and are the highest in the program’s history (accounting for 14 percent of plan payment). The average total rebates are 14 percent higher than in 2020 (\$17 higher per enrollee per month) (Table 12-4). Plans can devote the rebate (including administrative costs and profit) to lower cost sharing, lower premiums, or supplemental benefits. In 2021, the share of plan rebates allocated toward cost-sharing reductions are projected to fall. Plans project that \$64 per enrollee per month (46 percent) of rebates go toward reductions in cost sharing for Medicare services, a 5 percent increase relative to 2020 but a decrease in the share of rebate (49 percent).^{12,13} The growth rate of cost-sharing reductions is similar to CMS’s projected growth rate of all Part A and Part B expenditures (5.6 percent), 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 when beneficiaries

have first-dollar Medigap coverage (Medicare Payment Advisory Commission 2012a). Plans project that \$29 per enrollee per month (21 percent) of rebates will be used for non-Medicare-covered supplemental benefits, which often include coverage for some vision, fitness, hearing, or dental services.¹⁴ On a more limited basis, some plans have started using rebates for supplemental benefits intended to help address social determinants of health.¹⁵ Two other uses of rebate dollars are for reductions in Part D premiums (15 percent of projected rebates), Part D supplemental benefits (17 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.¹⁶

Plans bid at record low levels in 2021, but payments remain above FFS spending

In 2021, 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. 371). Payments to MA plans are determined using a plan’s bid—which represents the dollar amount that the plan estimates it will need to cover the Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides, which is based on local FFS spending and is

**TABLE
12-5**

**Overall plan bids at record low levels in 2021,
but payments remain above FFS spending**

Share of FFS spending in 2021

| Plan type | Benchmarks | Bids | Payments |
|---|--------------|-------------|--------------|
| All MA plans | 108%* | 87%* | 101%* |
| HMO | 108 | 86 | 100 |
| Local PPO | 109 | 92 | 103 |
| Regional PPO | 99 | 87 | 94 |
| PFFS | 107 | 100 | 104 |
| Restricted availability plans (SNPs) included in totals above | 107 | 90 | 101 |

***Values would be about 3 percentage points higher when coding intensity is reflected fully using our most recent estimate (e.g., payments for all MA plans average 104 percent of FFS spending if coding differences were fully reflected).**

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2021 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. The estimate of regional PPO benchmarks relative to FFS corrects the methodology from prior years that used an imputed benchmark amount rather than the benchmark in plan bid data. This correction has no effect on bids or payments for regional PPOs and has no substantive effect on overall benchmark estimates relative to FFS. The FFS spending denominator used in the table includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. For 2017, the Commission estimated that FFS spending for enrollees with both Part A and B was about 1 percent higher than spending for all FFS enrollees. Comparing benchmarks, bids, and payments with spending for FFS enrollees with both Part A and Part B would decrease the overall values for all MA plans 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 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 have slightly increased and payments remain above FFS spending levels. We estimate that in 2021, MA benchmarks (including quality bonuses) average 108 percent of FFS spending (before adjusting fully for coding intensity; see below) (Table 12-5). In contrast, benchmarks in 2020 averaged 107 percent of FFS (data not shown). In 2021, MA plans bid at record low levels. Overall plan bids average an estimated 87 percent of FFS spending in 2021, down from 88 percent of FFS in 2020 (latter data not shown). 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 101 percent of FFS spending in 2021; however, uncorrected coding intensity increases payments to 104 percent of FFS spending. An estimated 2 percentage points to 3 percentage points of MA payments relative to FFS spending are due to quality bonuses. MA payments relative to FFS increased by 1 percentage point to 2 percentage points compared with 2020.

MA benchmarks relative to FFS rose by 1 percentage point compared with 2020, but bids fell by 1 percentage point relative to FFS—resulting in overall payments that increased by 1 percentage point relative to FFS (before accounting for coding differences). The small increase in benchmarks and payments relative to FFS spending partially reflects a larger share of projected MA enrollment in counties with benchmarks that are 115 percent of FFS spending. In 2021, 28 percent of projected MA enrollment was in these high-benchmark counties, up from 26 percent in 2020.

**TABLE
12-6****Distribution of 2021 MA bids relative to FFS**

| Bids as a percent of FFS spending | Share of bids | Share of projected MA enrollment |
|-----------------------------------|---------------|----------------------------------|
| Less than 70% | 5% | 4% |
| At least 70%, less than 80% | 15 | 20 |
| At least 80%, less than 90% | 32 | 34 |
| At least 90%, less than 100% | 35 | 33 |
| At least 100%, less than 110% | 11 | 7 |
| 110% or more | 3 | 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.

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 2021 made by CMS actuaries at the time the benchmarks were published in April 2020. (See the text box about the effect of the coronavirus pandemic on our 2021 estimates, p. 372.) 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 percentage points. However, using the bid data allows for subgroup comparisons, such as by MA plan type, shown in Table 12-3 (see p. 366).

The ratio of MA plan payments to FFS spending for 2021 varies by plan type (Table 12-5). For example, HMOs as a group bid an average of 86 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 92 percent of FFS spending, and PFFS plans have average bids of 100 percent of FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 103 percent and 104 percent of FFS spending, respectively. Payments for beneficiaries enrolled in regional PPOs average 94 percent of FFS because of the regional PPOs'

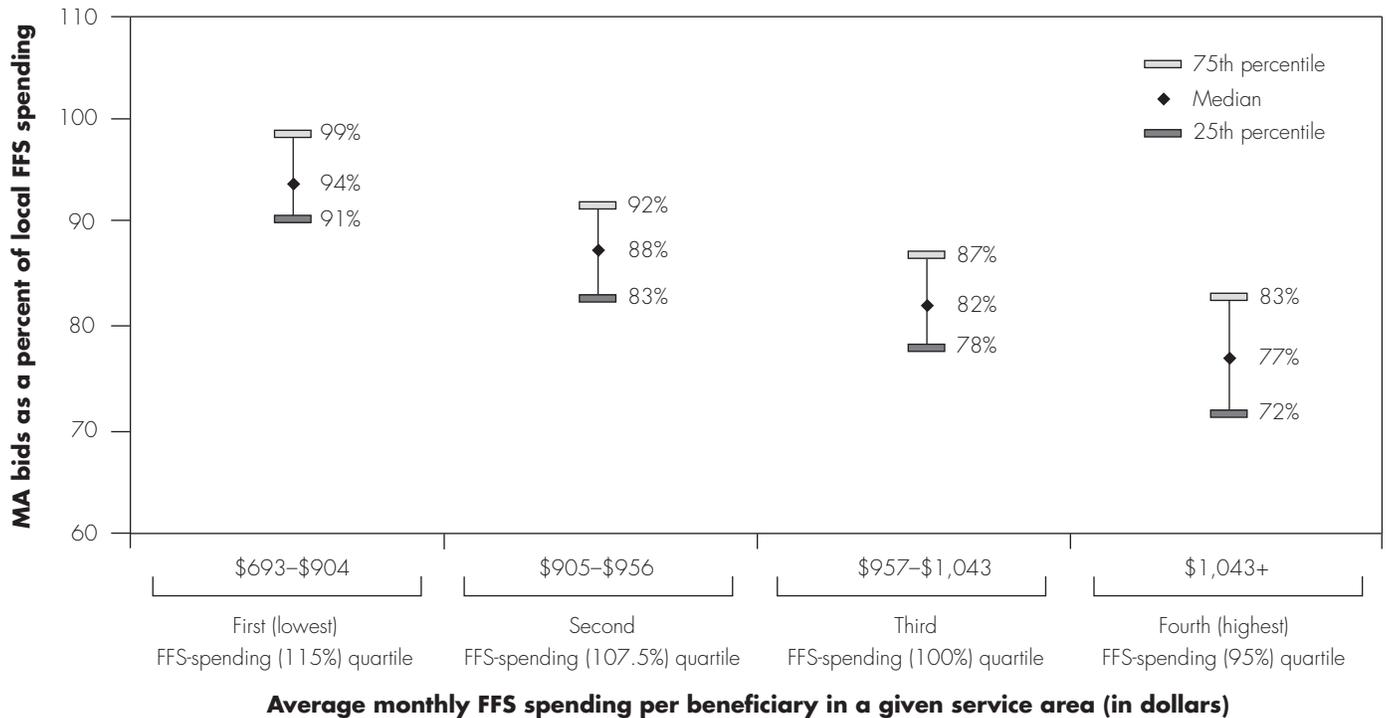
relatively low benchmarks (which are a blend of regional plans' bids and FFS spending).

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 three 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 the past, we recommended that CMS pay employer plans differently because the employer bids were not usually submitted for a competitive purpose, while the bids for other plans are submitted to compete for enrollment. (For more details on employer plans and our recommendation, see our March 2014 report 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, CMS began paying employer plans based on the bidding behavior of nonemployer plans. As a result, we expect that payments to employer plans will look somewhat like the payments to the plans in our analysis. We will continue to monitor MA payments to employer plans.

Variation in 2021 MA bids and payments

Almost all plans (about 87 percent) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits (Table 12-6). These plans are projected to enroll about 91

FIGURE 12-3**Medicare Advantage bids in relation to FFS spending levels, 2021**

Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 3,797 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.

percent of MA enrollees, excluding those in employer group and special needs plans. About 4 percent of MA enrollees are projected to enroll in plans that bid lower than 70 percent of FFS spending; 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 12-3 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 432 plans that include at least 2.9 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 with the lowest FFS spending, less than \$905 per month on average, most plans bid less than the FFS spending level for 2021 (Figure 12-3). In plan service areas averaging \$905 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 \$905 per month in 2021) began bidding below FFS far more frequently. The median bid for areas in this quartile declined between 2013 and 2021 from 111 percent to 94 percent of FFS. However, the

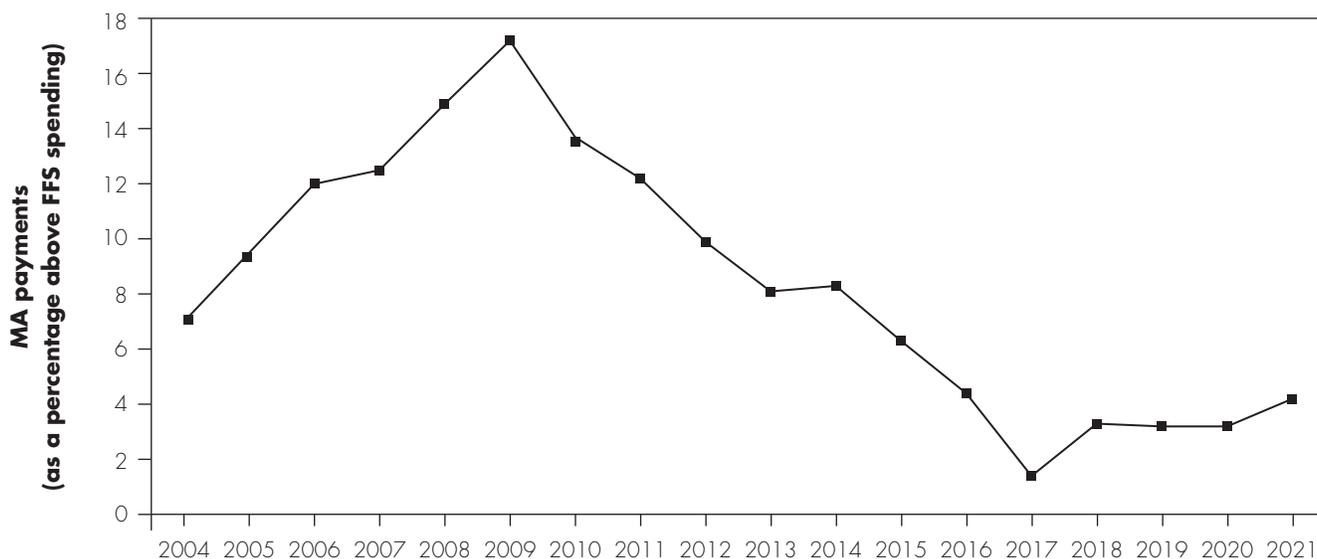
Aggregate Medicare payments to Medicare Advantage plans have never been lower than FFS Medicare spending

Our review of private plan payments suggests that over a 35-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in 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 (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and led to private plan payments that were higher than FFS Medicare (5 percent to 7 percent higher in the late 1980s and through the mid-1990s) (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996). Figure 12-4 shows that since 2004, payments to Medicare Advantage plans have been above the amount FFS Medicare would have spent for the same beneficiaries. ■

FIGURE 12-4

Medicare has paid more to MA plans than FFS Medicare spending would have been for the same enrollees, 2004–2021



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. In the figure, we conservatively assume that the coding intensity impact for 2020 and 2021 is the same as for 2019 (the most recent year of data available). Alternatively, assuming a coding intensity impact based on historical trend would increase MA payments by 1 percentage point in 2020 and by 2 percentage points in 2021. The FFS spending denominator in the figure includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. For 2017, we estimated that FFS spending for enrollees with both Part A and B was about 1 percentage point higher than spending for all FFS enrollees. Comparing payments to MA plans with spending for FFS enrollees with both Part A and B would shift the line in the graph down about 1 percentage point.

Source: MedPAC reports to the Congress 2006 through 2020, MedPAC analysis of 2021 data from CMS on plan bids and FFS expenditures.

The impact of the coronavirus pandemic on 2021 benchmarks, bids, and payments relative to FFS spending

Since early 2020, the ongoing coronavirus pandemic and associated public health emergency (PHE) 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, though by summer had returned to near-normal levels for many types of services. Although the pandemic's impact on utilization has varied by type of service and geographic region, the aggregate reduction in utilization due to delaying or forgoing the more common treatments has been 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 has lowered overall medical expenditures. In financial reports, public MA insurers reported medical expenses as a share of revenue (or medical loss ratios (MLRs)) at or near record lows during the second quarter of 2020 (April through June). In the third quarter of 2020, most MA insurers reported MLRs that were closer to, but still below normal, third quarter levels.¹⁷ Meanwhile, because Medicare payments to MA plans are established before the start of each calendar year based on prior year data, plan revenues in 2020 have remained at normal levels. As a result, plan profitability has increased during the pandemic, with one study of 2018 to 2020 financial data from the National Association of Insurance Commissioners finding that MA plans were more profitable during the first three quarters of 2020 compared with the first three quarters of 2018 and 2019 (McDermott et al. 2020). Although insurers remain concerned about delayed care rebounding as the pandemic ebbs, boosting future

medical expenses above normal levels, that scenario had not borne out as of publication of this report. In response to the coronavirus PHE, CMS allowed plans to change their benefit package in mid-2020. Many plans used the opportunity to reduce premiums or cost sharing, reflecting plans' lower medical expenditures.¹⁸

Our estimates of plan payments do not take into account the impact of the coronavirus pandemic, but given the prospective nature of MA payments, we do not anticipate the pandemic having a substantial impact on MA payments in 2021. We use CMS's estimate of 2021 fee-for-service (FFS) spending, which uses data through 2019 as the basis for 2021 MA benchmarks, bids, and payments. This estimate also represents the FFS spending levels assumed by plans when they submitted bids for 2021 in June of 2020. We do not yet know the full effect of the pandemic on beneficiary spending in 2021 and 2021 risk scores based on services in 2020. However, the record level of plan rebates in 2021 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 increased 2019 MA risk scores and payments by more than 3 percentage points and continues to increase MA risk scores and payments by 1 percentage point per year. At the start of 2021, many plans are at a financial advantage due to coding intensity before accounting for any potential negative impact on 2021 risk scores due to the pandemic. We will continue to monitor the impact of the coronavirus pandemic on plan availability and MA payments. ■

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 2021, Medicare is still paying an average of 109 percent of FFS spending in these areas because the benchmarks average 116 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 2019, show that MA

plans reported margins that averaged 4.5 percent.¹⁹ This figure excludes Part D—for which we do not have 2019 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 unknown.

We estimate that including Part D drug margins would raise the average MA plan margin by approximately 0.5 percent; and if employer plan data were available, the margin levels would likely be higher. The absence of data on employer plans—20 percent of MA enrollment in 2019—limits our ability to determine the average margin in the MA sector. In prior years, when employer plan bids were included in the bid data, we found that employer plan margins were higher than the margins of other MA plans (Medicare Payment Advisory Commission 2016).

Margins vary by plan tax status. In the 2019 data, nonprofit plans reported a margin of 0.9 percent; for-profit entities reported a pretax margin of 5.4 percent. As noted in our March 2018 report to the Congress, the large difference in margins (4.5 percentage points) between for-profit and nonprofit entities could be because the bid data do not include employer group plans (Medicare Payment Advisory Commission 2018b). Given the relatively high margins of employer group plans in prior years, including these plans 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 may obscure plan margins. Further, for-profit entities' MA plan margins were slightly higher in 2019 because MA plans were subject to payment of the ACA insurer fees in 2018 but not 2019.²⁰ In 2018, the insurer fees represented about 1.5 percent of total revenue.

All categories of SNPs had positive margins in 2019. Dual-eligible SNPs (D–SNPs), for Medicare–Medicaid dual-eligible beneficiaries, had margins of 7.8 percent. SNPs for enrollees with certain chronic conditions (C–SNPs) had margins of 10.7 percent. Institutional SNPs (I–SNPs) had margins of 12.1 percent. The 2019 profit margin among nonprofit D–SNPs was 2.5 percent.

Medicare Advantage risk adjustment and coding intensity

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 other enrollees 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 other enrollees.

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 may persist as beneficiaries who use more services may be wary of plans' limits on provider choice and thus may be less likely to enroll in MA; if they do enroll, they may 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).

Although favorable selection has been reduced, 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. In 2019, differences in diagnostic coding caused Medicare to pay MA plans \$9 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 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 diagnostic categories included in the model were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS applies additional criteria to ensure the validity and reliability of the model's diagnostic data. To be used in determining payment to MA plans, (1) diagnoses must appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional (including real-time audio and video telehealth visits), and (2) diagnoses must be supported by evidence in the patient's medical record.²¹ Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio telecommunication simultaneously with

video telecommunication to permit real-time interactive 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 RAPS to calculate risk scores, but in 2016, it began a transition to use encounters as the source of diagnostic information by generating two risk scores, one based on RAPS data and one based on EDS data.²² Figure 12-5 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.²³

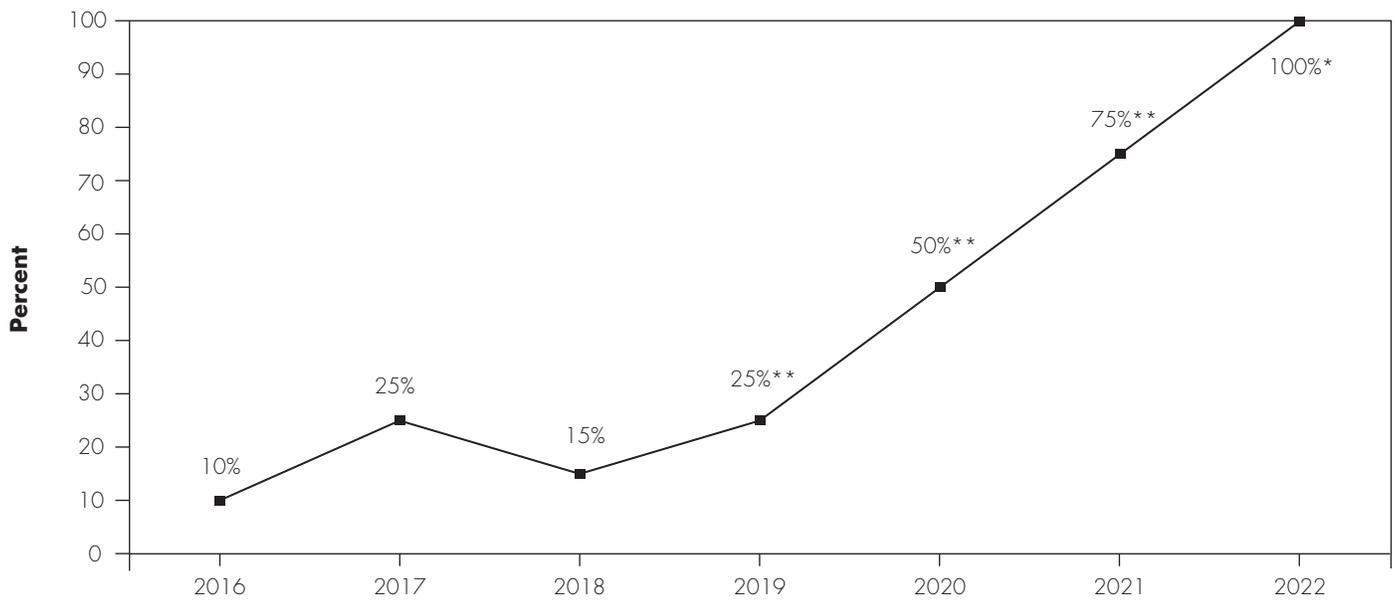
The share of risk scores based on pooled EDS and inpatient RAPS data increased to 50 percent in 2020 and 75 percent in 2021; for 2022, CMS will base risk scores entirely on encounter data with no use of RAPS data.²⁴ The Commission has strongly supported basing MA risk scores entirely on encounter data.

The incentive to code diagnoses more thoroughly in MA

Documenting additional diagnosis codes increases enrollees' risk scores, which both increases the monthly payment amount a plan receives and increases the rebate amount a plan uses to provide extra benefits to enrollees.

**FIGURE
12-5**

Use of encounter data for MA risk scores, 2016–2022



Note: MA (Medicare Advantage).

*Proposed for 2022.

**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.

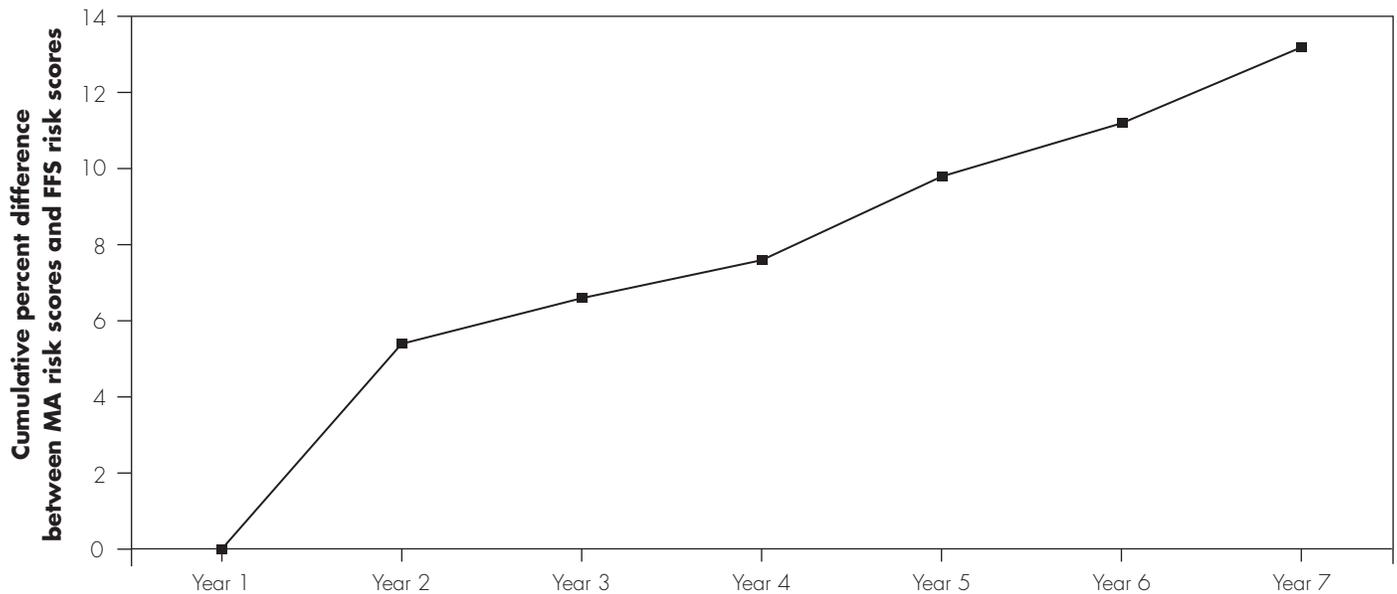
Each demographic and HCC component in the risk adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated using FFS Medicare claims data such that all Medicare spending in a year is distributed among the model 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.²⁵ To illustrate, the annual Medicare payment to the MA organization in 2018 for an 84-year-old male who was not eligible for Medicaid (demographic component valued at \$5,707) with diabetes without complication (HCC 19, valued at \$1,058) would have been \$6,765, the sum of the two model components.

Documenting each additional HCC for 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 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, although some HCCs increase payment by \$10,000 or more.

Because the CMS–HCC model is based on 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 through physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes and provide little incentive to document diagnoses for FFS beneficiaries.²⁶ 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

**FIGURE
12-6**

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.

above the value they would have if the diagnoses had been reported. It is necessary for MA payment accuracy that diagnoses be coded with the same intensity in FFS Medicare and MA, meaning that if all diagnoses reported in one program would also be reported in the other program, coefficients would produce accurate payments and would not be inflated. 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. We have found that because of the financial incentives for MA plans to code as many diagnoses as possible, coding intensity is higher in MA than in FFS Medicare, whose structure lacks such incentives, and payments to MA plans are thus higher than intended.

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 all subsequent

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

Figure 12-6 shows how average MA risk scores changed relative to the change in average FFS risk scores for all pairs of cohorts. From year 1 to year 2, average MA risk scores increased by about 6 percent more than FFS across all cohorts. For each subsequent year, average MA risk scores continued to increase more than FFS scores by about 1.5 percent across all cohorts.

**TABLE
12-7**

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

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

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

Higher payments to MA plans due to differences in coding intensity in MA and FFS Medicare are the result of a failure in risk adjustment policy, violating the assumption that diagnoses are documented with the same intensity in FFS Medicare (where less incentive exists) and in MA (where significant incentive exists). MA plans that document additional diagnoses for their enrollees (relative to FFS Medicare) are reacting to incentives when those diagnoses 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.

In addition to the direct increase in payment rates, greater diagnostic coding can allow a plan to offer more extra benefits and potentially attract more enrollees. The first step in the bidding process determines whether a normalized plan bid (for a person of average risk, or a 1.0 risk score) is at or above the plan's normalized benchmark (for the plan's service area). For plans that bid below the plan's benchmark, the second step of the bidding process determines the rebate amount available for extra benefits by comparing a plan's bid for its expected composition of enrollment (that is, it is not normalized to 1.0) and the area benchmark adjusted by the plan's expected average risk score. The size of the rebate (or the value of extra benefits) is a share of the difference between the bid and

risk-adjusted benchmark. Plans that put more effort into documenting all diagnosis codes, increasing their average risk score relative to other plans, can inflate the dollar value difference between the plan's bid and risk-adjusted benchmark, leading to greater value of extra benefits for the plan.

Table 12-7 illustrates this effect, using three hypothetical plans that cover the same set of hypothetical enrollees and therefore have the same cost of care, at \$900 per member per month. Although all three plans have actual costs of \$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. Because Plan B has a higher risk score, its rebate is larger than Plan A's rebate and it can offer enrollees more benefits: \$38 per month more in extra benefits (\$53 minus \$15). Because Plan B's aggressive diagnostic coding effort has inflated its risk score (its risk score otherwise would be the same as that of Plan A and Plan Z), Plan B will have an unfair competitive advantage. The higher risk score also gives Plan B, which has only 3.5 stars, an advantage over bonus-level Plan Z; Plan B has a higher total rebate amount: \$7 more. Thus, by increasing its risk score from 0.97 to 1.03, Plan B will be able to offer a level of extra benefits that is of more value than

that provided through quality bonuses. Thus, differences in coding practices can more than offset the effect of MA quality bonuses and can have significant consequences for MA payment policy.

The plans illustrated in Table 12-7 (p. 377) 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 12-8, p. 382).

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 and contribute to higher MA payments.

MA plans often identify enrollees with missing 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 coding incentives on to physicians with direct access to medical records and diagnostic information. In addition, plans actively collect diagnoses through health risk assessments, chart reviews of earlier provider encounters, and pay-for-coding programs, which pay doctors to complete patient assessment forms that confirm diagnoses that have not yet been documented. While these efforts can be used to improve care management, some companies offering services to collect diagnostic information use language that targets enrollees based on a lack of documentation rather than a clinical need. Our March 2018 report to the Congress describes the mechanisms that we believe contribute to higher rates of diagnosis documentation in MA, resulting in higher payments (Medicare Payment Advisory Commission 2018b).

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. The Office of Inspector General (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 based on chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to overpayments 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.²⁷ 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 chart review (violating Medicare’s rule that diagnoses must be supported by a medical record, and a code already submitted should be deleted if the plan finds no evidence in the medical record to support the diagnosis). Documentation from these whistleblower lawsuits sheds light on the profitability of chart reviews. During 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 are using 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 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,” where 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, decreasing payments by \$196.5 million. Chart reviews adding diagnoses increased payments to MA plans by \$6.9 billion (resulting in a net payment increase of \$6.7 billion, which we note 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 out of 137 parent organizations accounted for 79 percent of the increased payments to MA plans.

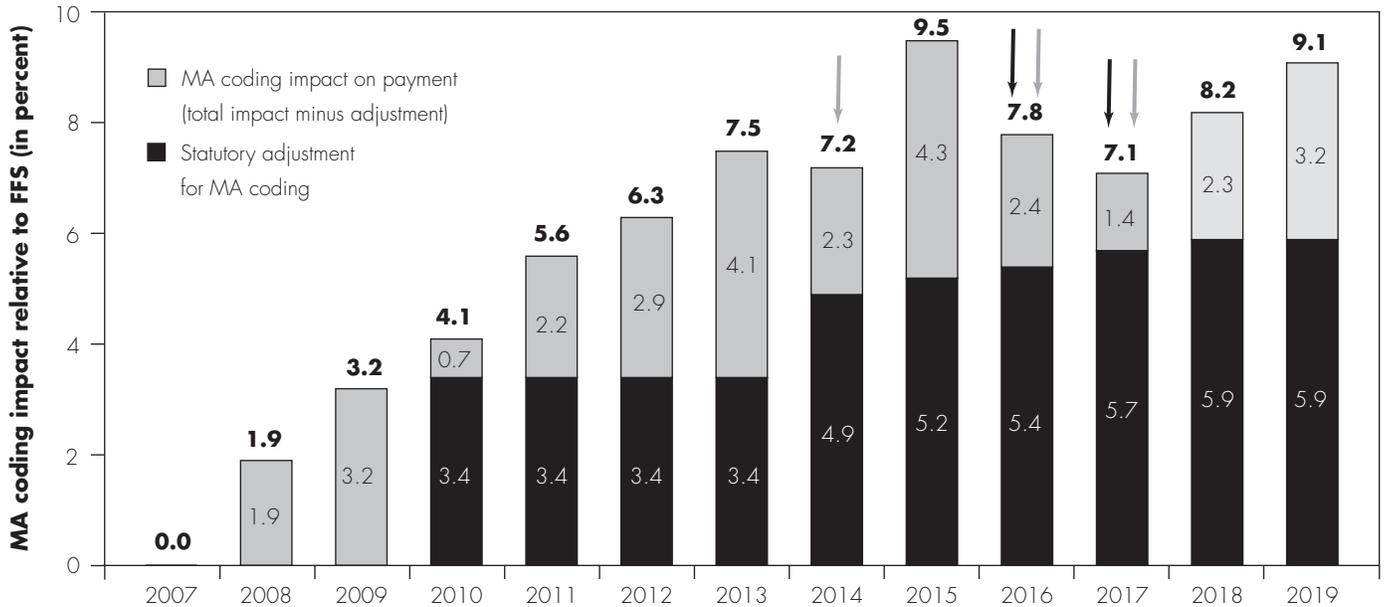
For 2017, we estimated that MA risk scores were about 7.1 percent higher than FFS risk scores before applying the mandatory coding adjustment. Based on OIG’s findings that in 2017 health risk assessments accounted for \$2.6 billion (or 1.2 percent of total payments to plans) and chart reviews accounted for \$6.7 billion (or 3.2 percent of total payments to plans), we estimate that health risk assessments and chart reviews were responsible for more than 60 percent of MA coding intensity in 2017.

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 coding differences between MA and FFS. 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 increased gradually to about 5.9 percent in 2018, where it will remain until CMS estimates a risk adjustment model using MA cost and

FIGURE 12-7

Impact of coding intensity on MA risk scores was larger than coding adjustment, 2007–2019



MA coding intensity increased MA risk scores by 1 percentage point or more 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.

use data. CMS reduced MA risk scores by the minimum amount required by law for 2014 through 2021 and has proposed the minimum adjustment amount for 2022, although larger reductions would have been allowed. 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.²⁸ Partial-benefit dual enrollees make up a larger share of dual enrollees in MA than in FFS Medicare, causing the overall 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 determined the risk scores of these two groups.²⁹ 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 nearly \$9 billion in 2019

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 2019. 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-model risk scores. Our analysis calculated differences in risk score growth by comparing FFS and MA cohorts with the same years of enrollment (e.g., 2007 through 2019, 2008 through 2019), adjusting for differences in age and sex.

Figure 12-7 shows 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) for payment years 2007 through 2019. The figure shows that 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 increased FFS coding. The coding intensity adjustment has never accounted for the full impact of coding intensity, resulting in additional spending relative to the amount Medicare would have spent if the same beneficiaries had been enrolled in FFS Medicare.

For 2019, MA risk scores were 9.1 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 3.2 percent increase in MA risk scores, leading to nearly \$9 billion in excess payments to MA plans. The magnitude of these findings is consistent with other research showing that the impact of coding differences on MA risk scores is larger than CMS’s adjustment for coding (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Kronick and Welch 2014).

In addition to the 1 percentage point annual increase in MA risk scores, we tracked the influence of three factors affecting the overall impact of coding intensity: changes in the risk adjustment model, changes in the relative growth rates of FFS and MA risk scores, and changes in the use

of encounter data as a source of diagnoses for MA risk adjustment.

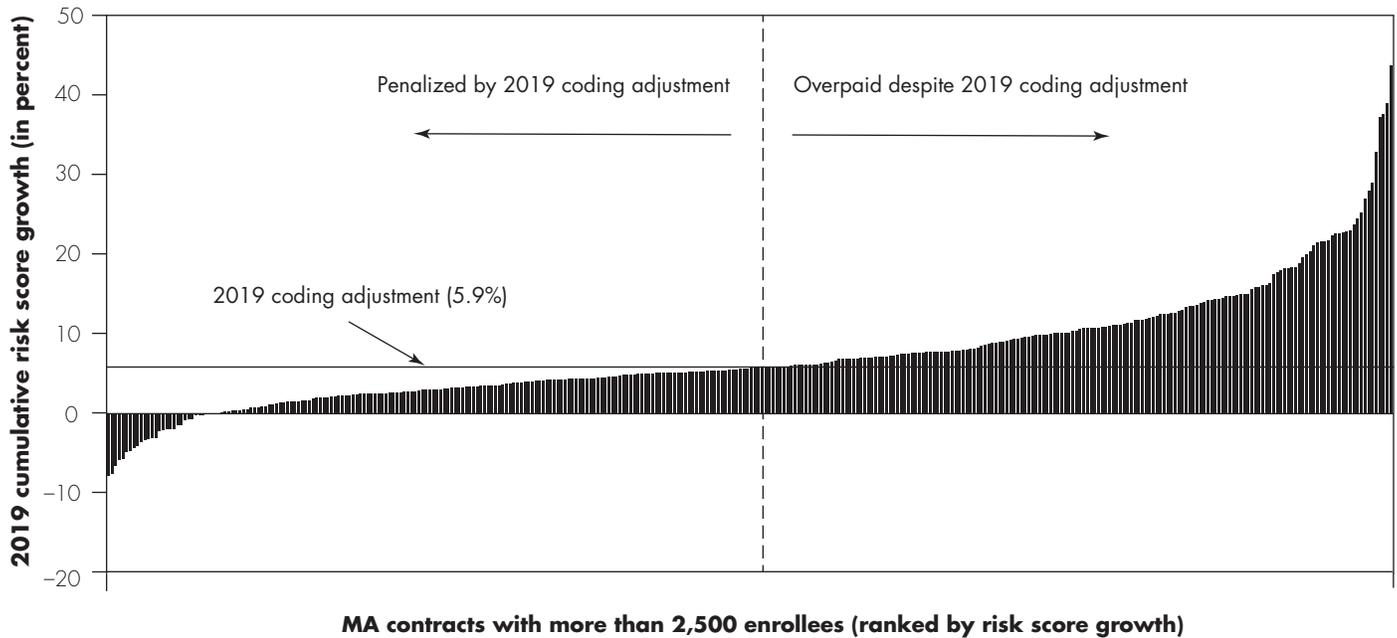
Changes in the risk adjustment model—Our analysis found that two newer versions of the CMS–HCC model have been less susceptible to diagnostic coding differences between MA and FFS. These model versions reduced risk scores in 2014, 2016, and 2017, noted in Figure 12-7.

- One new model version, phased in between 2014 and 2016, removed certain diagnoses with large differences in MA and FFS coding rates, thereby reducing the impact of coding differences by 2 percentage points to 2.5 percentage points when fully phased in. Figure 12-7 shows the impact of phasing in this model in 2014 and in 2016. In 2014, the model was the basis for 75 percent of MA risk scores, but in 2015 the model accounted for only 33 percent of MA risk scores and in 2016, accounted for 100 percent of MA risk scores.
- In 2017, CMS introduced a different version of the model, adding separate aged/disabled and Medicaid enrollment status segments. This model reduced the impact of coding differences by almost 1 percentage point.
- No changes to the risk adjustment model were implemented in 2018. In 2019, a new version of the model that added five HCCs to the 2017 model version had a relatively minor effect on the overall coding differences.

Relative growth rates for FFS and MA risk scores—Our analysis shows that, between 2007 and 2015, MA risk score growth outpaced FFS risk score growth in every year, increasing the overall impact of coding intensity on MA risk scores by an average of more than 1 percentage point in each year. Changes in FFS risk scores are offset by the normalization factor, which is applied to all risk scores and keeps the average FFS risk score at 1.0. MA risk score growth above the normalization factor contributes to excess payments to MA plans. Between 2015 and 2017, MA risk scores continued to increase at about the same rate as in prior years, but FFS risk scores grew at a faster rate.³⁰ The faster growth in FFS risk scores increased the normalization factor and thereby helped to reduce the impact of MA coding intensity in 2016 and 2017, shown in Figure 12-7. Between 2017 and 2019, MA risk score growth again reflected the underlying trend of MA risk scores outpacing FFS risk score growth by about 1 percentage point per year.

**FIGURE
12-8**

Cumulative MA risk score growth varied across contracts relative to local FFS, 2019



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 2019 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.

Encounter data as a source of diagnostic information—

Starting in 2016, CMS blended risk scores based on encounter data with risk scores based on RAPS data. Encounter-based risk scores were initially lower than RAPS-based risk scores, causing concern among plans that the transition to using encounter data would decrease payments. 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 2018.³¹ For enrollees with different encounter-based and RAPS-based risk scores, we also found that the average difference between the two has converged over time. Average encounter-based risk scores were about 2 percent lower than RAPS-based risk scores in 2016 and about 1 percent lower in 2018. For 2019, RAPS data were the basis for risk scores using the 2017 model, but CMS used encounter data pooled with inpatient RAPS data as the basis for risk scores calculated with a new model. The 2019 model adds five HCCs to the 2017

model. Therefore, we do not have a direct RAPS-based to encounter-based risk score comparison, but we found that the 2019 model risk scores with pooled data are 0.3 percent larger than the 2017 model risk scores based on RAPS data.

Considering the impact of encounter data on MA risk scores, we noted that in 2018, using encounter data reduced MA risk scores by about 0.2 percent relative to using only RAPS data (i.e., in 2018, encounter-based risk scores accounted for 15 percent of payments and were about 1 percent less than RAPS-based risk scores). For 2019, CMS applied a 25 percent weight to risk scores using the 2019 model with pooled data, resulting in an increase of about 0.1 percent to overall MA risk scores relative to using only RAPS data (i.e., in 2019, risk scores under the 2019 model with pooled data accounted for 25 percent of payments and were about 0.3 percent larger than RAPS-based risk scores).³²

Variation in coding intensity across MA contracts

For 2019, 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 2019 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 2019, thereby capturing the coding impact for each contract’s 2019 payments. Figure 12-8 illustrates the variation across contracts with more than 2,500 enrollees in 2019 relative to FFS in their local service area.³³

Our finding that coding intensity varies across MA contracts is consistent with other research (Geruso and Layton 2015, Kronick and Welch 2014). Given this variation, CMS’s across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by disadvantaging plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

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 who pay premiums to finance the Part B program.

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

which would replace the existing mandatory minimum coding intensity adjustment (which was 5.9 percent in 2019), 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.
- 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 to implement provisions of the Cures Act. 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.³⁴ 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 MA and FFS coding differences. 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 a face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. For both RAPS and encounter data, MA plan leadership signs an attestation that risk adjustment criteria are applied correctly and submitted data are accurate. However, only for encounter data does CMS independently verify that diagnoses result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional. The use of encounter data significantly improves oversight of payment data and offers the opportunity to ensure their validity before payments are made to MA plans. CMS must conduct RADV audits of both encounter and RAPS data to ensure that diagnoses are supported by the medical record, but RADV audits of RAPS data must also check whether diagnoses are made during an encounter with an appropriate type of provider.

RADV audits determine whether an MA plan was overpaid due to invalid data and are the basis for calculating an overpayment amount to recover from the

plan. CMS audits roughly 5 percent of MA contracts per year (about 30 contracts in early audit years) and, for each contract, uses a sample of 201 enrollees who had at least 1 HCC reported and met certain other criteria.³⁵ 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.³⁶ 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.³⁷

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

In reviewing the RADV audit process, 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).

Increase the use of encounter data for risk adjustment

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

For 2021, CMS will use encounter data along with inpatient RAPS data as the source of diagnoses for a new version of the risk adjustment model, which will be the basis for 75 percent of MA payments. For 2022, CMS will use encounter data as the sole basis for risk adjustment. The Commission supports increasing incentives for plans to submit complete encounter data, which could serve multiple purposes.³⁸ 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.

Quality in Medicare Advantage is difficult to evaluate

The law established, beginning in 2012, a quality bonus program (QBP) that ranks 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 of the reliability of data on the quality of MA plans (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting 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).

With 43 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare, including in accountable care organizations (ACOs), is necessary for proper evaluation. MA plans have a number of management tools that are not available in FFS but permit plans to improve the quality of care for their enrollees—tools such as selective contracting, care management, information systems shared across providers, and utilization management that can prevent overutilization of potentially harmful care. These tools provide MA the potential to improve quality relative to FFS, but a lack of sufficient data severely limits any definitive comparisons. Comparative assessments could help in evaluating MA performance and changes in performance over time, in evaluating payment policy in MA, and in determining the adequacy and appropriateness of the standards applied to MA plans (for example, by using quality results as an indirect measure of network adequacy in MA plans). The ability to compare MA and FFS quality, and to compare quality across MA plans, is also important for beneficiaries. Choosing between MA and FFS is a threshold choice that beneficiaries make before getting to the step of deciding among available MA plans.

A new MA value incentive program

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, should align across all Medicare-accountable entities and providers, including MA plans and ACOs. To avoid undue burden on providers, measures should be calculated or administered largely by CMS, preferably with data that are already being reported, such as claims and encounter data.
- Evaluation of quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA

plans with incentives to improve the quality of care provided in every geographic area.

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

Payment and access for enrollees with end-stage renal disease

Individuals with end-stage renal disease (ESRD) require regular dialysis treatments to remove waste from the blood stream. Medicare beneficiaries with ESRD have significantly higher Medicare spending than other beneficiaries. CMS projects that in 2021, spending for beneficiaries with ESRD in FFS Medicare will be over eight times higher than spending for FFS beneficiaries without ESRD (Centers for Medicare & Medicaid Services 2020e). About 31 percent of Medicare spending for FFS beneficiaries with ESRD is for dialysis treatments; 28 percent for inpatient hospital care; 12 percent for Part D prescription drugs; and the rest for other Medicare services (United States Renal Data System 2019). Given greater medical spending, beneficiaries with ESRD face significantly higher cost-sharing liability, averaging roughly \$13,000 per year for FFS beneficiaries with ESRD (Health Management Associates 2020). About 47 percent of FFS beneficiaries with ESRD are also eligible for Medicaid and have Medicaid assistance with cost-sharing coverage. Other ESRD beneficiaries in FFS Medicare can obtain cost-sharing coverage through an employer-sponsored plan or a Medigap plan.

But Medigap plans are not available to all ESRD beneficiaries. Medicare beneficiaries have guaranteed-issue rights for Medigap plans—meaning that a plan must be offered—when they turn 65. However, about half of individuals with ESRD become eligible for Medicare before reaching age 65, and federal guaranteed-issue rights do not extend to those beneficiaries. As of 2020, 33 states required insurers to offer at least one Medigap plan to beneficiaries under age 65, but only 30 states require insurers to offer a plan to those entitled to Medicare due to ESRD rather than because of disability (American Kidney Fund 2019b, Centers for Medicare & Medicaid Services 2020b). Even though a plan must be offered in these states, the insurer can charge a higher premium based on age, sex, or existing health conditions, depending on state insurance rating rules. Medigap plans can be expensive (when they are available to ESRD beneficiaries), and some patients get assistance paying plan premiums through the American Kidney Fund.³⁹

Alternatively, beneficiaries with ESRD can enroll in an MA plan to reduce their cost-sharing liability. MA plans generally offer reduced cost sharing for most services relative to FFS Medicare and are required to offer a maximum out-of-pocket (MOOP) limit on total cost-sharing expenditures in a year. Medicare requires MA plans to offer the same levels of cost sharing (including MOOP limit) to all plan enrollees, although different services may have different levels of cost-sharing coverage.⁴⁰

Historically, individuals with ESRD were prohibited from joining an MA plan during open enrollment unless the plan was specifically designed for ESRD enrollees.⁴¹ Under the prohibition, MA plan access was limited to (1) individuals with ESRD in an employer-sponsored health plan, who could enroll in an MA plan offered by the same insurer if one was available when initially enrolling in Medicare; (2) Medicare beneficiaries already enrolled in an MA plan, who could remain in that plan after developing ESRD; or (3) Medicare beneficiaries who could enroll in an ESRD chronic condition special needs plan (C–SNP) and certain other SNPs.⁴² As of January 2020, the availability of ESRD C–SNPs was limited to only a few states, and ESRD C–SNP enrollment represented less than 5 percent of ESRD enrollees in MA.⁴³

Even under the enrollment limitations, the share of ESRD beneficiaries in MA has been increasing; CMS estimates that about 131,000 enrollees with ESRD were in private

Medicare plans in 2019, about 25 percent of the 532,000 Medicare beneficiaries with ESRD (Centers for Medicare & Medicaid Services 2020e). By comparison, about 36 percent of all Medicare beneficiaries were enrolled in MA plans in 2019.

The 21st Century Cures Act established complete access to MA plans for beneficiaries with ESRD

Beginning with the 2021 plan (calendar) year, the Cures Act allows Medicare beneficiaries with ESRD to enroll directly in an MA plan.⁴⁴ The Cures Act also relieved MA plans from coverage of organ acquisition costs, authorizing coverage of those costs for MA enrollees through FFS Medicare and removing them from MA benchmarks. Some observers believe the Cures Act's changes will significantly increase MA enrollment among beneficiaries with ESRD as beneficiaries seek to reduce their cost-sharing liability. Because of Cures Act changes, CMS expects that an additional 83,000 beneficiaries will enroll in an MA plan between 2021 and 2026, making the share of ESRD beneficiaries enrolled in MA roughly equal to that of non-ESRD beneficiaries (Centers for Medicare & Medicaid Services 2020e).

In 2004, the Commission recommended that the Congress allow all beneficiaries with ESRD to enroll in private plans. The accompanying report noted that a new risk adjustment system would be implemented to improve payments to private plans for ESRD enrollees in the following year. The Commission also reported that a study evaluating a Medicare ESRD demonstration showed that the quality of care and outcomes of most plan participants were equal to or better than those for ESRD patients enrolled in FFS Medicare (Medicare Payment Advisory Commission 2004).

The Commission strongly supports beneficiaries' ability to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Some ESRD beneficiaries may find MA plan coverage to be superior to traditional Medicare, given the substantial extra benefits that plans offer (accounting for 14 percent of Medicare's payments to plans in 2021) and the care coordination and cost-control tools they employ. Extra benefits can reduce Part B and Part D premiums; reduce cost sharing for basic Medicare and Part D benefits; cover additional services such as dental, hearing, and vision; or offer assistance with transportation. The requirement that all MA plans have an out-of-pocket cap on cost sharing for

the basic Medicare benefit is likely to be a valuable benefit for enrollees with ESRD.

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits. The 21st Century Cures Act provides ESRD beneficiaries with the same access to Medicare coverage through an MA plan as other Medicare beneficiaries. The requirement that MA plans make all items and services available and accessible to each individual electing a plan guarantees that plan benefits are equally available to all plan enrollees. The Commission reiterates its support for the ability of all beneficiaries, including those with ESRD, to choose between traditional Medicare coverage or coverage through an MA plan.

Ensuring appropriate payments to MA plans for enrollees with ESRD

To assess whether ESRD beneficiaries have access to MA plans equal to that of other Medicare beneficiaries, we evaluated Medicare payments to MA plans for ESRD enrollees. We examined how MA plans are paid for ESRD and non-ESRD enrollees, how MA plan revenues for ESRD enrollees compare with MA plan costs for coverage of ESRD enrollees, and plan advocates' concerns about the adequacy of Medicare payments to MA plans for ESRD enrollees.

Medicare payments to MA plans differ for ESRD and non-ESRD enrollees

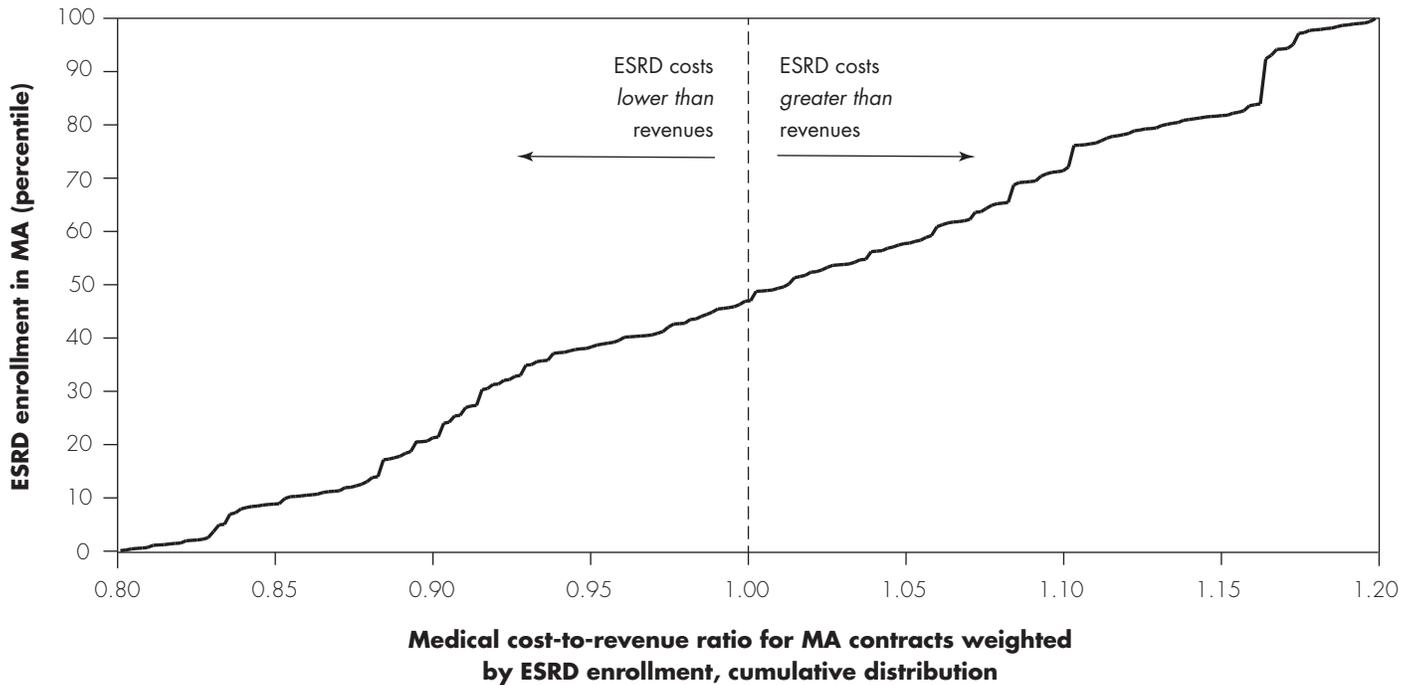
CMS pays MA plans a monthly amount for each enrollee that is the product of a base payment rate and a risk score; however, calculation of the base rate and risk scores differ for non-ESRD and ESRD enrollees.

In setting base payment rates for an MA payment area, CMS uses local FFS spending. For ESRD enrollees, a base rate is established for each state—called the “ESRD state rate”—and is equal to the average FFS spending for ESRD beneficiaries in that state. MA payment for an ESRD enrollee is the ESRD state rate based on where the enrollee resides, adjusted by the enrollee's ESRD risk score. The ESRD risk model is based on FFS beneficiaries with ESRD.⁴⁵

Because plans bid only for non-ESRD enrollees (ESRD state rates are calculated entirely by CMS), a plan's funding for extra benefits (i.e., the rebate) is based only on non-ESRD enrollees. However, all MA plan enrollees

**FIGURE
12-9**

MA ESRD revenues cover medical costs on average, but contracts' costs relative to revenue for ESRD enrollees varies widely, 2018



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The figure excludes ESRD chronic condition special needs plans, which submit bids through a specialized bid tool, and employer group waiver plans, which do not submit bids. About 1 percent of MA ESRD beneficiaries are enrolled in a contract with a medical cost-to-revenue ratio below 0.80, and about 6 percent are enrolled in a contract with a ratio above 1.20. The cost to administer an MA contract is not included in this analysis because administrative costs are not identified separately for ESRD enrollees in the bid payment tool data.

Source: MA 2020 bid payment tool data including 2018 cost and revenue information.

receive the same benefit package, including receipt of extra benefits or a requirement to pay a plan premium. CMS offers plans the option to reconcile financing for ESRD enrollees with the plan's rebate using the "ESRD subsidy."⁴⁶ For plans with ESRD payments that do not cover plan ESRD costs, the ESRD subsidy allows plans to cover the net ESRD costs by drawing down rebate funding and reducing the level of extra benefits. Conversely, for plans with ESRD payments that are greater than plan ESRD costs, the ESRD subsidy allows plans to add net ESRD revenues to their rebate funding and increase the level of extra benefits.

Medicare payments to MA plans cover medical costs for ESRD enrollees on average

To assess whether Medicare payments to MA plans for ESRD enrollees cover plan costs, we analyzed plan-submitted data for the 2020 plan year. The bid pricing tool

(BPT) includes information about a plan's 2018 financial experience for both non-ESRD enrollees and ESRD enrollees. The 2020 BPT data include 2018 plan costs and revenues for the vast majority of ESRD enrollees.⁴⁷ We aggregated plan-level BPT data to the MA contract level in our analysis and separately analyzed data for ESRD C-SNPs.⁴⁸

We found that ESRD enrollees' average medical costs of \$6,752 per member per month (PMPM) were slightly below the average plan revenue of \$6,769 PMPM—a medical cost-to-revenue ratio of 0.997. However, we found a wide range of ESRD medical cost-to-revenue ratios across MA contracts as shown by the cumulative distribution in Figure 12-9. MA contracts with lower ESRD medical costs than revenues have a cost-to-revenue ratio below 1.0 and include about 56 percent of MA ESRD enrollees. Contracts with higher ESRD medical costs than revenues have a ratio higher than 1.0 and include about

44 percent of MA ESRD enrollees. The cost to administer an MA contract is not included in this analysis because administrative costs are not identified separately for ESRD enrollees in the BPT data.

Although Figure 12-9 shows that Medicare payments adequately cover plan medical costs for ESRD enrollees for most MA contracts and most MA enrollees with ESRD, CMS estimates that plans have nonbenefit expenses of about \$350 PMPM for plan administration of benefits for ESRD enrollees (Centers for Medicare & Medicaid Services 2020f). Adding administrative expenses to average medical costs of \$6,752 means that the average plan revenue of \$6,769 PMPM does not cover total plan costs of about \$7,102 per ESRD enrollee, equating to a total cost-to-revenue ratio of about 1.05 for ESRD enrollees (not shown in Figure 12-9) (that is, total costs including administration were 5 percent higher than revenues, on average). We found that in 2018, plan revenues covered total plan costs for about 46 percent of ESRD enrollees.

In contrast, we found that Medicare payments adequately covered total plan costs for ESRD C–SNPs, which enroll only beneficiaries with ESRD. We separately analyzed costs and revenues for ESRD C–SNPs because those plans submit bid information through a specialized BPT, which for 2020 covers the vast majority of 2018 ESRD C–SNP enrollees. We found that, for C–SNPs in 2018, average ESRD enrollee medical costs (\$7,231) and revenues (\$7,678) were higher than for other MA plans, in large part because more than 70 percent of ESRD C–SNP enrollment in 2018 was in California, which had the third-highest ESRD state rate of \$7,748.72 monthly. The medical cost-to-revenue ratio for ESRD C–SNP enrollees was 0.942 (that is, costs excluding administration were 6 percent lower than revenues, on average). This ratio is about 5.5 percentage points lower than the average medical cost-to-revenue ratio for ESRD enrollees across all MA plans (0.997, noted above). The ESRD C–SNP BPT data also showed average administrative costs of \$302 PMPM for a total (medical plus administrative) cost-to-revenue ratio of 0.981 (that is, total costs including administrative costs were almost 2 percent lower than revenues, on average), indicating that ESRD C–SNPs have been profitable.

Most MA plans pay facilities more than FFS rates for dialysis services

Although Medicare payments to MA plans appear to cover medical costs for most ESRD enrollees, some plans have net costs for ESRD enrollees. One reason is that some

plans pay a higher price for dialysis services relative to FFS Medicare. The number of dialysis treatments a patient receives in a year does not vary much across beneficiaries, meaning that any variation in plan spending for dialysis services is primarily driven by differences in price rather than number of treatments. In FFS Medicare, dialysis spending accounts for about 31 percent of total spending for ESRD beneficiaries (United States Renal Data System 2019). If MA plans are unable to negotiate dialysis prices similar to (or lower than) FFS Medicare payment rates for dialysis, plans have to offset higher dialysis spending by reducing costs for other services provided to these enrollees (e.g., care coordination to reduce inpatient hospital and emergency room visits) or risk losses on ESRD enrollees.

We analyzed dialysis services reported in 2018 MA encounter data for the 50 states and the District of Columbia to estimate the price MA plans paid for dialysis. Although we previously found encounter data to be insufficiently complete to analyze MA service utilization (where missing encounter data introduce bias in utilization estimates toward lower utilization), an analysis of dialysis prices is not necessarily biased by incomplete data. To better understand the potential for bias due to incomplete encounter data, we evaluated the completeness of dialysis treatments reported in MA encounter data by calculating the number of dialysis treatments we would expect to observe and comparing that with the number of MA dialysis treatments included in our analysis (see text box on completeness of MA encounter data, p. 390).

In FFS Medicare, payments to dialysis providers are adjusted by facility-level factors (wage index, low-volume adjustment, and rural adjustment) and patient-level factors (age, body size, onset (first four months of dialysis treatment), and comorbidities). The MA encounter data did not include sufficient information to replicate the complete FFS payment calculation, but we were able to adjust MA plan payments to facilities by the two factors we consider having the greatest importance: wage index and age. We do not expect differences in the other factors to significantly affect the comparison of dialysis prices.

Accounting for age and wage index differences (geographic location), we found that in 2018, the prices MA plans paid for dialysis services averaged about 14 percent higher than FFS Medicare rates. The average price paid by MA contracts varied widely, suggesting that some MA plan sponsors negotiated rates similar to those in FFS Medicare, while most plan sponsors paid

Evaluating the completeness of MA encounter data for estimating dialysis prices paid by MA plans

To evaluate Medicare Advantage (MA) encounter data for use in estimating dialysis prices paid by MA plans, we calculated the share of dialysis treatments in fee-for-service (FFS) claims relative to the maximum number of possible treatments if all FFS beneficiaries in dialysis status received complete dialysis treatments (3 treatments per week × 52 weeks = 156 treatments per year). There are several reasons why the number of dialysis treatments provided is lower than the “maximum number possible.” First, dialysis patients do not always receive three treatments per week due to hospitalizations or missed treatments when transportation is not available, for example. Second, the number of individuals in dialysis status likely overestimates the number of current dialysis patients because patients who choose to end dialysis treatment without receiving a transplant may continue to be reported as in dialysis status.⁴⁹

In 2018, if the maximum possible treatments were provided to FFS beneficiaries in dialysis status, about 53.2 million dialysis treatments would have been provided. Our analysis of FFS claims data for 2018 found about 44.3 million dialysis treatments, or roughly 83 percent of the maximum possible treatments.

Using this FFS share of maximum possible treatments, we expected to find about 12.9 million dialysis treatments in MA encounter data based on the number of MA enrollees in dialysis status. Our analysis of 2018 MA encounter data identified about 10.1 million

dialysis treatments, or roughly 79 percent of the dialysis treatments we would expect to observe. Thus, we conclude that the available dialysis treatments in MA encounter data are a sufficient basis for estimating dialysis prices paid by MA plans without meaningful bias.

The discrepancy between dialysis treatments included in our analysis and the number of treatments we expected to find in MA encounter data could be due to missing dialysis treatment encounters or due to exclusions we applied to ensure accurate calculation of dialysis prices. MA encounter data are not adjudicated claims and have not been processed and verified by a Medicare administrative contractor, allowing some variables used to calculate dialysis payment in FFS Medicare to be missing or inaccurate in encounter data. We excluded encounters for dialysis treatments that did not have complete data or likely showed inaccurate reporting for one or more variables used to calculate price per dialysis treatment.⁵⁰ Some MA plans have capitated arrangements with dialysis facilities. MA plans are not required to report provider payment amounts for capitated encounters. Therefore, capitated encounters were likely excluded from our analysis because missing provider payment data would have caused such encounters to be excluded by our criteria. After applying exclusion criteria, we included the remaining encounters for dialysis treatments in our estimate of MA payment rates. ■

more than FFS Medicare rates for dialysis treatment. Specifically, 26 percent of MA contracts (covering about 18 percent of MA dialysis treatments) paid less than FFS rates, and 15 percent of MA contracts (accounting for less than 5 percent of MA dialysis treatments) paid rates at or above 40 percent of FFS rates. Figure 12-10 shows the distribution of MA-to-FFS dialysis payment ratios for MA contracts purchasing dialysis services.

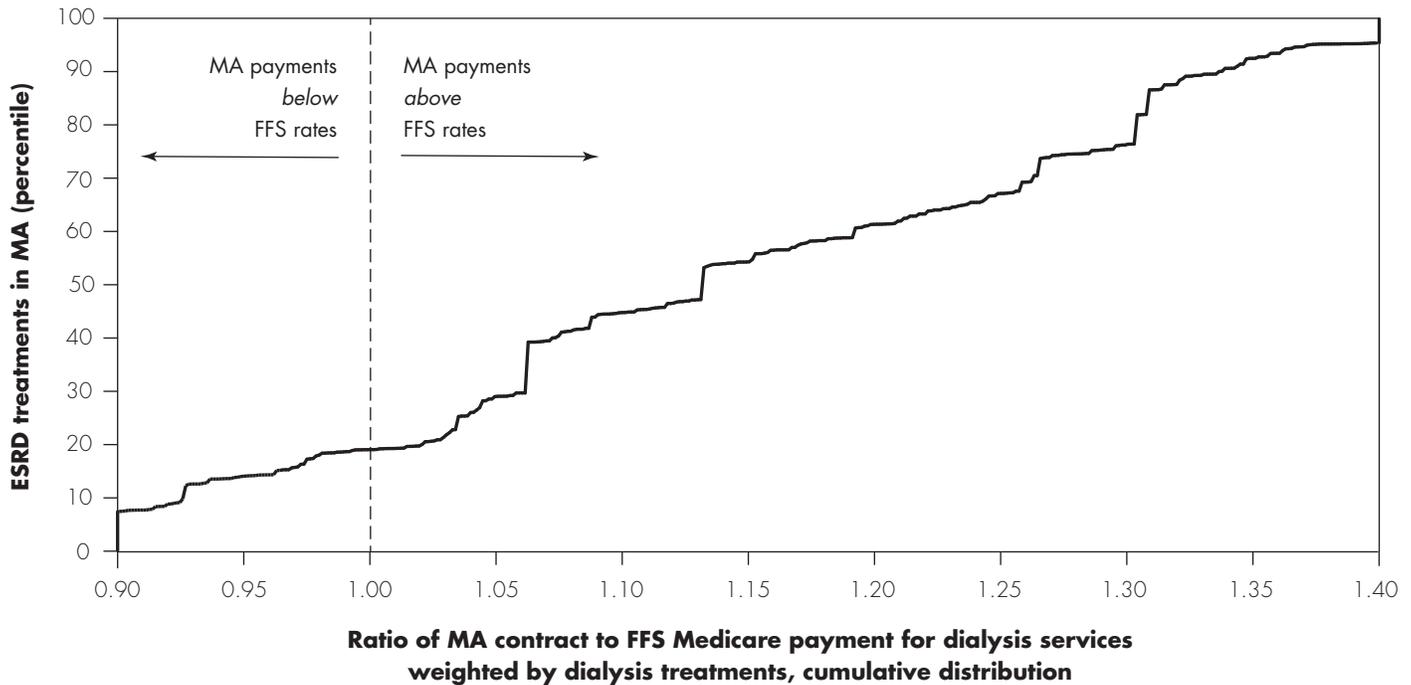
One reason that MA plans pay more for dialysis than FFS Medicare could be the high level of consolidation

in outpatient dialysis facilities. In 2018, two companies, DaVita and Fresenius, operated 74 percent of dialysis facilities, so MA plans are likely to be negotiating with these companies. In some counties, either DaVita or Fresenius is the sole operator of the county’s dialysis facilities.

Given that 2021 is the first year ESRD beneficiaries are able to enroll in any MA plan and that the number of MA ESRD enrollees is expected to increase, the balance of negotiating leverage between MA plans and dialysis

**FIGURE
12-10**

MA contracts frequently paid more per dialysis treatment than FFS Medicare rates, 2018



Note: MA (Medicare Advantage), FFS (fee-for-service), ESRD (end-stage renal disease). About 7 percent of dialysis treatments were covered by a contract with a payment ratio less than 0.9, and less than 5 percent of dialysis treatments were covered by a contract with a payment ratio greater than 1.4. Dialysis encounters that did not have complete data or likely showed inaccurate reporting for one or more variables used in our analysis were excluded (endnote 50 identifies the exclusions for this analysis). The analysis accounts for differences in age and geographic location (wage index) between MA and FFS treatments, but does not account for differences in other factors that affect FFS payment rates: low-volume facility status or rural location, patient body size, dialysis onset status (first four months of dialysis treatment), or comorbidities.

Source: MA encounter and FFS Medicare claims data, 2018.

providers could shift in the coming years. We will continue to monitor dialysis prices paid by MA plans and consider whether high dialysis prices provide an incentive for plans to design benefit packages and networks that may deter ESRD beneficiaries from enrolling in MA.

Medicare payment rates based on statewide average spending could overpay or underpay plans

ESRD state rates are currently based on average FFS spending for ESRD beneficiaries in each state; however, the Secretary has the authority to set ESRD payment rates using another geographic unit.⁵¹ The choice of geographic unit is limited by the number of ESRD FFS beneficiaries that serve as the basis for calculating ESRD payment rates in MA. To maximize accuracy, payments should

be based on the smallest geographic unit with enough ESRD FFS beneficiaries to attain stable payment rates in each payment area over time, thereby balancing the goal of stable payments with the goal of limiting the extent of FFS ESRD spending variation within each payment area. Under the current ESRD state rates, Medicare payments for ESRD enrollees can be too high if a plan's enrollment is concentrated in parts of the state with local FFS ESRD spending that is lower than the state average and vice versa.

One industry-sponsored analysis of this issue identified 15 metropolitan statistical areas (MSAs) and compared their average FFS spending for ESRD enrollees with the state's ESRD rates. The analysis found that the state rate was less than local FFS spending for 10 of the MSAs, ranging from 2 percent to 12 percent lower. For the other five MSAs,

the state rate was greater than local FFS expenditures by 1 percent to 9 percent (Avalere 2019). A separate industry analysis compared Medicare spending for FFS beneficiaries with ESRD in several large metropolitan areas in California, Florida, Ohio, and Texas. The analysis tracked ESRD FFS spending in each metropolitan area from 2015 to 2017 and found that spending in the metropolitan areas ranged from about 15 percent above or below the state average spending in each state. Spending in many metropolitan areas, however, was much closer to the state average (Health Management Associates 2020).⁵² These analyses suggest that there is room to improve MA payment accuracy for ESRD enrollees by establishing payment areas with less variation in ESRD spending than in states.

Ensuring equal access to MA plans for beneficiaries with ESRD

The 21st Century Cures Act sought to create access to MA plans for ESRD beneficiaries that is equal to that of other Medicare beneficiaries. Although the law eliminated enrollment barriers, some MA plans report ESRD losses and may seek to limit plan access for ESRD beneficiaries within the bounds of Medicare rules. One strategy is to impose high out-of-pocket spending for ESRD enrollees, diminishing ESRD beneficiaries' incentive to enroll in an MA plan to reduce their cost-sharing liability. A second strategy is for plans to restrict their dialysis facility networks to discourage ESRD beneficiaries from enrolling.

Cost-sharing coverage for ESRD enrollees in MA

MA plans can require enrollees to pay cost sharing up to the amount charged in FFS Medicare. Given the level of dialysis cost sharing in FFS Medicare (20 percent coinsurance) and the frequency of dialysis services (three treatments per week), ESRD beneficiaries enrolled in MA can face cost-sharing liability of about \$52 per dialysis treatment, or about \$8,068 per year (assuming FFS rates for dialysis and a complete set of annual treatments). We found that in 2018, 47 percent of ESRD beneficiaries in FFS Medicare had dialysis cost-sharing assistance through Medicaid, compared with 38 percent of ESRD beneficiaries in MA. MA enrollees generally do not have a Medigap plan as it is illegal for anyone to sell a Medigap policy to an MA enrollee, and Medigap policies cannot be used to pay MA cost sharing or premiums.

MA plans choose to reduce beneficiary cost sharing for most services (an extra benefit financed by plan rebates)

and are required to offer a MOOP limit. Each plan's benefits for cost sharing and limits on out-of-pocket spending must be the same for all enrollees; however, the level of cost-sharing coverage can differ across service categories.

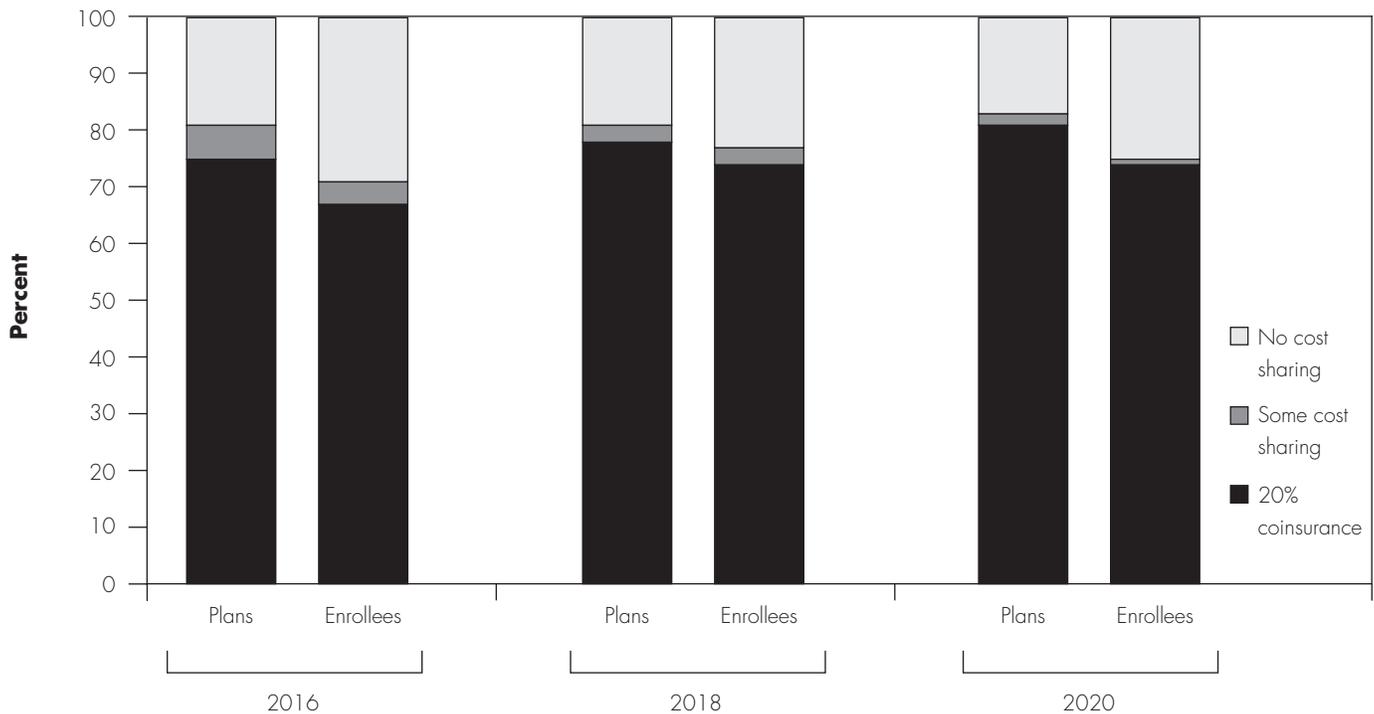
As shown in Figure 12-11, about three-quarters of MA plans had the maximum allowable cost sharing for dialysis services in 2016, prior to the passing of the Cures Act, affecting about two-thirds of ESRD enrollees. Setting cost sharing for dialysis services at the maximum allowable amount allows plans to redistribute rebate funding to other extra benefits, which can be beneficial for enrollees whose dialysis cost sharing is covered through other sources, such as Medicaid or employer-sponsored coverage. But setting cost sharing for dialysis at the maximum allowable amount may discourage beneficiaries without other sources of coverage from enrolling in the MA plan.

Since the Cures Act was passed, the share of MA plans with 20 percent coinsurance rose from 75 percent to 81 percent between 2016 and 2020, and the share of ESRD enrollees with 20 percent coinsurance rose from 67 percent to 74 percent between 2016 and 2018 (the most recent year of ESRD enrollment data). The share of plans and ESRD enrollees with some cost sharing, but less than the maximum allowable 20 percent coinsurance, fell between 2016 and 2020. For ESRD C-SNPs in 2020 (included in Figure 12-11), most plans and about 67 percent of enrollees had 20 percent coinsurance for dialysis services, while the remaining plans and their enrollees had no cost sharing. Although 20 percent coinsurance is the maximum allowable dialysis cost sharing for any Medicare beneficiary, it is possible for MA enrollees to pay a higher dollar value for dialysis cost sharing than is allowable in FFS Medicare, particularly in MA plans that charge 20 percent dialysis coinsurance and that pay dialysis prices well above FFS Medicare rates.

Despite most MA plans charging the maximum allowable cost sharing for dialysis services, the MOOP constrains total out-of-pocket spending for ESRD enrollees. Prior to 2021, the mandatory MOOP limit was set at the 95th percentile of beneficiary cost-sharing expenditures for FFS beneficiaries *without* ESRD, and the voluntary MOOP limit was set at the 85th percentile. In response to the Cures Act changes, CMS will begin to incorporate beneficiary cost sharing for FFS beneficiaries with ESRD when estimating MOOP limits (i.e., when calculating the 85th and 95th percentiles of out-of-pocket expenditures).

FIGURE 12-11

Large share of MA plans and MA ESRD enrollees with 20 percent coinsurance for dialysis services in 2016 increased modestly through 2020



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The maximum allowable cost sharing for dialysis services is 20 percent coinsurance. Plan enrollment in 2020 is assumed to be the same as in 2018, the most recent year of ESRD enrollment data.

Source: MedPAC analysis of plan benefit package data, 2016, 2018, and 2020.

Calculating the mandatory limit using cost-sharing data for all FFS beneficiaries (including those with ESRD) would increase the 2021 limit for all beneficiaries by about \$1,000. To limit the impact of the change in calculation method, CMS includes 40 percent of the difference in 2021, increasing the mandatory limit from \$7,175 (using the old method) to \$7,550 (rounded to nearest \$50 increment). A transition will continue to add 20 percent of the difference each year until 2024, when MOOP limits will be based on all FFS beneficiaries (Centers for Medicare & Medicaid Services 2020c).

Some plans may use high cost sharing to deter overuse of a particular service by steering enrollees to lower cost sites for care, such as steering patients away from the emergency department when an urgent care clinic or physician visit would suffice and is available. Frequent dialysis treatments, on the other hand, are necessary to

sustain the lives of ESRD patients. High cost sharing for dialysis services is not in the interest of ESRD patients and can be used to discourage ESRD beneficiaries without supplemental cost-sharing coverage from enrolling in an MA plan. Given the substantial out-of-pocket spending that ESRD beneficiaries face overall, the mandatory MOOP limit is essential for maintaining ESRD beneficiary access to MA plans and limits the impact of most plans charging the maximum allowable cost sharing for dialysis services.

Network adequacy for dialysis facilities

MA plans are required to maintain an adequate network of providers for all Medicare services. Network adequacy is enforced through two requirements that set a specific minimum or standard for each physician specialty and facility type. For facilities, plans must first maintain a minimum number of facilities per county and, second,

maintain access to facilities that is consistent with the prevailing community pattern of health care delivery. The second requirement uses travel time and distance standards that vary by county population and density.

In recent rulemaking, CMS eliminated both network adequacy requirements for outpatient dialysis facilities starting in 2021 and instead requires plans to attest to maintaining an adequate network of dialysis facilities (Centers for Medicare & Medicaid Services 2020d). CMS did not eliminate or propose to eliminate network adequacy standards for any other facility type. The Commission strongly opposed the elimination of time and distance standards for dialysis facilities because:

- CMS did not articulate the goal it was trying to achieve by eliminating the network adequacy standards (although the agency acknowledged concerns from stakeholders that network adequacy standards were leveraged by dialysis providers to obtain higher payments from plans);
- MA coverage should be the same for ESRD beneficiaries as for all Medicare beneficiaries, and if plans were allowed to construct networks with a lesser degree of coverage for dialysis facilities than for other provider types, it could allow plans some ability to discriminate against ESRD beneficiaries wishing to enroll in MA;
- proximity to a dialysis facility is important for dialysis care, and greater travel time has a negative correlation with health outcomes; and
- home dialysis is not a substitute for in-center dialysis for some beneficiaries due to home limitations, caregiver access and burnout, and the need to visit a facility for home dialysis training and for nephrologist visits at least one out of every three months. (CMS proposed one option allowing exceptions to dialysis facility time and distance standards for plans covering home dialysis for all enrollees, and in another context encouraged plans to exercise all options to access medically necessary dialysis care (Medicare Payment Advisory Commission 2020a).⁵³)

Despite our comments, CMS finalized the proposal to eliminate network adequacy requirements for dialysis facilities, potentially compromising access to MA plans for beneficiaries with ESRD. CMS argued that the new regulation did not diminish network adequacy

requirements for dialysis facilities. Under the new regulation, MA plans must attest to maintaining an adequate dialysis network, and other regulations also require plans to maintain an adequate network (including a requirement for plans to arrange for services outside of the plan's provider network when network providers are unavailable or inadequate). At the same time, CMS argued that the change in requirements for outpatient dialysis facilities would encourage competition and bring down high reimbursement costs for dialysis treatment. The two arguments appear to be contradictory. Although a plan's negotiating position would be improved by removing, or credibly threatening to remove, a dialysis provider from its provider network, it is unclear how a plan could use this new leverage and leave access to dialysis in the plan's network unchanged. Either the network adequacy requirements are unchanged and plans cannot achieve greater leverage by removing a facility from its network, or network adequacy requirements are relaxed, giving plans greater leverage when negotiating with facilities. If a plan removes a dialysis facility from its network for an upcoming plan year, dialysis patients receiving treatment from that facility are unlikely to remain in the MA plan or to join the plan. A plan's attestation that it will ensure access to dialysis is not readily apparent to dialysis patients when choosing Medicare coverage, and there is no clear means to convey such information to beneficiaries.

Commission plans for ensuring appropriate payment and access for MA enrollees with ESRD

The 21st Century Cures Act gave Medicare beneficiaries with ESRD full access to MA plans equal to other Medicare beneficiaries. However, this access may be compromised by regulatory decisions, plans' cost-sharing arrangements, and other plan behavior (which may, in some cases, be motivated by dialysis facilities' demands for payment above FFS rates). To the extent MA plans seek to discourage enrollment by beneficiaries with ESRD in order to reduce potential ESRD losses, access to MA plans and the care coordination and extra benefits they offer are diminished. MA plans bear full risk for Medicare expenditures, and given the tools available to them to control costs and improve efficiency, MA plans should see an opportunity to improve care and reduce the significant medical costs for ESRD enrollees. The Commission will continue to review issues with payments to MA plans and network adequacy to ensure equal access to MA plans for beneficiaries with ESRD.

Future direction of MA payment policy

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits. For the second consecutive year, MA enrollment has grown by 10 percent while enrollment in traditional FFS Medicare has declined. If the trend continues, MA is likely to become the most common form of Medicare coverage within the next several years. The MA payment system relies on FFS Medicare data for establishing benchmarks and calibrating the risk adjustment model, so the enrollment trend continues to increase the importance of using FFS data appropriately to set MA payment rates. 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; however, some policies are deeply flawed and in need of immediate improvement.

The Commission is currently discussing changes to MA benchmark policy that would improve equity and efficiency in the MA program. The discussion incorporates the Commission's prior recommendations on MA benchmark policy.⁵⁴ The Commission also has standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016) and (2) ensure the completeness and accuracy of encounter data as a means to improve the MA payment system, to serve as a source of quality data, and to facilitate comparisons with FFS (Medicare Payment Advisory Commission 2019a). Through reforms to the MA payment system, the Commission aims to better focus the program on the beneficiaries it serves and on ways to harness plan efficiency to improve Medicare's long-term financial sustainability.

In setting payment policy in the FFS sector, the Commission consistently applies a level of fiscal pressure on providers to promote the efficient provision of care while maintaining beneficiary access to high-quality care. FFS payment policies of that nature can affect MA payments through the benchmarks, which are based on FFS expenditure levels. Relying on fiscal pressure only in the FFS sector means that savings to the program that come from MA can be generated only indirectly through FFS spending reductions. The ACA-instituted payment reforms reduced MA program payments, causing some concern about whether MA would continue to grow and attract Medicare beneficiaries. However, this substantial fiscal pressure did not have the negative effect that some had predicted. Instead, bids have fallen in relation to FFS spending—even in areas where sponsors might have found it challenging to operate successful plans, such as in low-FFS-spending areas where MA benchmarks are at 115 percent of FFS. Further, the value of extra benefits offered to MA enrollees—now equal to approximately \$1,700 annually per enrollee, or 14 percent of the basic benefit—has reached a historical high for the fourth consecutive year.

Aggregate MA payments are 4 percent higher than FFS expenditure levels. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS, Medigap's effect of insulating beneficiaries from the financial impact of their utilization, and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare (through the Tax Equity and Fiscal Responsibility Act of 1982), in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, Medicare may be able to share in some of those efficiencies. ■

Endnotes

- 1 This section describes payments 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 “Medicare payments to MA plans differ for ESRD and non-ESRD enrollees” section (see pp. 387–388).
- 2 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.
- 3 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).
- 4 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).
- 5 To account for coding differences in 2021, we conservatively assume that the impact of coding intensity in 2021 is the same as in 2019. The coding intensity trend from 2017 to 2019 suggests that the impact in 2021 may be higher than in 2019. 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 the adjustment of CMS’s estimate of FFS spending for beneficiaries with both Part A and Part B, potential favorable selection of beneficiaries that choose to either switch from FFS to MA or exit MA, potential spillover of provider behavior that may occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of retrospective MA and FFS improper payment remittances.
- 6 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).
- 7 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 2020 data book (Medicare Payment Advisory Commission 2020b).
- 8 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.
- 9 For example, the Commission has found that the risk adjustment model tends to underpredict spending for beneficiaries with no medical conditions (Medicare Payment Advisory Commission 2020c). 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.
- 10 Beneficiaries in some parts of the country have access to Section 1876 cost-reimbursed HMOs. Such plans arrange for the full range of Medicare services. They receive reasonable cost reimbursement for Part B physician and supplier services, but the Medicare program directly pays providers for inpatient and outpatient institutional services. Enrollees of cost plans are not locked into the plan and can receive any out-of-network services and have them paid by the Medicare program. The statute calls for the phasing out of cost plans in areas in which there are at least two competing MA CCPs that meet a minimum enrollment requirement. The cost plans are expected to transition to MA plans, and some have already begun the transition.
- 11 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).
- 12 Plans estimate administrative expenses and margins separately for cost-sharing reductions. The allocated \$64 per enrollee per month for cost sharing includes administrative expenses of 10 percent and a margin of 2 percent.
 - 13 CMS estimates that the 2020 monthly actuarial value of Medicare deductibles and coinsurance for a beneficiary without end-stage renal disease is \$169.92 (Centers for Medicare & Medicaid Services 2020a). The Commission has previously summarized the evidence on the effects of cost sharing on Medicare spending and recommended an additional charge on supplemental insurance (Medicare Payment Advisory Commission 2012a) and commissioned a study finding higher Medicare spending for beneficiaries with Medigap coverage (Hogan 2009).
 - 14 Plans estimate administrative expenses and margins separately for supplemental benefits. The allocated \$29 per enrollee per month for supplemental benefits includes administrative expenses of 11 percent and a margin of 4 percent.
 - 15 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general use 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.
 - 16 When submitting Part D bids, plans may allocate administrative expenses and margin toward the Part D revenue that results from projected Part C rebates.
 - 17 MA plans annually report their MLRs to CMS. Plans may 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 submit MLRs to CMS in December of 2021, and CMS would begin subtracting remittances from regular monthly plan payment in July of 2022 to recoup any revenue difference between a plan’s actual MLR and the minimum MLR of 85 percent.
 - 18 Under Section 319 of the Public Health Service Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
 - 19 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. We removed 19 outlier contracts (accounting for 6 percent of reported plan revenues) that reported greater medical expenses than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and no revenue to cover administrative expenses). We identified outliers at the contract level to account for plans that may be subsidized by other plans (i.e., product pairing) within the same service area. Most of the outlier contracts we identified reported negative margins in the bid data for consecutive years. These contracts are likely atypical because CMS requires MA plans with negative margins to submit a business plan to achieve profitability and expects MA plans to meet or exceed the year-by-year margin targets in the business plan.
 - 20 The ACA insurer fee was in effect in 2020 but is entirely repealed in all subsequent years.
 - 21 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 (e.g., lab and imaging tests) are used to rule out having the diagnosis.
 - 22 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.
 - 23 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 its 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).
- 24 Except for Program of All-Inclusive Care for the Elderly contracts, which will continue to use pooled RAPS and encounter data as the basis for risk scores.
 - 25 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.
 - 26 The share of FFS Medicare payments that flow through accountable care organizations and other alternative payment models is increasing and has the potential to increase diagnostic coding incentives in FFS Medicare, but we have yet to see an effect on our analysis.
 - 27 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).
 - 28 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 also covers additional services not covered in the Medicare benefit.
 - 29 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.
 - 30 FFS risk score growth matched MA risk score growth between 2015 and 2016 for the first time since the full implementation of the HCC model in 2007. Risk score growth between 2015 and 2016 was affected by the transition from International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes. MA risk scores were still higher than FFS risk scores for comparable beneficiaries because of prior differences in coding rates.
 - 31 CMS identifies diagnoses from physician visits using a different method for RAPS and encounter data. Eligible physician visits in RAPS data are determined by physician specialty code, and eligible physician visits in encounter data are determined by procedure code. The two methods of filtering physician claims for use in risk adjustment were intended to produce equivalent results, but it is possible that RAPS-based and encounter-based risk scores would not be equivalent because of the different methods of filtering physician claims.
 - 32 CMS observed that encounter data inpatient submissions were low compared with corresponding RAPS inpatient submissions and therefore supplemented encounter data with inpatient RAPS data to calculate risk scores. However, we believe a large number (1.5 million in 2015) of physician office visits and outpatient hospital visits have been inaccurately reported as “inpatient stays” in RAPS data. Therefore, we believe CMS should not supplement encounter data with inpatient RAPS data to adjust for the discrepancy between the two data sources.
 - 33 Less than 1 percent of MA enrollees are enrolled in a contract with fewer than 2,500 enrollees.
 - 34 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.
 - 35 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.
 - 36 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.
 - 37 CMS proposed this method of determining overpayment recovery amounts in 2018 but has not yet issued a final rule (Centers for Medicare & Medicaid Services 2018). 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.

- 38 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 2020d).
- 39 The American Kidney Fund is a nonprofit organization that provides needs-based financial assistance to dialysis patients, including assistance with health insurance premiums, transportation to and from treatment, medical supplies, and prescription drugs. In 2019, the American Kidney Fund provided nearly \$271 million in direct patient aid (American Kidney Fund 2019a).
- 40 Plans can offer a "voluntary" MOOP limit lower than the mandatory limit in exchange for the ability to impose higher cost-sharing amounts for certain services, up to the limits CMS specifies. Cost-sharing limits vary by service category, and some service category limits are higher for plans using the voluntary MOOP. Some service-specific limits are specified in statute, including dialysis services, which cannot exceed the cost sharing of FFS Medicare (20 percent coinsurance per treatment).
- 41 Individuals with ESRD include patients on dialysis, patients undergoing kidney transplant, and patients with a functioning graft, but the prohibition on enrolling in an MA plan did not apply to ESRD patients with a functioning graft.
- 42 Prior to 2021, other SNPs (besides ESRD C-SNPs) had the option to enroll ESRD beneficiaries; however, we do not know whether any SNPs elected to allow beneficiaries with ESRD to enroll.
- 43 As of January 2020, ESRD C-SNPs were offered in select counties in Arizona, California, Connecticut, New Jersey, Nevada, and Texas.
- 44 Two possible exceptions are enrollment for ESRD beneficiaries in Medicare-Medicaid plans and certain SNPs for dual-eligible Medicare beneficiaries (who are also eligible for Medicaid). For these plans, known as D-SNPs, integrating Medicare and Medicaid coverage and services is the primary goal, and depending on the state, enrollment of ESRD patients in these plans may be restricted.
- 45 Medicare payment applies distinct risk-adjustment models for beneficiaries with ESRD based on their disease status: dialysis, transplant (month and two subsequent months), and postgraft (four or more months after transplant). Payments for beneficiaries in dialysis and transplant status are based on ESRD state rates, and payments for beneficiaries in postgraft status are based on county-level benchmarks used for non-ESRD enrollees.
- 46 The ESRD subsidy is a feature of the "bid pricing tool"—a form that includes the plan's bid for non-ESRD enrollees and plan information about revenues and costs for ESRD enrollees.
- 47 Employer group waiver plans do not submit bids and are not represented in the cost-to-revenue ratio analyses. We separately analyzed ESRD cost and revenue information for ESRD C-SNPs.
- 48 ESRD C-SNPs submit financial information using a specialized BPT because the plans do not have non-ESRD enrollees.
- 49 Dialysis status is indicated when a patient begins dialysis and the managing nephrologist submits a medical evidence form, required regardless of the patient's payer, to the CMS registry. A monthly dialysis status indicator is maintained in risk score data. The mechanism for turning off the dialysis status indicator is somewhat unclear for patients who continue living but choose to end dialysis treatment without receiving a kidney transplant (i.e., there is no kidney transplant claim or date of death documentation that can be used as evidence that the individual is no longer in dialysis status).
- 50 We applied the following exclusion criteria to both MA encounters and FFS claims (although many more MA encounters than FFS claims were excluded by these criteria): missing beneficiary identifier, age, or provider zip code on a claim/encounter; missing revenue center code, payment, or date; a claim or encounter record spanning more than one month; or a calculated monthly average price per treatment amount below \$92 (the FFS Medicare base rate for Puerto Rico, the area with the lowest wage index) or above \$3,900 (an amount that excluded about 5 percent of MA enrollee months with the highest average price per treatment). We also excluded home dialysis training treatments from both FFS claims and MA encounter records because it was unclear how MA plans reported payments for those services in the MA encounter data.
- 51 Social Security Act Section 1853(d)(3).
- 52 This analysis used a 5 percent sample of FFS claims. Although the analysis focused on large metropolitan areas where there are likely to be more ESRD beneficiaries in the sample data, analysis of complete Medicare data would more accurately estimate variation in FFS ESRD spending for metropolitan areas relative to the state average.

53 The Commission's March 2018 report to the Congress provides a more complete discussion of clinical and nonclinical factors that affect the use of home dialysis (Medicare Payment Advisory Commission 2018b).

54 The Commission has recommended eliminating the benchmark caps and quality double bonuses (Medicare Payment Advisory Commission 2016), basing benchmarks on FFS beneficiaries enrolled in both Part A and Part B (Medicare Payment Advisory Commission 2017), and revising geographic units for payment and quality assessment (Medicare Payment Advisory Commission 2020c).

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