

Understanding Medicare Advantage Payment & Policy Recommendations

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I. Overview

The rates paid to Medicare Advantage health plans are determined annually through a bidding system that is largely based on spending patterns in Traditional Fee-For-Service (FFS) Medicare. It is imperative that payments to Medicare Advantage health plans are accurate, adequate and stable to allow them to provide the necessary care to their enrollees, and to continue to innovate in new care models and service offerings.

This White Paper provides an in-depth explanation of the Medicare Advantage payment system, discusses current challenges and limitations of the payment system, and proposes several policy recommendations to ensure consistent and stable payments in Medicare Advantage.

BMA POLICY RECOMMENDATIONS TO ENSURE PAYMENT CONSISTENCY AND STABILITY:

1. Reduce frequency of major payment policy changes;
2. Improve the risk adjustment model and process;
3. Improve the accuracy of the benchmark calculation; and
4. Reward quality by eliminating the benchmark cap for plans with 4+ stars.

II. Background

A. General Overview

Medicare Advantage, also called Part C, is an option within Medicare that allows Medicare-eligible seniors and beneficiaries with disabilities to receive their benefits through a private plan of their choice, instead of receiving coverage through Traditional Fee-For-Service (FFS) Medicare. Medicare Advantage plans are approved and regulated by the Centers for Medicare & Medicaid Services (CMS). The Federal government, through CMS, pays Medicare Advantage plans a fixed (or capitated) monthly amount per beneficiary to provide health benefits to an enrolled individual. Medicare Advantage plans provide all Medicare Part A and Part B services, excluding hospice. Plans have the option to offer prescription drug coverage under Medicare Part D, which is funded through a separate bidding and payment system.

B. Rate & Policy Updates: Annual Rate Notice and Call Letter

Medicare Advantage payment methodology and rates, as well as other policies governing the Medicare Advantage program, are modified and updated each year. The Social Security Act requires the Secretary of Health and Human Services to make an annual announcement, called the **Rate Notice and Call Letter**, of these changes no later than the second Monday in April before the calendar year in which the changes will be made.¹ The Social Security Act further requires the Secretary to publish an **Advance Notice and Draft Call Letter** at least 60 days before publication of the Final Rate Notice and Call Letter, providing stakeholders an opportunity to comment on proposed changes to the Medicare Advantage program. In addition, the Secretary also issues an **Early Preview of the Rate Notice** in late November or early December *before* the Advance Notice.

C. Beneficiary Enrollment & Access

The Centers for Medicare and Medicaid Services (CMS) reports that 20 million beneficiaries – or more than a third of the more than 59 million eligible Medicare beneficiaries – are enrolled in Medicare Advantage in 2018, more than double the 9.7 million that were enrolled in 2008.² The Congressional Budget Office estimates that Medicare Advantage enrollment will grow to more than 30 million individuals over the next 10 years.³

While enrollment in Medicare Advantage continues to grow, substantial geographic variation in enrollment exists. Medicare Advantage enrollment rates at the state level range from a low of 2% in North Dakota to a

BMA's Medicare Advantage Enrollment Map provides Medicare Advantage enrollment information at the county and Congressional district level.

high of 44% in Oregon.⁴ This variation is due to many factors, including long-term insurance market factors in states as well as specific characteristics of each state – for example, low penetration rates due to a state being rural and sparsely populated (e.g. Vermont, Wyoming), high penetration rates due to a concentration of retirees (e.g. Florida, Arizona), or a large number of hospital-owned plans (e.g. Minnesota, Oregon).

Beneficiary access to Medicare Advantage is strong. In 2018, Medicare Advantage included 2,317 individual plan options.⁵ In total, 99% of all Medicare beneficiaries have access to a Medicare Advantage plan and most beneficiaries have multiple plans to choose from in their area.⁶ A recent analysis found that 90% of Medicare Advantage beneficiaries have a choice of at least five Medicare Advantage plan options, 71% have at least 10 plans options, and 55% have at least 15 plan options.⁷ More than 80% of all beneficiaries have access to at least one zero premium plan, and 40% of beneficiaries are enrolled in a zero premium plan.

D. Types of Medicare Advantage Plans

Medicare Advantage plans offer coordinated care, typically organized around a network of health care providers that works to manage enrollees' care. Each Medicare Advantage plan establishes its own network of providers, subject to legislative and regulatory requirements that determine the number and type of providers that must be included in a plan's service area.

The types of Medicare Advantage plans available to beneficiaries are:

- 1. Health Maintenance Organizations (HMOs):** HMOs often require members to choose a primary care physician to coordinate their care and utilize network providers or pay the full cost of care received outside the network. Generally, HMOs require a referral from a primary care physician to see a specialist. In 2018, more than 60% of enrollees are in HMOs.⁸
- 2. Preferred Provider Organizations (PPOs):** PPOs are similar to HMOs, but they may not require members to select a primary care physician, and they often do not require a referral to see a specialist. They may offer coverage for health care services received outside the network, but typically require members to pay a larger portion of the cost of out-of-network care. PPOs may be local (county-specific) or regional (span two or more states). In 2018, approximately 34% of enrollees are in PPOs.⁹
- 3. Private Fee-For-Service (PFFS):** PFFS plans allow enrollees to see any Medicare-eligible health care provider who accepts payment from that plan; however, they may offer members financial incentives to use certain providers. Just 1% of Medicare Advantage enrollees selected a (PFFS) plan. In 2018, less than 1% of enrollees are in PFFS plans.¹⁰
- 4. Special Needs Plans (SNPs):** SNPs are a type of Medicare Advantage plan tailored to serve frail, disabled, and chronically-ill beneficiaries. There are SNPs tailored to enrollees who are dually eligible for both Medicare and Medicaid, those who have a severe or disabling chronic condition, or those who live in a nursing home or who require skilled

nursing care at home. In 2018, approximately 13% of Medicare Advantage members are enrolled in SNPs.¹¹

5. Employer Group Waiver Plans (EGWPs): EGWPs are a type of Medicare Advantage plan offered by an employer to its retiree population. In 2018, approximately 20% of Medicare Advantage members are enrolled in EGWPs.¹²

E. Overview of Medicare Advantage Quality Star Rating System

Medicare Advantage plans are awarded a star rating between one and five based on performance on certain quality measures in the Medicare Advantage Quality Star Rating System. The Star Rating System plays a critical role in ensuring public accountability and enhancing consumer choice by providing quality information on plans. Star ratings foster competition between plans to improve quality and may lead to quality-based financial incentives for some plans and providers. In 2018, 73% of Medicare Advantage enrollees are enrolled in high-performing four- or five-star plans, almost quadruple the percent of those enrolled in high-performing plans in 2009.

F. Medicare Advantage & Traditional Fee-for-Service (FFS) Medicare

The financial framework in Medicare Advantage supports care delivery that focuses on care management, integrated care models, and early interventions. Because Medicare Advantage plans receive a capitated (fixed) monthly payment per beneficiary to provide health benefits to enrollees, the plan is at-risk if costs for an enrollee exceed the capitated payment (plus enrollee cost-sharing). At the same time, if costs are less than the capitated payment (plus enrollee cost-sharing), plans retain the savings.

The capitated payment structure aligns plan financial incentives with patient health outcomes, motivating Medicare Advantage plans to offer care coordination as well as preventive services, early interventions and other services that help enrollees stay healthy and avoid unnecessary, costly health care services, such as emergency room visits and hospital admissions. In addition, as described in detail below, if a plan receives rebates from CMS, it must use those funds to reduce enrollee out-of-pocket costs or to provide additional supplemental benefits, such as dental or vision coverage.

Payments to Medicare Advantage plans are based on FFS Medicare. As detailed below, Medicare Advantage payments are largely based on average FFS Medicare spending in individual counties across the country.

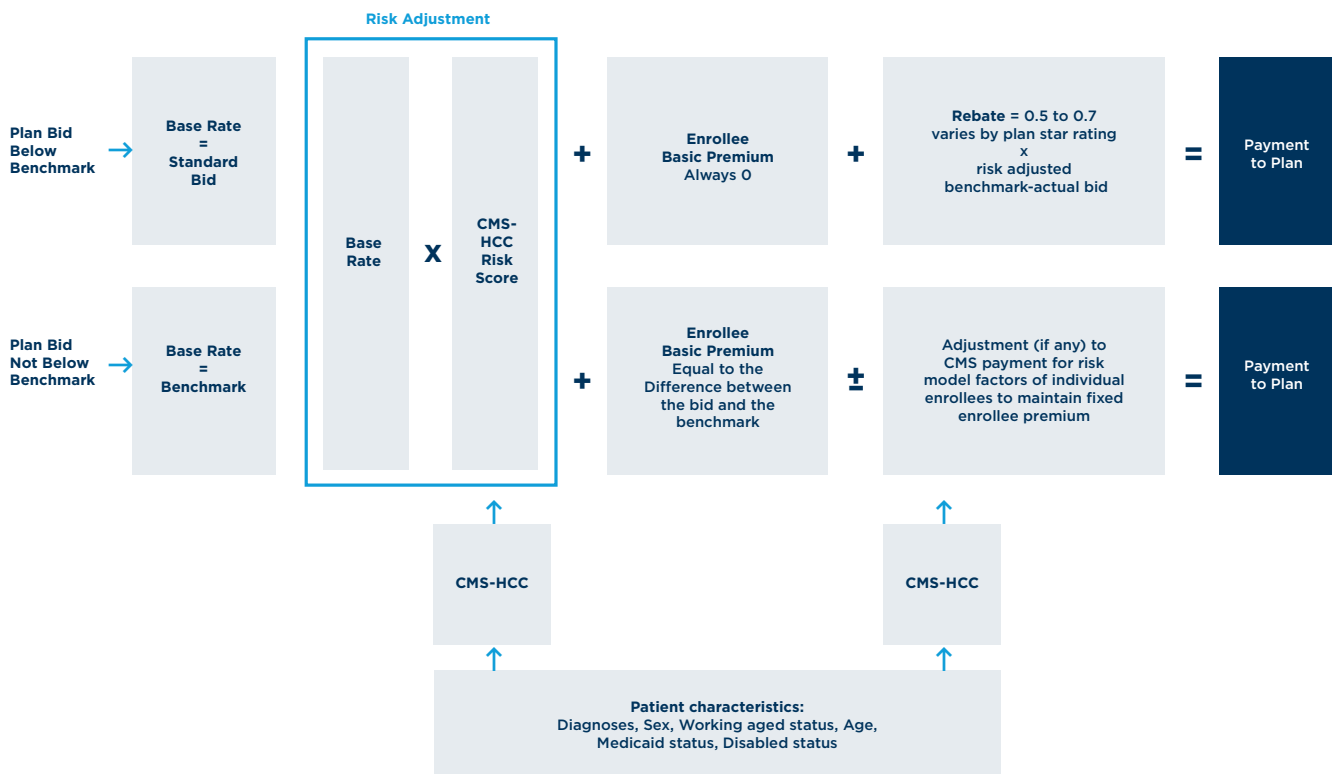
III. Components of Medicare Advantage Payment

There are four key components that together determine what Medicare Advantage health plans are paid to provide care for their enrollees:

- **Base rate.** The base rate is the lesser of the plan’s bid or the benchmark rate. If a plan’s bid is below the benchmark, then the base rate equals the plan’s bid. If a plan’s bid is above the benchmark, then the base rate equals the benchmark.
- **Risk adjustment.** The base rate for a particular enrollee is then adjusted to reflect that enrollee’s risk score.
- **Premiums.** Plans that bid below the benchmark may not charge any enrollee premium. Plans that bid above the benchmark charge a premium that is equal to the difference between the bid and the benchmark.
- **Rebates.** Plans that bid below the benchmark receive a rebate equal to a percentage of the difference between the benchmark and the bid.

Each of these components are described in greater detail below.

FIGURE 1: SUMMARY OF MEDICARE ADVANTAGE PAYMENT

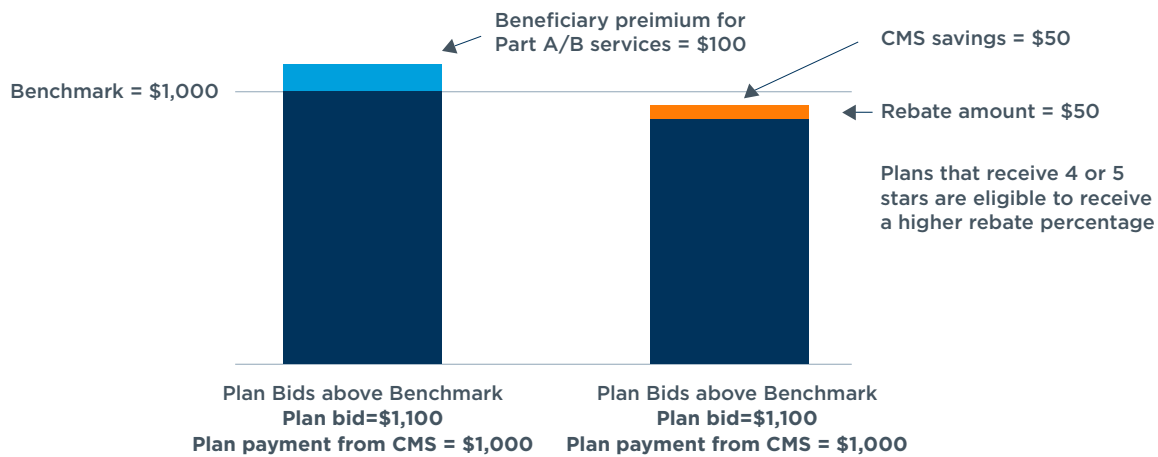


Source: MedPAC. “Medicare Advantage Payment System Basics.” October 2016. Available at: http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_ma_final.pdf?sfvrsn=0

A. Base Rate

The first component of the payment to a Medicare Advantage plan is the base rate. The base rate is determined by the relationship between the county-level benchmark and the plan bid. First, CMS determines the average FFS Medicare spending in each county, which, following adjustments for geography and demographics, becomes the benchmark. Second, Medicare Advantage plans bid to provide coverage in a county. Finally, CMS compares each plan's bid to the benchmark. The base rate is the lower of the plan's bid or the benchmark.

FIGURE 2: HYPOTHETICAL BID AND BENCHMARK SCENARIOS



1. Benchmarks

i. Benchmarks Defined

Benchmarks are the targets against which plans bid to provide coverage of Medicare Part A and Part B services. A separate benchmark is calculated for each county in the United States and is set as a percentage of average FFS Medicare spending per beneficiary. This means that Medicare Advantage benchmark levels in each county are based on the practice patterns of physicians and other providers who bill FFS Medicare.

For payment purposes, Medicare Advantage plans fall under one of two categories: local plans or regional plans. Local plans may be any type of plan (HMO, PPO, PFFS) and may serve beneficiaries living in one or more counties. Regional plans must be PPOs and serve all of one of the 26 regions established by CMS.

Establishing the benchmarks for both local and regional plans requires a determination of per capita FFS Medicare spending for each county. To make this determination, the Secretary first projects the national estimated FFS Medicare per capita costs for the following year (\$848.21 per month for 2018).¹³ This amount is then multiplied by a county-specific geographic index, which is based on a five-year rolling average of FFS Medicare

spending in the county, weighted for enrollment and average risk scores, to yield the per capita FFS Medicare spending amount for each county.

ii. County-Level Benchmark Calculation: Local Plans

To determine the county-level benchmarks for local plans, the per capita FFS Medicare spending amount is adjusted based on the county's historical costs relative to the rest of the nation. Counties with the lowest FFS Medicare spending receive the highest percentage of per capita FFS Medicare spending as their benchmark. These percentage adjustments were established by the Affordable Care Act as follows:

Highest-cost quartile	95% of FFS costs
Second-highest cost quartile	100% of FFS costs
Third-highest cost quartile	107.5% of FFS costs
Lowest-cost quartile	115% of FFS costs

For a local Medicare Advantage plan that operates in more than one county, an average benchmark is calculated across the counties in which the plan operates, weighted by enrollment.

iii. County-Level Benchmark Calculation: Regional Plans

The process for calculating benchmarks for regional plans, which must serve all of at least one of the 26 regions established by CMS, is a bit more complex. These regional benchmarks are a weighted average of:

- the average county-level benchmark (described above), weighted by the number of Medicare beneficiaries in each county and the national percentage of beneficiaries in FFS Medicare, **and**
- the average plan bid, weighted by each plan's projected enrollment and the national percentage of beneficiaries in Medicare Advantage.¹⁴

iv. Quality Adjustments to Benchmarks

Benchmarks for both local and regional Medicare Advantage plans are also adjusted based on plan quality. Plans with a 4, 4.5, or 5-star quality rating from CMS receive an increase in their benchmark (5% in 2018).¹⁵ In addition, these benchmark quality adjustments may be doubled for high-quality plans in certain qualifying counties (urban areas with FFS Medicare spending below the national average and historically high rates of enrollment in Medicare Advantage).

v. Benchmark Caps

In many counties across the country, benchmarks (including quality adjustments) are capped at their pre-ACA levels. In 2017, benchmarks in half of counties across the country were constrained in some way by the benchmark cap, meaning plans with 4 or more stars received a benchmark quality bonus less than the statutory 5% or received no quality bonus at all.¹⁶ In 2016, more than 2 million Medicare beneficiaries were enrolled in 4-star plans but denied enhanced benefits, including reduced cost-sharing, because of the benchmark cap.

2. Plan Bids

With benchmarks determined, the next step in the payment process is the submission of plan bids. Medicare Advantage plans submit bids reflecting the plan's estimated cost of providing all Medicare Part A and Part B services to a beneficiary with "average" health, with the exception of hospice. Bids include the estimated costs of medical services as well as administrative expenses and profit. However, plan administrative expenses and profit may not exceed 15% of total plan revenue, ensuring that 85% of revenue is dedicated to member benefits. Plans that do not meet this minimum medical loss ratio (MLR) requirement must refund CMS the difference between their MLR and 85%.

Medicare Advantage plans that wish to offer Part D prescription drug benefits submit a separate bid for the Part D portion of coverage. Payment for Part D-covered services is calculated separately, in the same manner as it is for plans offering standalone prescription drug coverage.

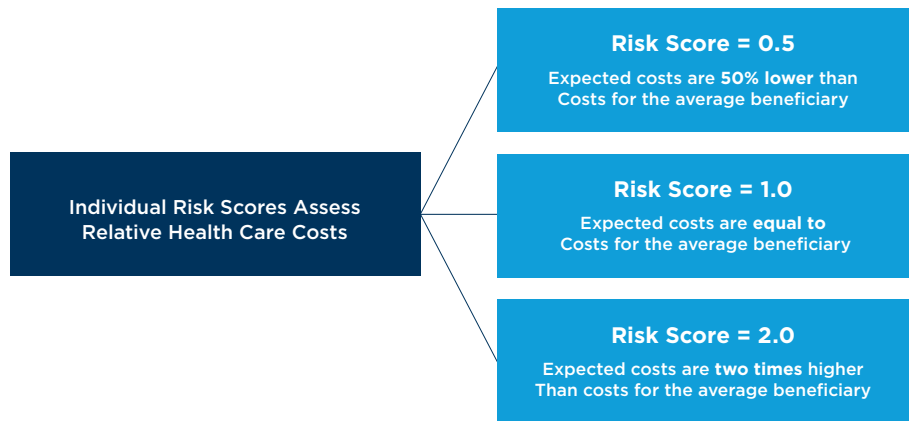
3. Calculation of the Base Rate

A Medicare Advantage plan's base rate is determined by comparing the plan's bid and the benchmark. If the plan's bid is below the benchmark, the bid becomes the plan's base rate. If the plan's bid is at or above the benchmark, then the benchmark becomes the plan's base rate, and the difference is returned to enrollees in the form of reduced cost sharing obligations or enhanced benefits.

B. Risk Adjustment

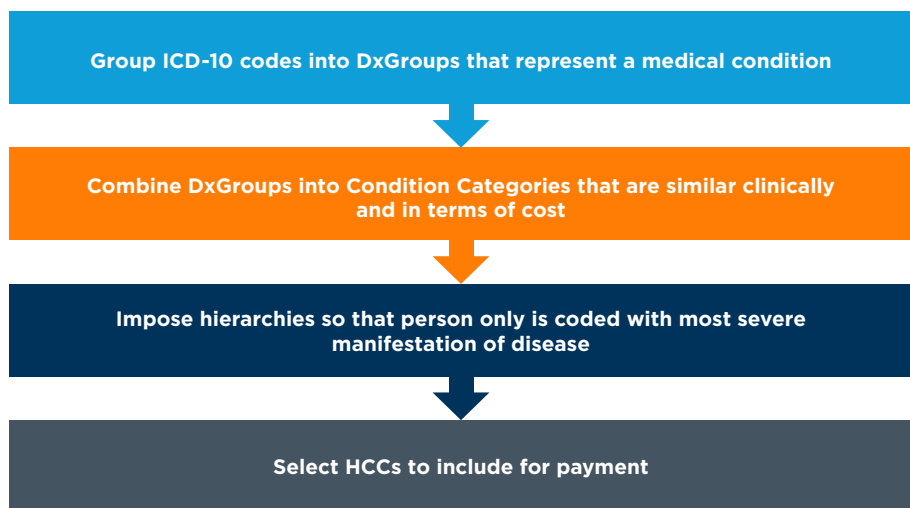
After the base rate is determined, CMS uses a system called "risk adjustment" to modify a plan's base rate to reflect the health status of each enrollee. This ensures capitated payments made to Medicare Advantage plans reflect the expected cost of providing health care to each beneficiary.¹⁷ A risk score of 1.0 implies that the person's expected costs are equal to the costs of a beneficiary of average health. An enrollee with a risk score of 2.0 is expected to cost twice as much as the average, whereas an enrollee with a risk score of 0.5 is expected to cost 50 percent less than average (see Figure 3).

FIGURE 3: INDIVIDUAL RISK SCORES



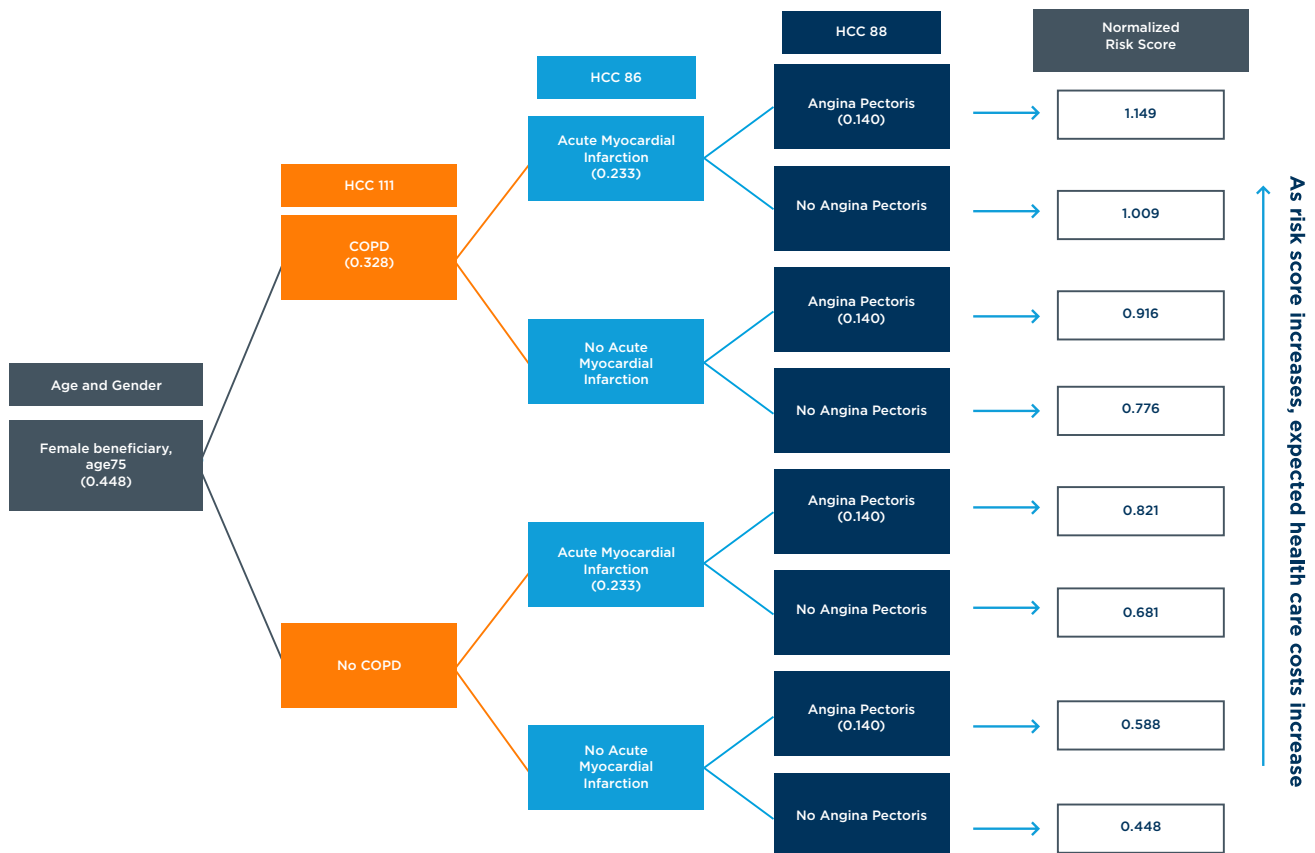
Since 2004, CMS has used the Hierarchical Condition Categories (CMS-HCC) model to risk adjust Medicare Advantage base rates. The CMS-HCC model uses diagnoses from inpatient, outpatient, and physician encounters to provide a comprehensive accounting for the full range of patient spending. To generate a risk score, CMS first groups all International Classification of Disease, Tenth Edition (ICD-10) codes into diagnostic groups called DxGroups. These groups include diagnosis codes that cover similar medical conditions. Second, CMS combines the DxGroups into Condition Categories (CCs), which groups enrollees based on similar clinical profiles and expected costs. Third, CMS imposes hierarchies on the model by dropping a less severe manifestation of the disease if a more severe manifestation is present. Finally, once the hierarchies are applied, CMS publishes the list of categories, or Hierarchical Condition Categories (HCCs), as part of the annual rate announcement, typically located in a table in a supplemental attachment. This process is illustrated in Figure 4 below.

FIGURE 4: MEDICARE ADVANTAGE RISK ADJUSTMENT PROCESS BEGINS BY GROUPING DISEASES AND ASSIGNING HCCS



Each HCC has an associated coefficient (or weight). The coefficients for each HCC are added, along with those for age and gender, to determine the risk score, as shown in Figure 5.¹⁸ CMS estimates the costs associated with different risk scores based on FFS Medicare spending and utilization data.

FIGURE 5: MEDICARE ADVANTAGE RISK ADJUSTMENT EXAMPLE



Because CMS uses FFS Medicare data to calculate payments to Medicare Advantage plans, it also must adjust those payments to account for coding pattern differences that exist between Medicare Advantage and FFS Medicare. These coding differences arise from structural, payment, and care model differences between FFS Medicare and Medicare Advantage. For instance, because CMS uses diagnosis codes submitted by providers to risk-adjust plan payments, Medicare Advantage plans have an incentive to ensure accuracy in diagnosis codes both to ensure adequate payment to meet beneficiary needs and to identify at-risk individuals for early intervention and care management. FFS Medicare does not require the same specificity in diagnosis coding because payments to providers rely on procedure codes. To account for this difference, Congress mandated an annual coding intensity adjustment in 2010 and subsequent years which requires CMS to reduce Medicare Advantage risk scores by a uniform, pre-determined factor every year. As of 2018, the reduction is 5.91% annually. CMS has the statutory authority to increase the annual coding intensity adjustment but, to date, has not used that authority.

C. Premiums

The third component of payment to a Medicare Advantage plan is the enrollee premium. Depending on how a plan's bid compares to the benchmark, the plan may charge enrollees a monthly premium. If a plan bids above the benchmark, then the enrollee pays a premium equal to the difference between the bid and the benchmark. If a plan bids below the benchmark, there is no member premium.

D. Rebates

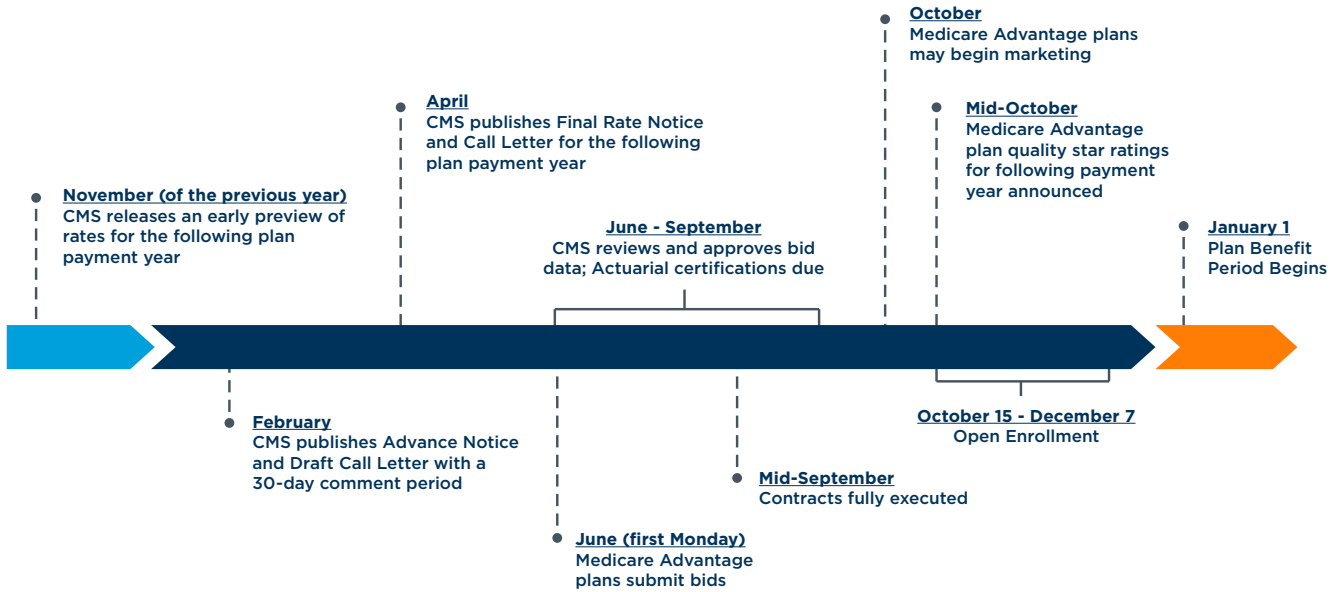
The fourth and final component of the payment to a Medicare Advantage plan is the rebate. All plans that bid below the benchmark receive a percentage of the difference between the bid and benchmark as a rebate, ranging from 50% to 70% of the difference between the bid and the benchmark. The amount of the rebate paid to the plan is determined by the plan's quality star rating; plans with higher star ratings receive Quality Bonus Payments (QBPs) in the form of a higher percentage of the difference as a rebate, as follows:

Plan Quality Star Rating	Percent of Bid-Benchmark Difference Paid to Plan as a Rebate
3 Stars or fewer	50%
3.5 - 4 Stars	65%
4.5 - 5 Stars	70%

Plans are required to use rebates and QBPs to provide supplemental benefits, such as hearing, dental or vision, to reduce beneficiary cost-sharing, or to provide innovations in care delivery, such as telemedicine or home care. The combination of zero premiums and additional benefits incentivizes Medicare beneficiaries to select high-quality, lower-cost Medicare Advantage plans.

E. Timeline of Annual Payment Policy Milestones

Benchmark development, bid submission, and determination of each plan's payment is a lengthy process with many steps, identified below.¹⁹



IV. Current Challenges & Policy Recommendations

There are challenges in the Medicare Advantage payment system that potentially undermine the consistency and stability of payment and may impact the resources available to care for beneficiaries and to invest and innovate in new models to improve care delivery and contain costs. To address these challenges, BMA makes the following recommendations:

BMA POLICY RECOMMENDATIONS TO ENSURE PAYMENT CONSISTENCY AND STABILITY:

1. Reduce frequency of major payment policy changes;
2. Improve the risk adjustment model and process;
3. Improve the accuracy of the benchmark calculation; and
4. Reward quality by lifting the benchmark cap.

1. Reduce frequency of major payment policy changes

Challenge. As noted above, CMS issues an Advance Notice of Methodological Changes and Draft Call Letter each year in February and finalizes these proposed changes each April. Through this annual rate setting process, CMS may change any or every element of Medicare Advantage payment rates, including changes to the risk adjustment model, Star Ratings system, and other factors that significantly influence payment rates. Plans operating in this unpredictable and unstable rate setting environment must prepare for unstable funding and unforeseen rate cuts, which may not be aligned with multi-year contracts between plans and multiple providers, including value-based contracts. This unpredictability impacts efforts to make investments in innovation and care delivery programs that better meet the needs of Medicare Advantage enrollees and may negatively impact beneficiary cost sharing reductions or enhanced benefits.

Policy Recommendation. To bring some stability to the rate setting process, BMA encourages CMS to consider a multi-year process for Medicare Advantage payment policy changes. Using a multi-year process will help streamline and alleviate unnecessary burdens in the regulatory process, provide predictability to Medicare Advantage plans so they may invest in innovation and care improvements, encourage multi-year value-based contracting that includes multi-year goals regarding risk-assumption by the provider, and reduce administrative burdens on health care providers. A multi-year policy change process would also bring stability to plans' community partners that are asked to build workforce and administrative infrastructure. In a multi-year policy setting process, CMS would be able to spread policy changes over a multi-year cycle while continuing to make annual rate updates required by statute.

2. Improve the risk adjustment model and process

Challenge. CMS has changed the risk adjustment model over the past several years in an effort to improve payment accuracy.²⁰ However, challenges remain both in terms of the model itself and the process for making further changes. While changes in the model to improve accuracy and adequacy of payment to meet beneficiary needs are essential, the stability of the model is also critical. Any changes to the risk adjustment model are difficult for stakeholders, including clinicians, to understand, assess, and implement. These challenges are amplified when stakeholders have limited information regarding the impacts, consequences, or concerns about both the current model and proposed changes.

In addition to challenges with the coding intensity adjustment, described above, several structural challenges exist within the risk adjustment model. First, CMS has found that the current risk model underpays Medicare Advantage plans for coverage provided to dual-eligible beneficiaries, who are among the most high-need, high-cost, high-risk enrollees and require more specialized care and management. Second, stakeholders continue to have concerns regarding the risk model's ability to accurately predict costs for individuals living with multiple chronic conditions.

Third, stakeholders have raised serious concerns about the transition to the Encounter Data System (EDS) as the single source of enrollee diagnosis data used as the basis for risk scores. These concerns were recently echoed by the Government Accountability Office, which concluded that limited progress has been made to validate the EDS, potentially resulting in inaccurate risk scores.²¹ CMS is transitioning the system used to gather diagnosis codes and is currently using a blended version of two different systems. Under the current system, Medicare Advantage plans filter diagnosis codes and submit them to CMS, where the files are reviewed and audited for accuracy. With the newer EDS, Medicare Advantage plans submit all unfiltered data directly to CMS, which then applies its own filtering logic to extract diagnosis codes.

Policy Recommendations.¹ A well-functioning risk adjustment program must adequately pay plans that enroll high-cost individuals and manage their care effectively. With millions of baby boomers aging into Medicare, it is essential that risk adjustment in Medicare Advantage provides for adequate payment to care for all beneficiaries, ensuring the long-term sustainability and effectiveness of the program.

Briefly, BMA recommends the following:

- Maintain coding intensity adjustment at the statutory minimum level, to achieve stability and adequacy of the prospective, capitated payment and enable plans and providers to gather the data necessary for early intervention and care management;
- Improve risk model accuracy for individuals with multiple chronic conditions, considering the cumulative impact of a large number of chronic conditions, the interaction between behavioral/mental health conditions and physical health conditions, the differences in dual-eligible beneficiary costs given different eligibility pathways, and the potential for using more than one year of data to establish risk scores;^{22, 23}
- Incorporate social determinants of health into the risk model as proposed and executed by CMS and the National Quality Forum (NQF) for quality measures in the Star Rating System. As Medicare Advantage grows and becomes increasingly complex, a better understanding of how social determinants of health affect beneficiary costs, and adjusting payments accordingly, will be critical;
- Validate the Encounter Data System to ensure accuracy of risk scores for Medicare Advantage enrollees before progressing further in calculating risk scores using encounter data; and
- Improve transparency of the risk adjustment model change process by improving the notice and comment process, publishing and responding to all comments received, and conducting open door forums.

3. Improve the accuracy of the benchmark calculation

Challenge. In order to measure average FFS spending to calculate county-level benchmarks, CMS uses data for all FFS beneficiaries in a county, including those who have both Part A and Part B, those who have only Part A, and those who have only Part B. However, in order to enroll in a Medicare Advantage plan, beneficiaries must enroll in both Part A and Part B. MedPAC has found that a smaller share of FFS Medicare beneficiaries are enrolled in both Part A and Part B over the past few years.²⁴ MedPAC has also found that per beneficiary spending is higher for beneficiaries enrolled in both Part A and Part B than the combined total of average spending for all beneficiaries enrolled in Part A and all beneficiaries enrolled in Part B. Finally, in its analysis of risk scores, MedPAC found that the average risk score of beneficiaries enrolled in both Part A and Part B is higher than average risk scores for all enrollees in either Part A or Part B.

Policy Recommendation. BMA supports MedPAC's recommendation that CMS should calculate Medicare Advantage benchmarks using FFS Medicare spending only for beneficiaries enrolled in both Part A and Part B in order to improve accuracy in the benchmark calculation.

4. Reward high quality by eliminating the benchmark cap for plans with 4+ stars

Challenge. The Quality Star Rating System program plays a key role in keeping Medicare Advantage effective and innovative by incentivizing improvements in quality. Medicare Advantage enrollees benefit from both these quality improvements and from the requirement that plans use rebates that result from bidding below the benchmark and quality bonuses to reduce enrollee cost-sharing or increase benefits. Under current law, county-level benchmarks (including quality adjustments) are capped at their pre-ACA levels.

The benchmark cap prevents plans in certain counties from receiving the bonus payments they earn and prevents beneficiaries from receiving the full benefits of enrolling in a high-quality plan. In 2017, benchmarks in half of counties across the country were constrained in some way by the benchmark cap, meaning plans with 4 or more stars received a benchmark quality bonus less than the statutory 5% or receive no quality bonus at all.²⁵ In 2016, more than 2 million Medicare beneficiaries were enrolled in 4-star plans but denied enhanced benefits, including reduced cost-sharing, because of the benchmark cap.

Policy Recommendation. CMS should lift the benchmark cap for high quality, 4-star and higher Medicare Advantage plans to ensure that all Medicare Advantage beneficiaries receive the full benefits of enrolling in a high-quality plan.

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