CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Medicare

Research Summaries & Highlights

The Center for Advancing Health Policy through Research (CAHPR)
Brown University School of Public Health

Medicare Advantage : Payments

Estimating the Budgetary Impact of Reforms to the Medicare Advantage Quality Bonus Program

This research letter uses Medicare Advantage data to estimate the 2026 budgetary impact of proposed reforms to the Medicare Advantage Quality Bonus Program (QBP). The study models four reform scenarios—including elimination of the QBP, conversion to budget neutrality, and removal of "double bonuses"—and finds potential federal savings ranging from $2.6 billion to $14.1 billion. The financial impact varied by insurer and contract demographics, with plans serving more dually eligible or racially diverse beneficiaries projected to lose more under certain reforms.

Read in JAMA

Two-Thirds of Hospital Coding Growth Linked to Upcoding: A $14.6 Billion Problem

CAHPR researchers analyzed 37.9 million discharges from 553 hospitals across Florida, Kentucky, New York, Washington, and Wisconsin, using State Inpatient Databases for 2011–2019. The study estimated that hospital upcoding contributed to two-thirds of the growth in high-intensity hospital discharges between 2011 and 2019, inflating healthcare costs by $14.6 billion in 2019 alone. Payments from private health plans, Medicare, and Medicaid totaled $5.8 billion, $4.6 billion, and $1.8 billion, respectively while Medicare saw the highest rate of upcoding growth. The most commonly upcoded diagnoses included heart failure and shock (+27% upcoding rate), chronic obstructive pulmonary disease (+17%), and simple pneumonia and pleurisy (+16%).

Read in *Health Affairs*

Potential Excess Federal Spending on Dual Medicare Advantage and Veterans Health Administration Enrollees

The study finds that between 2011 and 2020, the number of dual enrollees in Medicare Advantage (MA) and Veterans Health Administration (VHA) increased by 63%, with the VHA spending on these individuals growing from $4.5 billion to $12.1 billion annually. Moreover, over the decade, the VHA spent a total of $78 billion on dual enrollees.

Read in *JAMA*

Commercial Prices and Care for Medicare Beneficiaries With Prostate Cancer

This study examines how commercial prices paid to urologists influence Medicare spending for men with newly diagnosed prostate cancer. The study finds that in areas where commercial payments are higher — Medicare spending is actually lower by about $1,485 per patient. This is driven by fewer patients receiving treatment overall and a shift toward surgery rather than radiation (surgery provides higher reimbursement to urologists). These findings also support the target income hypothesis: physicians earning more from commercial insurers may limit care for Medicare patients. The authors emphasize the need for stronger price transparency, regulatory oversight, and antitrust enforcement to address growing price variation and market consolidation.

Read in *Health Services Research*

Health Risk Assessments in Medicare Advantage Drive Up Payments by $12 Billion Annually.

Health Risk Assessments (HRAs) significantly impact MA plan payments, contributing up to $12 billion annually. The study revealed that 44.4% of MA enrollees had at least one HRA, leading to a 12.8% average increase in Hierarchical Condition Categories (HCC) risk scores, with substantial payment differences across contracts. Higher HRA-related HCC scores were associated with lower-quality plans, higher profit margins, and less provider integration. To mitigate excessive coding, policy options limiting the risk-score impact of HRAs could reduce Medicare spending by $4.5–$12.3 billion annually.

Read in *Health Affairs*

Small Payment Changes to Quartile Adjustment System Show Limited Effect on Medicare Advantage Plans.

MA plans exhibit minimal sensitivity to slight alterations in payment rates. Primary care copayments, supplemental benefits, plan availability, contract offerings, and MA enrollment rates remain largely unaffected. Modest modifications to the quartile adjustment system could lead to cost savings without significantly impacting the benefits and offerings available to MA beneficiaries.

Read in *JAMA Health Forum*

Favorable selection in Medicare Advantage inflates benchmarks and leads to billions in annual overpayments.

Favorable selection of beneficiaries into MA resulted in overpayment to plans by an average of $9.3 B per year between 2017 and 2020. The analysis is consistent with recent research from USC and MedPAC finding that favorable selection in MA inflated benchmarks by 10% or more. While

legislative changes are warranted to reform benchmark payment, regulatory changes to risk adjustment in benchmark setting could likely mitigate the impact of favorable selection in MA.

Read in *Health Affairs*

Medicare Advantage : Plan Characteristics

Participation and Attrition in the Medicare Shared Savings Program

This study analyzes trends in participation and dropout rates in the Medicare Shared Savings Program, which relies on Accountable Care Organizations (ACOs) to manage care and reduce costs. From 2012 to 2024, ACO participation initially rose but plateaued after 2018, while clinician participation grew to over 650,000 by 2021. Yet attrition was substantial: only 55% of ACOs stayed in the program for more than six years, and clinicians remained for an average of just 3.6 years, with a 16% annual exit rate. The authors suggest that financial incentives—especially following policy changes that made savings targets harder to meet—may not be strong enough to sustain participation. High turnover threatens the program's ability to drive long-term care transformation, underscoring the need for more robust incentives and support to maintain engagement in voluntary value-based care models.

Read in *Health Affairs Scholar*

Combining Patient Surveys with Diagnosis Codes Enhances Medicare Advantage Risk Adjustment

CAHPR researchers found that integrating self-reported survey data with diagnosis codes significantly improves the accuracy of risk adjustment in MA. Traditional risk models explained 5.1% of variation in MA utilization, while models combining surveys with diagnosis codes explained up to 6.0%. Survey enhanced risk adjustment can limit the potential for upcoding while improving the predictive accuracy of risk adjustment. The findings highlight the value of including patient-reported health data to refine payment systems and improve care for high-need enrollees.

Read in *Health* Affairs

Examining Trends in Medicare Advantage Plan Disenrollment Associated With Expanded Supplemental Benefit Adoption

This study analyzed whether offering new supplemental benefits—like caregiver support, transportation, and food assistance—reduced disenrollment from MA plans. Using national data from 2017–2021, the authors find that the adoption of these benefits did not significantly affect

disenrollment rates for either dual-eligible or Medicare-only enrollees. Despite hopes that such benefits would help MA plans retain medically and socially complex members, the study suggests these offerings may not influence plan-switching behavior.

Read in *Health Services Research*

Medicare Advantage Plans that adopt Supplemental Benefits have a Modest Increase in Plan Ratings.

Recent findings underscore the impact of expanded supplemental benefits on MA plan ratings. A cohort study on 388,000 MA enrollees across 467 contracts and 2,558 plans in 2021 found that plans that adopted both Primarily Health-Related Benefits (PHRBs) and Special Supplemental Benefits for the Chronically Ill (SSBCIs) experienced a notable increase of 0.22 points (out of 10) in mean enrollee plan ratings, compared to plans offering neither. Thus, adding supplemental benefits to MA plans may help address member needs while also potentially enhancing their CMS Star Ratings.

Read in *JAMA Network Open*

Legacy Medicare Advantage Plans Enroll 1 in 6 MA Beneficiaries in 2020.

A study analyzing MA plans from 2011-2020 found that legacy-integrated MA plans like Kaiser Permanente and Geisinger, had beneficiaries who were more likely to be older and non dually eligible, and less likely to be White as compared to nonintegrated and non–legacy-integrated MA plans. As per plan characteristics, legacy integrated MA plans had higher premiums ($54.89), superior star ratings (4.6), and lower HCC risk scores (1.0) compared to non-integrated ($30.67; 3.5; 1.2) and non-legacy-integrated plans ($45.8; 3.6; 1.2).

Read in *JAMA Network Open*

Medicare Advantage disenrollment over time is higher than previously anticipated.

While over a one year timeline disenrollment is quite low, by the end of 5 years around 50% of MA beneficiaries will have left their plan for another MA plan, or for Traditional Medicare. This trend raises concerns about potential dissatisfaction and reduced incentives for plans to invest in long-term care, especially for chronic conditions, reflecting both a dynamic market and underlying systemic issues. Our research supports including long-term disenrollment in MA performance metrics, suggesting current structures don't fully incentivize addressing beneficiary needs over time.

Read in *JAMA Health Forum*

Medicare Advantage: Health Equity

Gender-Affirming Surgery for Transgender and Gender Diverse Medicare Beneficiaries

This study uses national Medicare claims data from 2016 to 2020 to examine the frequency and demographic patterns of gender-affirming surgery (GAS) among transgender and gender diverse (TGD) beneficiaries. The study found that GAS was rare—received by just 1.4% to 2.2% of TGD beneficiaries annually—and was more likely among younger individuals, those dually enrolled in Medicaid, and residents of the West Coast. Significant geographic and demographic disparities suggest persistent barriers to accessing medically necessary gender-affirming care within the Medicare program.

Read in JAMA Network Open

Dual-Eligible Patients Stuck in Lower-Rated Plans After Termination of D-SNP Look-Alikes

In 2023, CMS terminated "look-alike" Dual-Special Needs Plans (D-SNPs)—Medicare Advantage plans that resemble fully integrated D-SNPs but lack comprehensive coordination of Medicare and Medicaid benefits. A CAHPR study found that this transition affected 200,476 beneficiaries, predominantly in California. Intended to transition dual-eligible enrollees into fully integrated care plans, only 6.3% moved to highly integrated options, while most shifted to lower-rated plans with reduced benefits. Moroeger, Asian and Hispanic beneficiaries were disproportionately affected. As CMS expands this policy, stronger oversight is needed to ensure equitable transitions to high-quality, integrated care for dual-eligible populations.

Read in *Journal of the American Geriatrics Society*

Physician Diversity Gaps in Medicare Advantage Raise Equity Concerns

A study analyzing MA networks revealed that only 43.2% of Black physicians and 44.0% of Hispanic physicians were included in MA networks, compared to 51.1% of White physicians. Furthermore, 20% of Black and Hispanic beneficiaries had no access to racially concordant physicians in their counties. This lack of diversity raises concerns, as research links physician-patient racial concordance with better care outcomes.

Read in *Health Affairs*

Racial Disparities in End-of-Life Home Health Use in Medicare Advantage vs Traditional Medicare

This research letter finds that MA enrollees received less end-of-life home health care than those in Traditional Medicare (TM)—especially among racially and ethnically minoritized groups. For example, Hispanic descendants used home health care 11 percentage points less in MA than in TM. Overall, MA enrollees received 4.2% fewer home health services in their last year of life. The findings raise concerns about access barriers in MA plans, including network restrictions and prior authorization policies.

Read in *JAMA*

Medicare Advantage Contract Terminations: Implications for Beneficiary Enrollment.

This study explores the impact of Medicare Advantage (MA) contract terminations on beneficiary insurance choices. Analyzing data from 2016 to 2018, the authors found that 20.1% of MA enrollees switched to traditional Medicare (TM) after a contract termination. The study highlights significant disparities, with Black and dual-eligible beneficiaries experiencing the highest switch rates. Notably, beneficiaries with higher healthcare utilization—such as those with recent hospital, nursing home, or home health care use—were more likely to switch to TM. Among those who remained in MA, most chose higher-rated star plans without facing increased premiums. These findings underscore the need to address the potential disruptions in care and access resulting from MA contract terminations, particularly among vulnerable populations.

Read in the *JAMA Network Open*

Financial Hardships Persist in Medicare Advantage Plans Despite Additional Benefits.

Recent studies highlight the financial struggles associated with different healthcare plans, particularly MA compared to Traditional Medicare (TM). This study compared the financial implications of MA and TM, finding minimal differences in out-of-pocket costs, with a $168 annual increase associated with switching to MA. Moreover, vulnerable populations, especially those with low incomes, experienced heightened financial burden upon switching to MA. For instance, MA enrollees with mental health symptoms faced higher out-of-pocket costs, with an average increase of $292 annually, and were more likely to experience financial hardship, including a 5% higher likelihood of having ongoing medical bill payments. Furthermore, an analysis in *Health Affairs Scholar* of MA enrollment and post-acute nursing home care among patients with dementia found no significant improvement in outcomes, despite a 50% relative increase in MA enrollment. These studies suggest that MA's cost-saving strategies might not effectively reduce financial stress for high-need populations.

Read in *Annals of Internal Medicine*

Medicare Advantage Enrollees with Mental Health Symptoms Had Fewer Mental Health Visits Than Traditional Medicare Enrollees.

Mental health symptoms are a pervasive and costly challenge for Medicare beneficiaries. This study found that MA enrollees with mental health symptoms were less likely to have a specialty mental health visit and had high out-of-pocket spending.

Read in the *American Journal of Geriatric Psychiatry*

Medicare Advantage networks appear to disproportionately exclude providers who treat patients with greater health needs.

New research found that providers who treat more dually eligible beneficiaries [MA inclusion rate*: -3 percentage points], and beneficiaries with higher HCC scores [MA inclusion rate*: -6.5 percentage points] in Traditional Medicare were significantly less likely to be included in MA networks. CMS may consider strengthening network adequacy standards around providers that treat more socially vulnerable patients and those with complex care needs. Providing more publicly available data on network strength may also help beneficiaries make more informed decisions.
**the total number of MA contracts that operate with at least 1 physician in a given county, which serves as the denominator.*

Read in *JAMA Health Forum*

Traditionally Underserved Medicare Advantage Beneficiaries More Likely to Enroll in Plans That Offer Comprehensive Benefits.

In this study by CAHPR researchers, they aimed to identify if racial and ethnic minority groups and lower-income MA beneficiaries prefer plans with dental, vision, or hearing benefits. This study found that non-Hispanic Black individuals, individuals with lower income, and individuals with lower educational attainment were more likely to enroll in plans offering dental or vision benefits.

Read in *JAMA Health Forum*

Medicare Advantage penetration is inversely associated with postacute care use among traditional Medicare beneficiaries.

An increase in MA market penetration leads to substantial decrease in postacute care use for patients with congestive heart failure, hip fracture, and stroke, without a corresponding decline in hospital readmission rates or quality of care provided. Policymakers need to consider the influence of regional MA penetration, when evaluating and setting performance benchmarks for Accountable Care Organization (ACO) models.

Read in *Health Affairs*

Traditional Medicare

BPCI-A Yields $421 Million in Incentives for Physician Groups, with Larger Bonuses Received during COVID-19.

By examining the performance of physician group practices in the Bundled Payments for Care Improvement Advanced Model (BPCI-A) from 2018 to 2020. The study found that from 2018 to 2020, physician groups earned $421 million in incentives, with bonuses ranging from $139 to $2,775 per episode. Higher target prices led to larger bonuses, emphasizing the need for accurate target setting. While participation decreased over time, remaining practices, particularly during the COVID-19 pandemic received larger bonuses due to reduced postacute care use as compared to the pre pandemic cohort. These findings suggest that refining target prices and participation rules is essential as CMS expands BPCI-A and develops other payment models.

Read in *Health Affairs*

ETC Model Shows No Significant Impact on Home Dialysis and Kidney Transplants.

The End-Stage Renal Disease Treatment Choices (ETC) model introduced by CMS in 2021 aims to increase the use of home dialysis and kidney transplants. This study analyzed 724,406 Medicare patients with kidney failure and found no significant differences in the use of home dialysis or kidney transplants between ETC and non-ETC areas. There were also no significant changes based on race, ethnicity, or income, or on outcomes like mortality and hospital admissions. These findings suggest that the ETC model, which is expected to run through 2027, has had limited impact and suggests that CMS should provide more resources, especially to high-risk facilities to improve use and monitor the impact to prevent further disparities.

Read in *JAMA Health Forum*

Bundled Payments Lead to Quality Improvements in Hospitals' Skilled Nursing Facility Referral Networks.

This study looks at the impact of Medicare's BPCI program on hospital referral patterns and skilled nursing facility (SNF) quality for joint replacement patients. Hospitals participating in BPCI were found to significantly reduce SNF discharges by 1.69 patients or 10% per year. Moreover, hospitals did not change the number of SNF partners and overall referral concentration, thus preserving patient choice. Patients discharged to SNFs after BPCI participation were associated with small yet

measurable patient outcome ratings, suggesting that BPCI can promote higher-quality postacute care under cost-containment settings.

Read in *American Journal of Managed Care*

Target spending prices within the Bundled Payments for Care Improvement Advanced Model (BPCI-A) were inaccurately set for both hospitals and physician group practices.

During the first four performance periods of the BPCI-A from 2018 to 2020, physician group practices earned $421 million in bonuses. Bonuses varied significantly with target prices, with the lowest decile receiving $139 per episode and the highest decile $2,775. Miscalibration led to uneven financial outcomes where entities with higher preset target prices disproportionately received larger bonuses, indicating a systemic bias favoring higher spending participants - underscoring the need for recalibrating target prices to ensure a fairer and more effective distribution of incentives.

Read in *Health Affairs*

Estimated savings from the Medicare Shared Savings Program.

The Medicare Shared Savings Program (MSSP) was launched in 2012 to improve efficiency and generate financial savings for the Centers for Medicare & Medicaid Services (CMS). If medical spending is below a specific target (benchmark), ACOs are eligible for financial bonuses. For CMS to break even or achieve net savings for traditional Medicare beneficiaries in the MSSP, gross reductions in medical spending must equal or exceed the sum of bonus payments paid to ACOs. In this economic evaluation, we found that the MSSP led net losses to traditional Medicare of between $584 million and $1.423 billion between 2012 and 2021. Losses from MSSP-related reductions to MA benchmarks totaled between $191 million and $640 million. Across traditional Medicare and MA, the MSSP was associated with losses of between $775 million and $2.063 billion. This represents approximately 0.028% of combined spending for traditional Medicare and MA over the study period. This analysis suggests the MSSP has resulted in a small increase to CMS spending.

Read in *JAMA Health Forum*

Policy Options to Improve Medicare

Medicare's TEAM Model: Challenges and Solutions

The Centers for Medicare and Medicaid Services will launch the Transforming Episode Accountability Model (TEAM) in January 2026, a mandatory bundled-payment program to reduce healthcare costs. CAHPR authors stress the need for better risk adjustment to protect hospitals serving marginalized populations, recommend shifting to hospital-specific pricing for fairness, and urge on monitoring post-acute care impacts (given that bundled payments often reduce spending on post-acute care) to prevent burdening family caregivers - all to ensure the success of the TEAM program.

Read in the *New England Journal of Medicine*

Flaws in the Medicare Advantage Star Ratings

This viewpoint critiques the Medicare Advantage (MA) star ratings system, which influences over $10 billion in annual bonus payments. The authors argue the system is flawed: beneficiaries often don't use the ratings, the measures can be manipulated by plans, and they don't reflect care quality for vulnerable populations. They propose several reforms—like focusing on outcomes that matter to patients, adjusting ratings for social risk factors to better reflect plan performance across diverse populations, recalibrating the distribution of ratings so that high-performing and low-performing plans are more clearly distinguished, stratifying ratings by subgroups, such as those with high medical needs, and making the program budget-neutral to reduce excessive bonus payments with limited value.

Read in *JAMA Health Forum*

A New Medicare Agenda—Moving Beyond Value-Based Payment and the Managed Care Paradigm

This viewpoint argues that value-based payment (VBP)—the dominant Medicare reform model—has failed to reduce costs and has added corporate intermediaries without improving care. The authors criticize this model for burdening clinicians with insurance functions and overlooking the real cost drivers: high prices, expensive technology, and administrative waste. They propose a new agenda that shifts away from total-cost-of-care models toward a reformed fee-for-service Medicare that includes — more rigorous pricing of new technologies (e.g., through value-based coverage), capping out-of-pocket costs, adding benefits like dental and vision, adjusting physician payments to support primary care, and eliminating incentives that push providers into risk-bearing contracts.

Read in *JAMA*

Are Changes To The Medicare Physician Fee Schedule Driving Value In US Health Care?

The Medicare Physician Fee Schedule is a cornerstone of U.S. healthcare policy, directly influencing how services are priced and covered. This Health Affairs blog delves into a brief analysis of the CY25 Physician Fee Schedule Proposed Changes and what impact it could have moving forward.

Read in *Health Affairs Forefront*

2025 Medicare Advantage Advance (MA) Notice: Small Changes, Missed Opportunities.

While the proposals under the CMS 2025 MA Advance Notice represent careful adjustments to the MA payment system, they do not constitute a significant overhaul of the program. The article emphasizes the expected revenue increases for MA plans and minor changes in risk adjustment practices, highlighting the impactful changes on the horizon and the critical reforms that still await attention.

Read in *Health Affairs Forefront*

Legislative and Regulatory Options for Improving Medicare Advantage

Researchers at CAHPR identify statutory and regulatory policy options to improve effectiveness, realize cost-saving, and offer long-term budget stability in the Medicare Advantage (MA) Program, through a focus on three domains of reform in MA: (1) policies for setting base payments; (2) policies for risk adjustment; and (3) policies for adjusting payment based on quality performance. Among the policy options discussed, the regulatory options presented for risk adjustments are the most impactful and easiest to implement, with the potential to save over $500 billion in a decade.

Read in *Journal of Health Politics, Policy and Law*

Affordable Care Act's quartile-based payment system on Medicare Advantage results in significant additional payments.

From 2013 to 2021, additional payments increased from $796.7 million to $11.9 billion annually, totaling to $46.7 billion in overpayments. Eliminating the quartile system and setting payments at 100% of traditional Medicare spending could save $2 billion annually, with minimal impact on MA enrollment, and number and quality of plans offered as indicated by previous research. Thus, eliminating the quartile system could generate huge savings without significant effects on plan behavior or quality.

Read in *JAMA Health Forum*

It’s Time For A New Season Of Episode-Based Payment.

This article underscores key principles for reforming episode-based payment in traditional Medicare, aligning with CMS's expressed interest in such reforms.

Read in *Health Affairs Forefront*
