CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Legislative and Regulatory Strategies for Revitalizing Medicare Advantage

Policy Brief

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This analysis identifies statutory and regulatory policy options to improve effectiveness, realize cost-saving, and offer long-term budget stability in the Medicare Advantage (MA) Program. [Our analysis](#)focuses 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. We further weigh implementation tradeoffs, plan participation, fiscal impact, and legal considerations (1,2) to advocate for a strategic blend of the presented policy options to improve MA.

Table 1. Options for Improving Medicare Advantage (MA) Payment Policy

	Policy Option	Type of Policy Action	Estimated Impact ($)
A. Policies for Setting Base Payments			
1	Eliminate / loosen actuarial equivalence requirement	Statutory	$2.16 billion annually. (1)
2	Modify / eliminate the quartile applicable percentages used to determine county-level benchmarks	Statutory	$11.9 billion annually. (2)
3	Eliminate rebates	Statutory	$50.5 billion annually.(3)
4	Modify risk adjustment for benchmarks to offset favorable selection	Regulatory	$9.3 billion annually.(1)
B. Policies for Risk Adjustment			
5	Increase the coding intensity adjuster	Regulatory / Subregulatory	$10.2 billion annually to $66.67 billion annually.(4)(5)
6	Increase recoupment of overpayments	Regulatory / Subregulatory	$4.7 billion over next decade under new RADV audit final rule.(6) $10.2 billion annually with more aggressive enforcement. (4)
7	Alter risk adjustment formula to regularly reweight coded risk factors	Regulatory	Estimates not available
8	Restrict the use of chart reviews and health risk assessments in risk adjustment	Regulatory	$2.3 to $9.2 billion annually. (7)(8)
C. Policies for Adjusting Payment Based on Quality Performance			
9	Convert QBP into a budget neutral program where plans receive bonuses or penalties and net payments from CMS are zero.	Statutory	$10 billion annually.(9)
10	Modify criteria to make quality bonuses more difficult to achieve	Regulatory	Dependent on the changes to program design. recently proposed changes from CMS would reduce spending by $124 million annually.(10)
11	Eliminate double-bonuses	Statutory	~$1.5 billion annually, or $18.2 billion between 2021-2028.(9)

Background and Analysis | Policy Recommendations

Setting Base Payments in MA

Background and Analysis

MA's current base payment rates are based on average spending per Traditional Medicare (TM) beneficiary in the plan's local area to ensure actuarial equivalence. However, this current benchmark system results in overpayments to MA plans due to:

- Enrollment of healthier beneficiaries in MA, leading to overestimation and overpayments to MA insurers. (11)
- The current quartile system for adjusting MA benchmarks favors low-spending areas with higher adjustments. (12)
- MA plans bidding above actual costs due to imperfect competition—leading to higher expenses for Medicare and plan costs. (12)

Policy Recommendations

1. Congress could eliminate or loosen actuarial equivalence requirements to create competition and avoid excessive rebates based on inflated benchmarks. This can foster competitive bidding, price competition, and the availability of high-quality, cost-effective plans. (11) (Statutory)
2. Congress could modify or eliminate the quartile percentages used to determine county-level benchmarks to encourage fairer benchmarks and avoid payment distortions near quartile thresholds. With rural and urban beneficiary enrollment reaching parity, extra subsidies for low-spending areas may no longer be necessary. (Statutory)
3. Congress could eliminate rebates to make plans bid at actual costs, promote price competition, and ensure savings for Medicare. (Statutory)
4. CMS could modify risk adjustment to mitigate adverse selection in the calculation of both the national fee-for-service rate (the United States Per Capita Costs) and the regional adjustment factor (the average geographic adjustment) in benchmark calculations (Regulatory)

Risk Adjustment

Background and Analysis

MA risk adjustment aims to account for beneficiary health risks but can be manipulated, resulting in overcompensation. This is driven by aggressive risk coding, clinically unsupported through the use of chart reviews and health risk assessments leading to 6-16% higher risk scores than TM, costing $10.2 billion in annual overpayments. (3) MA plans are obliged to return known overpayments but lack incentives to identify them.

While CMS can use coding intensity adjustment to rectify coding differences, it hasn't fully utilized this authority. CMS's Risk Adjustment Data Validation (RADV) audits attempt to recoup overpayments, but are limited in scope of audits and face a lengthy appeals process. (13) CMS has the authority to revise the risk adjustment methodology, currently based on TM but is distorted by disease severity differences between MA and TM, making it prone to inflated coding.

Policy Recommendations

5. CMS could increase the coding intensity adjuster beyond the statutory minimum of 5.9% to decrease substantial overpayments and enable recovery of overpayments from heightened coding. (Regulatory)
6. CMS could increase recoupment of overpayments by rigorous enforcement of RADV audits and the 2014 Overpayment Rule. (Regulatory)
7. CMS could alter the risk adjustment formula by calculating specific Hierarchical Condition Category (HCC) weights for the MA population to provide an accurate representation of risk. (Regulatory)
8. CMS could restrict the use of chart reviews and health risk assessments to limit HCC scores inflation and promote substantial savings. (Regulatory)

Quality Bonus Payments

Background and Analysis

The MA Quality Bonus Payment (QBP) program provides bonus payments to plans achieving at least a four-star rating. The measures making up the star ratings are of limited salience to patients. Nearly 80% of MA beneficiaries are in plans receiving ratings of 4 or higher. (14) There is no evidence that the program has improved quality in MA.(15)

Policy Recommendations

9. Congress could convert the QBP into a budget neutral program, where rewards and penalties are based on plan performance relative to set targets. (Statutory)
10. CMS could toughen QBP criteria to raise quality standards, making quality bonuses more difficult to achieve, and motivating plans to improve their quality of service. (Regulatory)
11. Congress could eliminate double-bonuses, as there is no evidence that they increase MA plan quality or enrollment. (15) (Statutory)

Conclusion

Congress and the CMS have a number of options that could be pursued simultaneously to improve the MA program. The regulatory options presented for risk adjustment are the most impactful and easiest to implement, with the potential to save over $500 billion in a decade. For MA reforms requiring congressional action, base payment policies could generate substantial savings (with an uncertain impact), and QBP policies have the potential to generate savings of $50-$100 billion in a decade.

Reforming MA faces a number of significant challenges that are driven by the interests of key stakeholders such as insurers, beneficiaries, and providers. However, the potential to generate substantial savings from MA provides a unique window for impactful policy change and addresses the pressing concern of maintaining fiscal sustainability for the Medicare program.

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