Promoting Transparency and Alignment in Medicare Advantage

American College of Physicians

A Position Paper

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A Position Paper of the American College of Physicians

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Introduction

This position paper of the American College of Physicians (ACP) provides an overview of the Medicare Advantage (MA) Program, the current marketplace, and the payment structure within MA while exploring quality of care, utilization, and cost of services in the MA Program compared with traditional Medicare fee-for-service (FFS). The paper outlines a set of policy recommendations to address some areas of concern within the MA Program as they relate to payment, program transparency, and administrative burden. The following specific recommendations are offered in the paper:

1. ACP supports current policies to ensure that MA plans are funded at the level of the traditional Medicare program and that at least 85% of that funding goes to actual beneficiary care.

2. ACP urges Medicare Advantage Organizations (MAOs) to be transparent in their processes, policies, and procedures for how they develop and administer their MA plans and portfolios for all key stakeholders to ensure program integrity. Moreover, MAOs administering MA plans must collaborate with all relevant stakeholders to streamline and align varying policies, procedures, and contracting arrangements with physicians to further promote transparency and reduce excessive and burdensome administrative tasks.

- **a. MA plans' administrative processes and contracting arrangements with participating physicians should be transparent and standardized across all MAOs and plans to reduce administrative burden associated with participation in the MA Program.**
- **b. ACP calls for more research on the effects of excessive administrative tasks on physicians and beneficiaries who participate in MA plans as well as research on best practices to help reduce excessive and burdensome administrative tasks and further align administrative processes within the MA Program and across traditional Medicare.**
- **c. The quality measurement systems for both MA plans and traditional Medicare should align to promote high-quality care for all beneficiaries, streamline quality reporting across Medicare programs, encourage administrative simplification, and provide beneficiaries with a clear and understandable means to compare benefits and options across Medicare programs.**
- **d. All payment models and incentives, including new alternative payment models, implemented by MAOs with participating physicians should be developed in a transparent manner, foster high-value care to all beneficiaries, and aim to engage participating physicians in designing and implementing value-based payment. They should also encourage delivery system reforms that allow them and other members of the clinical care team to share in savings associated with providing high-value, coordinated primary and comprehensive care.**
- **e. Processes and requirements for risk stratification and capturing severity of illness should be transparent and align across all MA plans. ACP calls on CMS, Office of Inspector General (OIG), and external independent bodies to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans. Further, when any fraudulent activity is identified, the responsible MAO or MA plan should be held liable for that activity and not the physicians participating in the MA plan.**
- **f. MA plans should provide beneficiaries with a clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare; therefore, the process of "seamless conversion" into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not**

automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out.

3. ACP calls for more research on how federal payments to the MA Program are utilized by MAOs. Specifically, ACP calls for further research on the types of payment models used and prices paid by MAOs to contracted physicians, hospitals, and other clinicians compared with the models used and prices paid by traditional Medicare and commercial health insurance plans.

Glossary of Acronyms

ACA: Affordable Care Act
AHIP: America's Health Insurance Plans
APM: Alternative Payment Model
CMS: Centers for Medicare and Medicaid Services
EHR: Electronic Health Record
FFS: Fee-for-Service
GAO: Government Accountability Office
HCC: Hierarchical Condition Category
HCP LAN: Health Care Payment Learning and Action Network
Health IT: Health Information Technology
HMO: Health Maintenance Organization
HMOPOS: Health Maintenance Organization Point of Service
ICD-10: International Classification of Diseases
MA: Medicare Advantage
MACRA: Medicare Access and CHIP Reauthorization Act of 2015
MAO: Medicare Advantage Organization
MedPAC: Medicare Payment and Advisory Committee
MIPS: Merit-based Incentive Payment System
MLR: Medical Loss Ratio
MMA: Medicare Prescription Drug, Improvement and Modernization Act of 2003
MSA: Medical Savings Account
OIG: Office of Inspector General
PFFS: Private Fee-for-Service
PFS: Physician Fee Schedule
PPO: Preferred Provider Organization
QPP: Quality Payment Program
SNP: Special Needs Plans

Overview

The Medicare Advantage (MA) program, or Medicare Part C, is available to Medicare beneficiaries as an option to receive their Medicare benefits through private insurance plans rather than from the traditional fee-for-service (FFS) Medicare program (1,2). MA plans are offered through MA Organizations (MAOs), comprising private payers that have contracted with the Centers for Medicare & Medicaid Services (CMS), to provide, at minimum, the core set of Medicare Part A and B benefits—except for hospice care. MA plans are designed to enhance care coordination and quality of care as well as provide supplementary benefits, including dental coverage, vision coverage, and wellness plans. All MA plans, except the Private Fee-for-Services plans (described below), are required to provide a plan with a prescription drug coverage option (Medicare Part D) (1,2).

Types of Plans

There are multiple MA plan types available to beneficiaries. Health Maintenance Organization (HMO) plans are the most common type of MA plan in which beneficiaries must obtain health care services from specific physicians or hospitals on the plan's list (except in an emergency), and most plans require referrals from the beneficiaries' primary care physician. Preferred Provider Organization (PPO) plans allow beneficiaries to pay lower costs for receiving health care services from physicians or hospitals on the plan's list (i.e., in-network) and pay higher costs for seeking health care services out-of-network. Private Fee-for-Service (PFFS) Plans may have networks of physicians and hospitals and some may not—the difference between these plans and the traditional FFS Medicare is that the specific plans determine how much they will pay physicians, hospitals, and other clinicians and how much the beneficiary pays for health care services. Special Needs Plans (SNPs) are similar to HMOs and PPOs but offer tailored benefits only to those with specific diseases or health characteristics. Other less common plans include HMO Point of Service (HMOPOS) plans that allow beneficiaries to receive services outside of the HMO network for a higher cost and Medical Savings Account (MSA) plans, which are high-deductible plans that provide a bank account in which Medicare deposits money for beneficiaries to use for medical costs throughout the year (1).

MA Premium Costs

Persons enrolled in MA plans are responsible for paying the standard Medicare Part B premium (the 2016 standard Part B premium was $121 and could be slightly higher depending on the beneficiary's income) in addition to any premium their MA plan may charge. There are also MA plans that do not charge an additional premium and are referred to as "zero premium plans." The price of the MA plan's premium is based on the difference between the cost of providing the required and supplementary benefits, and the amount that CMS pays to the MAO for the benefits provided (3). In 2016, the average monthly premium for MA plans with prescription drug coverage was $37 per month. HMO plans have the lowest monthly premiums at an average of $28 per month compared with local PPOs at $63 per month, and regional PPOs at $37 per month (3). Most "zero premium plan" offerings are through HMOs, and approximately 81% of MA beneficiaries have access to these types of plans. The average out-of-pocket limit for MA beneficiaries in 2016 was slightly higher than it was in 2015, at $5257. Thirty-nine percent of plans have the maximum limit of $6700 and 24% of plans have a limit of $3400 or less (4).

The Current MA Marketplace

Since 2004, the number of beneficiaries enrolled in MA plans has tripled from 5.3 million to roughly 17.6 million in 2016, which accounts for 31% of the entire Medicare beneficiary population (57 million) (5). The remaining 69% are enrolled in the traditional FFS Medicare. The private payers offering most MA plans—accounting for 75% of MA enrollment—include UnitedHealthcare, Humana,

Blue Cross Blue Shield, Kaiser Permanente, Aetna, Cigna, and Wellcare (5). On average, MA enrollees have 19 MA plans to choose from, and most plans are HMOs (64%) with local PPOs accounting for 23% of MA enrollment. Regional PPOs account for 7% of MA enrollment, and all other plan types account for roughly 5% of MA enrollment (5). In 2015, the percentage of Medicare beneficiaries enrolled in MA varied by state, ranging from 55% in Minnesota, to 39% in California, 38% in Arizona, and 17% in Oklahoma, down to less than 10% enrolled in Wyoming, Alaska, Vermont, and New Hampshire (6).

CMS Payments to MA Plans

For payment purposes, CMS groups MA plans into two categories: regional and local (2). Regional MA plans, which were established to provide rural beneficiaries with access to MA plans, must be a PPO and serve all of one of the 26 regions established by CMS. Local plans can be any type of MA plan and are paid for by CMS based on the county in which the enrollee resides (2). CMS pays MAOs a monthly, prospective, capitated rate based on the relationship between their MA plan's bid and the local/regional benchmark. Benchmarks are calculated under statutory formulas (the formulas differ for regional and local plans) and depend on various factors including the quality (star) rating for a specific plan, among others. If an MA plan bid exceeds the benchmark, the plan will charge beneficiaries a premium. If an MA plan bid falls under the benchmark, CMS pays the MAO a rebate that is required to be returned to the plan's beneficiaries in the form of lower premiums or supplemental benefits (2). Throughout the MA Program, the practice of balance billing (i.e., billing the patient for the difference between what CMS pays for the service and what the patient was charged) by MAOs and all participating physicians for Medicare-covered services is prohibited, except within the PFFS plans (7).

Additionally, CMS utilizes the Hierarchical Condition Categories (HCC) risk-adjustment model which further adjusts the amount CMS pays to MA plans for each beneficiary enrolled. The HCC risk-adjustment model uses the International Classification of Diseases (ICD-10)—or diagnosis—codes recorded on both inpatient and outpatient claims from the previous year for all beneficiaries enrolled in the MA plan. To calculate the risk score for each individual beneficiary, all diagnoses are grouped into HCCs according to severity of the diagnosis and assigned a weight, based in part on the cost of treating the same condition in traditional Medicare. For beneficiaries with multiple diagnoses and conditions, CMS adds together the weight of each condition to calculate the risk score (8). On average, CMS pays roughly $10,000 a year per MA beneficiary, totaling more than $170 billion per year (9).

In 2010, the Affordable Care Act (ACA) included provisions to reduce wasteful Medicare spending that changed the payment structure for MA and transitioned MA payment benchmarks to be equivalent to traditional FFS. Since the passing and implementation of the ACA, ACP has supported these policies calling for payment parity between traditional FFS Medicare and the MA Program (10). In addition to phasing down the overpayments to MA plans, the ACA also limits MA beneficiaries' out-of-pocket costs for certain services and requires MA plans to spend at least 85% of their overall revenue on direct beneficiary care instead of administrative costs or profits (11). Since 2014, all MAOs and Part D sponsors have been required to submit their medical loss ratio (MLR) data to CMS. This ratio represents the percentage of revenue used for patient care rather than other administrative costs or profit. The MLR numerator is the sum of all amounts reported as claims or as health care quality improvement expenses, and the MLR denominator is the total revenue after subtracting the sum of any licensing or regulatory fees, federal and state taxes, and allowable community benefit expenditures. MA plans and Part D sponsors are subject to financial or other penalties if they do not reach an MLR of at least 85% (12).

Even with the transition to financial neutrality and decreased payments to MA plans over time, as well as increased consumer protections and requiring specific percentages of funding for direct patient care, enrollment in the program has continued to increase and MA plans are still widely available (13). Moreover, insurance company executives have reported that well-functioning MA plans can see profit margins of 4% to 5%, with approximately 84% of total revenue allocated for medical care and 11% going toward administrative functions (14, 15).

Discussion of Quality, Utilization, and Cost of Care in MA Compared with Traditional Medicare

Throughout the MA Program's almost 50-year existence (albeit in various capacities and different names), the role of private plans within Medicare remains a source of debate among policymakers and the health care industry as a whole (16). The central focus of most of this debate is on maintaining the right balance between promoting beneficiary choice, maintaining quality of care, providing access to MA plans, and setting the cost of these private plans. The capitated payment structure provides MAOs with incentives to provide quality care and manage health care costs but also has the potential to incentivize MA plans to enroll healthier beneficiaries (17). The CMS risk-adjustment methodology used in the MA Program addresses some of these issues, but there is still some concern regarding how risk is captured across different MA plans. As enrollment in the MA Program continues to increase, there is growing interest in understanding the differences in care delivery, quality, resource utilization, and cost between MA and traditional Medicare.

The Medicare Payment and Advisory Committee (MedPAC), an independent congressional agency established to advise Congress on issues affecting Medicare, has strongly supported the MA Program and the option for beneficiaries to choose between traditional FFS Medicare and privately managed MA plans based on their specific needs or preferences. In addition to providing beneficiaries with choices, MedPAC believes the capitated payments as well as the managed, coordinated care structure of MA plans incentivizes maintaining quality care and keeping costs down (18).

A 2014 Kaiser Family Foundation report (19) provided an extensive review of the quality and access to care data in MA compared with traditional Medicare through literature published between 2000 and 2014. The review found that MA HMOs perform slightly better than traditional Medicare in providing preventive services and having lower resource utilization, an area in which HMOs have historically performed well. However, when patient-reporting measures were evaluated, beneficiaries rated traditional Medicare more favorably than MA plans on access and quality measures. There was an even bigger rating differential in the access and quality measures between sicker and healthier beneficiaries, with sicker beneficiaries favoring traditional Medicare over MA. A 2017 Government Accountability Office (GAO) report went a step further and looked into actual MA disenrollment rates based on beneficiary health status. Specifically, it examined 126 MA plans with high-disenrollment/low-quality ratings and found that in 35 of those plans, sicker beneficiaries were substantially more likely (47%) to disenroll than healthier beneficiaries. These findings indicate that some of the MA plans may not provide adequate services for beneficiaries in poorer health (20).

Research has also provided evidence in support of MedPAC's assertions about the MA Program's innate motivation and ability to control utilization and cost of services. A study reviewing data on service utilization among beneficiaries enrolled in MA HMOs showed more appropriate utilization for those beneficiaries than those enrolled in traditional Medicare (21). Additional research has shown MA plans to be successful in keeping resource use down and quality of care high compared with traditional Medicare for care of specific diseases (22) and some studies even show a potential "spillover effect" on care delivery and resource utilization from MA plans into traditional Medicare (23,24). However, whether MA plans actually operate more efficiently than traditional Medicare or if there are other underlying factors involved is still unclear. Recent studies have

started to review data on the actual unit prices that MA plans pay to hospitals compared with traditional Medicare and commercial plans. One study in particular found that MA plans pay hospitals 5.6% less than traditional Medicare for equivalent services (25). Despite the growing interest among researchers and policymakers to understand these differences, the available data and research still do not provide a clear enough picture into the fundamental reasons for the differences in quality, cost, and utilization across all Medicare programs.

After reviewing the various aspects of the MA Program discussed above, ACP outlined a set of public policy statements and recommendations as follows:

Policy Recommendations and Rationale

1. ACP supports current policies to ensure that MA plans are funded at the level of the traditional Medicare program and that at least 85% of that funding goes to actual beneficiary care.

Since the 1970s when managed care was introduced into Medicare through the Social Security Act (SSA) Amendments of 1972, there have been several legislative attempts to enhance and promote participation in the program (26).The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) renamed the program from "Medicare+Choice" to the current title "MA" and also substantially increased federal payments to MA plans as a way to further encourage MAO participation in the program. However, this payment structure led to MA plans at one point receiving payments that were roughly 16% higher than those made to traditional FFS plans for comparable beneficiaries and costing taxpayers almost $1000 more per MA beneficiary. This payment inequality gave rise to unnecessary program spending as well as inefficient MA plans that provided extra benefits while increasing cost for the taxpayer and beneficiary premiums (27).

As discussed earlier, the 2010 passage of the ACA included provisions to address payment inequality between Medicare programs as well as established requirements for specific portions of MAO revenue to go directly to patient care. As of 2017, payment benchmarks to MA have been fully transitioned to be equivalent to those of traditional Medicare and since 2014, MAOs have been required to report their division of revenue allocated for direct patient care, administrative costs, and profit. Even with full implementation of these ACA provisions, enrollment in and availability of MA plans continue to rise while high-quality care is maintained across the program.

2. ACP urges MAOs to be transparent in their processes, policies, and procedures for how they develop and administer their MA plans and portfolios for all key stakeholders to ensure program integrity. Moreover, MAOs administering MA plans must collaborate with all relevant stakeholders to streamline and align varying policies, procedures, and contracting arrangements with physicians to further promote transparency and reduce excessive and burdensome administrative tasks.

The growing popularity of the MA Program along with the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and ongoing transformation of the U.S. health care system to focus on linking quality of care to physician payment highlights the need for increased transparency and alignment in the MA Program. One of the major limitations in the studies discussed earlier comparing MA and traditional Medicare was the lack of recent and relevant MA Program data describing the underlying reasons for the program's successes and setbacks. There are clear gaps in available information on quality and access as well as specific cost and utilization data across all MA markets. Requiring transparency throughout the program is an essential step in gathering and strengthening the data necessary to accurately assess the MA Program and promote alignment within and across Medicare.

The following subrecommendations highlight specific areas of focus regarding program transparency and alignment:

a. MA plans' administrative processes and contracting arrangements with participating physicians should be transparent and standardized across all MAOs and plans to reduce administrative burden associated with participation in the MA Program.

Payers, including MAOs, have their own approaches and rules related to their business operations, billing requirements, prior authorizations, reporting of quality measures, referrals and treatment plans, and so on. As part of their practice or organization, physicians participate in a number of different plans and contract with multiple payers (28). An extensive literature review conducted as part of an ACP policy paper on reducing administrative tasks in health care indicates that these varying and duplicative contracting arrangements and subsequent administrative tasks and requirements have a negative effect on physicians' time and cost to run their practice. Of most concern is how these tasks and requirements decrease physicians' ability to provide timely and appropriate patient care (29). Specifically, the research shows that physicians and their staff spend an estimated 3 to 5 hours per week on administrative tasks, primarily dealing with billing and insurance related activities, with some estimates of nearly 9 hours per week (30,31,32,33,34). One specific study showed the breakdown of administrative time burden between physicians and support staff with the average for physicians at 4 hours per week and the average for practice support staff at 5 hours per week (35). Further, when these estimates of time are converted to effects on cost, some experts have calculated approximately 10% to 14% of net practice revenue is spent on these billing and insurance-related administrative tasks, with approximately $68,000 to over $85,000 spent per full-time physician per year (36). The ACP policy paper also discussed a study focused on the primary care practice costs specifically associated with the prior authorization process. The study found that the average annual burden of cost on primary care physician practices ranged from $2,161 to $3,430 per full-time physician (37). These issues are of great concern to all practicing physicians but are particularly burdensome for smaller practices that may not have the staff or workflows available to address the additional administrative work, potentially impeding access to care in underserved areas with provider workforce shortages.

In addition to the effects of multiple and varying billing and insurance-related tasks on practice cost and time, some MA plans may send guidance to participating physicians on certain services to provide to a patient based on the patient's specific MA plan and what the physician can bill for, even if that service is not entirely necessary at the time of the visit. These varying processes and guidelines make it difficult for a physician practice to manage and capture the appropriate charges (e.g., some MA contracts may allow physicians to bill for an Annual Wellness Visit [AWV] even though the patient received an AWV three months prior, whereas other MA plans allow an AWV to be billed 11 months apart, and others 365 days plus one day). Physicians should be clear on the intent of contracting arrangements and associated policies and procedures for participating in the plan so the appropriate and timely care of the beneficiary is at the forefront. To address these issues of intent, transparency, and excessive and duplicative tasks, MAOs should collaborate with one another and CMS to identify and analyze contracting arrangements and associated administrative tasks required for participation in their plans and align varying arrangements and tasks, streamline duplicative tasks, or remove entirely tasks that are deemed excessive and burdensome using the comprehensive framework developed in ACP's position paper "Putting Patients First by Reducing Administrative Tasks in Health Care."

b. ACP calls for more research on the effects of excessive administrative tasks on physicians and beneficiaries who participate in MA plans as well as research on best practices to help reduce excessive and burdensome administrative tasks and further align administrative processes within the MA Program and across traditional Medicare.

In addition to continued research on the broader effects of administrative tasks on physicians and their patients, research should delve into the specific administrative burdens associated with the MA Program. Within the ACP literature review discussed previously, there were clear gaps in the research specific to the effects of administrative tasks on patients as well as evidence-based best practices to help clinicians address the burdens faced regularly in their practices (38). This information could be useful to policymakers to understand the effects and intent of these tasks within the MA Program and assist in streamlining or eliminating administrative processes, tasks, and requirements. This research can also help guide the development of evidence-based solutions to alter or eliminate burdensome tasks and provide more time for physicians to provide high-quality patient care.

c. The quality measurement systems for both MA plans and traditional Medicare should align to promote high-quality and high-value care for all beneficiaries, streamline quality reporting across Medicare programs, and encourage administrative simplification.

Aligning and streamlining the performance measurement system across Medicare programs and the commercial insurance market should be a priority in the efforts to decrease excessive and burdensome administrative tasks in the health care system. In addition to the complexities involved in contracting with multiple payers, navigating the differing data collection mechanisms and performance metrics systems across individual plans can become extremely time-consuming and burdensome and take away from providing the high-quality care the metrics seek to capture. In some cases, there is a clear reason for applying different performance metrics to different plans. For instance, certain control targets for diseases will differ based on the age of the patient population (older Medicare beneficiaries vs. younger beneficiaries in the individual marketplace), but there are still a number of performance metrics that may lack clinical rationale based on the specific patient population or type of physician practice as well as varying reporting methods (39). ACP believes that a key approach in addressing these issues is for all stakeholders, including payers, electronic health record (EHR) vendors, and physicians, to collaborate in better utilizing existing and innovative health information technology (HIT) to seamlessly extract information from EHRs and address issues of burdensome data collection and performance measure reporting (40).

The current CMS Star Rating System used throughout the MA Program does not align with the quality measurement system being rolled out in either track (Merit-based Incentive Payment System or advanced Alternative Payment Models) of the Medicare Quality Payment Program (QPP) for traditional Medicare. Moreover, this rating system is not uniform across MA plans and metrics are implemented at the MAO-MA plan contract level so physicians participating in multiple MA plans could have varying quality metrics on which to adhere and report (41).These inconsistencies within MA and across programs and insurance plans can lead to an overwhelming amount of conflicting reporting requirements. Even more concerning, physicians may receive conflicting indicators on how they should treat clinically homogenous patients.

CMS, along with Americas Health Insurance Plans (AHIP), National Quality Forum, consumer and physician organizations, and other stakeholder groups, have begun work through the Core Measure Collaborative to address these issues and harmonize the quality measurement system across programs (42). It is important that their efforts, along with similar ones to harmonize measures and reporting, continue in order to decrease administrative burden and, most

important, provide high-quality care to all beneficiaries without negatively influencing individualized care for the unique needs of patients (e.g., individualized pain management treatment) (43).

d. All payment models and incentives, including new alternative payment models, implemented by MAOs with participating physicians should be developed in a transparent manner, foster high-value care to all beneficiaries, and aim to engage participating physicians in designing and implementing value-based payment. They should also encourage delivery system reforms that allow them and other members of the clinical care team to share in savings associated with providing high-value, coordinated primary and comprehensive care.

MAOs have experience in developing and implementing plans that feature elements integral to alternative payment models, including population-based payment approaches, quality-adjusted payments, and emphasis on care coordination (44). It is important for all stakeholders to have access to this information to provide a better understanding of what does and does not work in these models—especially for development of models for Medicare beneficiaries population. However, it is important to note that not all MA plans are alternative payment models because the incentives reside strictly within the contracts between CMS and MAOs; thus, MAOs do not necessarily incorporate these value-based elements and financial incentives into the next level of the process, which is the MAOs' contracts with physicians (45). While MAOs cannot automatically be considered alternative payment models themselves, they may be conducting some activities or programs that could lend themselves to being or at least informing alternative payment models or alternative payment model development due to the capitated payment arrangement they have with CMS. A Health Care Payment Learning and Action Network (HCP LAN) report found that 41% of MA spending fell into Categories 3 and 4 of their "APM Framework," which consists of alternative payment models built on a traditional Medicare FFS construct (Category 3) and alternative payment models built solely on population-based payments (Category 4) (46). For example, the Central Ohio Primary Care group has successfully incorporated value-based shared savings arrangements in their contracts with MA plans so that physicians receive a portion of the overall savings for providing cost-effective and quality care (47). ACP strongly supports further development and incorporation of these value-based arrangements and incentives by MA plans to engage physicians directly in providing greater value and improving care coordination.

Moreover, MACRA's QPP, which seeks to link physician payment in Medicare Part B directly to quality and patient outcomes while streamlining previous quality and cost-reporting programs, provides an "All-Payer" option in later performance years. This option allows for physician participation in the MA Program also to count toward a physician qualifying for participation in the advanced alternative payment model track in the QPP and receive a bonus payment (48). However, MA plans must be willing to provide timely information on their contracting arrangements with physicians and how they measure the quality of care provided by physicians participating in their plans (49). Not only does this option encourage MA plans to engage in more value-based payment arrangements with physicians but also helps to further align processes across the MA and traditional Medicare programs.

Through the "All-Payer" option, CMS has a clear opportunity to promote these value-based payment arrangements within the MA Program. It also allows them to use their authority to standardize the rules around how MA plans are administered to promote transparency and alignment, lessen the administrative burden associated with participation in plans, and most important promote high-value care for all Medicare beneficiaries. CMS has taken steps through rulemaking in the 2017 Physician Fee Schedule (PFS) Final Rule to promote data transparency in the MA Program and requires plans to release some portions of plan data, including the MLR, for public review. However, ACP feels that CMS could go fur-

ther and require more recent and relevant data to assist others in developing successful alternative payment models for the Medicare population.

e. Processes and requirements for risk stratification and capturing severity of illness should be transparent and align across all MA plans. ACP calls on CMS, OIG, and external independent bodies to investigate potentially fraudulent activity and the misuse of risk stratification by MA plans. Further, when any fraudulent activity is identified, the responsible MAO or MA plan should be held liable for that activity and not the physicians participating in the MA plan.

Understanding how MA plans capture beneficiary risk through comprehensive diagnoses documentation is an important example of the need for increased transparency within the program. Risk-adjustment is an integral component of developing value-based payment models because physician payment is tied to cost and patient outcomes, and sicker beneficiaries are more likely to have higher cost and worse outcomes than healthier patients. For this reason, plans may be more inclined to only enroll healthier beneficiaries as a way to enhance quality and cost scores, and risk-adjustment addresses these concerns as a way not to disadvantage sicker beneficiaries. As discussed, the HCC risk-adjustment methodology allows CMS to calculate a risk score for each MA beneficiary based on various demographic characteristics and health status through the use of ICD-10 codes, which then determines how much the plan is paid for that beneficiary. Sicker patients receive higher risk scores and plans receive higher payments for those beneficiaries. The use of this model has been shown to reduce favorable beneficiary selection in the MA Program (50), and all MA plans should capture disease severity in a transparent manner to ensure that beneficiaries are not cared for differently based on differing HCC-specific documentation requirements across MA plans.

CMS must also address issues of fraud and abuse in the MA Program. Reports from such organizations as The Center for Public Integrity discuss allegations that some MA plans overbill CMS by exaggerating illness severity in some of their patient populations (51). Requiring transparency and specifically requiring publication of how the plan captures illness severity through use of the HCC risk-adjustment methodology could help in identifying areas of potential fraud and promote a more cohesive method of capturing severity across all MA plans. To further promote and maintain program integrity, the CMS's Center for Program Integrity, the OIG, and such external independent organizations as MedPAC and the GAO should take the lead in investigating potential situations of fraud or "gaming the system" (52) by MA plans to increase profitability by misusing the risk-stratification process. Taking a closer look at these potentially fraudulent practices as well as gathering general information on how risk is captured across MA plans will also help to provide insight into the intent of MA plans' benefit design. It will also foster clinically homogenous care to all Medicare beneficiaries as opposed to providing care based on the coding or quality metric requirements of the specific MA plan.

f. MA plans should provide beneficiaries with a clear and understandable means to compare benefits and options when deciding between an MA plan and traditional Medicare; therefore, the process of "seamless conversion" into these plans should be stopped entirely and reevaluated so that newly eligible Medicare beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out.

MA Program transparency at the consumer level is also very important. The enrollment process, details regarding available benefits, cost-sharing arrangements and premium costs, and network directories should be readily available to all Medicare beneficiaries and presented in a clear and understandable manner. For example, the process of "seamless conversion" should be stopped entirely and reevaluated so that newly eligible Medicare

beneficiaries are not automatically enrolled in their commercial insurer's MA plan without their knowledge or understanding of the need to opt out. Additionally, comparing MA plan networks and available benefits still remains a challenge for beneficiaries due to the lack of readily available plan information. Beneficiaries and clinicians need to be fully aware of any differences in coverage that could result in delays to appropriate care, such as prescription drug coverage and any potential prior authorizations that were unnecessary on their previous plan. MA plans can also make significant changes to benefit options, cost-sharing arrangements, physician networks, and other details from year to year, making comparison even more difficult (53). ACP supports the MA Program and its ability to provide beneficiaries a choice of health coverage as long as benefit requirements and essential consumer protections are ensured, including providing valid and reliable information to facilitate informed decision-making.

3. ACP calls for more research on how federal payments to the MA Program are utilized by MAOs. Specifically, ACP calls for further research on the types of payment models used and prices paid by MAOs to contracted physicians, hospitals, and other clinicians compared with the models used and prices paid by traditional Medicare and commercial health insurance plans.

As discussed earlier, numerous studies have identified cost advantages in the MA Program that could be attributed to the emphasis on care coordination and less utilization of unnecessary services by beneficiaries. However, future research should focus more on the specific price differences and variations in MA markets across the country to help determine the reason for quality and cost differences between MA plans and traditional Medicare. A more systematic review of the prices paid by MA plans relative to those paid by traditional Medicare is needed to determine whether any cost-savings are due to the actual care provided in MA or if they have more to do with the specific unit prices MA plans pay to contracted physicians and hospitals. It is important that this type of research also take into consideration the potential of any unintended, adverse effects accompanying full public disclosure of negotiated price data, because it may increase patient cost. More detailed information on pricing can help highlight whether and how the MA Program's lower utilization improves economic efficiency (54). This type of research will also promote transparency in pricing and contract arrangements through the MA Program discussed in the previous recommendations.

Conclusion

As enrollment in the MA Program continues to grow and physicians are presented with more opportunities to participate in MA plans, maintaining the current payment parity provisions within the ACA remains an essential component to managing overpayments and reducing wasteful spending to ensure Medicare solvency. Additionally, with the MA Program's potential to help influence and guide further development of coordinated care delivery models and alternative payment models, program transparency is of the utmost importance. MACRA's QPP promotes the move to linking physician payment to high-value care and provides MA plans the opportunity to engage in more quality-adjusted and risk-sharing payment arrangements; however, MAOs must be willing to work with CMS and physicians, in a transparent manner, on the development of these complex models. MACRA also provides a clear opportunity for CMS to use their authority to require program transparency to align the MA and traditional Medicare programs, lessen the administrative burden associated with participation in plans, and most important, promote high-value care for all Medicare beneficiaries.

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