EDITORIAL

HEALTH CARE POLICY AND LAW

Ensuring a Sustainable Medicare Program Through Effective Oversight

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Medicare is a trillion-dollar government program that covers 70 million lives through either traditional Medicare (TM) or Medicare Advantage (MA). In contrast to TM, which pays clinicians directly using a system of fee schedules, MA is based on a system of competing private plans that contract with the government and then pay clinicians. Given the scale of Medicare, program integrity in TM and MA is essential, although MA attracts particular attention because it now enrolls more than half of Medicare beneficiaries, and there is concern that MA plans have incentives to inappropriately deny care, aggressively code diagnoses to influence risk adjustment, or engage in other deleterious behavior.[1]

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In this issue of *JAMA Internal Medicine*, Chen et al[2] provide a unique window into the nature of MA oversight by analyzing US Centers for Medicare & Medicaid Services (CMS) enforcement actions against MA plans using 2010 to 2023 data they gathered via a Freedom of Information Act request. Of roughly 8000 observed contract-years, they found 844 enforcement actions. Fines, which were relatively small (less than $3.00 per enrollee in most years), were the most common sanction, with suspensions and terminations much less common. Nearly half (42%) of all contracts received an enforcement action. Contracts subject to enforcement actions had lower star ratings and more beneficiaries of racial or ethnic minority groups or with Medicaid eligibility than those not subject to these actions.

Chen et al[2] provide a novel quantification of MA oversight, building on insights from the Government Accountability Office,[3] the Office of Inspector General,[4] and the Department of Justice[5] that highlight the opportunity for better oversight (eg, by reducing overpayment or inappropriate denials of care). However, it is just a start. To really understand if we should have more, less, or different MA oversight, we need to also understand what share of actual infractions were captured. How serious were the infractions? How many inappropriate denials of care were there? How much is fraud vs improper payment? How do these infractions compare with those found in TM? What are the implications for vulnerable patients or beneficiaries in poor-performing plans?

Placing these results in context also requires understanding the role MA plays in supporting affordable, high-quality care. First, and most importantly, there are ample opportunities to reduce spending in Medicare without reducing quality. This is evidenced by wide geographic variation in TM spending without commensurate quality differences,[6] as well as substantial direct evidence of overuse and low-value care across programs.[7]

In TM, the fee-for-service (FFS) payment model provides no incentives to deliver care efficiently and generally encourages higher volume. Thus, the main tool available to control spending in FFS is price, but Medicare fee schedules are already set to rise at a rate less than inflation.[1] There are many ways fee schedules can (and should) be improved, including by setting base rates more in line with costs, improving relative prices within fee schedules, harmonizing payments for similar services across sectors, and, even better, restructuring the schedule altogether. Yet, maintaining appropriate fees is challenging given the multiple sectors and multitude of codes involved. On balance, it is unlikely that there will be substantial overall savings from further reforms to the Medicare fee schedules, suggesting attention to service volume and intensity is particularly important.

Given the inherent inability of FFS to address growing volume and intensity, building an efficient health care system depends on the structures and institutions developed to mitigate the incentive problems. In fact, other countries and many MA plans pay FFS. The point often overlooked is that places that successfully use FFS typically include other ways to mitigate overspending. Commonly, other countries rely on budgets or supply constraints.

CMS has developed some programs to counteract FFS incentives in TM and in particular reduce low-value care. For example, the US Center for Medicare and Medicaid Innovation's WISeR model is intended to address low-value care, but it covers a limited set of services in a few states. The nuances associated with low-value care (which reflect the details of the clinical situation) limit the ability of approaches such as coverage determinations to reduce delivery of low-value care.[8] A broader armament is needed. Alternative payment models within TM represent one broader approach and have demonstrated the potential not only to lower net spending, but also to modestly reduce low-value care.[9]

MA should be understood as one such structure to mitigate incentive problems. It offers an important opportunity to promote higher-value care through tools like utilization management, network restrictions, value-based contracting with clinicians, and beneficiary engagement activities. On balance, MA can be successful. For example, a systematic review of MA and FFS Medicare concluded that "Medicare Advantage was associated with more preventive care visits, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower health care spending. Medicare Advantage outperformed traditional Medicare in most studies comparing quality-of-care metrics."[10] This suggests that, on average, MA plans can lower

spending on care without substantial quality decrements. There is also evidence that MA beneficiaries experience less low-value care than TM beneficiaries.[11,12] Yet, on almost all metrics, there is substantial heterogeneity across plans.

More relevant to our fiscal concerns, MA does not currently save the system money because the benchmark, risk adjustment, and performance bonus systems result in MA plans being paid more than would be spent in FFS.[1] This may be partially associated with program integrity issues, as highlighted by Chen et al,[2] but a lot of that is simply the design of the program. The added funds (intended or not) support more generous benefits and lower premiums, so policy makers must weigh the value of those benefits against the added spending.

Of course, the success of MA on average does not imply that there are no areas of concern, as the study by Chen et al[2] illustrates. There is heterogeneity across MA plans, and regulators must be vigilant to make sure some plans are not excessively limiting care or aggressively manipulating the risk adjustment and performance bonus programs (both of which need reform). But such oversight must acknowledge that care in MA should not mimic the care beneficiaries would get in TM. The whole point is to allow care efficiencies to be achieved.

Ultimately, the most important challenges facing Medicare are likely associated with program design, such as better risk adjustment and performance bonus systems. Yet, program integrity is also crucial for MA and TM. Effective oversight, for example to ensure that vulnerable patients are not denied needed care and plans do not receive inappropriate payment, can protect patients, constrain spending, and even support more effective competition. The goal is oversight that achieves these goals while enabling MA and TM to achieve efficiencies and, ultimately, improve patient outcomes.

ARTICLE INFORMATION

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