VIEWPOINT

Time to Release Medicare Advantage Claims Data

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Medicare Advantage plans represent a sizable and growing segment of the Medicare program as well as important private plan alternatives to traditional Medicare. According to the latest statistics, enrollment in Medicare Advantage plans increased from 13% of the Medicare population, or 5.3 million individuals, in 2004 to almost 33%, or 19 million individuals, in 2017, and government payments to Medicare Advantage plans have increased from $77 billion to more than $200 billion per year over the same period. With these payments, Medicare Advantage plans are obligated to provide at least the same level of coverage as traditional Medicare. However, Medicare Advantage plans have significant flexibility to augment benefits, and many plans both add benefits (eg, vision and dental coverage) and lower cost sharing; these enhancements have proven to be popular to many beneficiaries. These additional benefits can also come with certain restrictions not present in traditional Medicare, such as more limited networks of clinicians or health care organizations and more referral requirements to see specialists.

Despite the important and increasing role of Medicare Advantage plans, there is fairly little insight into the relative value Medicare Advantage provides to beneficiaries or the funder, the US taxpayer. This is attributable mainly to a lack of access to comprehensive claims- or encounter-level data regarding the Medicare Advantage program for researchers, or even more aggregated information that could be made available to the general public. Some researchers have used Healthcare Effectiveness Data and Information Set (HEDIS) data to compare quality of care between Medicare Advantage and traditional Medicare, and other investigators have acquired access to pockets of Medicare Advantage encounter data, but there has been no research on the Medicare Advantage program comparable with the breadth and depth of research available for traditional Medicare.[1] Traditional Medicare data have been available for many decades, facilitating insights into health care utilization, quality, and cost.

Until 2013, the primary reason for this lack of access to Medicare Advantage encounter data was that Medicare Advantage plans were not required to submit it to the Centers for Medicare & Medicaid Services (CMS). Until then, plans submitted only "bids"(ie, estimates of coverage costs) along with some limited information on diagnosis codes for enrollees to facilitate calculation of payment rates and risk adjustment. However, in 2013, the CMS began to collect more detailed encounter data from Medicare Advantage plans for the purpose of more accurate risk adjustment of payments. These data were carefully vetted over a number of years by data experts at the CMS and adjudged to be suitable for release for broader research purposes in mid-2017. However, in June 2017, the CMS abruptly cancelled the Medicare Advantage data release, citing concerns about data quality, but with very little explanation.[2]

This abrupt shift is troubling for a number of reasons. First, taxpayers deserve to know how their money is being spent, considering that Medicare Advantage plans receive substantial payments from the federal government and provide care for a significant and growing proportion of beneficiaries. The taxpayer cost of a Medicare Advantage enrollee exceeds that of a comparable traditional Medicare enrollee. The average per-enrollee government payment rate to Medicare Advantage plans was 104% of per capita traditional Medicare spending in 2017, after accounting for coding intensity.[3] Multiple audits have found that Medicare Advantage plans have overcharged the government by overstating the severity of the diagnoses of patients, and the Department of Justice continues to investigate allegations of medical upcoding against Medicare Advantage plans,[4] although a federal judge did recently strike down a specific Department of Justice allegation.[5] Given the high stakes, the data should be subjected to evaluation by researchers and, to the extent it does not identify beneficiaries, public and media scrutiny.

Second, apart from cost, there have been many claims made over the years regarding the merits of Medicare Advantage in contrast to traditional Medicare. Some studies show that Medicare Advantage has higher quality in certain dimensions, such as higher rates of preventive care and screenings among recipients.[6] Others suggest that Medicare Advantage does not serve certain beneficiaries well, such as those with greater illness severity.[7] But findings such as these have been based on aggregate or incomplete data. The quality of Medicare Advantage relative to traditional Medicare cannot be thoroughly adjudicated with existing Medicare Advantage data because such data are not comprehensive with respect to all the care enrollees receive or as granular as traditional Medicare data.

Third, there is a compelling argument to release these data to continue the recent advances made in transparency and open government. In the last several years, the CMS has publicly released multiple data sets that provide information about how physicians bill under traditional Medicare for medical services and prescription drugs. These data have been used to better understand physician practice patterns and identify questionable billing behavior.[8] However, in certain states, such a large proportion of the Medicare population is enrolled in a Medicare Advantage plan that data releases based on traditional Medicare do not provide a comprehensive picture of provider billing patterns. For example, in Minnesota almost 60% of Medicare beneficiaries are enrolled in a Medicare Advantage plan, and in California and Florida more than 40% are enrolled in these plans. The addition of Medicare

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Advantage data to these releases would provide more complete information about physicians' interactions with the Medicare program and its beneficiaries and could permit researchers and the media to examine differences between practice patterns for patients in the 2 programs.

The CMS has indicated that the decision to not release Medicare Advantage data was based on concerns regarding data quality.[2] However, the data continue to be used to calculate risk adjustment payments to plans. A recent Office of Inspector General report analyzing Medicare Advantage encounter data from 2014 found that only 5% of the records reviewed contained a potential error after CMS data edits.[9] Furthermore, it would likely be more beneficial to the CMS if researchers were to have access to the data, even with caveats about overall data quality, so they could work collaboratively to identify which specific data elements are of high quality vs low quality. With encounter data, researchers could address questions that have been unanswerable to date. For instance, does Medicare Advantage provide Medicare benefits more efficiently than traditional Medicare? If so, what is the source of that efficiency, provision of less low-value care or the same care in different ways? Are there some populations (eg, with certain chronic conditions) that seem better served by Medicare Advantage vs traditional Medicare? What are the health care resource use consequences of the enhanced benefits that Medicare Advantage provides, and are they high or low value? Do physicians use services similarly for their patients enrolled in Medicare Advantage and traditional Medicare? Moreover, allowing researcher access before public access would provide additional time to identify any gaps in the data and potentially resolve them.

Traditional Medicare data have been made available for many years to researchers with the full knowledge that certain data elements are incomplete or unreliable. With that knowledge, researchers have dealt with these data limitations to create a body of original and compelling work that has informed countless legislative efforts in recent years. Researchers, and subsequently, the media have done a notable job identifying the gaps and limitations of the data while underscoring the value of the data and creating important and meaningful research and reporting. There is no compelling reason to think that the same cannot be accomplished for Medicare Advantage, if only the equivalent data were released. For the past few years, those not directly involved in running Medicare Advantage have been squinting through keyholes to make some sense of what it provides. The time to bring the program into the full light of day is long overdue.

ARTICLE INFORMATION

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