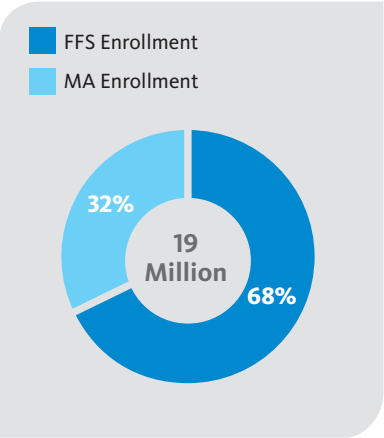
EXECUTIVE SUMMARY

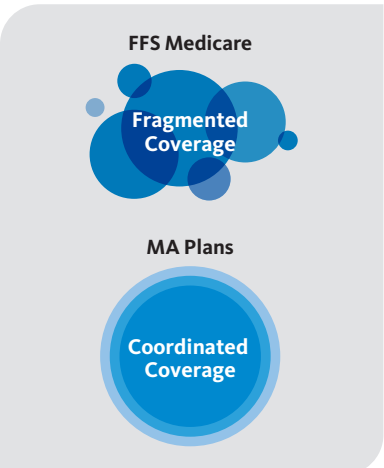
Understanding Medicare Advantage Payments

November 2017

Medicare Enrollment, 2017



Source: Medicare Payment Advisory Commission (MedPAC). Status Report on the Medicare Advantage Program, March 2017.



Almost one-third of the Medicare population, approximately 19 million beneficiaries, receive their benefits through a Medicare Advantage (MA) plan. MA plans are private plans that provide Medicare benefits as an alternative to traditional Medicare, also known as Medicare fee-for-service (FFS). MA plans offer a more coordinated approach to care compared to the fragmented coverage generally received through FFS.

MA plans receive monthly capitated payments to provide all Medicare benefits to enrollees. While MA plan payments are determined using a method very different from FFS, on average MA plans are reimbursed for each enrollee an amount essentially the same as the cost of an average FFS enrollee.[1] Though the current MA payment structure pays the plan the average amount a FFS enrollee would cost, there is evidence that quality and outcomes are better in MA.[2]

Medicare Advantage is a different model than FFS Medicare

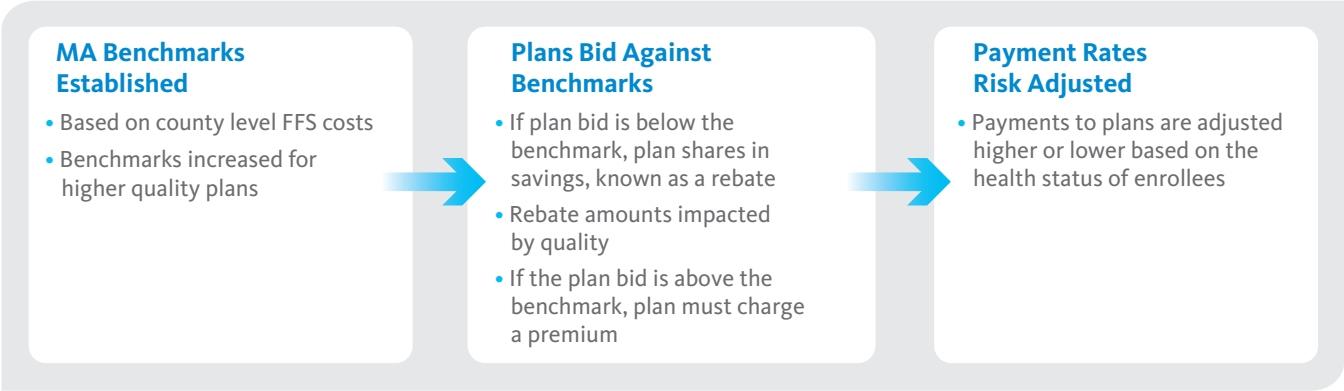
The FFS system pays providers based on the number of services they perform, regardless of the relative appropriateness of those services. This creates a system that rewards providers that perform more, and sometimes unnecessary, services and tests, and often penalizes those that provide high value, clinically appropriate care that results in fewer clinical encounters.

In contrast, MA plans bear the full risk of providing the Medicare benefits within the capitated payment; they will not receive more payment in a given month if their members use more, or more costly, services or if their costs exceed their payments. This payment structure creates incentives for MA plans to improve care management and coordination, emphasize disease management programs, and encourage members to use higher quality providers and services.

MA plan payment overview

Plans' capitated payments are set based on plans' bids as compared to administratively set benchmarks and plans' quality performance (as measured using the MA Star Ratings system, a 5-star quality rating system). MA benchmarks are set in each county as a percent of FFS costs. Counties are divided into quartiles based on the level of their FFS costs, with benchmarks in the lower spending quartiles set at more than 100% of FFS costs and benchmarks in the highest spending areas set at less than 100%. Also, higher performing plans —those with 4 or more stars—are eligible for higher county benchmarks.

This approach for determining the county benchmarks was set by the Affordable Care Act (ACA) with the intent of better aligning plan payments with FFS costs. The higher benchmarks in the lowest quartiles help promote plan participation in rural areas, and are offset by lower benchmarks in the higher spending areas. While the benchmarks vary by county, on average across all counties, plans' payments equal 100% of FFS costs.



MA plans submit bids representing their estimated costs for providing the Medicare Parts A and B benefits. The MA plan bids are compared to the benchmarks for those counties in which the plan chooses to offer coverage. If a plan bids below the benchmark, it retains a portion of the difference between its bid and the benchmark, which is known as a "rebate." Rebates can be used to provide extra benefits for enrollees such as reduced cost sharing or enhancing the Part D benefit if the plan offers prescription drug coverage. If a plan bids above the benchmark, it must charge a premium to the enrollee for the amount above the benchmark. Plans with higher quality scores or stars retain a larger portion of the difference between the bid and benchmark as a rebate.

Finally, plans' payments are adjusted to account for the health status, or "risk level" of each enrollee. Known as risk adjustment, this helps ensure that plans are paid appropriately for the known health status of the beneficiaries that enroll in their particular plan.

In calculating plans' risk scores, CMS makes some adjustments to the scores. One such adjustment, required by law, is known as the coding intensity adjustment, which accounts for "coding pattern differences" between FFS and MA. This adjustment reduces MA plans' risk-adjusted payments.

How MA plans use payments

Plans contract with physicians, hospitals, pharmacies, and a range of other providers to ensure that their members have access to all Medicare-covered health care services, as well as supplemental benefits. Plans also use payments for important activities such as case management and disease management programs, customer service, quality improvement programs, and efforts to deter fraud, waste, and abuse.

MA plans positively impact the traditional Medicare program

MA plans' efforts to improve care, including more robust care coordination, influence how providers deliver care to all of their patients – in both MA plans and traditional FFS Medicare. The positive "spillover effects" that MA has on the FFS program have contributed to improvements in health care service utilization for all Medicare beneficiaries and, importantly, a slowdown in overall Medicare spending.[3]

One recent study examined the impact of the rate of MA enrollment on the treatment for FFS beneficiaries with a diagnosis of Acute Myocardial Infarction (AMI). Areas with higher rates of MA enrollment were associated with a reduction in both the costs and the treatment intensity of FFS AMI patients.[4]

In one study, researchers found that as rates of MA enrollment increased in a county, avoidable hospitalizations—compared with expected hospitalizations—decreased for both MA and FFS beneficiaries.[5]

Recent studies show that MA plan practices can also lead to more effective use of hospital services including lower hospitalization costs and shorter lengths of stay for FFS beneficiaries.[6]

Another study found that when more beneficiaries enroll in MA plans, hospital costs decline for all Medicare beneficiaries as well as for commercially insured younger populations.[7]

Conclusion

With nearly a third of Medicare beneficiaries enrolled in MA plans, the MA program provides an important option for health care coverage for Medicare beneficiaries. Not only do MA plans offer a higher quality, more coordinated approach to care than FFS, but they also provide meaningful extra benefits as well as cost-sharing reductions and other out-of-pocket protections for beneficiaries. MA plans offer seniors a valuable alternative to the more fragmented care found in traditional FFS.

Endnotes

[1] Medicare Payment Advisory Commission (MedPAC). (March 2017). Report to Congress, Status Report on the Medicare Advantage Program. Retrieved from medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0 (accessed October 4, 2017).

[2] See for example Huckfeldt, P. J., Escarce, J. J., Rabideau, B., Karaca-Mandic, P., & Sood, N. (2017). Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage than Those in Fee-for-Service. Health Affairs, 36(1), 91-100; and Ayanian J.Z., Landon BE, Zaslovsky AM, Saunders R, Pawlson L.G., & Newhouse JP. (2013). Quality of Ambulatory Care in Medicare Advantage HMOs and Traditional Medicare. Health Affairs 32 (7): 1228-1235. (accessed October 6, 2017).

[3] Johnson, G., Figueroa, J.F., Zhou, X., Orav, E.J., & Jha, A.K. (2016). Recent Growth In Medicare Advantage Enrollment Associated With Decreased Fee-For-Service Spending In Certain US Counties. Health Affairs, 35(9), 1707-15.

[4] Callison, K. (2016). Medicare Managed Care Spillovers and Treatment Intensity. Health Econ., 25: 873–887. Retrieved from 10.1002/hec.3191 (accessed October 6, 2017).

[5] Robert Graham Center. (2016). Understanding the Impact of Medicare Advantage on Hospitalization Rates - A 12 State Study. Retrieved from www.bettermedicarealliance.org/policy-research/resource-library/understanding-impact-medicare-advantage-hospitalization-rates-12 (accessed October 6, 2017).

[6] Baicker, K., Chernew, M., & Robbins, J. (2013). The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization. Journal of Health Economics, Vol. 32, 1289-1300; and Mueller, A., & Larsen, B. (2016). Might Medicare Advantage Impact Traditional Medicare Costs? Retrieve from us.milliman.com/uploadedFiles/insight/2016/2191HDP_20160304.pdf.

[7] Baicker, K., Chernew, M., & Robbins, J. (2013). The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization. Journal of Health Economics, Vol. 32, 1289-1300.

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