Advising the Congress on Medicare issues

The Medicare Advantage program: Status report; recommendations on special needs plans

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MEDPAC

The Medicare Advantage program

- The Medicare Advantage program allows beneficiaries to receive their Medicare benefits through a private plan
- MA plans paid monthly capitated amount to provide Medicare benefits
- About 27 percent of beneficiaries enrolled in MA plans in 2012

Plan types

- Coordinated care plans (CCPs)
  - HMOs
  - PPOs
    - Local PPOs
    - Regional PPOs
- Private fee-for-service (PFFS) plans

- Other categories
  - Special needs plans (SNPs)
  - Employer or union group plans (employer-group)

Note: HMO (Health Maintenance Organization), PPO (Preferred Provider Organization)

Percentage of Medicare beneficiaries with an MA plan available, 2005-2013

Type of plan	2005	2010	2011	2012	2013
Any MA	84%	100%	100%	100%	100%
Local CCP	67	91	92	93	95
Regional PPO	N/A	86	86	76	71
PFFS	45	100	63	60	59
Avg. number of choices	5	21	12	12	12
Zero-premium plan with drugs	N/A	85%	90%	88%	86%

Note: CCP (coordinated care plans), PFFS (private fee-for-service), MA (Medicare Advantage), zero premium plan (no enrollee premium beyond Medicare Part B premium).

Source: CMS website, landscape file, and plan bid submissions.

Medicare Advantage enrollment 2011-2012

	2012 Enrollment / total Medicare	November enrollment		
		2011	2012	change
Total	**27%**	**12.1**	**13.3**	**10%**
HMO	17	8.0	8.8	10
Local PPO	6	2.3	3.0	30
Regional PPO	2	1.2	1.0	-16
PFFS	1	0.6	0.5	-12
Urban/rural areas				
Urban	29	10.6	11.6	9
Rural	16	1.5	1.8	13

Note: PFFS (Private fee-for-service) , HMO (Health Maintenance Organization), PPO (Preferred Provider Organization).
Source: MedPAC analysis of CMS enrollment data.

MA plan payment policy

- Payments based on bids, bidding targets (benchmarks), and quality scores
- Benchmarks under PPACA range from 115% of FFS in lowest-FFS counties to 95% of FFS in highest-spending counties, phased-in by 2017
- If bid > benchmark, program pays benchmark, enrollee pays premium
- If bid < benchmark, plans get a percentage of the difference as a "rebate" for extra benefits, Medicare keeps the rest of the difference
- Rebate percentages for 2013 range from 58% for plans with the lowest quality indicators to 72% for plans with the highest quality indicators

Benchmarks, bids, and payments relative to FFS for 2013

	Benchmarks/ FFS	Bids/ FFS	Payments/ FFS
All MA plans	110%	96%	104%
HMO	110	92	103
Local PPO	111	107	108
Regional PPO	106	97	102
PFFS	110	105	107
Restricted availability plans included in totals above			
SNP	111	96	105
Employer groups	111	106	108

Note: MA (Medicare Advantage), PFFS (private fee-for-service), SNP(Special Needs Plan).
Source: MedPAC analysis of CMS bid and rate data.

Bonus program affected plan behavior

- Bonuses based on star rating measuring overall plan performance; maximum 5 stars
  - Ratings based on process measures, outcomes, patient experience measures, and contract performance
- Plans improved their star ratings between 2012 and 2013
- Based on November, 2012 enrollment, comparing 2012 stars to 2013 stars, shifts in enrollment share in 4+ star group:
  - For HMOs, increased from 35% to 41%
  - For local PPOs, increased from 13% to 35%

Which measures have improved?

- Improved rates for measures that plans report
  - Process measures such as assessment of body mass index, colorectal cancer screening
  - Intermediate outcome measures such as control of blood pressure
- No changes in survey-based measures
  - Patient experience measures—enrollee ratings of plan and its providers
  - Two-year outcome results for improved physical or mental health of enrollees

Direction of enrollment, payment, and quality trends

- Continued and projected steady growth in local CCP enrollment
- Bids lower relative to FFS
- Payments closer to FFS (but still over FFS)
- Quality potentially improving

Other issues

- Age differences, disparities in quality measures in MA

Outline of SNP analysis

- Description of SNP program and current enrollment and availability
- Review findings presented in October and November Commission meetings
- Review draft recommendations

SNP authority expiring

- Medicare Advantage special needs plans (SNPs) limit their enrollment to certain classes of beneficiaries
- Authority for exclusive enrollment expires at end of 2014
- Plans can continue as regular MA plans

SNP types, enrollment and prevalence

SNP type	Beneficiary category	Enrollment, Dec. 2012	Plan Availability, 2013
D-SNPs	Medicare-Medicaid dual eligibles	1.3 million	Available to 82 percent of Medicare beneficiaries
C-SNPs	Beneficiaries with specific chronic or disabling conditions	233,000	Available to slightly over half of beneficiaries
I-SNPs	Institutionalized beneficiaries, or in community at institutional level of care	50,000	Available to slightly under half of beneficiaries

Differences between SNPs and regular MA plans

- SNPs can design benefit packages tailored to a specific population
- SNPs must meet additional structure and process requirements and additional reporting requirements
- Rules on enrollment differ

Framework for evaluating policy options

- How does the recommendation impact Medicare program spending?
- Will it improve the quality of care Medicare beneficiaries receive?
- Will the recommendation advance payment reform? Does it move away from fee-for-service and encourage a more integrated delivery system?

Effect of SNP reauthorization on Medicare spending

- Small number of beneficiaries in SNPs will likely go to FFS once SNPs expire
- Reauthorization will increase Medicare spending because spending on SNPs is generally higher than FFS
- 2013 payments to SNPs estimated to be 5 percent higher than FFS

Summary of findings on I-SNPs

- Quality:
  - Perform better than other SNPs and regular MA plans on hospital readmission rates and certain other quality measures
- Integration:
  - I-SNPs' reduction of hospital readmissions suggests that they do provide a more integrated and coordinated delivery system

Summary of findings on C-SNPs

- Quality:
  - C-SNPs tend to perform no better than, and often worse than, other SNPs and regular MA plans
  - Regional PPO C-SNPs have higher than expected rates of hospital readmissions and low star ratings

Summary of findings on C-SNPs (continued)

- Integration:
  - Importing the C-SNP model of care into MA would enable MA plans to provide more integrated delivery systems
  - Regular MA plans could be given the flexibility to offer separate benefit packages for chronically ill beneficiaries
  - May be a rationale for maintaining C-SNPs for certain conditions – ESRD, HIV/AIDS, chronic and disabling mental health conditions
    - C-SNPs could allow for continued innovation in care delivery for these conditions
    - Ability of regular MA plans to adequately care for these conditions should be revisited in the future

Summary of findings on D-SNPs

- Quality:
  - D-SNPs tend to have average to below average performance compared to other SNPs and regular MA plans
  - However, some D-SNPs that furnish some or all Medicaid benefits have high star ratings (4 or 4.5)

- Integration:
  - D-SNPs intended to integrate Medicare and Medicaid benefits to eliminate conflicting incentives in FFS
  - Widespread integration of some or all Medicaid LTSS and/or behavioral health has not occurred through state contracts

Summary of findings on D-SNPs (continued)

- Integration:
  - Two scenarios where incentive for clinical and financial integration exists:
    - A single D-SNP furnishes some or all Medicaid LTSS and/or behavioral health through its state contract.
      - Approximately 25 of these plans currently; account for about 5% of all D-SNP enrollment
    - A managed care organization has a D-SNP, a Medicaid managed care plan that furnishes some or all Medicaid LTSS and/or behavioral health, and same dual eligibles enrolled in both plans.
      - Approximately 35 of these plans; account for about 19% of all D-SNP enrollment

Administrative barriers to D-SNPs' integration with Medicaid

- Medicare and Medicaid have separate processes for appeals and grievances
- D-SNPs cannot jointly describe the Medicare and Medicaid benefits they cover on marketing materials
- Dual eligibles may have multiple enrollment cards if they are enrolled in one D-SNP or one managed care organization for both Medicare and Medicaid
- There is not a model D-SNP contract for states to use as a resource