Industry and Consumer Perspectives on Medicare Advantage as an Effective Driver of Value Transformation

The Health Care Transformation Task Force's (HCTTF or the Task Force) main objective is to drive widespread delivery system transformation away from fee-for-service dominated reimbursement systems and toward a system that provides person-centered, value-based care through innovative care delivery and payment reforms. Effective value-based health systems take multiple forms in serving various patient populations, as there is no one-size-fits-all solution to moving away from the misaligned and perverse incentivizes of outdated fee-for-service medicine.

Introduction

For value-based transformation occurring in Medicare, the Task Force has long focused on innovative models such as the Medicare Shared Savings Program and various accountable care, primary care and clinical episode models which have been tested by the CMS Innovation Center (CMMI). HCTTF also recognizes the importance and potential of the Medicare Advantage (MA) program as a value transformation driver, both due to its flexible benefit and care delivery platform, as well as its significant market penetration, and exponential enrollment growth. While considerable strides are being made in both traditional Medicare and Medicare Advantage to realize a truly value-based system, both programs have challenges and limitations that need to be overcome to best position Medicare for continued success in caring for its beneficiaries.

This issue brief sets forth the proposition that Medicare Advantage – from both the industry and Medicare enrollee perspectives – is an effective driver of value-based care and can incentivize participation in alternate payment models (APMs). This brief also includes viewpoints – gleaned through conversations with Medicare beneficiary advocates – on how MA enrollees are experiencing the program, which informs the consumer perspective on opportunities for future improvement.

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Background

Medicare beneficiaries have the option of receiving covered benefits through traditional Medicare or Medicare Advantage. Under traditional Medicare, the program pays a fee-for-service reimbursement directly to providers for medically necessary care provided to beneficiaries. Under MA, the government pays private insurance plans a per member per month amount to account for all covered benefits being provided to plan enrollees. While coverage under Medicare FFS is generally limited to services available under Parts A and B, MA coverage (also known as Part C) covers Parts A and B services and may extend to prescription drug coverage under Part D, along with a wide range of supplemental benefits not available under traditional Medicare.

In recent years, there has been an undeniable enrollment shift occurring between traditional Medicare and MA. MA plans are experiencing surging enrollment, with 45 percent of Medicare beneficiaries enrolled in MA in 2022 and the Congressional Budget Office projecting increases in enrollment up to 51 percent of Medicare beneficiaries by 2030.[1]

The MA program is premised on a system of competition among plans aimed at creating transparency and consumer choice for beneficiaries. On an annual basis, MA plans submit proposed rates to the Centers for Medicare and Medicaid Services (CMS) to provide a wide range of covered benefits in certain geographic areas, with MA plans regularly offering multiple plan options in a service area with varying levels of covered benefits. Once approved by CMS, the MA plan can be marketed to Medicare beneficiaries during annual enrollment windows.

While this approach allows for more competition and product choice for Medicare beneficiaries, the number of plan offerings can also be overwhelming; as of 2021, the average Medicare beneficiary[2] has nearly 33 MA plans to choose from. The measurement and reporting of MA plans' quality performance through the Star Ratings system is also seen a driver of competition between plans and a transparency tool available to beneficiaries to choose a plan. However, some Medicare beneficiary advocates expressed perspectives that the tools available to help them wade through the growing number of available MA plans are often not helpful to selecting a plan.

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The flexibility inherent in MA plan benefit design also allows for greater affordability for beneficiaries. Many MA plans are designed to reduce or eliminate cost sharing obligations for beneficiaries, while many traditional Medicare beneficiaries often need to purchase Medi-gap supplemental insurance to cover the structural cost-sharing obligations embedded in traditional Medicare policies.

MA beneficiaries see the MA cost-sharing mitigation as one of the most attractive aspects of the program and a key driver of rising enrollment. Also, the MA supplemental benefits offerings and the resulting improvement in clinical outcomes are compelling focal points of person-centered care.[3, 4] While the initial understanding of lower costs is a major factor in MA enrollment, some researchers and advocates note that there are beneficiaries who report having to address higher-than-expected cost sharing in certain circumstances, due to either a change in their condition, or a misunderstanding of what benefits are included.

While enrollees often view MA plans as a more affordable option than traditional Medicare, the comparison is more complex from a taxpayer perspective.

As noted in the March 2022 MedPAC report[5], growth in MA enrollment, coupled with the increased per beneficiary payment by CMS to MA organizations as compared to Medicare FFS beneficiaries, is creating concerns about MA's impact on the Medicare Trust Fund overall. Moreover, MedPAC and others have raised concerns over how MA's risk adjustment calculation creates incentives for providers to completely and accurately code beneficiary diagnoses (sometimes to the point of over-coding concerns) since it results in increases to their base payment rates. At the same time, MedPAC also found that based on 2022 bids, MA plans delivered the core Medicare benefits (i.e., all benefits available via Medicare Part A and Part B) at 15 percent lower cost than traditional Medicare. The overall cost of MA increases when supplemental benefits and Part D benefits are included.

Given that value-based care's purpose is to provide high quality care at lower cost to drive better health outcomes, the MA financing and risk adjustment concerns are material. Both concerns are noted here as important aspects of the ongoing policy debate to improve MA. However, they do not impact the attractiveness and potential of the MA platform as an effective value transformation driver due to how its inherent flexibilities support innovation.

The remainder of this issue brief largely focuses on the features of the MA platform that the Task Force views as most beneficial for enrollees and that can be replicated for other populations to accelerate system-wide value-based transformation. The brief also focuses on how other facets of MA plan offerings and design elements impact the beneficiary experience, and what lessons can be learned to inform future person-centered care strategies in MA and beyond.

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MA Value Proposition to Beneficiaries

Beneficiaries have increasingly chosen MA plans over traditional Medicare and indicate high satisfaction rates with MA.[6] These high satisfaction ratings are driven by MA plans including additional benefits above those offered by traditional Medicare, including Part D prescription drug coverage and supplemental benefits such as wellness, dental, vision and hearing care among others that are not covered by Medicare FFS.

These supplemental benefits have the potential to not only improve health outcomes through direct coverage but also may address social determinants of health (such as food insecurity and access to care) and social risk factors. Underlying this is the value inherent in the care coordination efforts that providers are financially supported to offer due to the flexible MA contracting and payment structure.

MA beneficiary advocates shared perspectives that some of this value may be attributed to MA's narrow provider networks and subsequent limited choice of providers. Advocates noted that providers may leave a network during an enrollment year, which may leave beneficiaries having to find new providers unexpectedly. They also spoke about how cost-sharing terms included in plan marketing materials may not always reflect the true out-of-pocket costs a beneficiary may experience especially if the individual is diagnosed with a new condition or treatment need.

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Data show that on average, beneficiaries enrolled in MA may spend less in out-of-pocket costs than those in traditional Medicare.[7] However, advocates note that there are cases in which beneficiaries choose MA due to “sticker shock” over the Medigap premium, not realizing that in certain cases, over the course of a year they may pay more overall for MA than they would have if they enrolled in traditional Medicare with a Medigap plan.

MA Value Proposition for APM Development

Alternate Payment Models (APMs) are defined by their ability to provide person-centered care and improve outcomes while tying financial incentives to achieving desirable quality metrics; this aligns to some of the design features in place for MA plans. Increasingly, MA plans are using APMs with providers to drive healthcare transformation from a volume to value focus. MA has several distinct features that make it well suited to implementing APMs in plan-provider contracting arrangements.

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Capitation Spurs Innovation

The flexibility around Medicare's capitated payments to MA plans is one lever that spurs the adoption of innovations that can potentially improve outcomes and reduce costs. Importantly, this capitation is paired with the Star Ratings program's quality and patient satisfaction measures as guardrails to limit stinting on health care services. Proof of concept for the importance of these MA design features was illustrated in a study investigating the effects of capitation on clinical practice transformation, which saw a decrease in hospital-based services, an increase in office-based care, and a six percent improvement in survival rates.[8]

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Yet, it is not the CMS capitated payments to MA plans alone that create a value-based care system. The ability to innovate and design payment arrangements for MA provider networks that target success on value-based care goals is key to a MA plan's success in delivering person-centered, value-based care.

Innovative Provider Payment Arrangements are Key

MA plans' ability to innovate and realign network contracting incentives is truly what sets them apart from the shackles of traditional Medicare's fee-for-service system. Historically, MA plans have paid providers fee-for-service rates; that remains the prevalent payment methodology. However, APMs in MA network contracts are growing, resulting in more providers bearing risk – based on their per member per month amount – that allows them the flexibility to design and deliver care in a way that makes the most sense for their patient populations and communities. For example, in recent years, many new companies have emerged which accept sub-capitation payments for a full range of primary care services for MA enrollees. The ability to have flexible payment arrangements with providers is foundational and integral to APM design.

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Each year, the Health Care Payment Learning and Action Network (LAN) oversees a survey of commercial insurers to track their progress in alternate payment arrangements with providers based on the LAN's widely accepted APM Framework.

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Based on CY 2020 data, MA plans reported having 58 percent of their provider payment arrangements in categories 3 and 4 of the LAN APM Framework, which includes one- and two-sided shared savings arrangements as well as a variety of population-based arrangements. Thus, the movement toward APMs as an MA provider network contracting strategy is growing. However, the percentage of total spend in APMs may not be the sole metric upon which to base an assessment of plan success in promoting value-based care, given that this is essentially a process measure. The true outcome measure by which value-based care should be assessed is whether better care is being delivered at lower cost to satisfy patients.

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MA offers a laboratory for private payers to gain experience with APMs through innovative provider relationships, which are often challenging to navigate. By offering MA plans, payers establish an infrastructure to support implementing alternate payment which aligns incentives to meet quality of care and cost reduction targets.[9] Their MA offerings also create knowledge and experience that plans can use to inform alternate payment arrangements with providers related to non-Medicare populations (e.g., Medicaid managed care and commercial populations).

Tying Plan Performance to Payment Promotes Value

A key MA design element that provides a template for how plans and network providers can work together to deliver higher quality and better outcomes for patients is the Star Ratings program. The Star Ratings program links payment to performance in a similar manner to other APMs, using measures of quality and enrollee experience. Each MA plan is rated between one and five stars based on its most recent performance period.

Those plans with four or five stars are designated as high-quality MA plans, which qualifies them to receive a five percent bonus per month on top of the benchmark Medicare payment.[10]

As of 2021, the Star Ratings encompasses 46 measures categorized into nine domains, including: (1) chronic disease management, (2) health maintenance, (3) beneficiary satisfaction, (4) beneficiary complaints, (5) customer service, and (6) four separate domains scoring Part D plans.[11] As an example of how MA Star Ratings are utilized, health plans are required to share the percentage of MA female beneficiaries (appropriately risk stratified) who received a mammogram as a quality measure of breast cancer screening.[12] CMS recently announced the MA program will employ quadruple weighting for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey which captures

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beneficiary and caregiver experience with care. This means that the beneficiary experience will total nearly 32 percent of the overall Star Rating score for 2021.[13] This additional CAHPS weighting, while not without its limitations, provides an important guardrail for healthcare consumers in choosing providers and health plans.

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There is evidence that the Star Rating program has translated to improved clinical outcomes as well. For high need, high-cost beneficiaries enrolled in MA plans, there are better outcomes in 17 out of 22 quality care measures, such as rates of pneumonia vaccination, eye exams for diabetics, and rates of depression screening compared to a matched traditional Medicare cohort.[14] However, there are arguments, made by MedPAC and others, that it is difficult-to-impossible to make an "apples to apples" comparison to traditional Medicare, given that there is not a parallel measure set used to quantify quality in fee-for-service Medicare.

In areas where there are ostensibly parallel measures, such as hospital readmissions, the data indicates that MA outperforms traditional Medicare. However, a similar conclusion cannot be made across the board,[14] given the incongruity between many measures in MA and traditional Medicare.

The Star Rating system has encouraged MA plans to innovate to improve quality for their patients while also serving as a public reporting/transparency tool for beneficiaries to utilize when choosing an MA plan.

However, MedPAC has opined in recent years that the Star Ratings do not provide a meaningful reflection of MA plan quality; the March 2022 MedPAC report encourages replacing it with a value incentive program that allows for comparisons between MA plans and ACOs, evaluates quality at the local market level, accounts for differences in enrollees' social risk factors, and provides incentives to improve at every level by establishing a continuous scale of performance.[15] Consumer advocates echo this sentiment, noting that while the Star Ratings program is designed to both hold MA plans accountable for quality, and offer consumers a decision-making tool, some beneficiaries do not see enough differentiation between plans to use it in this way. For example, in 2021, 49 percent of all MA plans (that included Part D coverage) were rated at least four stars.[16] There are ways to improve the consumer-focus of the Star Ratings program, such as updating the CAHPS survey language to reflect enrollee diversity, and publicly reporting the CAHPS results in more granular detail.[17]

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Many believe there is room for improvement in making the ratings a more valuable tool to accelerate the transformation to desirable value-based care outcomes. CMS's recent solicitation for input on a value-based care measure for MA plans reflects one area of ongoing policy development.

Care Coordination Within and Outside of the Clinical Setting Benefits Enrollees

The MA platform allows for focused efforts to ensure that an enrollee's care is being coordinated within a clinical setting and beyond. MA plans can facilitate multiple touch points between plans, providers, and enrollees throughout the care continuum by creating appropriate incentives to do so.

An example of the importance of care coordination is evident in a pilot program launched by Blue Cross Blue Shield Association and AHIP called the Vaccine Community Connectors.[18] This program was able to swiftly vaccinate seniors using a combination of appointment scheduling, vaccination education, transportation services and public-private partnership that helped deliver vaccines to underserved communities. Notably, this pilot program incorporates financial levers including waiving co-pays for primary care, telehealth and COVID 19 medical treatment that aided in the uptake of vaccination.

A broader example is reflected in the health plan innovations being tested by CMMI via the MA Value-Based Insurance Design (VBID) model. MA VBID allows MA plans to reduce cost sharing for high-value services; encourages beneficiary participation in disease management (or related programs) for those with diabetes, COPD, CHF, CAD, past stroke, hypertension, and mood disorders; and offers coverage of additional supplemental benefits. In 2020, the model (which began in 2017), allowed MA plans to test one or more of the following interventions: VBID insurance design by condition, socio-economic status, or both; MA and Part D rewards and incentives; telehealth networks; and wellness and healthcare planning, including advance care planning. In CY 2021 the VBID model began testing a hospital benefit in MA.

The Reach and Impact of Supplemental Benefits

A major – and possibly most significant – differentiating factor between MA and traditional Medicare is the ability of MA plans to offer supplemental benefits to enrollees.
In 2020, Congress allowed for certain supplemental benefits to be provided in a more targeted way to a category of MA enrollees that qualify as chronically ill, allowing for MA plans to focus more targeted interventions without running afoul of Medicare's longstanding antidiscrimination policy (i.e. , every beneficiary must have access to the same benefits).

The evolution of the supplemental benefits policies allows MA plans to better address the needs of both individuals and communities in meaningful ways, including tailoring extra benefits to those most in need.

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Broader benefit design opportunities and flexibility in targeting interventions to specific populations means more effective attention can be paid to addressing social determinants of health, social risk factors, and social needs. As noted in a 2021 Task Force infographic, MA plans are increasingly offering a wide range of supplemental benefits and are developing important relationships with community-based organizations in doing so. These trends are expected to continue and be joined by the likely addition of a health equity plan requirements in future years to address care disparities and inequities.

Supplemental benefits (together with care coordination discussed above) reflect a key concept inherent in the move to value-based care: a recognition that so much of an individual's health care status and outcomes depends on factors that are not clinical, but for which the clinical system is well-positioned to help individuals receive the supports they need to best achieve their health care goals.

This concept is one that payers and providers can and should translate into flexible benefit design options across all market segments.

Medicare enrollee advocates note that while the concept of supplemental benefits is very positive, the way these benefits are marketed during the MA open enrollment period can lead to misunderstandings resulting in enrollees being disappointed by the lack of access to certain benefits (e.g. , therapeutic dental care beyond diagnostic screenings) that enrollees assumed they would be receiving. By statute, MA plans are required to follow specified marketing requirements, and CMS continues to issue additional guidance to plans to address and help reduce the risk of beneficiary confusion and identify instances of misleading marketing.

Infrastructure that Supports Value-Based Payment

Successful APM implementation requires a robust data infrastructure that allows for bi-lateral, timely sharing of data between payer and provider. This infrastructure facilitates MA organizations working together with provider organizations to be innovative in their use of data and analytics to understand the health status of their Medicare beneficiaries. This infrastructure could be readily applied to improving APM performance by identifying those who are at a high risk of a cardiac event, asthma exacerbation, or progression of diabetes and intervene early.

For example, payers are partnering with analytics companies to improve compliance with collection and submission of Healthcare Effectiveness Data and Information Set (HEDIS) measures for their MA populations.

The same analytic capabilities [MA plans and providers] are using to better identify targets for resource optimization and enhance members outcomes and satisfaction can be translated into other value-based payment models.

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For MA, these efforts are helping plans identify gaps in cancer screening and diabetic care management which allow them to connect beneficiaries with providers earlier in their disease course.[19] This type of agile data gathering, sharing, and analysis is critical in improving outcomes of patients under an APM. Importantly, this includes data infrastructure that connects clinical systems to community-based organizations to assess availability of safe housing, food security and other social determinants of health metrics. Again, investments in data infrastructure such as this is instrumental to the success of new APMs as they are designed, tested and implemented.

Conclusion

Medicare Advantage is an ideal platform for advancing person-centered, value-based care and is making significant strides in doing so. The flexibilities associated with the MA program allow for faster and more targeted innovations which benefit patients based on service delivery and affordability.

Like traditional Medicare, many opportunities remain to improve the MA program for Medicare enrollees and the MA plans' network providers – such as the MA VBID model described above – and generally leverage MA as a chassis to refine how value-based care is operationalized through APM development.[20] As MA plans continue to increase enrollment and innovation, their potential to serve as an APM incubator and leader to move providers along the value-based payment continuum will continue to grow and help facilitate a path forward for value-based care across all covered populations. Yet, understanding both how MA's unique design features are working successfully and how the plan offerings and contracting arrangements can be improved to provide holistic value-based care opportunity is important to fully realizing MA's value proposition as an important driver of value-based care.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.

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