

## Medicare Advantage program: Status report

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### Today's presentation

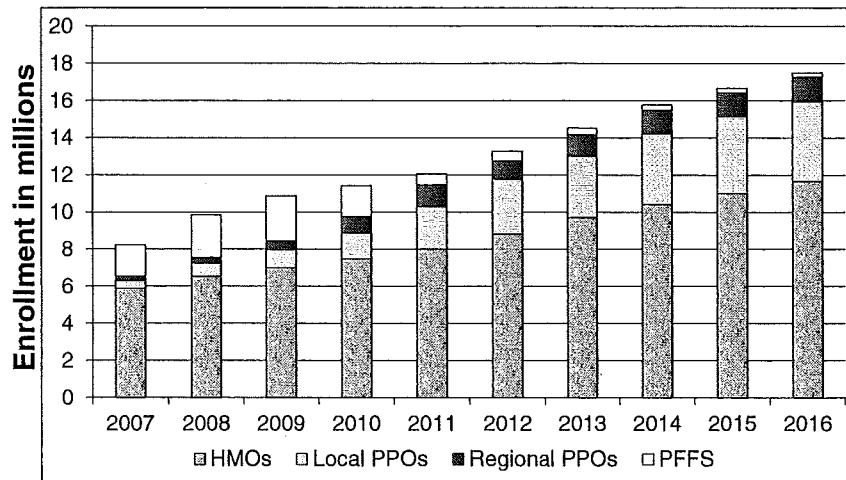
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- Status report on Medicare Advantage (MA) enrollment, availability, benchmarks, bids, and payment
  - Policy issue – calculating county FFS spending
- Update on plan quality performance

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## MA enrollment by plan type, 2007-2016



Source: CMS enrollment data

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## Percentage of Medicare beneficiaries with an MA plan available, 2011-2017

Type of plan	2011	2012	2013	2014	2015	2016	2017
Any MA	100%	100%	100%	100%	99%	99%	99%
HMO/ Local PPO	92	93	95	95	95	96	95
Regional PPO	86	76	71	71	70	73	74
PFFS	63	60	59	53	47	47	45
Avg. number of choices							
County weighted	12	12	12	10	9	9	10
Beneficiary weighted	26	19	19	18	17	18	18
Average rebate for non-employer, non-SNP plans	\$83	\$85	\$81	\$75	\$76	\$81	\$89

Note: PFFS (private fee-for-service), MA (Medicare Advantage)  
Source: CMS website, landscape file, and plan bid submissions.

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## Benchmarks, bids, and payments relative to FFS for 2017

	Benchmarks/ <u>FFS</u>	Bids/ <u>FFS</u>	Payments/ <u>FFS*</u>
All MA plans	106%	90%	100%
HMO	106	88	99
Local PPO	111	101	107
Regional PPO	101	94	98
PFFS	110	108	109
Restricted availability plans included in totals above			
SNP	105	92	100

Note: MA (Medicare Advantage), PFFS (private fee-for-service), SNP (Special Needs Plan). All numbers reflect quality bonuses, but not coding differences between MA and FFS Medicare.

\* Payments would exceed FFS if coding intensity were to be reflected fully.

Source: MedPAC analysis of CMS bid and rate data.

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## Summary of MA program status

- MA enrollment continues to grow faster than overall Medicare (MA share 31%)
- Improvement in some measures of plan availability, including rebates
- Average plan bid has declined to 90% of FFS
- Progress toward financial neutrality with Medicare FFS
- But there are unresolved coding intensity differences (about 4%) and inter-county equity issues

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## Measuring county-level FFS spending for use in MA benchmarks

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- CMS calculates average per capita FFS Part A and Part B spending for each county to set the benchmarks
- Mismatch in FFS spending data used
  - MA benchmarks are based on spending of all FFS beneficiaries (100% of FFS beneficiaries)
  - MA enrollment allowed only for beneficiaries with both Part A and Part B (87% of FFS beneficiaries)

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## Issues with including all FFS beneficiaries in benchmark calculations

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- Understates benchmarks because 12% of all FFS beneficiaries are Part A-only (No B)
- Part A only beneficiaries spend less than half on Part A than those with both Part A and Part B spend on Part A
- The share of Part A-only varies by county
- The average share of Part A-only is increasing

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## Use only beneficiaries with A and B in FFS calculation for benchmarks?

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- Some counties would be affected more than others
- As MA penetration increases, the proportion of Part A-only will grow and FFS calculations will become less reflective of MA enrollment

## Commissioner questions

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- Response rates for the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) surveys
  - In 2014: 41 percent in FFS, median of 45 percent among MA plans
- Enrollment in contracts CMS identified as low performers at risk of termination: 67,000 (October 2016)

Source: CMS data

## MA quality and star ratings

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- Quality indicators generally remained stable over the last year, with fewer than one-third of measures improving and a small number declining
- On a net basis, 1 million fewer enrollees will be in bonus plans when comparing 2016 and 2017 star ratings, using the October 2016 enrollment distribution
- For 2017, about 700,000 enrollees are being moved to bonus-level contracts through contract consolidations

## Concerns about the star ratings

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- With contract consolidations, more contracts cover wide, non-contiguous geographic areas
  - Because measures are determined at the contract level, not the market level, reported performance for the contract as a whole may not be representative of local performance
- Stars have cut-points based on relative performance among plans in each year, but pre-set thresholds may be a better way of promoting improved quality