

Medicare Advantage Is a High-Value Option for Consumers

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Introduction

Medicare Advantage, also called Part C, is an option within Medicare that allows Medicare-eligible seniors and individuals with disabilities to choose a private integrated managed care plan to receive their Medicare benefits, instead of receiving care through Traditional Fee-For-Service (FFS) Medicare. Medicare Advantage health plans are required to provide beneficiaries with all Part A (hospital insurance) and Part B (medical insurance) Medicare benefits.

Medicare Advantage provides the same benefits as FFS Medicare, with additional consumer protections, quality assessment, and supplemental benefits. Medicare Advantage possesses unique elements that make the program a valued option for nearly 20 million Medicare beneficiaries today. Medicare Advantage provides:

- Important consumer protections focused on access and coverage;
- Quality information for consumers to make informed decisions;
- High-value provider networks; and
- Innovative and flexible benefits aimed at improving care and health outcomes for chronically ill beneficiaries.

The government projects Medicare enrollment to grow from 58 million to 77 million beneficiaries over the coming decade, a 33% increase.¹ The Medicare Advantage program is also projected to grow as a percentage of Medicare enrollment. By 2028, 42% of all Medicare beneficiaries are projected to be enrolled in Medicare Advantage, up from 34% today.² As the Medicare-eligible population continues to grow, the Medicare Advantage program becomes an increasingly important coverage option for seniors.

Medicare Advantage health plans are available across the country and include consumer protections from high out-of-pocket costs for core Medicare benefits and access to an integrated managed care system. Medicare Advantage uses flexibility and innovation to more effectively manage care by offering enhanced benefits not covered by FFS Medicare, and coordinated care designed to meet the needs of seniors with chronic conditions.

Quality is incentivized through the Star Ratings System. The Stars Rating System measures achievement on 34 Part C measures and publishes public ratings on scale of 1 to 5. Currently, 75% of beneficiaries are in 4 or 5-star high quality health plans. Medicare Advantage also enhances the Centers for Medicare & Medicaid Services' (CMS) efforts to advance value-based payment and delivery reform by supporting innovative relationships between plans and providers.

Together, these characteristics offer opportunities for beneficiaries to choose coverage that meets their unique health care needs and personal financial circumstances. Key differences between FFS Medicare and Medicare Advantage are outlined in Table 1.

TABLE 1

Medicare Advantage Offers Unique Components Not Provided in FFS Medicare

FFS Medicare		Medicare Advantage
No out-of-pocket cost protections	Cost	Once a beneficiary reaches yearly limits on out-of-pocket costs, they pay nothing
Covers services under Part A (hospitals) and Part B (medical coverage), and does not cover vision, dental or hearing benefits	Coverage	Must cover all Part A (hospitals) and Part B (medical coverage) services, and usually offers supplemental benefits like vision, dental, and hearing benefits
Most beneficiaries pay a monthly, income- based premium for Medicare Part B	Part B	Most beneficiaries are still required to pay a monthly Part B premium, Medicare Advantage may help cover the premium
Beneficiaries may consider buying a Medigap policy from a private insurance company to help pay additional costs	Supplemental Coverage	Medigap is not needed – Medicare Advantage is provided through private health insurance companies
Beneficiaries need to buy Part D (drug coverage)	Prescription Drugs	Most Medicare Advantage health plans include drug coverage
FFS Medicare does not have a Star Rating System to measure quality	Quality	Medicare Advantage health plans are rated every year in a Star Rating System on a scale of 1 to 5
Beneficiaries go to any doctor that accepts Medicare and receive more fragmented care	Network	Health plans build high-value networks to provide care management for beneficiaries

Consumer Choices for Medicare Coverage

Medicare Beneficiaries Have Coverage Options and Choices to Make

Individuals eligible for Medicare have a choice of how they will receive their Medicare benefits. Most beneficiaries have an opportunity to choose between FFS Medicare or Medicare Advantage. Some beneficiaries choose FFS Medicare, which is administered by the government and includes limited coverage for hospital and other inpatient care (Part A), such as a stay in a skilled nursing facility; and provider services (Part B), such as a primary care visit. Many beneficiaries who choose FFS Medicare buy a Medicare Supplemental plan, otherwise known as a Medigap plan, to help pay some or all out-of-pocket costs for services. Beneficiaries who choose FFS Medicare must enroll in a stand-alone prescription drug plan (PDP) for access to the Part D drug benefit.

Other beneficiaries choose Medicare Advantage offered through private insurance companies. Medicare Advantage guarantees all FFS Medicare Part A and B benefits, protects beneficiaries from high out-of-pocket costs, may offer supplemental benefits, and usually includes the Part D drug benefit as part of the plan. Beneficiaries value the simplicity of receiving Medicare Part A, B, and often Part D benefits in one package under Medicare Advantage. Medicare Advantage may also include additional supplemental benefits that are not covered under FFS Medicare, such as coverage for vision, hearing, dental services, and programs like Silver Sneakers, a fitness program for seniors intended to contribute to a person's overall health. Those individuals who do not make an active choice of FFS Medicare or Medicare Advantage are enrolled in FFS Medicare by default.

Capitated Payment Structure Creates Incentives for Care Management

In Medicare Advantage, the government pays health plans a capitated (monthly) fixed, prospective amount to cover care for enrollees, including all Part A and Part B services (hospice is excluded). Therefore, the payment amount remains the same regardless of the volume of services enrollees receive. Medicare Advantage relies on risk adjustment for each individual to account for anticipated health care costs for enrollees based on health status. This capitated structure creates incentives for plans to better manage enrollees' health care, including access to disease management programs, care management services, and a focus on primary care to prevent avoidable and costly visits to the emergency room or hospitalizations. FFS Medicare pays providers per service delivered, and providers do not take on financial risk for care provided. Medicare Advantage health plans and providers are at-risk for the costs of caring for each beneficiary. Capitated payments incentivize high-value care that is focused on preventing long-term health consequences and costs. FFS Medicare payments incentivize a higher volume of services.

Beneficiaries May Enter and Exit Both the Medicare Advantage and FFS Medicare Programs

Some beneficiaries receive Medicare Part A and B automatically, but most have to sign-up individually for Medicare Part A and/or B. Once enrolled, there is annual Open Enrollment. Open Enrollment for Medicare takes place from October 15 to December 7. To enroll in Medicare Advantage, beneficiaries must be enrolled in Medicare Parts A and B, and live in a health plan's service area. Most Medicare-eligible beneficiaries have a choice every year about whether to join, switch, or leave Medicare Advantage. There are other specific times when beneficiaries can sign-up or choose a Medicare Advantage health plan, including special enrollment periods.³ Beneficiaries are eligible for different enrollment periods depending on circumstances such as changes in eligibility, health insurance coverage, and health status. Notably, Medicare Advantage health plans rated with 5 stars can enroll individuals year-round. The Better Medicare Alliance's [Open Enrollment Handbook](#) and CMS' [Medicare & You Handbook](#) offer greater detail on enrollment in Medicare.

Under current law, the Medicare Advantage Disenrollment Period is a 45-day period (January 1 through February 14), during which an individual can disenroll from Medicare Advantage, return to FFS Medicare and enroll in a standalone PDP. Beginning in 2019, the 21st Century Cures Act expands this period to a continuous open enrollment and disenrollment period for the first 3 months of the calendar year where beneficiaries can make a one-time change to another Medicare Advantage health plan or elect FFS Medicare or Part D coverage.⁴

Consumer Protections and Out-of-Pocket Costs in Medicare

Medicare Advantage Guarantees Access Medicare Benefits, Rights, and Protections

As indicated in CMS' "[Medicare Rights & Protections](#)" booklet, Medicare Advantage beneficiaries have the same basic rights and protections as FFS Medicare beneficiaries, including:

- Comprehensive Medicare coverage information;
- Access to Medicare-covered services in an emergency (including those out-of-network);
- Ability to appeal or file a complaint about coverage decisions;
- Right to obtain a coverage decision for an item or service and receive notice from FFS Medicare or Medicare Advantage⁵; and
- Access to a treatment plan from a doctor and ability to see a specialist consistent with the treatment plan as many times as the patient and the doctor deem necessary.

Medicare Advantage health plans must provide beneficiaries with all Part A and Part B FFS Medicare benefits, including zero cost-sharing preventive services, without limiting the coverage, choice, or availability of a service. Cost sharing for these services must be actuarially equivalent in both Medicare Advantage and FFS Medicare. Medicare Advantage health plans must also employ a medical director responsible for ensuring the clinical accuracy of all medically necessary determinations.

Medicare Advantage Includes Consumer Protections from High Out-of-Pocket Costs

Every year, Medicare Advantage health plans submit a bid to CMS, which is an estimate of the cost in a given year to provide Medicare-covered benefits to their enrollees. CMS examines Medicare Advantage health plans' proposed cost-sharing (the portion of costs paid by beneficiaries), which includes co-payments (the fixed amount beneficiaries pay for a covered health care service), co-insurance (the percentage of costs beneficiaries pay for a covered health care service), and deductibles (the amount beneficiaries pay for a covered health care service before insurance starts to pay). CMS can deny Medicare Advantage bids due to significant increases in cost-sharing or decreases in benefits from one year to the next, referred to as the Total Beneficiary Cost metric.⁶

Some beneficiaries pay less in Medicare Advantage than they would in other Medicare plans for more robust benefits. In 2018, the average Medicare Advantage premium for beneficiaries is \$30 per month, and 84% of beneficiaries had access to a \$0 premium MA-PD plan.⁷ Unlike FFS Medicare, all Medicare Advantage health plans provide maximum out-of-pocket (MOOP) cost protections for beneficiaries. As shown in Table 2, CMS limits out-of-pocket costs in Medicare Advantage health plans to no more than \$6,700 annually but recommends no more than \$3,400. Table 2 details the premiums and cost sharing associated with FFS Medicare versus Medicare Advantage.

TABLE 2

Medicare Advantage Covers Medical Care and Drugs, and Often Offer Extra Benefits and Lower Out-of-Pocket Costs Compared to FFS Medicare

	2018 Plan Year	Coverage	Monthly Premium	Cost Sharing*
FFS	Part A	Hospital Services	Typically \$0, or up to \$413 based on income	Deductible: \$1,316/year Copay/ Coinsurance: Varies
	Part B	Physician Services	Typically \$109, or \$134+ based on income	Deductible: \$189/year Coinsurance: Typically 20%
Part D	Part D	Medications from a Pharmacy	\$33.50 on average	Deductible: Limited to \$405 Coinsurance: 25% for up to \$5,100 in total drug costs**
MA	Part C	Hospital Services, Physician Services, Medications from a Pharmacy, and Other Supplemental Benefits	\$30 on average	Total Cost Sharing: Limited to \$6,700/year***

FFS: Fee-for-Service; MA: Medicare Advantage; OOP: Out-of-Pocket

Note: A beneficiary enrolled in Part A and/or B through the federal government is covered under FFS. OOP Costs are based on 2018 data from CMS.

*Includes deductibles, copayments/coinsurance

**Before the coverage gap; in 2019, beneficiaries will pay 25% coinsurance until they reach the catastrophic/OOP threshold (estimated beneficiary drug spend only, excludes rebates)

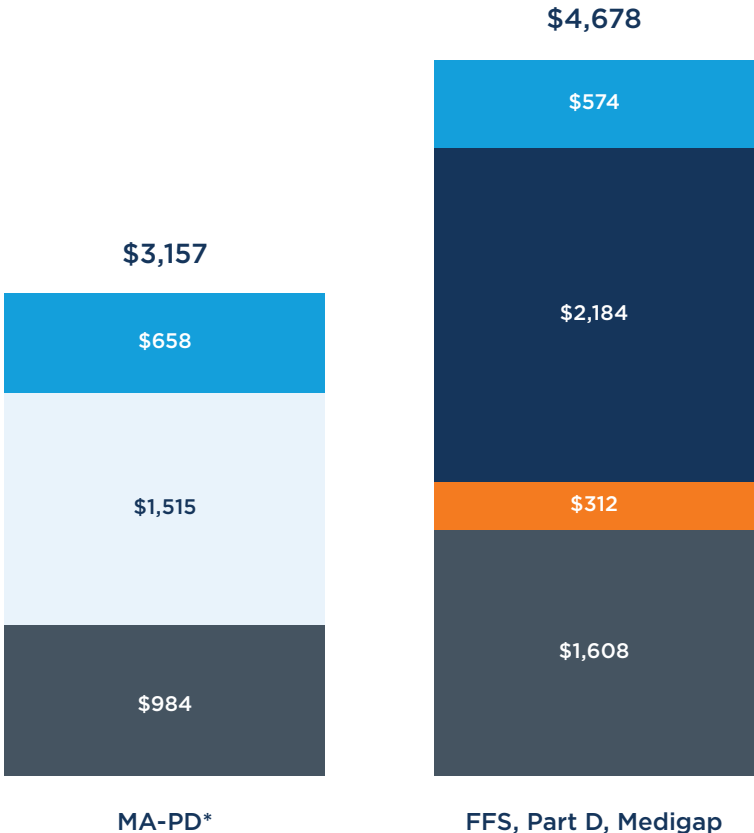
***CMS recommends no more than \$3,400

Beneficiaries with multiple chronic conditions may pay significantly less with Medicare Advantage. In Figure 1, out-of-pocket costs for a Medicare beneficiary with Type 2 diabetes and several co-morbidities were compared in FFS Medicare versus Medicare Advantage. In this example, the beneficiary pays significantly less in total out-of-pocket costs in Medicare Advantage with a prescription drug plan compared to FFS Medicare with Medigap and a prescription drug plan. Overall, the beneficiary pays about \$1,500 less in Medicare Advantage than in FFS Medicare. The Medicare Advantage health plan in this example has a zero premium and offsets the beneficiary’s Part B premium. This health plan also offers dental and vision benefits, providing the beneficiary with services not covered in FFS Medicare.

FIGURE 1

For a Patient with Multiple Chronic Managed Conditions, Medicare Advantage Costs Significantly Less

PATIENT OOP SPENDING SCENARIO, MA VS. FFS, 2018



OOP COST SHARING

- Drug OOP
- Medical OOP

PREMIUM SPENDING

- Medigap Premium
- PDP Premium
- Part B Premium
- MA Premium

OOP: Out-of-Pocket; MA: Medicare Advantage; FFS: Fee-for-Service; PDP: Prescription Drug Plan

*Includes prescription drugs and MA premium is \$0 **Includes FFS Parts A, B, Part D Plan, and Medigap Plan

Note: Premiums include MA, Part B, PDP, and Medigap premiums.

Source: Avalere analysis of 2018 Medicare benefit designs, accessed through Medicare Plan Finder.

Quality of Care Ratings in Medicare Advantage are Available to Consumers

Medicare Advantage Health Plans Are Evaluated on Quality Annually

Quality care in Medicare Advantage is measured and reported through a Star Rating System. FFS Medicare has no equivalent public quality accountability. Star ratings play a critical role in measuring quality, ensuring public accountability, and giving beneficiaries more information to choose high quality health plans. Star ratings evaluate Medicare Advantage health plans on 1-5 scale, with a 5-star rating being the highest quality. Enrollment in plans with at least 4 stars has nearly quadrupled since 2009. Today, 75% of Medicare Advantage enrollees are in plans rated 4 stars or higher, nearly 6 percentage points higher than 2017, which provides beneficiaries with access to more high-quality plans. Star ratings are displayed online on Medicare Plan Finder to assist beneficiaries and caregivers in comparing plan options – this additional information regarding plan quality is not available in FFS Medicare. Beneficiaries may enroll in a 5-star plan at any point in the year via a special enrollment period.⁸

The star ratings are based on plan performance on 48 measures ranging from managing chronic conditions to member experience. Ratings are based on 48 measures, across 9 categories or domains: Staying Healthy, Managing Chronic Conditions, Member Experience, Member Complaints, Customer Service, Drug Plan Customer Services, Drug Plan Member Complaints and Audits Findings, Member Experience with Drug Plan, and Drug Pricing and Patient Safety. CMS establishes raw score thresholds, or “cut-points,” for each domain that are used to determine each plan’s overall star rating. CMS relies on five main sources to determine the Star Rating measures: (1) CMS administrative data on plan quality and member satisfaction, (2) the Consumer Assessment of Healthcare Providers and Systems (CAHPS), (3) the Healthcare Effectiveness Data and Information Set (HEDIS), (4) the Health Outcomes Survey (HOS), and (5) the Pharmacy Quality Alliance (PQA).

Medicare Advantage Health Plans Use Quality Bonus Payments to Offer Extra Benefits

Medicare Advantage health plans submit bids to CMS based on the FFS Medicare benchmark, determined primarily based on average per capita cost for each county’s FFS Medicare beneficiaries. The bid-to-benchmark ratio determines the capitated payment amount the health plan will receive to care for the average beneficiary. This amount is risk adjusted for each beneficiary to account for differences in health status and other characteristics. Health plans can receive a portion of the difference between their bid and the benchmark, called the rebate, to apply to supplemental benefits for beneficiaries. Mandatory supplemental benefits are benefits that, if offered, must be offered to all enrollees in a plan or targeted to chronically ill beneficiaries. They are paid for with rebate dollars or with beneficiary premiums and cost-sharing.⁹

Medicare Advantage health plans with star ratings of at least 4 stars receive bonus payments that must be used to offer additional benefits to enrollees. Most health plans offer additional supplemental benefits. Supplemental benefits may include reduced cost sharing to lower Part B premiums, or add dental, hearing, or vision coverage. According to CMS data, over 97% of Medicare Advantage health plans offer at least a vision, hearing, or dental benefit, and half offer all three benefits.¹⁰ The higher a plan's star rating, the more rebate dollars the plan receives to provide extra benefits or reduce premiums and cost sharing.

CMS Continues to Improve the Star Ratings

The recent Part C and D regulation for contract year 2019 codified the star ratings methodology by more clearly defining rules for adding, updating, and removing measures. CMS also codified the guiding principles it has historically used to make changes to both the Medicare Advantage and Part D star ratings. Additionally, CMS will implement substantive star ratings changes through regulation and use the annual 2019 Medicare Advantage and Part D Rate Notice and Call Letter to make less-substantive changes and solicit feedback. Overall, CMS' proposals will enhance transparency and predictability of changes to the star ratings methodology and process, enabling providers to better prepare and successfully meet new measures and improve care for beneficiaries.

Medicare Advantage Offers Consumers High-Value Provider Networks

High-Value Provider Networks in Medicare Advantage

A provider network is a defined group of health care providers, such as doctors and hospitals, with whom a health plan contracts to provide care to its enrollees. Medicare Advantage partners with providers to build high quality service networks. Beneficiaries can then choose to see any health care provider within their plan's network to receive care. Overall, provider networks in Medicare Advantage help health plans to better coordinate care for their enrollees and manage chronic conditions to achieve better health outcomes and create efficiencies in the Medicare program. FFS Medicare does not have provider networks – beneficiaries may see any doctor, specialist, or hospital that participates in Medicare, which often leads to fragmented care.

Medicare Advantage provider networks must meet strict standards to ensure beneficiary access to care. CMS has national standards on provider networks based on: (1) distance; and (2) beneficiaries' clinical needs. Medicare Advantage health plans monitor and evaluate the quality and efficiency of providers in their networks, ensuring their enrollees have access to high-value providers. Networks must include at least 27 provider specialty types and 23 facility specialty types within a certain distance to beneficiaries' homes to ensure proper access to care.

In addition to identifying providers to offer care, health plans must ensure that beneficiaries can see a psychiatrist in a network if treatment is medically necessary. When making significant network changes, CMS may determine if such a change should afford beneficiaries a special election period to change plans.¹¹ See Figure 2 for other specific Medicare Advantage provider network requirements.

To enhance oversight, starting in 2019, CMS will start reviewing Medicare Advantage networks on three-year cycles rather than only when a Medicare Advantage organization applies to enter the market or renews their status in the program. The agency will also conduct intermediate full-network reviews under certain circumstances if Medicare beneficiaries report access issues.¹²

Medicare Advantage is designed to provide managed health care for consumers. The structure of the program, including establishing provide networks, enables plans to provide care in the most appropriate setting, with network adequacy requirements to improve health outcomes, while preventing avoidable health care costs. Provider networks in Medicare Advantage also facilitate care management by creating a structure between providers that enables coordinated care for beneficiaries.

FIGURE 2

Medicare Advantage Provider Networks Have Strict Requirements to Ensure Beneficiary Access to Care

Identify providers to offer particular service, mental health and substance abuse treatment, and primary care.

Verify and regularly update network directories (at least quarterly), including when there is a change.

Make provider directories available to all beneficiaries annually.

Work with CMS to make any significant network changes, and notify and provide beneficiaries alternative provider options if necessary.

Innovation and Unique Medicare Advantage Attributes

Innovations in Medicare Advantage Lead to Quality Outcomes

Medicare Advantage facilitates early intervention, care management, care in the home, patient engagement and the capacity to address social determinants of health. Studies show access to primary care in Medicare Advantage increases preventive health visits. One study showed rates of annual preventive care was 20% higher in Medicare Advantage for some of the most vulnerable seniors.¹³ Medicare Advantage health plans also engage in care management, disease management, and programs to identify fraud, waste, and abuse. In a 2017, The Robert Graham Center for Policy Studies in Family Medicine and Primary Care and BMA partnered to understand essential elements in successful models of care management in Medicare Advantage.¹ With a defined panel of patients and providers, along with incentives to improve coordination and quality and data analytics, interviewees reported that Medicare Advantage allows them to design systems around the needs of patients. The report examines four successful models of care management:

CareMore	Medicare Advantage payer and provider aligned model that utilizes teams to manage chronic diseases and transitions of care for 80,000 Medicare Advantage beneficiaries in CA, NV, AZ, OH, VA, GA, IA, and TN.
Indiana University Health Methodist Hospital	Utilizes the GRACE Model to provide care management teams that facilitate in-home care to 11,000 Medicare Advantage beneficiaries.
InterMed	Physician-owned medical group that provides care management services facilitated through a pod structure that fosters trust and continuity for 4,400 Medicare Advantage beneficiaries in Maine.
Johns Hopkins Medicare Advantage Plan	Payer utilizing care managers and community health workers to care for 5,000 Medicare Advantage beneficiaries in Maryland.

CMS Provides Medicare Advantage Increased Flexibility to Offer Beneficiaries More Tailored Care

The Bipartisan Budget Act of 2018 and the final Part C and D Rule in April 2018 extended flexibility to Medicare Advantage to customize benefit designs for beneficiaries with specific diseases, including, reduced cost-sharing and deductibles for certain covered benefits, and specialized supplemental benefits. Specifically, in 2019, Medicare Advantage health plans may offer standard supplemental benefits to all enrollees or targeted supplemental benefits for qualifying enrollees by health status or disease state. In 2020, Medicare Advantage health plans may offer supplemental benefits specifically aimed at addressing the needs of chronically ill enrollees.

In April 2018, CMS also reinterpreted uniformity requirements in Medicare Advantage to provide flexibility for customized benefit designs that address the specific health needs of certain beneficiaries. This new flexibility permits reduced cost-sharing for additional or customized benefits, tailored supplemental benefits, and lower deductibles for enrollees with specific diagnoses certified by a physician. Notably, all enrollees meeting a plan's diagnostic criteria must have access to the tailored benefit package and health plans must abide by non-discrimination rules and present their customized benefit designs for CMS' approval during the plan bid process.

Additionally, recent policy changes provide more flexibility to supplemental benefits to address chronic conditions and social determinants of health. In the final Part C and D rule, CMS removed previous meaningful difference standards to allow Medicare Advantage greater flexibility to innovate and to provide health plans at different price points, so beneficiaries can select a plan that meets their health and affordability needs. For 2019, CMS will permit variation of supplemental benefits by geographic service areas, as well as premium and cost sharing, to better accommodate beneficiary needs.

The Financial Framework of Medicare Advantage Facilitates Care Management, Particularly for the Chronically Ill

The innovative financial framework of risk-based, capitated payments under Medicare Advantage improves service delivery through value-based payment arrangements and care management to better meet patient needs, particularly for those with chronic conditions. Medicare Advantage allows payers and providers to collaborate and align care and quality incentives. A capitated arrangement allows Medicare Advantage health plans to contract with providers in different ways, such as offering FFS reimbursement rates or value-based arrangements. A 2015 survey of Medicare Advantage found most health plans are moving towards value-based arrangements with providers because it is an effective tool for shifting providers from volume-based to value-based payment arrangements.¹⁴

Fifty-four percent of family physicians indicate their practices participate in value-based payment models.¹⁵ The incentives inherent in Medicare Advantage's capitated monthly payment for patients encourages providers and payers to work together and share data at the population health level in real time for individual patient care. Furthermore, the structure enables providers to treat patients at the most appropriate site of care and to offer additional benefits as needed to meet care goals. These incentives align to enable providers to think creatively about how to best deliver care to meet patients' needs and improve outcomes.

With a more flexible payment structure, Medicare Advantage can offer providers and patients tailored services to meet patients' needs, with appropriate practitioners and in appropriate settings. The prospective nature of Medicare Advantage payment also allows organizations to invest in the infrastructure needed to engage in population health management by executing effective care management, new communication avenues, and data analysis to identify high risk patients who need more attention.

Medicare Advantage Is Uniquely Poised to Advance Care for High-Need, High-Cost Beneficiaries

Continued growth in Medicare and the ongoing importance of treating high-need, high-cost (HNHC) beneficiaries with multiple chronic conditions places greater importance on Medicare Advantage health plans' capacity to address this population's unique care needs. The HNHC population's needs vary based on risk factors related to each beneficiary's health, medical, and social support needs. Medicare Advantage is a crucial policy vehicle for serving this population as Medicare Advantage is designed to help beneficiaries better manage their health through coordinated and personalized care, compared to fragmented FFS Medicare coverage. With its emphasis on the provision of coordinated, well-managed, high-quality care to Medicare beneficiaries, Medicare Advantage is uniquely positioned to deliver innovative care solutions for the HNHC population.

In addition, Medicare Advantage is well equipped to attend to the needs of HNHC beneficiaries through Special Needs Plans (SNPs), which are a specialized type of Medicare Advantage health plan designed to serve frail, disabled, and chronically-ill individuals. Over 4 million FFS Medicare beneficiaries in 2014 had six or more chronic conditions, representing 51% of spending. SNPs enable Medicare Advantage to target care to high risk beneficiaries. SNP Medicare Advantage health plans tailor care to the needs of a targeted population with complex conditions. SNPs are designed to manage and treat beneficiaries through approved Models of Care. The program aligns incentives and contains costs by emphasizing primary care, chronic care management, and integrated health care services.

Telemedicine in Medicare Advantage Can Improve Health for Beneficiaries

Telemedicine is offering new and potentially transformative options for the delivery of health care. Medicare Advantage is well suited to adopt these innovations to enhance patient access, reduce costs, and improve health for beneficiaries. Telemedicine is a set of health care services delivered through a range of online, video, and telephone communication between patients and their health care providers. Under current law, Medicare Advantage health plans must cover the same basic telemedicine services as those provided through FFS Medicare, but they also may use rebate dollars to offer additional telemedicine services. In addition, the Bipartisan Budget Act of 2018 enabled Medicare Advantage to offer additional, clinically appropriate telemedicine benefits in the annual bid, above and beyond the services currently reimbursed under Medicare Part B.

The Medicare Payment Advisory Commission (MedPAC) reports that utilization of telemedicine services in Medicare has grown rapidly in recent years. Telemedicine visits increased by more than 500% from 2008 to 2014. Interest in using telemedicine in the Medicare program is expanding, with increasing legislative interest and proposals to broaden the use of telemedicine, particularly in Medicare Advantage.

Medicare Advantage Can Incentivize Beneficiaries to Engage in Their Health

Medicare Advantage can create reward and incentives programs to improve beneficiaries' engagement and health. For example, Medicare Advantage can offer services or activities that may include a screening, education, and improve adherence to treatment. Broadly, the rewards must be designed so all enrollees are able to participate and cannot be in the form of monetary rebates, however, rewards may be marketed. Additionally, Medicare Advantage health plans are now able to create rewards and incentives to beneficiaries for participating in a Health Risk Assessment tool designed to assess, and analyze medical, functional, and mental health needs of each beneficiary.¹⁶ These incentives can help motivate Medicare beneficiaries to engage with providers and act on recommendations that improve outcomes and lower health care costs.

Medicare Advantage Health Plans and Providers Are Bridging Gaps in Health Care Delivery through Community-Based Partnerships

The growing demand for health care services increases the need for innovative community partnerships enabled by Medicare Advantage. Community partnerships help seniors age "in place," outside of traditional health care settings. Medicare Advantage health plans and providers are bridging gaps in health care delivery by actively engaging in partnerships with community-based organizations to meet the health and social needs of Medicare beneficiaries to improve outcomes and slow disease progression.¹⁷

Organizations like Meals on Wheels America (MOWA), Silver Sneakers, and YMCA of the USA (YMCA) are working with Medicare Advantage to reach seniors who would benefit from their services. For example, MOWA partnered with the Humana FeelGoodFood™ Program to provide 135,000 Medicare Advantage seniors in 36 states with a one-time delivery of 10 frozen meals and follow-up calls. The program showed when a pack of 10 healthy frozen meals was provided to a beneficiary through a discharge planning program after a hospitalization, lower hospital readmissions occurred. In addition, the Medicare Advantage beneficiaries who participate in the YMCA's Diabetes Prevention Program (DPP) learn strategies for long-term dietary change, appropriate physical activity, and behavior changes to control weight and decrease the risk of type 2 diabetes. The program has proven cost savings of 5:1 return, saving an estimated \$2,650 over 15 months per beneficiary.

Medicare Advantage is pioneering the use of effective community partnerships for beneficiaries by focusing on prevention, early intervention, disease management, and filling the gaps in health care. The capitated payment system gives Medicare Advantage the ability to design benefits that provide crucial supplemental care in addition to core Medicare benefits to meet patient's needs. Medicare Advantage health plans and providers use this flexibility to innovate and integrate care by identifying needs and then connecting the resources and expertise available in the community to the beneficiary to meet those needs. Additional Medicare Advantage flexibilities are expected in the future that will increase opportunities for community partnerships and innovative business partnerships to meet patients needs and improve outcomes.

Conclusion

Medicare Advantage is a highly regulated, high-quality option for Medicare beneficiaries. Medicare Advantage's framework and additional flexibilities are moving providers towards high-value, high-quality care, improving the health care experience for physicians and their patients. Overall, Medicare Advantage has additional benefits for consumers above and beyond FFS Medicare that includes care coordination, supplemental benefits, quality standards, financial protections, and innovations in core and benefit design to meet the needs of beneficiaries.

Recent legislative and regulatory policy changes enable Medicare Advantage to offer even more flexibility to tailor provider network, benefit structures, and supplemental benefits to deliver value to consumers. Consumer protections, quality ratings, and benefits to attend to the needs of chronically ill beneficiaries and deliver more high-value care in Medicare Advantage beyond the benefits offered in FFS Medicare.

Sources

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