The Medicare Advantage Experience: Lessons for Reform to Original Medicare

Kenneth E Thorpe, PhD
Emory University
kthorpe@emory.edu

Any opinions expressed in the paper reflect those of the author and not necessarily Emory University.
Virtually all the spending in the Medicare program is associated with chronically ill patients. High and rising prevalence of chronic diseases such as diabetes are a key contributor to the growth in Medicare spending. Yet despite the central role that chronic disease plays in Medicare, the program does not cover lifestyle-related preventive benefits and currently does not provide care coordination for most patients. A key direction for reforming Medicare needs to focus on reducing the rise in preventable chronic health care conditions, and introducing evidence-based elements of care coordination into traditional Medicare.

Fortunately, we have a substantial body of published research highlighting the impact that key elements of care coordination and prevention have on reducing spending and improving quality. Components of these data are derived from the experience of Medicare Advantage plans, as well as other care coordination initiatives in the private sector. Identifying the best practice techniques and adopting them into traditional Medicare should be a key element of entitlement reform. These key prevention and care coordination initiatives include transitional care, comprehensive medication therapy management, health coaching, and providing team based care. In addition, making evidence-based programs like the diabetes prevention program,
a program with established results that reduce the incidence of diabetes and related chronic conditions among adults (and seniors in particular) should be added to the Medicare program. Introduction of these key elements into traditional Medicare will slow the growth in spending and improve the quality of care provided.
Overview

Reducing the size of the federal budget deficit is a key federal policy priority. Since Medicare and Medicaid account for nearly 40 percent of the projected rise in federal expenditures over the next decade, slowing the growth in federal health care spending is integral to achieving that priority. Successful policy options for slowing spending growth must have a clear understanding of factors accounting for the rise in spending over time.

Recent research examining the growth in spending in the Medicare program found that:

- More than 90 percent of spending in the program is associated with patients with one or more chronic health care conditions;¹

- Twenty percent of Medicare patients were treated for five or more chronic conditions during the year. These patients accounted for half of total Medicare expenditures.²

- Most of the rise in Medicare spending is traced to rising rates of treated disease prevalence and increased intensity of treatment;

- Virtually all the growth in Medicare spending since the late 1980s is associated with patients treated for five or more medical conditions;

- Rising rates of obesity among seniors accounts for approximately 10 percent of the increase in spending;³

- Twenty percent of hospitalized Medicare patients are readmitted to the hospital within a 30 day window. These readmissions are potentially preventable and could account for more than $500 billion in spending over the next decade.⁴

- One-fourth of all adults went to an emergency room for a condition that could have been treated in a more cost-effective non-emergent setting.

¹ http://www.fightchronicdisease.org/sites/fightchronicdisease.org/files/docs/Thorpe%20Care%20Coord%20Savings%20Final-1.pdf
² http://content.healthaffairs.org/content/25/5/w378.full.pdf+html
³ http://content.healthaffairs.org/content/28/5/w822.full
Collectively, these data highlight the need for policy proposals that are designed to reduce the rise in preventable chronic disease, more effectively manage and engage chronically ill patients, and reduce clinically unnecessary use of health care services. The original Medicare program is really not designed to address any of these issues. There is currently no care coordination in the program, no comprehensive efforts to reduce preventable readmissions, and preventive lifestyle modification interventions are not covered. Clearly any comprehensive efforts to reform Medicare must find more effective and comprehensive means to avert chronic disease, increase detection and manage chronically ill patients to keep them healthier. Accomplishing these goals will require important changes in the Medicare program. The good news is that Centers for Medicaid and Medicaid Services recently released their new CY 2013 physician fee schedule that includes two new billing codes (CPT codes 99495 and 99496) that would pay care management involving post-discharge transitional care management services. Since the rule was released, the American Medical Association has also added new CPT codes for the care coordination services medical practices provide.

The Affordable Care Act also included several important provisions that would both prevent and more effectively manage patients with multiple health care conditions. These include the Independence at Home demonstration, the inclusion of a transitional care program, section 2703 for medical homes in the Medicaid program among others. These provisions are all moving the health care system in the right direction. While these pilots and optional programs represent a good start, broader, more comprehensive efforts to promote prevention and

---

5 Federal Register / Vol. 77, No. 146 / Monday, July 30, 2012 / Proposed Rules at p 44774 and
based care that include all components of evidence-based care coordination, including comprehensive medication management should be our next set of priorities. In short, we need to scale and replicate interventions where the evidence demonstrates improved quality and reduced costs throughout the Medicare program. The following sections highlight some of these data and outline an agenda for health reform build around averting disease and more effective management of engaging patients with multiple chronic health care conditions.

**Brief Background on Medicare Advantage**

Federal payment policies for private health plans in Medicare have varied dramatically over time. Medicare has contracted with private plans since the 1970s, and the program has seen several changes. Some of these major changes in policy include the Balanced Budget Act of 1997 (BBA), which created Medicare+Choice (M+C). The M+C program was intended to broaden the types of private plans in the program beyond HMOs to include point of service plans, medical savings accounts, private fee for service and provider-sponsored organizations. The BBA also reduced payments to private plans as part of a broader budget deal designed to reduce and ultimately balance the budget. The BBA slowed the growth in payments to health plans dramatically resulted in plan exodus from the program and loss of enrollment. In 1999, 6.9 million beneficiaries were enrolled in M+C yet by 2003 that figure had dropped to 5.3 million. The Medicare Modernization Act of 2003 (MMA) created Part D of Medicare—the prescription drug benefit—as well as renamed M+C to Medicare Advantage. Declining enrollment and uneven availability of private plans in rural areas led to another round of substantial changes in federal payment policies to health plans. Under the Act, plans were paid
increasingly more in an effort to entice more plans into Medicare, particularly in rural areas, and increase enrollment. The additional payments to plans resulted in more generous benefits over and above the traditional Medicare program. The additional benefits attracted higher enrollment. By 2012, enrollment in Medicare Advantage hit 12.7 million beneficiaries more than doubling the pre-MMA enrollment. These additional payments intended by the Congress to increase plan availability and enrollment were successful.

The Affordable Care Act reversed direction from the MMA and will gradually reduce payments to plans over time. These reductions were used to contribute to the financing of the ACA and were designed to eliminate “overpayments” to plans. However, these additional payments were precisely what Congress intended when they passed the MMA in 2003 to increase enrollment in the program.

Examining the key functions performed by successful plans and providers that reduce chronic disease prevalence, and reduce spending among chronically ill patients is essential for successful reform proposals. The following sections examine the data and evidence, drawing from the experience of Medicare Advantage plans, as well as other on-going prevention and care coordination programs in the private section. We highlight these proven best practice strategies and propose that they be included into the traditional Medicare program.

**Adopting Best Practice Prevention and Care Coordination for Traditional Medicare.**

Designing evidenced-based prevention and care coordination approaches for traditional Medicare represents a major policy challenge. One place to start is to examine the experience
with Medicare Advantage and see what evidence exists about best practice approaches for reducing costs, improving quality and ensuring patient satisfaction that could be made available to those beneficiaries who account for the largest segment of the Medicare population – those in traditional Medicare. In addition to Medicare Advantage, there is a considerable body of published research that has evaluated core elements of care coordination. These include transitional care, high risk case management, medication therapy and management, health coaching, and team-based care, among others. Large randomized trials have also evaluated the impact of comprehensive lifestyle modification interventions such as the Diabetes Prevention Program and the Stanford Chronic Disease Management Program.

**Interventions that Avert Disease**

Perhaps the best-known lifestyle modification program is the Diabetes Prevention Program (DPP). Randomized trials of other programs such as the Stanford Chronic Disease Management Program produce results similar to the DPP. The original DPP protocol was delivered to overweight, pre-diabetic adults on a one-on-one basis. The large scale randomized trial of the DPP found that lifestyle intervention reduced the prevalence of diabetes by 58 percent relative to placebo. The reduction in diabetes prevalence (as well as hypertension) was traced to a 5 to 7 percent reduction in weight among participants. The largest reductions in weight and diabetes prevalence occurred among participants aged 60 and older. Those 60 and older lost an average of 8.2 percent of their starting weight after 12 months compared to 7.5 percent for

---

6 [http://content.healthaffairs.org/content/31/6/1156.full](http://content.healthaffairs.org/content/31/6/1156.full)

those aged 45 to 59 and 6.6 percent for adults under age 45.\(^8\) As a result, the prevalence of diabetes was 71 percent lower than placebo for those 60 and older compared to the overall average of 58 percent.\(^9\) The Y(formerly the YMCA) has adapted the DPP protocol to group settings, resulting in dramatically lower costs for administering the program. Making the DPP a covered benefit under traditional Medicare would save the program money and improve health outcomes. Enrolling one cohort of overweight, pre-diabetic seniors into the program would generate a net savings of about $2 Billion over 10 years and more than $7 Billion during the lifetimes of those participating in the program.

Traditional Medicare currently provides a physical exam, clinical preventive services, a health risk appraisal and a personal care plan for beneficiaries. However, the program does not cover lifestyle interventions, like the DPP, that would generate weight loss, reduce conversion to Type 2 diabetes, and lower rates of chronic disease incidence. Some private sector health plans, including UnitedHealthcare and some Blue Cross plans, have contracted with the Y to provide the DPP intervention to at-risk adults. Payments are based on results with the anticipation of about a 7 percent average reduction in weight. Based on results from randomized trials, and real world application of the DPP, Medicare should include coverage of the program starting with overweight, pre-diabetic seniors.

Care Coordination

Despite the fact that most of the spending in traditional Medicare is associated with chronically ill patients, the program currently provides no care coordination. This contrasts sharply with the Medicare Advantage program where health plans routinely provide care coordination. Chronic condition special needs plans (C-SNPs) are an important case in point. Authorized through legislation in 2003, they are designed to provide coordinated care to patients with certain chronic health care conditions. One recent analysis examined the performance of one C-SNP in managing diabetic patients compared to that of traditional fee-for-service Medicare. The study examined the impact of care coordination on inpatient admissions and readmissions, outpatient hospital visits, and physician office visits. Per enrollee use of services was generally lower among diabetic patients enrolled in the C-SNPs compared to those in traditional Medicare. For instance, hospital days were 21 percent lower, readmissions 11 percent lower, and hospital outpatient visits 10 percent lower than traditional Medicare. Physician office visits were five percent higher in the C-SNP than in traditional Medicare.10 These results are similar to those estimated by Lemieux and colleagues.11 After adjusting for risk of admission, they found that 30 day readmission rates for Medicare Advantage patients overall were approximately 13 to 20 percent lower than similar patients in traditional Medicare.

MedPAC, among others, also has compared quality more broadly in Medicare Advantage plans to traditional Medicare along three dimensions: HEDIS clinical quality measures, consumer assessments of care (include measures such as vaccination rates and access to care) and health 10

---

10 [http://content.healthaffairs.org/content/31/1/110.full](http://content.healthaffairs.org/content/31/1/110.full)

status. MedPAC found that HMOs improved their clinical quality measures in 14 of 45 measures between 2010 and 2011. Brennan and Shepard found that Medicare Advantage plans scored substantially better than traditional Medicare on eight of 11 HEDIS measures, slightly better than traditional Medicare on one measure, and worse than traditional Medicare on two measures.\(^\text{12}\)

How did the Medicare Advantage plans achieve these results? In this case, through the adoption of a chronic care treatment model that contains several functions shown in earlier studies to be associated with improved clinical outcomes and lower costs. These design features include in-person visits from specially trained nurses to provide a detailed health risk appraisal, individual care plans, and follow up on executing the care plans. A 24/7 nurse call line for health coaching also is included. A transitional care program specifically designed to assist beneficiaries transferring across settings (such as being discharged from a hospital) is designed to reduce hospital readmissions. Comprehensive medication management therapy includes conducting an individual assessment to identify drug therapy problems, developing a care plan to achieve patient-specific goals of therapy, and performing follow-up evaluation to resolve drug therapy problems. The program also coordinates social services for members who may be eligible for non-Medicare benefits such as Medicaid and low-income energy programs.

Discussion

These elements of care coordination and proven clinical models outlined above could be integrated into the original Medicare program to improve outcomes and reduce costs in a program where many of these solutions are not available at any price. Care coordination could be organized within traditional Medicare by health plans, health teams, or other entities. While the proposed rule by CMS to establish a billing code for care coordination represents a good start, it is incomplete. Real care coordination will require broader teams of providers such as nurse practitioners, nurses, pharmacists, social workers and others, all engaging patients to keep them healthy. There are several policy options that would allow patients in traditional Medicare to receive prevention and care coordination services. This ranges from creating an enhanced plan that could be offered in traditional Medicare, to making the care coordination functions available throughout the program on a contracted basis.

Regardless of the ultimate reforms that occur within Medicare, the first step in reform is to build a national capacity to provide evidence based efforts to avert, detect and manage chronic illness. We have a considerable body of evidence, both from randomized trials and from private health plans in Medicare and Medicaid, which could provide important information regarding the effective design of delivery system innovations in Medicare. These reforms focused on prevention and care coordination should serve as the foundation for the next wave of discussions regarding entitlement reform.
## Comparison of Cost

| Biles, et al., 2011 | Payments to MA plans have exceeded FFS Medicare since the passage of the Medicare Modernization Act of 2003.  
| Commonwealth Fund | In 2010, payments to MA plans exceeded FFS Medicare nationally by 8.9% - or $8.9 billion.  
| *Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field* | This is a decrease relative to 2009 when MA payments were 13.0%, or $11.4 billion, greater than FFS Medicare. |
| Biles, 2012 | The following is a series of descriptive statistics of MA plan cost data from 2009. This data was first provided from CMS to researchers in 2011.  
| Presentation at AcademyHealth 2012. | Nationwide, MA plans cost an average of 103.4% of FFS Medicare costs in the same county.  
| *Do Medicare Private Plans Cost Less Than Traditional Medicare?* | MA plans cost 102% of traditional Medicare costs in urban areas and 105.9% in rural areas.  
|  | MA costs vary by MA plan type  
|  | • MA PFFS plans are 113% of FFS Medicare cost  
|  | • Local PPO plans are 107% of FFS Medicare costs  
|  | • Regional PPO costs are 105% of FFS Medicare costs  
|  | • HMO plan costs are 98% of FFS Medicare costs  
|  | MA costs are:  
|  | • Higher than traditional Medicare costs in the counties with the lowest FFS Medicare costs (which contain 50% of beneficiaries)  
|  | • Similar to traditional Medicare costs in the counties with moderate to higher traditional Medicare costs (which contain 30% of beneficiaries)  
<p>|  | • Lower than traditional Medicare costs in counties with the highest traditional Medicare costs (which contain 20% of beneficiaries) |</p>
<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedPAC, 2012&lt;br&gt;&lt;i&gt;The Medicare Advantage Program: Status Report&lt;/i&gt;</td>
<td>For 2012, MedPAC estimates that MA benchmarks, bids, and payments will average 112%, 98%, and 107% of FFS Medicare spending, respectively (assuming no SGR reduction in Medicare physician payment rates during 2012).</td>
</tr>
<tr>
<td>Friedman, et al., 2009&lt;br&gt;AHRQ, Healthcare Cost and Utilization Project&lt;br&gt;&lt;i&gt;Hospitals Spend Less for Patients in Medicare Advantage than for Patients in Fee-for-Service Medicare&lt;/i&gt;</td>
<td>Patients in MA had shorter stays than their fee-for-service counterparts – 5.2 days compared to 5.9 days. In MA plans, 35.5% of patients were categorized as “most severely ill”, compared with 35.8% among FFS Medicare patients. 52% of patients in MA went home after their hospital days, and not to a nursing home or under the care of a home health care agency, compared to 47% among FFS Medicare patients. This analysis was conducted on 5.7 million hospital stays of patients over the age of 65 in 13 states in 2006.</td>
</tr>
</tbody>
</table>
## Comparison of Quality of Care

<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayanian et al., 2011</td>
<td><em>Quality of Care in Medicare Advantage and Traditional Medicare: A National Comparison</em></td>
<td>MA enrollees were substantially more likely than comparable FFS Medicare enrollees to receive breast cancer screening and diabetic eye exams across all study years. MA enrollees were also more likely to receive glaucoma screening, hemoglobin A1c and cholesterol testing for diabetes, and pneumococcal and influenza vaccinations in most study years. However, FFS Medicare enrollees reported better access to needed care and better ratings of both their doctors and their overall care than MA enrollees.</td>
</tr>
<tr>
<td>Brennan and Shepard, 2010</td>
<td><em>Comparing Quality of Care in the Medicare Program</em></td>
<td>A comparison of MA managed care and FFS Medicare plans from 2006-2007 found that MA plans scored substantially better than FFS Medicare on 8 of 11 HEDIS measures, slightly better on 1 measure, and worse than FFS Medicare on two measures. However, the three measures that MA plans did not score substantially better than FFS Medicare were all newer measures. The authors suggest that this indicates a learning effect in MA plans, and the MA plans may improve their measurement and quality over time as they become more familiar with the newer measures.</td>
</tr>
<tr>
<td>Basu and Mobley, 2012</td>
<td><em>Medicare Managed Care Plan Performance: A Comparison Across Hospitalization Types</em></td>
<td>Using 2004 hospital data, the authors found that MA plans were associated with reductions in preventable hospitalizations in all three of the states examined – New York, California, and Florida. The relative risk of preventable admissions among MA plan enrollees in New York and Florida became even more pronounced after accounting for selection bias.</td>
</tr>
<tr>
<td>Lemieux, et al., 2012</td>
<td></td>
<td>After adjusting for risk of admission and excluding patients</td>
</tr>
<tr>
<td>Source</td>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>The American Journal of Managed Care</td>
<td>Hospital Readmission Rates in Medicare Advantage Plans under 65 years of age, the authors estimated that 30-day readmission rates for MA patients were approximately 13 to 20% lower than those for FFS patients over the three year period. The authors compared the hospital readmission rates among patients enrolled in MA plans compared to those in FFS Medicare from 2006 to 2008.</td>
<td></td>
</tr>
<tr>
<td>AHIP Center for Policy and Research, 2010</td>
<td>Using AHRQ’s ‘Revisit’ Data to Estimate 30-Day Readmission Rates in Medicare Advantage and Traditional Fee-for-Service Program Across 5 different states over data years ranging from 2006-2008, this report found that both “same-quarter” and 30-day readmission rates were much lower among MA enrollees than FFS Medicare enrollees.</td>
<td></td>
</tr>
<tr>
<td>AHIP Center for Policy and Research, 2009</td>
<td>Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare FFS in the Same Service Areas This report examined data from two large, multi-state MA HMO plans and found that risk-adjusted comparisons of the MA plans compared to FFS Medicare found that MA enrollees had fewer inpatient days, inpatient admissions, emergency room visits, readmissions, and potentially avoidable admissions. However, MA enrollees had as many outpatient visits, but more office visits.</td>
<td></td>
</tr>
<tr>
<td>AHIP center for Policy and Research, 2009</td>
<td>Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada, 2006 In 2006, risk-adjusted rates of inpatient days per patient were 30% lower for MA enrollees than for FFS enrollees in California, and 23% lower in Nevada. Same quarter re-admission rates for the same DRG were 15% lower among MA patients in California and 33% lower among MA patients in Nevada. Risk-adjusted MA patients had a 6% lower rate of avoidable admissions than FFS enrollees in both California and Nevada. All comparisons were adjusted for health status.</td>
<td></td>
</tr>
<tr>
<td>Basu, 2012</td>
<td>Health Care Management Science Medicare Managed Care and Primary Care Quality: Examining Racial/Ethnic Effects Across States Among White, African-American, and Hispanic ethnic groups in New York, California, and Florida, the authors found that Medicare Advantage plans had lower rates of preventable admissions compared to white patients. In addition, Basu found that MA plans were associated with lower rates of preventable admissions compared to patients enrolled in traditional Medicare.</td>
<td></td>
</tr>
<tr>
<td>Cohen, et al., 2012</td>
<td>Health Affairs Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients Among enrollees in the Medicare Advantage Chronic Condition Special Needs Plans (C-SNP), people with diabetes – particularly nonwhite beneficiaries – had lower rates of hospitalizations and readmission than those in FFS Medicare.</td>
<td></td>
</tr>
</tbody>
</table>
Risk-adjusted hospital days per enrollee among special-needs plan participants were 19% lower than for FFS Medicare enrollees. This was more pronounced among nonwhite enrollees, who had a 27% reduction compared to FFS Medicare enrollees.

Risk-adjusted physician office visits were 7% higher among MA C-SNP enrollees compared to FFS MA enrollees. This was 26% higher for nonwhite enrollees compared to FFS Medicare enrollees.

<table>
<thead>
<tr>
<th>MedPAC, 2012</th>
<th>Overall, quality indicators for MA plans improved in 2011. Many process and outcome measures improved compared with past years, but there was variation among plan types.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Medicare Advantage Program: Status Report</td>
<td>• Local PPO plans had results similar to HMO plans on many measures.</td>
</tr>
<tr>
<td></td>
<td>• Regional PPOs and PFFS plans generally had poorer results than other plan types.</td>
</tr>
<tr>
<td></td>
<td>The health outcome survey of MA enrollees showed some improvement in outcomes, but a small number of plans showed worse than expected outcomes.</td>
</tr>
</tbody>
</table>

### Comparison of Patient Satisfaction

<table>
<thead>
<tr>
<th>Mellman Group, 2007</th>
<th>71% of enrollees thought their MA plan was better than traditional Medicare, and 75% were likely to recommend the health plan to a friend or relative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage Research Findings</td>
<td>Enrollees were also asked to state the most important attribute they considered when choosing a health plan – the following five characteristics were named as the “most important attribute in a health care plan” by 71% of members: low monthly premiums, high quality of care, prescription drug coverage, doctor choice, and comprehensive benefits.</td>
</tr>
<tr>
<td></td>
<td>Across these five characteristics, 65% or more of MA enrollees rated their MA plan as “excellent” or “good”. In a separate question, 65% of enrollees rated their MA plan as “excellent” or “good” when asked to assess its value while taking premiums into consideration.</td>
</tr>
<tr>
<td>Source</td>
<td>Title</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Avalere, 2010</td>
<td>Avalere Analysis of Medicare Data</td>
</tr>
<tr>
<td>Merlis, 2008</td>
<td>Henry J. Kaiser Family Foundation</td>
</tr>
<tr>
<td>Elliot, et al., 2011</td>
<td>Health Services Research</td>
</tr>
</tbody>
</table>

**Avalere, 2010**

On average, MA beneficiaries received an additional $70 in additional benefits and reduced cost sharing at no additional cost. The average enrollment weighted rebate amount was $74 per member per month.

This analysis found that there was significant geographic variation in cost-sharing and added benefits.

**Merlis, 2008**

This report estimated that enrollees received a net value of $73.46 in additional benefits, and on average, beneficiaries had 49% lower cost-sharing compared to those in FFS Medicare.

**Elliot, et al., 2011**

The authors found that the experiences of lower income, less healthy, female, less educated, and black individuals was worse among MA managed care enrollees compared to traditional Medicare.

The authors examined the patient health care experiences across seven vulnerable subgroup characteristics: eligible for low-income subsidy, no high school degree, poor or fair self-rated health, age 85 and older, female, Hispanic, and black.