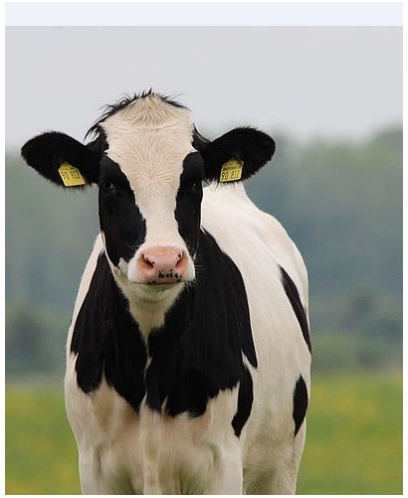
Removing the Medicare Advantage Program's Key Disadvantages – Guidance From the Health Policy Cows



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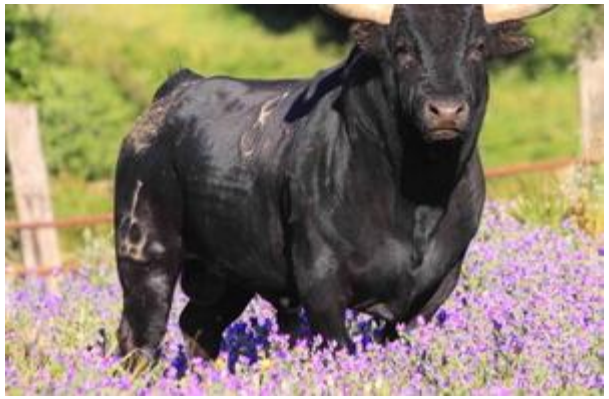

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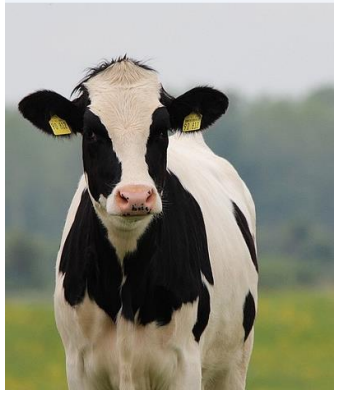
Medicare Advantage's Chronic Condition: Decades of Net Costs Imposed on US Taxpayers

- Overall, the Medicare Advantage program is projected by the Medicare Payment Advisory Commission to cost 102% of Medicare fee-for-service in 2016. That is about a $3.5 billion annual hit to our taxpayers (before considering lost opportunities for actual savings).
- Every component of Medicare Advantage is more costly than the traditional unfettered FFS model, ranging from HMOs and Special Needs Plans (101% of FFS) to the private fee-for-service model (chiming in at 110% of Medicare FFS).
- This situation is not a one-time outcome; the Medicare Advantage program has imposed net costs on the US taxpayer for decades, entirely due to its design features. Several percentage points of savings are available if our policymakers can give this program an opportunity to perform optimally.



"A lot of policy makers will look at this and say: *See, managed care doesn't save anything.* But the problem isn't managed care's lack of cost-effectiveness. It's the policymaking design that perpetuates the availability of an ineffective FFS option. Of course I'd rather go wherever I want for health care whenever I want, and have other bovines pay for it all. Not exactly shocking that providers also love that model. It ends up being irritatingly costly. Turns good decent cows into mad cows." -- Millicent

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Medicaid's Coordinated Care Design Sheds Light On How Medicare Advantage Can Evolve

	Medicare Advantage	Typical Medicaid Coordinated Care Program
Health Plan Selection Process	All organizations participate that successfully complete application and ongoing compliance processes	State determines best-qualified MCOs through competitive procurement; contracts only with small group of top-scoring MCOs
Number of Participating MCO Options Nationwide	3,500	285
Benefits Design	Enormous, confusing set of product/premium options exists for most beneficiaries	Uniform benefits package provided; some "value add" benefits provided by specific MCOs
Enrollment Model	Voluntary enrollment across available coordinated care plans and Medicare FFS	Mandatory enrollment into MCO model; beneficiaries choose their MCO (or are auto-assigned to an MCO if they do not choose) and cannot remain in FFS
Approximate Program-Wide MCO Enrollment	18,200,000	50,100,000
Average Enrollment Per Health Plan	5,000	175,000
Taxpayer Costs Needed to Move Population into MCO Setting	Extensive marketing occurs; large set of additional benefits often provided	Almost none; minimal marketing allowed; plans often provide modest benefits enhancements to attract members

"Medicaid has put tens of millions of persons into MCOs using mandatory enrollment -- people with no means of buying care outside what their MCO covers. This has worked out well clinically and financially. Treating Medicare fee-for-service like some sort of sacred cow is of course annoying to us actual cows. But it's particularly bad for humans."

-- Franny

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Isn't Passive Enrollment A Sufficient Middle Ground Between Voluntary and Mandatory Enrollment Models?

- Coordinated care demonstrations for dual eligibles have used a passive enrollment model whereby persons are enrolled in MCOs unless they proactively elect to remain in FFS.
- Passive enrollment does not remove the FFS option. 72% of demo-eligible duals remain in FFS.
- Providers and beneficiaries will find their way to the FFS option as long as it exists.
  - Patients prefer to go where they want, and providers prefer to deliver what they want – *if* a fairyland environment exists where other peoples' money pays for it all and no one on the front lines involved in the day-to-day decisions is motivated to contain costs.

"It's hard to make Medicare more costly. Everything about the Medicare FFS model other than its unit price controls drives costs up. Incredibly, the way the program's managed care component has been designed costs even more than FFS. And yes, I can talk and chew at the same time." -- Giselle

What's Working Well On A Large Scale In Medicaid Is Yet To Even Be *Tested* In Medicare

- Enrolling an area's entire Medicare population into a small number of competitively selected MCOs -- and not allowing marketing costs or additional benefits "carrots" simply to move persons out of FFS – will create a high-powered rather than disadvantaged coordinated care program.
- The quality improvement and financial savings opportunities associated with serving seniors entirely in a coordinated care setting are exciting.
  - Medicare beneficiaries are covered by the program for the remainder of their lives, and many have an array of chronic health conditions and high per capita costs in areas (inpatient and outpatient hospital, pharmacy, etc.) that coordinated care models can and do favorably impact.

"How many more years – or decades – will go by before you test mandatory coordinated care enrollment in Medicare? And how many percentage points of Medicare's money will you keep giving away just to entice people out of FFS? Take it from a big cow that this is a big shortcoming in Medicare." -- Gilligan

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National Health Policymakers Have An Important Opportunity to Improve Medicare

- Test the mandatory enrollment coordinated care model in Medicare.
- Contract with a small number of competitively procured MCOs in selected counties/states.
- Set a level and simple playing field with regard to additional benefits. Create a small set of enhanced benefits options for beneficiaries (encompassing Parts A, B and D), similar to the A-J concept used for supplemental "Medi-gap" coverage.
- Let's discern what a full commitment to care coordination in Medicare (getting completely off the fee-for-service bus) can do for the beneficiaries and the US taxpayer.

"I don't always speak up about Medicare fee-for-service. But when I do, I urge that we give that model the pink slip." -- Armando (still widely held to be the world's most interesting cow)

Data Sources and Contact Information

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Data Sources: Medicare numbers cited in this edition are largely drawn from the Medicare Payment Advisory Commission's March 2016 Report to Congress on Medicare Payment Policy and from CMS website data. Medicaid statistics derived from Kaiser Family Foundation website and from direct Menges Group data acquisition from several states.

Our 5 Slide Series conveys data and/or opinions with the intention of helping inform and improve health policy decision-making involving the Medicaid and Medicare programs. Our company's focus is on the design and operation of coordinated care programs that strive to make optimal use of taxpayer funds to favorably impact the health status of public health program beneficiaries.

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