Congress should direct CMS to strengthen its day-to-day oversight of Medicare Advantage (MA) Plans and implement additional avenues for beneficiaries and providers to provide input on plan performance and receive assistance from CMS staff on MA plan challenges.

Background
Congress created the Medicare Advantage (MA) program in 2003 in an effort to control rising healthcare costs. Under the program, Medicare pays private plans a fixed per-member amount, and the plan is responsible for managing all benefits available under traditional Medicare Parts A and B. In contrast to traditional Medicare fee-for-service (FFS), private plans can employ resources to coordinate a beneficiary’s care across providers and services, which are expected to improve outcomes and reduce costs for beneficiaries and taxpayers. However, most analyses have found that Medicare payments to private plans exceed the costs of providing coverage through traditional fee-for-service (FFS) with limited impact on outcomes. In addition, wide variation in costs across plans indicates that there is room for greater efficiency and improved accountability.1

In 2010, the Affordable Care Act (ACA) imposed changes to the MA program designed to reduce MA payments while providing incentives for quality improvements. The Centers for Medicare and Medicaid Services Office of the Actuary (OACT) as well as the Congressional Budget Office project continued enrollment growth despite MA payment reductions contained in the ACA.2 Today, approximately 31 percent of Medicare beneficiaries are enrolled in private MA plans nationwide (Figure 1).3 Twenty states (AZ, CA, CO, FL, GA, HI, ID, MI, MN, NM, NV, NY, OH, OR, PA, TN, TX, UT, RI, WI) have over 30 percent of Medicare beneficiaries enrolled in MA plans.4 Additionally, MA Special Needs Plan, in particular Duals Special Needs Plan (D-SNP) enrollment continues to grow rapidly.

With over 17 million Medicare beneficiaries choosing MA in 2016 and enrollment continuing to grow (Figure 2.), it is increasingly important that policymakers ensure that plans are held accountable for cost and quality outcomes, and that all stakeholders have access to information necessary to inform future policy surrounding MA operations.

3 Kaiser Family Foundation. Medicare Advantage Enrollees as a Percent of Total Medicare Population. 2015,
Key Issues

Limitations in Access and Choice
Beneficiaries who report poorer health, use more health services, and have higher health care spending are more likely than other MA enrollees to switch to FFS, raising questions about the ability of MA plans to serve high-need beneficiaries.  

Increased Costs to Taxpayers
- Although the ACA included reduced payments to MA plans over time, MedPAC estimates that 2014 payments to plans will average 106 percent of FFS.  
- Excess payments to MA plans are approximately $10.5 billion annually, or about $640 per MA enrollee per year.  

Lack of Transparency and Plan Accountability
- Providers and beneficiaries have inadequate avenues and options for communicating with federal officials on challenges associated with MA plan coverage and operations.  
- Stronger provisions are needed to ensure plans comply with federal requirements for important functions related to ensuring access to needed services (i.e., prior authorizations, network adequacy, timely processing of grievances and appeals).  
- Because of CMS’ interpretation of federal law, the Agency plays virtually no role in ensuring plan contracts with providers offer adequate protections to Medicare beneficiaries and providers.  
- Reimbursements in excess of costs of coverage are expected to be passed through to the consumer to MA plans either through reduced copayments and/or premiums or additional benefits, however recent findings suggest that less than one-fifth of the additional funding is passed through.  
- MA Plans often pay far outside of federally required timelines and create administrative complexities which jeopardize care.  

Limited Data Available for Program Evaluation
- Although some studies show differences in utilization among MA enrollees when compared to FFS beneficiaries, it is unclear whether these differences can be attributed to better coordinated care or other factors, such as beneficiary case-mix.  
- Policymakers have voiced difficulty in accessing meaningful MA data which can help assess program and plan strengths and weaknesses and inform CMS’ risk adjustment and plan payment processes.  

References:
5 Momotazur Rahman, Laura Keohane, Amal N. Trivedi and Vincent Mor. High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage And Joining Traditional Medicare, Health Affairs 34(10). October 2015  