Published by Physician Practice Roundtable

Medicare Advantage

Educational briefing for providers

What is Medicare Advantage?

Medicare Advantage (MA) is a type of insurance plan funded by the Centers for Medicare and Medicaid Services (CMS) but administered by a private payer. MA plans cover all traditional Medicare benefits (Parts A and B) and many include prescription drug benefits (Part D). CMS gives the MA payer a lump sum, determined by county benchmarks, enrollees' risk scores, and the plan's quality rating, to cover Part A and B benefits. If beneficiaries' health care costs exceed the capitated rate, the sponsoring organization must cover the difference. However, if costs fall below the target, the organization can share in the savings. MA plans are gaining popularity among both enrollees and providers. By 2025, experts expect about 30 million, or about 40% of Medicare beneficiaries, to be enrolled in MA plans.

How does Medicare Advantage work?

MA differs from Medicare in terms of coverage, patient accountability, network design, and physician payment.

Characteristic	Traditional, FFS[1] Medicare	Medicare Advantage
Coverage	• Includes Medicare Part A and Part B • Ability to buy supplemental coverage • Must buy separate Part D prescription drug plan	• Also called Medicare Part C • Commonly bundles Part A, B, and D into one plan • May include services like dental, vision, and hearing
Patient accountability	• Patients pay premium for Part B coverage, deductible, and 20% coinsurance	• Patients pay Part B premium, deductibles, co-pay • May be charged additional premium beyond Medicare
Payer and network	• Administered by federal government (CMS) • Patients see any provider that accepts Medicare	• Plans sold by commercial insurers • Patients may be limited to in-network providers • Most common plan types are HMOs[5], PPOs[6], and PFFS[7]
How payment works	• Paid by CMS through relevant fee schedule (IPPS[2], HOPPS[3], MPFS[4], etc.)	• Medicare pays a capitated rate per enrollee to commercial MA plans

Provider payment under Medicare Advantage may be affected by the Star Rating System, which scores Medicare Advantage Organizations (MAOs) on a five-star scale. It's used to determine organizations' eligibility for bonus payments based on the quality of services across five categories: outcomes, intermediate outcomes, patient experience, access, and process. To succeed under the Star Rating System, providers must have an infrastructure and staff in place to track and report on outcomes and process measures. They must also improve HCC[8] coding to guarantee an accurate reflection of their risk pool and maximize potential reimbursement.

Updated November 2018.

1) Fee-for-service.
2) Inpatient prospective payment system.
3) Hospital outpatient prospective payment system.
4) Medicare physician fee schedule.
5) Health maintenance organization.
6) Preferred provider organization.
7) Private-fee-for-service.
8) Hierarchical condition category.

Source: "Medicare Advantage," *Kaiser Family Foundation*, May 11, 2016: http://kff.org/medicare/fact-sheet/medicare-advantage/; CBO, "March 2015 Medicare Baseline;" CMS, "What Medicare Covers" medicare.gov; Kaiser Family Foundation, "Medicare Advantage," May 11, 2016, available at: kff.org; Advisory Board research and analysis.

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Educational briefing for providers (continued)

Why is Medicare Advantage a key issue for medical groups?

- **Groups can more effectively manage MA's defined patient population:** In MA, the patient population is better defined, and there is less churn than under traditional Medicare. This enables groups to better manage patient populations, resulting in higher quality care and higher reimbursement.
- **MA has higher reimbursement rates than traditional Medicare:** Year over year, Medicare Advantage baseline payment is slightly higher than Medicare payment. Importantly, providers who participate in 4+ star plans can earn up to 107% of Medicare fees, making MA reimbursement particularly attractive for high-quality providers.
- **Groups have greater flexibility over contracting and plan design:** In MA, groups have the opportunity to negotiate network design, benefit design, attribution methodology, and reimbursement. They may also be able to take on operational functions plans typically cover such as case and utilization management.

Sample contracting terms groups can negotiate:

- Attribution methodology
- Monthly claims data feed
- Input into benefit and network design
- Standardized quality metrics

Sample operational functions groups can take on:

- Case and disease management
- Utilization management (full or partial)

Additional Advisory Board research and support

Grow your Medicare Advantage book of business with our Independent Medical Group Strategic Resource Guide for Growing MA.

You can also contact your group's Dedicated Advisor or email pprresearch@advisory.com for more research on this topic or other strategic priorities for your group.

Source: Advisory Board research and analysis.