AHIP
Guiding Greater Health

NEW DATA SHOWS

Medicare Advantage Provides Higher Quality of Care And Better Rates of Preventive Service Use

WHEN COMPARED TO ORIGINAL MEDICARE

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More than 32 million seniors and people with disabilities choose Medicare Advantage (MA) because it delivers better service, better access to care, and better value. Medicare Advantage has been proven to provide better access to preventive health care, helping to reduce disease risk and detecting illnesses at an early stage.

In this brief, AHIP examines how often clinical guidelines were met in original Medicare versus Medicare Advantage, focusing primarily on measures of preventive and chronic disease care for major chronic conditions. **Higher performance on key preventive and chronic disease care measures suggests Medicare Advantage enrollees received higher quality care than those in original Medicare.**

Study & Findings

To assess differences in quality of care and utilization of services and medication, we compared performance results for certain Healthcare Effectiveness Data and Information (HEDIS) measures focused on preventive and chronic disease care in original Medicare and Medicare Advantage in 2019. **Across 11 HEDIS measures, Medicare Advantage outperformed original Medicare in all but one (Table 1).**

One standout measure highlighted in the study is cancer screenings. Overall, a higher share of Medicare Advantage enrollees were screened for 2 common forms of cancer than their original Medicare counterparts. Specifically:

- Compared to those enrolled in original Medicare, a higher share of Medicare Advantage beneficiaries received screening for breast cancer (73.3% vs 69.9%) and colorectal cancer (38.9% vs 33.1%).

Across many other areas of preventive care, Medicare Advantage outperformed original Medicare, including:

- A higher share of Medicare Advantage enrollees completed a course of beta-blockers after a heart attack (81.8% vs 80.7%) and were prescribed (83.1% vs 81.6%) and completed statin therapy (82.7% vs 80.8%) in cases of cardiovascular disease.
- A higher share of Medicare Advantage enrollees with diabetes had at least one blood sugar level (HbA1c) test (91.7% vs 90.4%) and were prescribed (76.2% vs 72.5%) and completed statin therapy (83.4% vs 80.4%).
- Similarly, a higher share of Medicare Advantage enrollees received disease-modifying antirheumatic drugs (DMARD) therapy for rheumatoid arthritis (84.5% vs 81.3%) and osteoporosis management after a fracture (42.1% vs 20.5%).
- Medicare Advantage enrollees who qualified for Medicare based on disability status (and are under age 65) had a higher share of asthma controller to reliever medications, indicating a higher level of control of their condition.
- A higher share of Medicare Advantage enrollees with chronic obstructive pulmonary disease (COPD) were prescribed systemic corticosteroids (73.3% vs 70.8%) and bronchodilators (65.5% vs 64.8%), although the difference in bronchodilator treatment was not statistically significant. In contrast, for newly diagnosed COPD patients, a lower share of Medicare Advantage enrollees received spirometry testing to confirm the diagnosis (41.5% vs 44.7%). However, the difference was not statistically significant.

Medicare Advantage outperformed original Medicare across many areas of preventive care

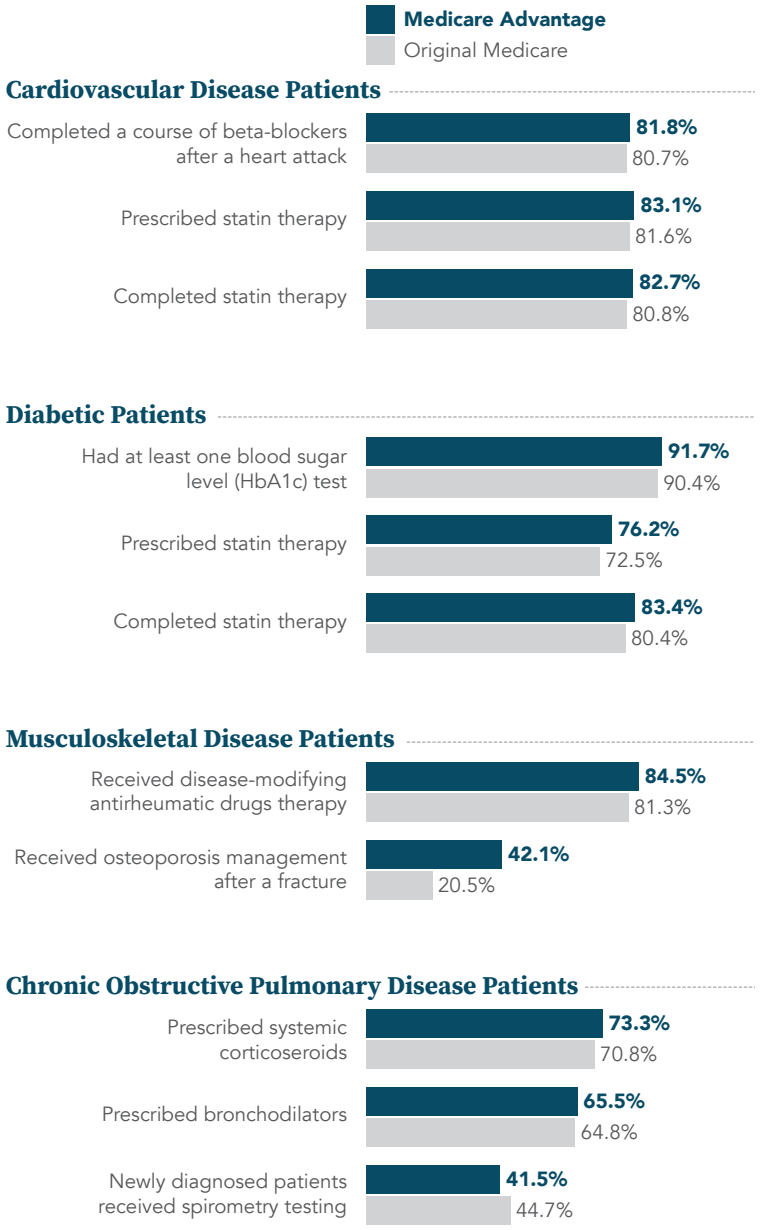

Table 1. Performance Measures for Enrollees in original Medicare and Medicare Advantage, 2019

HEDIS Measure	OM	MA	Absolute Difference
Cancer Screening			
Breast Cancer Screening	69.9%	73.3%	3.4%*
Colorectal Cancer Screening[a]	33.1%	38.9%	5.7%*
Cardiovascular Disease Care			
Persistence of Beta-Blocker Treatment After a Heart Attack	80.7%	81.8%	1.1%*
Statin Therapy for Patients with Cardiovascular Disease			
• Received Statin Therapy	81.6%	83.1%	1.5%*
• Statin Therapy Adherence	80.8%	82.7%	1.9%*

HEDIS Measure	OM	MA	Absolute Difference
Diabetes Care			
HbA1c Screening	90.4%	91.7%	1.4%*
Statin Therapy for Patients with Diabetes			
• Received Statin Therapy	72.5%	76.2%	3.7%*
• Statin Therapy Adherence	80.4%	83.4%	3.0%*
Musculoskeletal Disease Care			
DMARD Therapy for Rheumatoid Arthritis	81.3%	84.5%	3.2%*
Osteoporosis Management in Women Who Had a Fracture	20.5%	42.1%	21.6%*
Respiratory Conditions Care			
Asthma Medication Ratio[b]	73.6%	76.4%	2.9%*
Pharmacotherapy Management of COPD Exacerbation			
• Corticosteroid treatment	70.8%	73.3%	2.5%*
• Bronchodilator treatment	64.8%	65.5%	0.7%
Use of Spirometry Testing in Assessment and Diagnosis of COPD	44.7%	41.5%	-3.2%

Notes: * results significant at p<0.05; a) measure uses look back period of 4 years instead of required 10 year due to data limitations; b) includes beneficiaries ages 5-64 who qualify for Medicare based on disability status.

Discussion

Use of preventive services is one important factor in maintaining good health and keeping chronic health conditions from getting worse. The findings presented here show that Medicare Advantage enrollees have higher rates of use across a wide range of preventive services than their original Medicare counterparts, consistent with prior studies showing Medicare Advantage plans have higher performance on HEDIS preventive measures than original Medicare.[1]

The continued high performance of Medicare Advantage on ensuring access and use of preventive care is important for several reasons. First, other research has shown that an increasing share of low-income and minority enrollees choose Medicare Advantage. These groups have historically had lower rates of preventive care use and worse health outcomes,[2] and are therefore especially likely to benefit from Medicare Advantage's focus on preventive care for individuals with chronic illness.

Second, these findings show that Medicare Advantage plans have been able to deliver high quality care even as they continue to achieve greater cost efficiency relative to the original Medicare program.[3] A study conducted by Avalere showcased that if FFS Part A utilization were equivalent to Medicare Advantage, spending would decrease which may increase the solvency period of the HI Trust Fund by 17 years, until 2048.[4] And a recent Harvard Medical School-Inovalon study further supports the benefits of Medicare Advantage, finding that enrollees have fewer readmissions, fewer preventable hospitalizations, and lower rates of high-risk medication use than people in original Medicare.[5]

1 Timbie, et al. HSR 2017.
2 Hostetter and Klein. Commonwealth Fund. 2018
3 Wakely. Value of Medicare Advantage Compared with Fee for Service. https://www.ahip.org/documents/Value-of-MA-_Response-to-MedPAC_09.21.2022.pdf
4 Avalere. Medicare HI Trust Fund Solvency Assuming MA Utilization. https://avalere.com/insights/medicare-hi-trust-fund-solvency-assuming-ma-utilization
5 Teigland et al. Quality Outcomes Under Medicare Advantage vs. Medicare Fee-for-Service. https://www.inovalon.com/wp-content/uploads/2023/11/FINAL-INS-23-2164-Harvard-Campaign-White-Paper.pdf

Methodology

This study used Centers for Medicare & Medicaid Services (CMS) 2016-2019 dataset containing medical and pharmacy claims data from the representative 5% sample of Medicare enrollees, including both original Medicare and Medicare Advantage enrollees. Zip code level data on socio-economic indicators, e.g., median household income, unemployment level, and poverty level, were obtained from the American Community Survey published by the U.S. Census Bureau.[6] The Census data were linked to Medicare claims data based on the enrollee's zip code.

The study included enrollees who were continuously enrolled in either original Medicare (Part A and B) or Medicare Advantage (Part C) and were enrolled in drug benefit coverage (Part D) between January 1, 2018 and December 31, 2019. For select measures, enrollees had to be continuously enrolled for 4 years from January 1, 2016 to December 31, 2019. The study excluded Medicare enrollees who qualified for Medicare due to end-stage renal disease. The study further excluded enrollees who switched between programs or terminated their coverage.

Propensity score matching was used to construct matching cohorts of original Medicare and Medicare Advantage enrollees to account for socioeconomic, demographic, and health status differences between the populations enrolled in the 2 programs. Compared to original Medicare, Medicare Advantage plans serve a population that is more urban and racially diverse, have lower incomes, and are more likely to suffer from chronic diseases.[7] The cohorts were matched in a one-to-one match using logistic regression based on the following demographic and socio-economic variables: age, sex, racial minority status, full or partial-dual eligibility, Charlson Comorbidity Index, urban/rural residence, share of residents with less than high-school diploma (zip code level), median household income quartile (zip code level). Matching resulted in a final study cohort of 539,461 matched pairs of enrollees.

To construct preventive quality of care measures, the study relied on the 2019 Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA).[8] Only measures that applied to Medicare patients and could be constructed using administrative claims data were selected. In addition, measures that relied on provider specialty identification were excluded since CMS' Medicare Advantage encounter data set did not include data on provider specialty. A chi-square test was performed to assess the statistical significance of the difference between the quality of care measures in original Medicare and Medicare Advantage programs.

Limitations

While HEDIS rates calculated in this study are for the most part similar to those reported by health plans, they diverge substantially in some cases. There are several sources of divergence between the estimated and reported rates. First, the study relies exclusively on administrative data to calculate the HEDIS rates for original Medicare and Medicare Advantage programs, which can result in underreporting in some cases due to incomplete data. In contrast, HEDIS rates reported by the Medicare Advantage health plans to NCQA rely on a mix of administrative data and medical records for a more comprehensive view. Second, as a result of cohort matching, the sociodemographic composition of the Medicare Advantage cohort in the study was slightly different from the overall Medicare Advantage population. The matched cohort had the sociodemographic characteristics that were the average of the two programs. Finally, due to data limitations, the study used a shorter lookback period for some measures (e.g., 4-year lookback instead of the required 10-year period in Colorectal Cancer Screening), which resulted in lower measure scores.

6 U.S. Census Bureau. American Community Survey. https://www.census.gov/programs-surveys/acs

7 Medicare Advantage Demographics. https://www.ahip.org/resources/medicare-advantage-demographics

8 National Committee for Quality Assurance. "Healthcare Effectiveness Data and Information Set." (2019); Available at: http://www.ncqa.org/hedis- quality-measurement