

UNDERSTANDING THE IMPACT OF MEDICARE ADVANTAGE ON HOSPITALIZATION RATES: A 12-STATE STUDY



Policy Studies in Family Medicine and Primary Care

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INTRODUCTION

Greater use of Medicare Advantage (MA) over traditional fee-for-service Medicare (TM) in certain populations, and even across small areas, has been associated with fewer overall hospitalizations and avoidable hospitalizations.^{1,2,3,4} Proponents attribute these associations to successful care management, and a focus on preventive services and primary care among MA users, while detractors say it is due to self-selection of healthier individuals into MA plans. We set out to update and advance previous analyses, using the most contemporary multistate hospitalization data and focusing on the impact MA penetration has on avoidable hospitalizations. We asked the following:

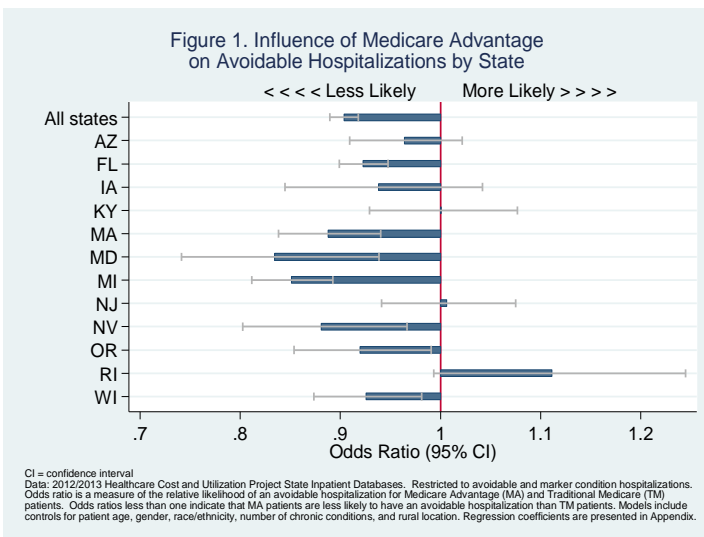
1. Do MA enrollees have different rates of avoidable hospitalization, even after controlling for expected hospitalization?
2. How does regional MA penetration impact avoidable hospitalizations among MA enrollees, and is there a spillover effect on TM beneficiaries as regional MA penetration increases?

BACKGROUND

Medicare Advantage, also known as Medicare Part C, was established to authorize Medicare to contract with private plans to provide coverage to Medicare-eligible beneficiaries in exchange for a risk-adjusted per-person per-month payment. The stated goals of MA are to offer better health care coordination and comprehensive care, and to achieve the cost savings and efficiencies received by managed care in the private sector. MA is required to cover the same core benefits as TM. MA plans are incentivized by a star rating system to improve quality and are also able to provide additional benefits such as vision, dental, or hearing care. In 2015, MA enrollment was more than 17 million individuals, which was more than 31% of Medicare beneficiaries. Enrollment in MA varies widely by state and county, in large part due to MA enrollment differences between urban and rural areas.

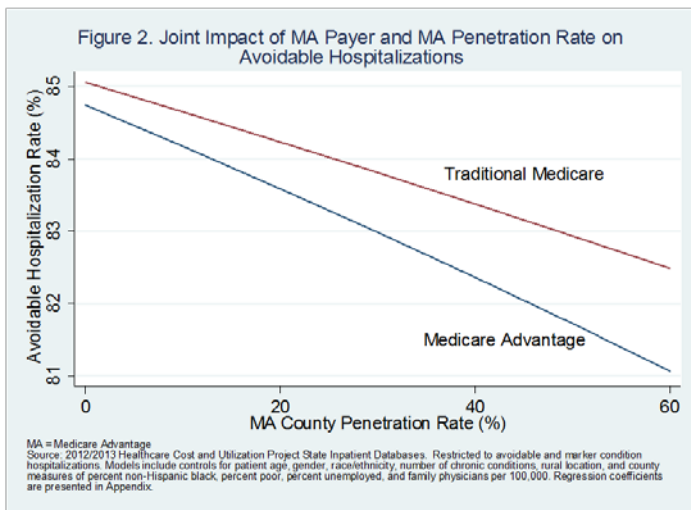
KEY FINDINGS

1. MA Patients 10% Less Likely to Have Avoidable Hospitalizations



Despite changes to TM delivery that result from changing policy and environmental conditions, users of MA plans continue to have fewer avoidable hospitalizations than TM beneficiaries, controlling for expected hospitalizations. With state-to-state variation, the overall adjusted likelihood of an avoidable hospitalization is about 10% lower for MA patients than for TM patients after adjusting for differences in patient age, gender, race/ethnicity, number of chronic conditions, and geography.

2. High MA Penetration Rates Associated With Decreasing Avoidable Hospitalization Rates for Both MA and TM



Care received by some patients may “spillover” and positively affect the care of others.⁵ Treating a large number of MA patients could influence a physician’s practice style, which would, in turn, affect all patients the physician treats, not only those in MA. Our study found that MA penetration was associated with a positive “spillover effect” on TM beneficiaries. As county MA penetration rates increase, avoidable hospitalizations—compared with expected hospitalizations—decrease for both MA and TM beneficiaries.

SUMMARY

- Looking at Medicare hospitalizations in 12 sample states, we found that MA enrollees were 10% less likely to have avoidable (sometimes labeled “preventable” or “ambulatory care-sensitive”) hospitalizations than TM enrollees, even after controlling for differences in age, race/ethnicity, and gender, and indexing against marker condition (also labeled “expected” or “unavoidable”) hospitalizations.
- Our findings are consistent with those reported by other researchers that show MA plans reduce avoidable hospitalizations by approximately 10% after adjusting for individual and contextual factors.
- MA was also associated with a positive “spillover effect” on TM beneficiaries. Counties with higher MA penetration rates have fewer avoidable hospitalizations for both MA enrollees and TM beneficiaries, even after controlling for other explanatory factors.

This study uses data from 2012/2013 Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases, restricted to the 12 states that differentiate between MA and TM as the main payer in the HCUP data. The total sample was 3,060,427 hospital discharges. The report was prepared by Stephen Petterson; Andrew Bazemore; Yalda Jabbarpour; Peter Wingrove; and Megan Coffman. The full report is available at www.graham-center.org.

¹ Basu J, Mobley LR, Thumula V. The small area predictors of ambulatory care sensitive hospitalizations: a comparison of changes over time. *Soc Work Public Health*. 2014;29(2):176-188.

² Lemieux J, Sennett C, Wang R, Mulligan T, Bumbaugh J. Hospital readmission rates in Medicare Advantage plans. *Am J Manag Care*. 2012;18(2):96-104.

³ Basu J, Mobley LR. Medicare managed care plan performance: a comparison across hospitalization types. *Medicare Medicaid Res Rev*. 2012;2(1):E1-E21.

⁴ Nicholas LH. Better quality of care or healthier patients? Hospital utilization by Medicare Advantage and fee-for-service enrollees. *Forum Health Econ Policy*. 2013;16(1):137-161.

⁵ Baicker K, Robbins JA. Medicare payments and system-level health-care use: the spillover effects of Medicare managed care. *Am J Health Econ*. 2015;1(4):399-431.