ATI Advisory

August 2023

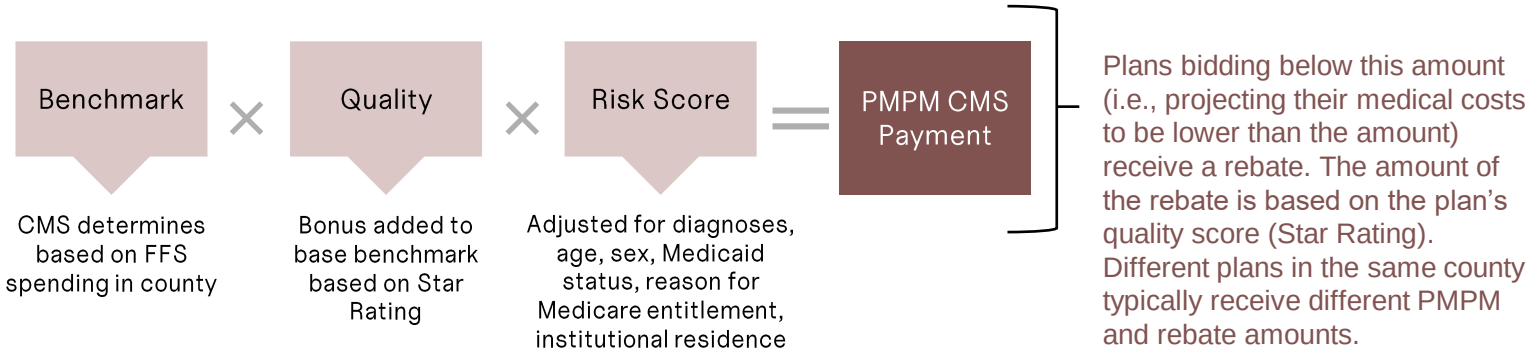
Bid and Benefit Design Considerations Following the Transition of the MMP

About the Issue

→ States using the Medicare-Medicaid plan (MMP) model to advance integration establish a benefit package that MMPs must offer, typically inclusive of Medicare and Medicaid benefits. **It's important that transitioning MMP states are aware of the benefit design approach that occurs in Dual Eligible Special Needs Plans (D-SNPs) as part of the standard Medicare Advantage bidding process.** States can engage in this process but typically have less oversight than in the MMP.

DEFINITIONS

- **Medicare Benchmark.** CMS publishes county per member per month (PMPM) benchmark amounts for Medicare Advantage plans, against which D-SNPs and other Medicare Advantage plans "bid." Benchmarks vary by county and are a percentage of Medicare fee-for-service (FFS) spending. Counties with higher FFS spending receive a lower proportional benchmark, due to the expectation that Medicare Advantage plans have more opportunity to reduce costs in those counties.
- **Rebate.** If a Medicare Advantage plan bids below the published [quality and risk-adjusted] benchmark, the savings are shared between CMS and the plan. The plan's portion is referred to as the rebate and must be used to lower their enrollees' cost sharing or premiums, and/or provide supplemental benefits.
- **Supplemental Benefits.** Via rebate dollars or additional premiums, Medicare Advantage plans can provide supplemental benefits that go beyond core Medicare benefits. These typically include dental, vision, and hearing, and may include non-medical benefits such as food, transportation, and in-home support services. Supplemental benefits are part of Medicare Advantage marketing materials, which can influence Medicare beneficiary enrollment choices.



IMPORTANT CONSIDERATIONS FOR STATES

A Medicare Advantage bid is subject to certain year-over-year margin gain/loss requirements at both a plan ID and organization level, which means adjusting one plan ID (e.g., a D-SNP) impacts the organization's whole bid. Adjusting benefits on a single plan ID late in the bid cycle can be especially difficult given this organizational impact. In addition, Medicare Advantage plans typically begin planning their benefit packages a year prior to enrollment, and they generally cannot file a benefit unless they already have a contracted provider able to provide the filed benefit. This means Medicare Advantage plans may need a provider network contracted 6 – 12 months before enrollment begins. Final bids across the whole Medicare Advantage organization for all plan IDs are due in June of the year preceding enrollment.