ADVANTMED

High Priorities for the U.S. Healthcare System:

POWERFUL END-TO-END SOLUTION TO INTEGRATE PATIENT CARE

Introducing the first in a three-part series of white papers designed to explore 1) Why the nation's health system is facing a financial crisis, 2) How providers that accept Medicare Advantage plans and other risk-bearing entities will play an increasingly important role, and 3) A critical need to help patients better manage their health through a range of innovative approaches that foster prevention and self-management.

Advantmed's powerful end-to-end solution integrates with patient care to help managed care organizations improve outcomes by delivering the optimal combination of capabilities designed to meet key objectives, including risk adjustment analytics, software containing NCQA-certified HEDIS® measures, medical record retrieval, medical record abstraction, in-home assessments, risk adjustment coding and provider education.

Part One:
FEDERAL POLICY AND MEDICARE'S IMPACT ON THE ECONOMY

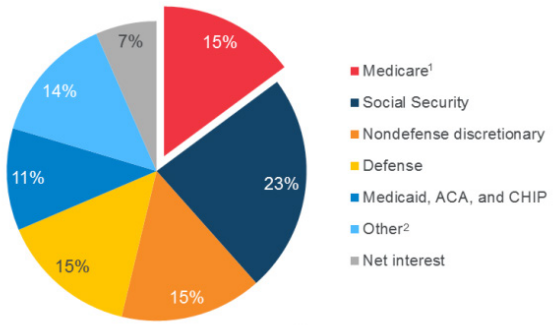
The nation's healthcare system faces a potentially catastrophic challenge: aging baby boomers are creating a significant shift from enrollment in private health insurance to Medicare and driving an unsustainably high rate of healthcare spending, according to the Centers for Medicare & Medicaid Services (CMS).[1]

Projections show that national health expenditure growth is expected to average 5.5 percent annually to reach $5.7 trillion by 2026. This growth rate would be higher than the projected increase in Gross Domestic Product (GDP) by 1.0 percentage point from 2017 to 2026, pushing health spending's share of GDP from 17.9 percent in 2016 to 19.7 percent by 2026.[2]

As a result, the Medicare trust fund will be insolvent by 2028, according to the 2016 Medicare trustees.[3] What's more, an increase in spending of 0.75 percent in the federal debt could comprise 129 percent of GDP by 2040,[4] and Medicare—originally started with 4.6 working people per beneficiary—will be reduced

Figure 1

Medicare as a Share of the Federal Budget, 2017



Total Federal Outlays, 2017: $4.0 trillion
Net Federal Medicare Outlays, 2017: $591 billion

NOTE: All amounts are for federal fiscal year 2017. [1]Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. [2]Includes spending on other mandatory outlays minus income from offsetting receipts. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program.
SOURCE: KFF analysis of federal spending from Congressional Budget Office, The Budget and Economic Outlook, 2018 to 2028 (April 2018).

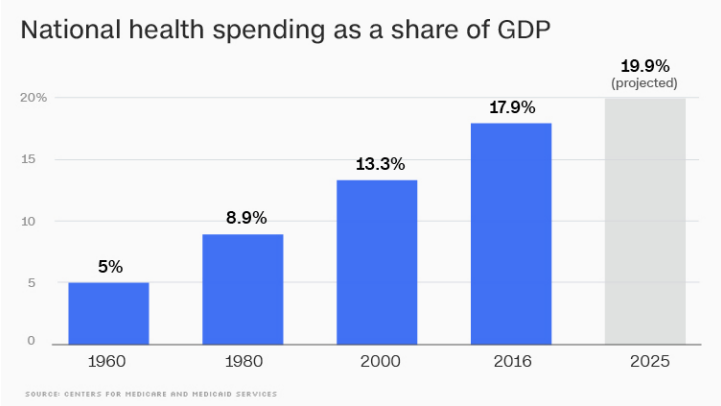
KFF

Source: Kaiser Family Foundation; The Facts on Medicare Spending and Financing; June 22, 2018; https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/; accessed June 27, 2018.

to 2.5 workers per beneficiary by 2040.[5]

Healthcare spending accounts for an ever-growing share of the economy, and a growing expense for businesses and individuals. CMS estimated that spending grew 5.4 percent in 2017 due primarily to faster growth in Medicare and private health insurance spending. Fueled by Medicare and Medicaid spending, CMS projects 5.9 percent growth for 2018 and 2019.[6]

Further complicating this issue, programs created to reduce the spending burden for 2040



Source: http://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html

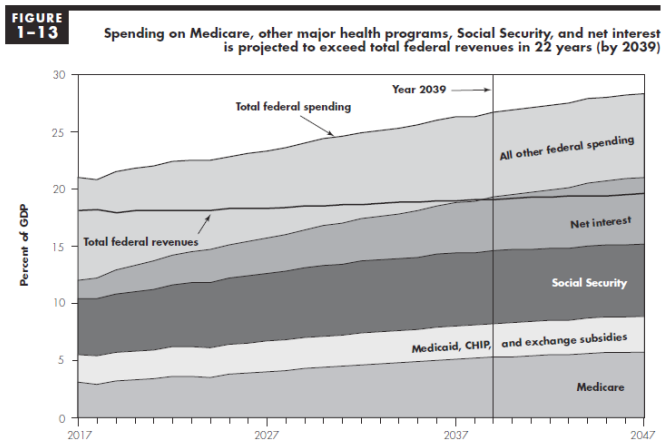
face depletion. Hospital Insurance (HI) Trust Fund Payroll taxes are not growing as fast as Part A spending[7] and will be insolvent by 2028 to 2030. Supplemental Medical Insurance (SMI) covers Part B and D financed by premiums (25 percent) and general revenue (75 percent). Reset each year, general revenues account for 42 percent and will increase to 48 percent by 2030. Federal borrowing for a 75-year projection is $28 trillion.[8]

As a result, expect deepening reliance on Medicare Advantage (MA) plans, a form of private insurance that provides Part A and B health services to beneficiaries.

Value-Based Medicare Advantage Care Delivery

If further cuts to Medicare entitlements occur in 2018, then deductibles and cost-sharing for seniors in original Medicare will likely increase, which will make MA plans that much more attractive for the nation's aging population.[9]

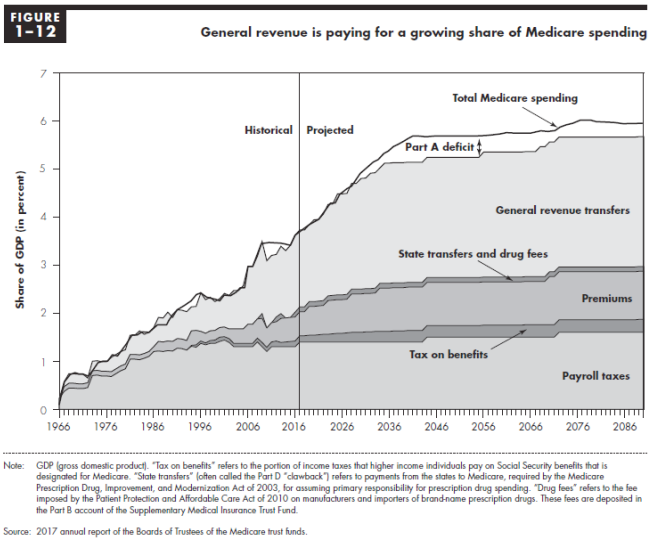
MA plans provide an alternative to traditional fee-for-service (FFS) Medicare, and have been a commercial success, accounting for 17.5 million (30.6%) of all Medicare enrollees and $204.7 billion (28.9%) of Medicare's 2017 gross



SOURCE: Medicare Payment Advisory Commission; Report to the Congress: Medicare Payment Policy; March 2018; http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0; accessed May 29, 2018.

spending budget.[10]

Access to MA plans remains high in 2018, with most Medicare beneficiaries having access to many plans. In fact, nearly all Medicare beneficiaries (96 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 74 percent of beneficiaries. Forty-one percent of beneficiaries

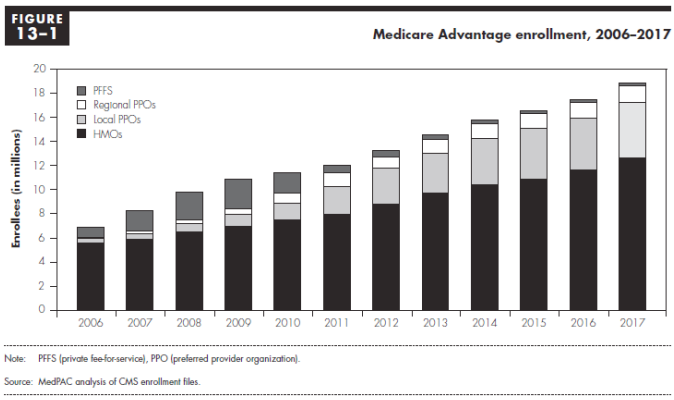


SOURCE: Medicare Payment Advisory Commission; Report to the Congress: Medicare Payment Policy; March 2018; http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0; accessed May 29, 2018.

have access to PFFS plans. Overall, 99 percent of Medicare beneficiaries have access to an MA plan.[11] An analysis of the MA program's market structure shows that, compared with 2007, MA enrollment in 2017 is more heavily concentrated.

Validation

In a seminal paper "Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival" published in the American Journal of Managed Care, the authors tested the hypothesis of payer-provider risk contracting promoting high-value care within MA. This program has grown significantly representing over 30 percent of all Medicare enrollees.[12]



SOURCE: Medicare Payment Advisory Commission; Report to the Congress: Medicare Payment Policy; March 2018; http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0; accessed May 29, 2018.

With different statutory authority private Medicare Advantage Organizations (MAOs) perform an annual risk-adjusted competitive bid process based on a county fee for service benchmark. CMS reimburses MAOs with prospective, monthly, severity of illness or risk-adjusted capitated payments. In return for providing healthcare benefits to MA enrollees during the calendar year, MAOs receive risk-adjusted payments based on the CMS-HCC model during the following payment year.

Due to the stability and transparency of the CMS-HCC model, medical groups can contract typically between 30 percent to more than 80 percent of the MAO premium. This unique contracting capability enables downstream innovation at a local provider level.[13]

To determine if risk-based contracting improved clinical outcomes, one metropolitan statistical area, as defined by CMS, was chosen with two different provider groups standard FFS (control) and a risk-based contracting (interventional). Researchers concluded that risk-based contracting demonstrates superior clinical outcomes and improvement in mortality.[14]

Recent proposals, including 1115A waivers for AMPs in MA, may accelerate the development of further risk-based contracting to achieve the Triple Aim—improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare—to improve the lives of patients.

Value-based contracting generates cost efficiencies and improves clinical outcomes in MA. For MA plans and risk-bearing entities to remain sustainable, however, they must adopt innovative quality and risk adjustment programs to meet the growing demand for effective care strategies.

MedPAC & MA Enrollment

The Medicare Payment Advisory Commission (MedPAC), a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program, strongly supports the inclusion of private plans in the Medicare program, stating that beneficiaries should be able to choose

between the traditional FFS Medicare program and alternative delivery systems that private plans can provide.

Because Medicare pays private plans a risk-adjusted per-person predetermined rate rather than a per-service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

On average, quality bonuses in 2018 will add four percent to the average plan's base benchmark and will add three percent to plan payments. Risk adjustment and coding intensity affect Medicare payments to MA plans and are enrollee specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code.[15]

Most claims in FFS Medicare are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify ordering a procedure.

In contrast, MA plans have had a financial incentive, since the current risk adjustment model was introduced, to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan.

The Commission's updated analysis for 2016 shows that higher diagnosis coding intensity resulted in MA risk scores that were eight percent higher than scores for similar FFS beneficiaries. This estimate is lower than the prior year due to the full implementation of a new risk adjustment model and an increase in FFS risk score growth, matching the growth rate of MA risk scores.[16]

Quality Measures

MA plans are able to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS's 5-star rating system. At the end of 2017, 1.4 million enrollees were in a non-bonus contract that was absorbed by another contract with a rating of 4 stars or higher.[17]

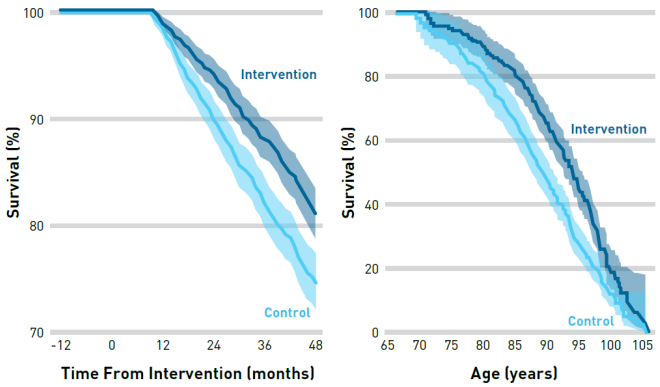
The 1.4 million enrollees under the original contracts that were not in bonus-status contracts are in bonus status for the 2018 payment year because of consolidations. Since 2013, over four million enrollees—over 20 percent of MA enrollees—have been moved among contracts to secure bonus payments that would not otherwise be payable. Therefore, while over 70 percent of MA enrollees are classified as being in plans rated 4 stars or higher, taking into account the enrollees who are in bonus-status plans because of consolidations, the actual share could be as low as 50 percent.[18]

The Commission recommends that contract consolidations should not be allowed to affect star ratings and bonus payments when two contracts serving different geographic areas are consolidated.

In conjunction with the recommendation addressing consolidations, the Commission restates its recommendation, first made in 2010, that the geographic unit for quality reporting should be the local healthcare market area. In addition to the unwarranted bonus payments, the wave of contract consolidations has resulted in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area. The consolidations have also limited the Commission's ability to report quality results in MA in its usual manner of comparing year-over-year contract-level results.[19]

Alternative ways of looking at changes in quality over time—such as by using weighted average results across all plans—indicate that quality results are mixed, with most measures unchanged; among the small number of measures where there was a significant change, a greater number improved than declined.

FIGURE 3. Kaplan-Meier Curves for Survival for Matching Cohorts of Medicare Advantage Enrollees During the Study Period[a,b]



Source: Adapted from the February 2017 article American Journal of Managed Care "Valued-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival"

Innovative Approaches

Value-based contracting can drive utilization patterns and improve clinical outcomes among chronically ill, elderly MA members.

One study tested the hypothesis that payer-provider risk contracting promotes high-value care and concluded:

- In the future, more clinicians will have to bear the monetary risks associated with healthcare utilization.
- The MA program provides a unique milieu for investigating provider groups that have either risk-bearing or fee-for-service contracts with private health plans.
- Full-risk capitation combined with a revenue gainshare agreement sparked a clinical practice transformation at the provider group level, associated with increased office-based care and decreased hospital-based services.
- The clinical practice transformation resulted in a six percent survival benefit and lowered the hazard of death by 32.8 percent.[20]
- Value-based contracting benefits all stakeholders of the MA program.

The intervention group's overall survival rate was 82 percent, and the control group's was 76 percent. This six percent survival benefit first became apparent at 16 months after the intervention, coinciding with the first year that the intervention group had higher office-based utilization than the control group.[21]

Age provided a natural time-scale for calculating the hazard of death for this elderly population with multiple comorbidities and a higher risk of all-cause mortality. Intervention-group members had a 32.8 percent lower hazard of dying (P <.001). The survival benefit was more apparent among those aged 82 to 96 years. Randomization inference confirmed these survival data, whether time (P <.001) or age (P <.001) was the time scale.[22]

> Improved survival is related to and attributable to enhanced CMS-HCC data and value-based contracting, which then transform primary care delivery.

Optimizing the Opportunity

MA plans should look at the full spectrum of the patient and apply an end-to-end solution. When done effectively and efficiently—and combined with payment reform—it's possible to enhance care coordination using analytics, in-home care, retrospective solutions and care management to significantly improve outcomes. This approach is beneficial for the healthcare system, patients and

every stakeholder.

For example, MA plans can gain clinical insight into risk-adjusting conditions to enhance their traditional analytical platforms. The best way to do this is with a Physician Record Review (PRR), a two-stage retrospective chart review process from a 1) certified coder and 2) board-certified physician.

To gain a robust view of members and their care needs, providers can also rely on prospective health assessments (PHA). PHAs help to lay the groundwork for developing more accurate reporting documentation, improving patient engagement and compliance, enhancing disease management, and reducing utilization.

This kind of full-spectrum, end-to-end approach to care helps providers identify gaps in care and manage patients more productively. It also helps health plans that are serving as intermediaries execute solutions and assume risk. Ultimately, the greatest benefit goes to the patient, who will be guided toward more preventive care and self-management early in the care process.

1. Connole, Patrick; CMS Says Aging Boomers a Big Factor in Health Spending Forecast; Provider Magazine; Feb. 16, 2018; http://www.providermagazine.com/news/Pages/2018/FEBRUARY%202018/CMS-Says-Aging-Boomers-a-Big-Factor-in-Health-Spending-Forecast.aspx; accessed May 29, 2018.
2. Connole, 2018.
3. KHN; Medicare Fund Could Be Depleted By 2028, Trustees Say; June 23, 2016; https://khn.org/morning-breakout/medicare-fund-could-be-depleted-by-2028-trustees-say/; accessed May 29, 2018.
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