MEDICARE ADVANTAGE

PLANS NEED EFFECTIVE RISK, QUALITY AND CARE STRATEGIES

By SCOTT HOWELL

Licensed Medicare insurance brokers provide invaluable guidance for retirees making healthcare coverage decisions that can have serious consequences on their health and financial well-being. Therefore, it's critical that they have a firm grasp on trends, innovations and helpful solutions in the Medicare Advantage (MA) space.

First of all, the nation's untenable rate of healthcare spending has sparked a growing reliance on MA plans, which provide an alternative to traditional fee-for-service (FFS) Medicare. In fact, MA plans now represent 30.6 percent of all Medicare enrollees and 28.9 percent of Medicare's 2017 gross spending budget.

Second, individuals can get Medicare benefits from original Medicare or a MA plan, such as an HMO or PPO. With the former, the government pays for Medicare benefits. With MA plans, the coverage is offered by private companies approved by Medicare. MA plans provide all Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage.

The Best Possible MA Plan

The most effective MA plans on the market 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.

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. For example, MA plans can gain clinical insight into risk-adjusting conditions to enhance their traditional analytical platforms.

How Does a Risk Adjustment Model Work?

Risk adjustment is an actuarial tool used to calibrate payments to health plans based on the relative health of the at-risk populations. If insurers are limited in the extent to which premiums can vary by health status or other factors that are associated with health spending, risk adjustment can help ensure that health plans are appropriately compensated for the risks they enroll.

Significantly, most claims in fee-for-service 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 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.

Consider two examples of how an MA plan can be optimized: Advantmed's Physician Record Review (PRR) is a two-stage retrospective chart review process from a 1) certified coder and 2) board-certified physician.

Advantmed's Prospective Health Assessments (PHA) provide a robust view of members and their care needs. Providers can also rely on PHAs 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 plan members more productively. It also helps health plans that are serving as

intermediaries, executing solutions and assuming risk.

Ultimately, the greatest benefit goes to the plan member, who will be guided toward more preventive care and self-management early in the care process.

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 that 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 6 percent survival benefit and lowered the hazard of death by 32.8 percent.

Value-based contracting benefits all stakeholders

The intervention group's overall survival rate was 82 percent, and the control group's was 76 percent. This 6 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.

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.

Improved survival is related to and attributable to the Centers for Medicare and Medicaid Service's (CMS) Hierarchical Condition Category (HCC) data and value-based contracting, which then transform primary care delivery.

Brokers should also be aware that CMS expanded how it defines the "primarily health-related" benefits that private insurers are allowed to include in their MA policies, with insurers including these extras on top of providing the benefits of traditional Medicare. For instance, air conditioners for people with asthma, healthy food, rides to medical appointments and home-delivered meals may be among the new benefits offered to Medicare beneficiaries who choose private sector health plans, when new federal rules take effect. This means MA beneficiaries will have more supplemental benefits and be better able to lead healthier, more independent lives. ★

Scott Howell, M.D., MPH & TM, CPE, is chief medical officer, Advantmed. Advantmed, LLC is a healthcare solutions company dedicated to partnering with health plans, provider groups and risk-bearing entities to optimize risk adjustment and quality improvement programs. Our integrated and technology-enabled solutions improve health plan financial results and offer insights on health plan members. For more information on Advantmed's solutions, visit www.advantmed.com. Look under the "resources" tab for our recently published white-paper on the federal policy and the economics of Medicare.