Our three-part series of white papers explores 1) Why the nation's health system is facing a financial crisis, 2) How providers that accept Medicare Advantage (MA) 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. MA plans are a form of private insurance that provides Part A and B health services to beneficiaries.

Part Two of our series looks at the trends driving the growing adoption of MA plans, provider opportunities — and challenges — in the increasingly value-based healthcare system, and innovative approaches designed to meet growing demand for effective risk adjustment, quality and care strategies.

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 Two:
RISE OF MEDICARE ADVANTAGE PLANS AND ITS IMPLICATIONS FOR RISK-BEARING HEALTHCARE PROVIDERS

MA plans have been in operation in various forms since the 1970s. They receive capitated, per member per month (PMPM) payments and bear financial risk for the total cost of care for a beneficiary. For the most part they have been administered by experienced commercial insurers that have leveraged benefit design, geography and enrollment to be financially successful in managing risk.[1]

Increasingly, provider-led organizations are taking on risk but without some of the benefits that MA plans have had, especially when it comes to risk-adjustment models. Risk adjustment is the process of modifying payments and benchmarks to reflect the degree of illness, which enables the Centers for Medicare & Medicaid Services (CMS) to estimate future spending and allows providers to understand the health characteristics of their managed population. In MA plans, this risk adjustment methodology is called Hierarchical Condition Categories (HCCs).

HCCs could more accurately be described as patient conditions and prospective costs. Knowing how CMS uses them to calculate expenditure benchmarks or PMPMs is critical for a risk-bearing provider's ability to earn shared savings while avoiding shared loss.[2]

Gradually, such knowledge is becoming relevant for the operational viability of all independent practice owners and health systems. Ultimately, the goal is to improve patient outcomes at reduced costs, with providers being accountable for both.[3] Because MA plans have been able to optimize the HCC methodology with significant financial success, providers are well advised to study their methods.[4]

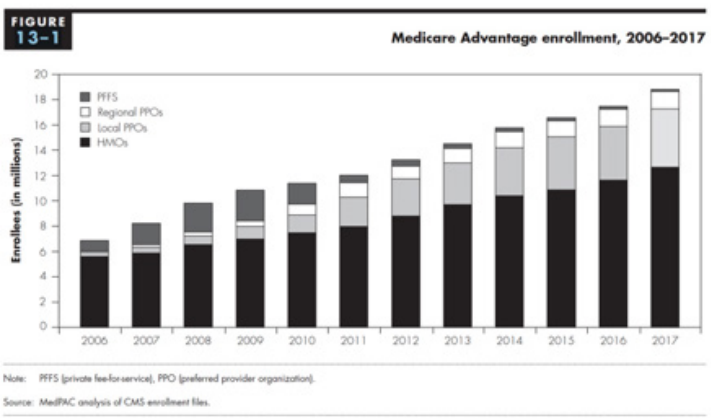
Shifting Demographics Drive Rise of MA Plans

Aging baby boomers have sparked a significant shift from enrollment in private health insurance to Medicare — driving an unsustainably high rate of healthcare spending:[5]

- Health expenditure growth is expected to average 5.5 percent annually to reach $5.7 trillion by 2026.
- Health spending's share of Gross Domestic Product (GDP) will rise from 17.9 percent in 2016 to 19.7 percent by 2026.[6]
- The Medicare trust fund will be insolvent by 2028.[7]
- Fueled by Medicare and Medicaid spending, CMS projects 5.9 percent growth in healthcare spending for 2018 and 2019.[8]
- Programs created to reduce the spending burden for 2040 face depletion, including the Hospital Insurance (HI) Trust Fund Payroll and Supplemental Medical Insurance (SMI).[9]

As a result, there will be increased reliance on MA plans. If further cuts to Medicare entitlements occur, 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.[10]

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 spending budget.[11]



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.

New Opportunity for Providers

These trends have fueled new opportunities for primary care physicians who embrace risk-based payment models and capitation.[12] Practices that succeed at making the shift from FFS to managing risk are routinely able to increase their practice profitability by at least 25 percent.[13]

This economic benefit is associated with a provider's ability to handle two-sided risk: 1) upside risk associated with sharing in cost-savings bonuses based on operational efficiencies, and 2) downside risk associated with losing revenue based on failure to meet clinical and/or financial performance thresholds.

Many providers continue to depend on the predictability of FFS revenue, but the shift to value-based revenue is expanding. Value-based models enable primary care to recapture revenue that typically goes to downstream providers.[14]

Success often hinges on being fully committed to comprehensive workflow redesign to improve performance related to saving on clinical costs, attaining quality outcome measures, and documenting coding and reporting of risk-based quality metrics.

Success in value-based approaches pivots around delivering on total patient health, cost, and quality rather than relying on the traditional paradigm of maximizing relative value units, revenue and downstream referrals.[15]

Risk-based models of care generate income for primary care providers and cost savings for payers by reducing spending relative to

benchmarks set by CMS. Most of the economic value comes from reducing hospitalizations. In fact, some risk-bearing practices are reducing hospital days by 38 percent on a risk-adjusted basis.[16]

Savings are also generated by reducing use of post-acute care facilities, emergency departments, diagnostic tests, and referring to more cost-effective specialists who do not add facility fees, order fewer expensive diagnostic tests, are better at engaging patients in their care, and are more cautious in their approach to procedures.[17]

Validation of Value-Based Contracting

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.[18]

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.[19]

Challenges

The shift toward providing more specific and complete documentation of all medical problems on an annual basis will be a challenge for many providers. Failing to adequately capture a patient's risk through documentation and coding could mean an inaccurately low level of attributed risk and reduced reimbursement.[20]

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 comparison, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan.

Higher diagnosis coding intensity resulted in MA risk scores that were eight percent higher than scores for similar FFS beneficiaries.[21] This highlights the point that 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 programs to meet growing demand for effective risk adjustment, quality and care strategies.

Innovative Approaches

Value-based contracting can drive utilization patterns and improve clinical outcomes, especially 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 FFS 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.[22]
- 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.[23]

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.[24]

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

When risk-based practices redesign their care processes to improve health and reduce hospitalizations, they should strive for more accurate coding to potentially improve revenue.

This entails making a concerted effort to complete annual wellness visits for most patients, typically more than 70 percent of patients, to document all diagnoses annually. By repeating these processes every year, in addition to reductions in hospital utilization, the risk-bearing practices can increase the risk scores of their patient populations by about 20 percent per year and improve Medicare Star measure performance.[25]

One study showed that savings are concentrated in patients with congestive heart failure, COPD, chronic pain, coronary artery disease, depression, and type 2 diabetes due to proven outpatient treatment strategies that can dramatically reduce exacerbations of these conditions. Because patients typically stay with their doctors for up to seven years and these risk-bearing primary care doctors are not limited to billable procedures, efforts to change patient social determinants and lifestyle choices can yield significant results.[26]

Advantmed offers a tailored suite of integrated risk adjustment and quality improvement services that meet the needs of a value-based payment system with integrated solutions:

- Risk Adjustment Analytics
- Medical Record Retrieval
- Risk Adjustment Coding
- Claims & Data Validation
- Prospective Health Assessments
- Physician Record Review
- HEDIS® Measurement & Reporting
- HEDIS & ACO Submission
- Medical Record Abstraction
- Member Engagement & Outreach
- Provider Education

For example, to gain a robust view of members and their care needs, providers can rely on Prospective Health Assessments (PHA) 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. Yeatts, John & Sangvai, Devdutta; HCC Coding, Risk Adjustment, and Physician Income: What You Need to Know; Fam Pract Manag. 2016 Sep-Oct;23(5):24-27; https://www.aafp.org/fpm/2016/0900/p24.html; accessed October 19, 2018.
2. Yeatts, 2016.
3. Yeatts, 2016.
4. Yeatts, 2016.
5. 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.
6. Connole, 2018.
7. 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.
8. Sahadi, Jeanne; Warren Buffett is right. Health care costs are swallowing the economy; Money; January 30, 2018: http://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html; accessed May 29, 2018.
9. Medicare Payment Advisory Committee: Report to Congress; Medicare Payment Policy; 2018.
10. Reuters; Medicare Advantage Plan Enrollment Expected to Rise in 2018-19; Feb. 8, 2018; https://www.reuters.com/brandfeatures/venture-capital/article?id=27244; accessed May 29, 2018.
11. Mandal, Aloke K. et al; Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival; The American Journal of Managed Care; February 2017; http://www.ajmc.com/journals/issue/2017/2017-vol23-n2/value-based-contracting-innovated-medicare-advantage-healthcare-delivery-and-improved-survival; accessed May 30, 2018.
12. Golden, William; Changing How We Pay for Primary Care; NEJM; November 20, 2017; https://catalyst.nejm.org/changing-primary-care-payment/; accessed October 19, 2018.
13. Golden, 2017.
14. Golden, 2017.
15. Golden, 2017.
16. Tanio, Craig & Chen, Christopher; Innovations At Miami Practice Show Promise For Treating High-Risk Medicare Patients: Health Affairs; June 2015; https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0201; accessed October 19, 2018.
17. Golden, 2017.
18. Mandal, 2017.
19. Mandal, 2017.
20. Yeatts, 2016.
21. MedPac, 2018.
22. Mandal, 2017.
23. Mandal, 2017.
24. Mandal, 2017.
25. Medicare.gov; Star Ratings; https://www.medicare.gov/find-a-plan/(X(1)S(4sazt2p43qelwtp5eieupp21))/staticpages/rating/planrating-help.aspx?AspxAutoDetectCookieSupport=1
26. Golden, 2017