Medicare Advantage: Modernizing Medicare Through Innovation in Financing and Care Delivery

By Allyson Y. Schwartz

Medicare Advantage plans, which are improving patient outcomes, offer a better path forward for Medicare.

The aging of our nation's population will place new demands on every sector of society, and no sector will be more adversely affected than the healthcare system. With 10,000 people turning age 65 every day, the number of older Americans is projected to double in the next few decades, growing from 48 million in 2018 to 98 million by 2060, at which point nearly one in five Americans will be ages 65 or older.

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How we meet these new demands on the healthcare system is an ongoing conversation in Washington, D.C., with an expected divide breaking down on whether the answer is to cut spending or garner new revenue, or enact some combination of the two. While policy makers are focused on the financial pressures on Medicare (as the largest payer of healthcare for older adults), there is an increasing realization that an important part of the solution is to modernize Medicare financing and care delivery to better to meet the needs of today's and tomorrow's older adults.

Medicare Beneficiaries' Changing Healthcare Needs

The health needs of older Americans have changed dramatically over time. The healthcare financing system established in 1965 with Medicare was designed to meet the concerns and reality of the day. Fifty years ago, older Americans needed help to pay for acute episodes of care that meant a hospital stay, which was unaffordable for most elders. Medicare addresses these expensive hospitalizations and accompanying services by covering the majority of the cost of hospital stays, associated physician services, tests, and procedures. Providers are reimbursed

→ABSTRACT Older adults are living longer with more chronic conditions and benefit from person-centered care that also addresses social determinants of health. Integrated, value-based care can better serve the Medicare population's changing healthcare needs. This article explores the way Medicare Advantage (MA) is modernizing Medicare financing and care delivery to meet the needs of today's and tomorrow's older adults, and how MA plans have shown improved outcomes for beneficiaries with chronic illness. **| key words**: *traditional Medicare, Medicare Advantage, chronic conditions, social determinants of health, integrated care, person-centered care, value-based care*

for covered benefits on a fee-for-service basis, with rates set by the federal government. Beneficiaries pay a deductible and co-payments, with many also purchasing supplemental coverage for outpatient and physician services.

The fee-for-service system created by traditional Medicare is fragmented and ill-suited for today's needs. While there still are people who will contract acute illnesses and inpatient care is a necessary and important part of all healthcare coverage, the field of medicine has become much more complex, with more specialists, treatments, and medications. The result, most significantly, is that more older adults are living longer with chronic conditions that need long-term management.

Older adults with chronic conditions are growing in number, as are the quantity of conditions they need help managing. They see multiple specialists, many of whom do not coordinate with each other. On average, Medicare patients see seven different physicians in four practices (Pham et al., 2007). Three in four adults older than age 65 have multiple chronic conditions (Gerteis, 2014). Seventy-seven percent have at least two conditions, and 14 percent have six or more (National Council on Aging, 2018). Those with multiple conditions account for 93 percent of fee-for-service Medicare costs each year (Gerteis, 2014). These are high-need, high-cost individuals who require ongoing clinical and support services in an integrated care system that can help them to manage their conditions and to live full and healthy lives.

The importance of integrated, value-based managed care

An integrated system, in which payments and benefits align to incentivize integrated care that encourages primary care, early intervention, and care management, is a better solution. This alternative exists in Medicare today—it is called Medicare Advantage (MA). The MA system is based on risk-based capitated payments to cover Medicare benefits, offered by private health plans, with accountability for provider adequacy and quality performance. And, it is increasingly the choice for Medicare-eligible beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) projects that the number of individuals choosing MA will grow to 22.6 million in 2019, which will account for 36.7 percent of the Medicare population (CMS, 2018). This represents an 11.5 percent increase from 2018, which had been the largest increase in recent years. Nationally, there are 3,700 MA plans, with more than 91 percent of beneficiaries having access to ten or more plan options in their region. Most of these plans offer both Medicare hospital and physician benefits, as well as Part D prescription drug coverage, along with supplemental benefits not covered by traditional Medicare. These benefits typically include dental, hearing, and vision care, wellness programs, and reduced cost-sharing with lower premiums and annual out-of-pocket costs for the beneficiary. MA premiums are low, with 2019 average monthly premiums about $28, and half of enrollees are enrolled in zero premium plans.

The risk-based capitated system of financing healthcare in MA has led to a transformation in care delivery, enabling providers to offer person-centered care that focuses on primary care teams. According to recent report by the Health Care Payment Learning & Action Network, nearly 50 percent of providers under contract to MA plans are in alternative payment arrangements, with providers assuming some level of financial risk (Health Care Payment Learning & Action Network, 2018). This is significantly higher than traditional Medicare, and much higher than in commercial insurance. These plans and providers work together to address shortfalls in care and build innovative ways to offer care that are improving outcomes—at the same or lower cost than traditional Medicare.

MA's Innovations in Care Delivery

Three approaches described below illustrate the care delivery innovations underway in MA. First is the focus on primary care, early intervention,

and care management. Second are the opportunities available in Special Needs Plans (SNP) in MA, and third are the increasing flexibilities available to MA plans to offer supplemental benefits.

Person-centered care management

Integrated care is built upon several principles essential to its success in addressing the needs of people who have serious chronic conditions. A 2017 report sponsored by the Better Medicare Alliance and issued by the Robert Graham Center highlighted several primary care providers and identified the essential elements of successful care management (Better Medicare Alliance, 2018).

The findings and showcased examples all indicate that successful person-centered care management requires the following:

√ A financing mechanism that offers financial incentives for improved outcomes over volume of services, encourages innovation, and allows flexibility to meet the person's needs;

√ An organizational culture that promotes and supports care management, invests in the necessary infrastructure of staff and operations, and supports sustained staff education and training;

√ Effective teams that routinely communicate with each other, define roles and responsibilities, and attend to care transitions;

√ Active use of risk stratification data to identify and address peoples' needs, individualized care plans that are operationalized, and actions aimed at removing barriers to care; and

√ Trust among providers at all levels, recognition of the need to build relationships with each other and with the people under their care, and shared decision-making.

MA Special Needs Plans

MA plans are using their risk-based, capitated systems to identify high-risk beneficiaries and to intervene and engage them early and where they are, both physically and mentally. One of MA's unique aspects involves the opportunity to develop and implement SNPs for targeted populations with complex needs. SNPs may target populations of people who are frail, have disabilities, or are chronically ill. There are three types of SNPs: D-SNPs available for those individuals who are dually eligible for Medicare and Medicaid; C-SNPs for people with chronic conditions; and I-SNPs for individuals who are eligible for institutional care.

Each type of plan is required to establish a care model that identifies the population, establishes protocols for care coordination and care transitions, operationalizes a provider network appropriate to the population, and reports quality measurements. Each beneficiary has a customized treatment plan. There are almost 700 SNPs across the country, and they are showing lower rates of hospitalizations, more care provided in the home, and lower readmission rates.

Fourteen percent of older adults have six or more chronic conditions and need long-term-care management.

Supplemental benefits and new flexibilities in MA

MA plans offer supplemental benefits not covered in traditional Medicare. These benefits are offered using rebate dollars available to plans that bid below the adjusted benchmarked cost for traditional Medicare beneficiaries. These rebates also are adjusted based on the plans' quality performance, with high-quality plans receiving an extra financial bonus for meeting quality measurements. The plans are required to use these rebate dollars to directly benefit their enrollees. Such benefits include reduced cost-sharing, dental, vision, and hearing benefits, wellness programs, and, more recently, telemedicine.

Almost all plans offer at least one additional benefit and 50 percent of plans offer at least three supplemental benefits. Due to the CHRONIC Care Act's enactment, the types of benefits that plans can offer have been limited

to services that are "primarily health-related" and benefit offerings must be approved by CMS. CMS recently expanded the definition of allowable benefits to define "primarily health-related" to include any service that allows for the diagnosis, prevention, or treatment of an illness or injury; that compensates for physical impairments; that ameliorates the functional/psychological impact of injuries or health conditions; or that reduces avoidable emergency or healthcare utilization.

This has meant new opportunities for plans to offer targeted populations caregiver support, in-home modifications, direct care in the home, and other services that may be expected to compensate for physical impairments, address impact of injuries or health conditions, or reduce avoidable hospital use.

This definition of allowable supplemental benefits will be further expanded in 2020, as a result of congressional action intended to address the needs of individuals with chronic conditions. This action is in response to the recognition of the role social determinants of health play in achieving better patient outcomes. Lack of transportation and in-home supports, food insecurity, and functional impairments all have been seen to have an impact on a person's capacity to improve his or her health status. Unlike traditional Medicare, MA can identify populations of beneficiaries in need and deliver these additional benefits to address the social determinants of health.

MA beneficiaries with chronic conditions used fewer high-cost services, more preventive services and screenings, and had better outcomes.

These new efforts will be tested in the years ahead, and can yield valuable lessons for reforming MA and, possibly, traditional Medicare. It remains to be seen if the potential impacts of these efforts in transforming financing, benefits, and care delivery can meet the needs of Medicare beneficiaries, particularly those having complex needs.

MA Shows Outcomes Improvement in Chronic Conditions

The opportunities inherent in MA to improve healthcare and outcomes at the same or lower costs than traditional Medicare have been reported in numerous small-scale studies over the years. However, it was not until July 2018 that a research report from Avalere Health offered findings from a large-scale national comparative analysis that found outcomes in MA were better for high-need, chronically ill beneficiaries than in traditional Medicare (Mendelson, Teigland, and Creighton, 2018).

Sponsored by Better Medicare Alliance, the research compared demographic, cost, utilization, and quality metrics for 1.6 million MA beneficiaries and 1.2 million beneficiaries in traditional Medicare with one of the selected chronic conditions of hypertension, hyperlipidemia, and diabetes.

While the two study populations had similar demographic profiles, MA had a higher proportion of beneficiaries with clinical and social risk factors shown to affect outcomes and cost. This included a 15 percent higher likelihood of being dually eligible, a 57 percent higher rate of serious mental illness, and a 16 percent higher rate of substance abuse.

Despite this higher proportion of risk factors, MA beneficiaries with chronic conditions experienced lower use of high-cost services, higher rates of preventive services and screenings, and better outcomes.

Specifically, for the study population, MA achieved 23 percent fewer inpatient hospital stays, 33 percent fewer emergency room visits, and a 29 percent lower rate of potentially avoidable hospitalizations. They also experienced a 13 percent higher rate of LDL (low-density lipoprotein) cholesterol testing and a 5 percent higher rate of breast cancer screening.

Finally, for the two highest need cohorts, those who are dually eligible for Medicare and Medicaid and those with diabetes, the rates were even higher in reduced, potentially avoidable admissions, lower rates of complications, and lower per-beneficiary costs.

These findings build on the growing body of evidence that MA is providing high-value care through innovations in care delivery and payment arrangements, which are satisfying the needs of beneficiaries, including those having complex needs.

Conclusion

MA's managed care framework offers greater simplicity, affordability, and enhanced benefits that improve healthcare and well-being for millions of individuals in Medicare. With policy and payment stability, and increasing investment and enrollment, MA plans offer a path toward a brighter future for Medicare.

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