Managing care and competition: Efficiencies of integrated care and improved risk assessment seen in Medicare Advantage

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Medicare Advantage (MA), with more than 10 million enrollees, is the largest alternative to traditional Medicare. MA's managed care approach was designed to provide coordinated, integrated care for patients and savings for taxpayers, but since the program launched as Medicare Part C in 1985, critics have said that the system limited enrollee freedom of choice without significant benefit or savings to the Medicare program. They also pointed to the tendency of some private payers to design benefit plans and marketing campaigns that attracted healthier patients, leaving sicker, moreexpensive patients in traditional Medicare— a process known as favorable selection.

Three new studies led by researchers from Harvard Medical School's Department of Health Care Policy address these issues. The first shows that enrollees in MA use health care services more efficiently and cost effectively. The second and third studies show that a series of risk-adjustment reforms that began in 2004 have mitigated the adverse affects of favorable selection. All three papers appear in the December issue of *Health Affairs*.

Bruce Landon, HMS professorof health care policy and co-authors compared the service utilization patterns of MA HMO enrollees with traditional Medicare enrollees from 2003-2009. The authors found 25 to 35 percent lower emergency room use and 20 to 25 percent lower inpatient medical days among the MA HMO patients. Elective knee and

hip replacement use was 10 to 20 percent lower. In contrast, MA patients had open-heart surgery at consistently higher rates in accordance with current practice guidelines. These heart surgeries are more expensive than other treatments, but provide more durable repairs and therefore may represent a better value in the long term.

"Integrated care provided by managed care plans, with their ability to put in policies and procedures to control utilization appear to be having desired effects," Landon said, adding that the study demonstrates the potential for MA to control resource use, theoretically leading to overall savings, although currently MA is more expensive than traditional Medicare. One reason for those higher expenses has been favorable selection. Cuts to Medicare Advantage payments in the Affordable Care Act are designed to bring costs down and realize those potential savings by reducing overpayment.

"Because the Medicare Advantage plans attracted healthier than average patients, yet were paid based on the costs of an average patient, the Congressional Budget Office concluded in the 90s that the government paid 8 percent more per patient in Medicare Advantage than they would have for the same patients in traditional Medicare," said Joseph Newhouse, John D. MacArthur Professor of Health Policy and Management at Harvard University and professor of health care policy at Harvard Medical School. "If you could get healthy people in your plan, you made money."

Congress enacted a series of reforms designed to counter favorable selection, including reforms that prevent patients from shifting from MA to traditional Medicare from month to month and a new risk adjustment system that adjusts payments based on the diagnoses of MA patients from the previous year. Plans now receive less per healthy patient than they do for patients who have had heart attacks, diabetes and other diagnoses in the previous years.

In two complementary studies using different methods, Newhouse and Michael McWilliams, assistantprofessor of health care policy and medicine at Harvard Medical School, each found that favorable selection has been greatly reduced since 2004, when reforms were phased in.

According to Newhouse and McWilliams, the reforms have succeeded in making it more difficult for health plans to compete by attracting favorable risks and they must now focus on managing medical risk. Since similar means of assessing risk and assigning higher payments to plans that cover less healthy, more expensive patients will be used in the health care exchanges and in other aspects of health care reform that will be implemented under the Affordable Care Act, there is reason to be optimistic about how well these reforms will function, the researchers said.

"Ideally, we would want health plans to compete on the basis of costs and quality," said McWilliams. "Together, these three papers attempt to gauge if Medicare Advantage is heading in theright direction. Examining utilization of services addresses whether MA plans can create more efficiency and value. Examining selection addresses whether plans might be competing on another basis, by selecting favorable health risks and profiting from the difference between the payments and the costs for healthier patients."

All three papers were produced under the umbrella of a large program project grant from the National Institute on Aging that supports a comprehensive evaluation of different aspects of Medicare Advantage, including ongoing work on the quality of care provided under the system and that Newhouse directs. "There are tremendous synergies across the individual papers that come out of this work," said Landon.

More research remains to be done to fully understand the workings of MA, the researchers said, not least because the program will undergo

another series of reforms as the Affordable Care Act is fully implemented.

"It will be important to continue to monitor all of these factors during implementation to make sure that the system is delivering the highest quality and highest value care we can provide," said Landon.

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