Fixed payments not a barrier to quality of care in HMOs, study finds

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Ever since the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the number of enrollees in Medicare Advantage, Medicare's managed care program, has jumped from 5.3 million to 14.4 million in 2013. While most individuals in Medicare opt for the traditional, fee-for-service benefit, many more are enrolling in HMOs and other managed care options.

This dynamic heightens the importance of a question health care professionals and policymakers have been asking for many years: Does the system of fixed reimbursement inherent to HMOs and other forms of health plans compromise care, especially when compared with traditional fee-for-service plans which, typically, are not limited by external financial caps?

Researchers from the Harvard Medical School Department of Health Care Policy found that between the years 2003 and 2009, patients in Medicare HMOs were more likely to receive recommended ambulatory preventive services such as breast cancer screening, cholesterol testing, and diabetes exams, than patients in traditional fee-for-service Medicare. What's more, by 2009, patients in HMOs rated their primary care physicians more favorably than patients in traditional fee-for-service care did—something that was not the case in 2003.

"For these services, HMOs were able to deliver more appropriate care despite potential incentives to limit care due to fixed payments," said John Ayanian, professor of health care policy at Harvard Medical

School.

The findings were reported in the July 2013 issue of *Health Affairs*.

Medicare has a traditional fee-for-service structure that dates back to 1965, one in which patients can use whatever services their physicians prescribe without any constraints. Over the last 30 years the program has developed a more prominent role for health maintenance organizations, or HMOs, which receive fixed payments from Medicare no matter how many services a patient receives. As more patients enroll in HMOs, policy makers have wondered how these two structures affect patient care.

To answer this question, Ayanian and Harvard Medical School health care policy colleagues Joseph Newhouse, Bruce Landon, Alan Zaslavsky—as well as experts from the National Committee for Quality Assurance and the law firm Stevens and Lee—analyzed data on the use of these recommended preventive services submitted by Medicare health plans as compared with performance in traditional fee-for-service Medicare using Medicare claims data. All told, the investigators studied data for approximately 2 million beneficiaries in 2009 representing both HMOs and traditional Medicare.

The researchers matched the demographic profiles of enrollees in both parts of Medicare as closely as possible so that regional variations and differences in age, sex and economic status would not confound the data.

Looking specifically at mammograms, diabetes exams and cholesterol testing for cardiovascular disease, patients in HMOs were more likely to receive appropriate services than patients in traditional plans. What's more, the differences remained consistent over the six-year period.

The researchers also looked at vaccination rates for flu and pneumonia,

and satisfaction with physicians. The researchers found that in 2003 HMO patients were more likely, by a slight margin, to receive these vaccines, but by 2009 the differences were nearly eliminated. In 2003, patients in traditional Medicare tended to have a slightly higher rate of satisfaction with their primary care doctors and also gave a faint edge to specialists. By 2009, those numbers flipped for primary care doctors, but remained consistent for specialists.

Landon, who is a professor of health care policy, found these latter findings particularly noteworthy. "Back in 2003, there was a tradeoff between higher quality of preventive care seen in HMOs and better experiences, seen in traditional Medicare," he said. "Now, our data suggest that both quality and patient experiences are higher in Medicare Advantage."

Looking more closely into the different kinds of HMOs, the team found that older, larger, not-for-profit HMOs ranked higher on all measures than smaller, newer, for-profit ones. In fact, when it came to vaccinations and ratings of specialists, the traditional fee-for-service plans ranked higher than the newer, smaller, for-profit HMOs.

One possible explanation for these findings, the authors note in the paper, is that the highly integrated systems characteristic of these older more established health plans may have offset any potential financial incentives to restrict care.

"These findings suggest that, at least for these particular services, managed care does not appear to compromise care," said Ayanian. "The caveat is that we looked at an important but limited set of services. There may be other aspects of care not publicly reported where HMOs are not performing as well."

"As the Medicare Advantage program has expanded, it is important to

see what is being bought compared with the traditional Medicare program," said Newhouse, who is a professor of health care policy at HMS and the John D. MacArthur Professor of Health Policy and Management at Harvard University. "With Medicare dollars increasingly constrained by the Affordable Care Act, getting the best value for what we spend becomes ever more critical."

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