2009 ISSUE BRIEF
REFORM MEDICARE
PRESERVE PATIENT BENEFITS THROUGH DIRECT CONTRACTING

Issue

Many in Congress have recommended making financial changes in Medicare Advantage HMO/PPO (MA) plans to help finance health care reform. To preserve the strengths of the MA HMO/PPO program, which include care coordination and a broader package of benefits than included in standard Medicare, and to avoid dislocation of millions of patients, the American Medical Group Association (AMGA) recommends that Congress authorize Medicare to contract directly, or through an intermediary, with multispecialty groups and other organized systems of care for beneficiary health care services, including care coordination.

Background

Medicare Advantage (MA) was created in 2003 to provide an alternative to traditional Medicare. Under MA, private insurers sell Medicare health plans directly to beneficiaries and contract with providers to deliver specified health care services. Providers would be paid directly by the health plan for each beneficiary/enrollee treated. The idea was to create an option within Medicare that mirrored many of the components and structures to be found in private managed care plans. To attract private sector participation, average funding to health plans was set higher than per-patient costs in traditional Medicare with the expectation that health plans would provide their enrolled patients with enhanced benefits at the same or lower premiums than those for traditional Medicare.

Benefits of MA

Typically MA HMO/PPO plans offer their beneficiaries services not found in traditional Medicare such as prescription drugs, vision and dental care, chiropractic services, and wellness and preventive services. Medicare Advantage participants often pay lower out-of-pocket costs for their health care services. The most important component of additional benefits offered is care coordination for patients with chronic disease. It must be emphasized that of the types of MA plans, HMO/PPO variants offer a number of enhanced services and benefits to those enrolled. This distinguishes and differentiates them from MA private fee for service plans (PFFS), where this is typically not the case.

Coordinated care is characterized by a team approach between physicians and practice settings a reliance on health information technology to share and retrieve a patient's electronic medical records, performance feedback for improving care, patient registries to identify and track patients, technology to monitor treatment and provide timely interventions, and reinforcement of patient behavior, among other features.

MA is disproportionately popular in rural and urban areas, and reducing its benefits may have a significant impact on these underserved populations. In fact, a report issued in September, 2008, by the Henry J. Kaiser Foundation found that MA plans have enjoyed considerable growth in recent years. It concluded that 23 percent of the nearly 45 million Medicare beneficiaries were

enrolled in an MA plan. Furthermore, beginning in 2003 through July, 2008, the number of patients in these private Medicare plans nearly doubled to the current 10.1 million from 5.3 million.

Position

AMGA believes that coordinated care and other health care benefits available to MA HMO/PPO beneficiaries must not be lost. We believe the positive attributes of these plans may be maintained by authorizing CMS, or other CMS certified intermediary, such as a provider-sponsored plan, a Blue Cross/Blue Shield Plan, etc., to enter into a direct contracting relationship with capable organizations for the delivery of coordinated care and covered services to Medicare patients.

In a direct contracting arrangement:

- CMS and a medical group or organized system of care would contract for the provision of coordinated care and other services to patients enrolled.
- Funds established on an actuarially sound and transparent basis would flow directly from Medicare to the contractor.
- CMS and the contractor would agree to the Medicare benefits and services provided to patients and the level of funding for these services.
- Incentive arrangements would be in place for medical groups or other contractors to provide value as determined through metrics for efficiency (use of health information technology, cost effectiveness and coordinated care), clinical quality and patient experience.
- Accountability and transparency would be provided through public reporting of contractor performance.
- Direct contracting would extend beyond bundling and mean involvement related to covered services with “systems thinking” using such tools as coordinated care, patient registries and health information technology including electronic medical records.
- Direct contracting requires assumption of financial and utilization risk. The contracting organization assumes financial responsibility for the provision of a defined set of benefits by accepting prepayment for some or all of the costs of care. Arrangements will have to assure sufficiency of the scope of clinical services and a threshold number of enrolled patients to make manageable the financial risks to be borne by the contracting systems of care.
- Interested multispecialty groups and organized systems of care would be identified and invited to participate in a direct contracting model.

Payment Alternatives for Medicare Advantage

There are other alternatives to MA payment reforms Congress could consider in addition to direct contracting. Some are outlined in the “Call to Action: Health Care Reform 2009” white paper issued last November by Sen. Max Baucus (D-MT), Chairman of the Senate Finance Committee, who is widely recognized on Capitol Hill and in the health care community for his leadership in Medicare reform efforts. These include:

- Increasing MA HMO/PPO reimbursement rates for providers who currently meet certain performance measures or standards as identified, for example, by the National Council on Quality Assurance or some other recognized standard-setting entity; and

- Setting MA HMO/PPO reimbursement rates in consideration of insurers' cost differentials by region as a "benchmark" with traditional fee-for-service.

Conclusion
Any change in MA proposed by policymakers should enhance, not jeopardize, the benefit of care coordination. Irrespective of the arguments surrounding Medicare Advantage, continuation of the care coordination benefits offered patients enrolled in MA HMO/PPO is an important contribution to Medicare. The benefits are independent of the Medicare Advantage program itself, and have been widely recognized for their value by participants and Medicare alike. The benefits of coordinated care must be coupled with clear value metrics generated by providers for patients and the Medicare program, combined with transparency of accountability through public reporting of performance.

AMGA Asks Congress To:
Preserve coordinated care for Medicare beneficiaries by authorizing CMS to initiate a direct contracting program with organizations capable of providing care coordination services (either directly or through "virtual" arrangements), which might include multispecialty medical groups, organized systems of care, or other capable contractors.