

Partnered Evidence-Based Policy Resource Center

POLICY BRIEF

Vol. 1, No. 3 November 2016

Cost, Quality, and Access under Risk-Based Contracting: The Medicare Advantage Experience

Christine Yee, PhD, Assistant Professor of Economics, University of Maryland, Baltimore County
Health Economist, Partnered Evidence-Based Policy Resource Center

Austin Frakt, PhD, VA Boston Healthcare System
Assistant Director, Partnered Evidence-Based Policy Resource Center

Steven Pizer, PhD, VA Boston Healthcare System
Chief Economist, Partnered Evidence-Based Policy Resource Center

VA



U.S. Department of Veterans Affairs

Veterans Health Administration
[Quality Enhancement Research Initiative](#)

Through the Choice Act,¹ the VHA expanded its role as a purchaser of care, alongside its more familiar role as a provider. Under the Act, the VHA purchases non-VHA care at fee-for-service (or Traditional) Medicare prices for Veterans living too far from or waiting too long for care at a VHA facility. Further expansion of purchased care invites an opportunity for the VHA to reconsider not just to whom to offer it, but how to pay for it.

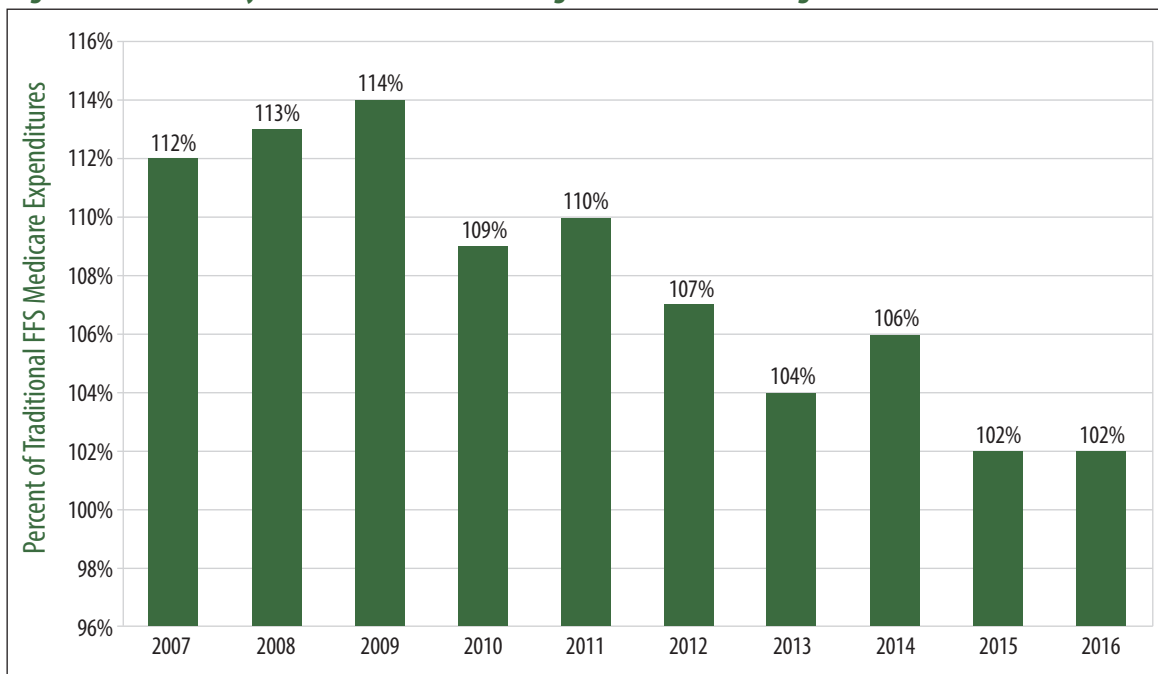
Previous studies can help us understand the impact on cost and quality of different ways to pay for health care. A prior policy brief (PEPReC Policy Brief 2016 Vol. 1, No. 2) describes potential consequences if the VHA purchased care from providers by paying a fee per service like Traditional Medicare (TM) does. The consequences include higher prices, greater volume of care, lower quality of care, but potentially more access to care and choice of providers (if the VHA pays well enough). One alternative is risk-based contracting, in which non-VHA providers or private insurers bear all or some of the financial risk associated with patient care. To provide insight into the potential consequences of this approach, this policy brief explores the strengths and challenges of a large and well-studied risk-based contracting program: Medicare Advantage (MA).

Cost of Purchasing Care: One Amount per Enrollee

MA plans are private alternatives to TM. For each Medicare beneficiary that enrolls in an MA plan, the Medicare program pays that plan a fixed amount per month, adjusted for the health of that enrollee (i.e., higher for sicker patients). The amount is prospective, meaning it is determined prior to the delivery of services and does not depend on the price or quantity of services delivered during the plan year. An MA plan must offer the standard TM benefit but may augment it with additional benefits—sometimes charging an additional premium to enrollees. MA plans use cost sharing (such as deductibles and copayments), restricted networks, and other managed care techniques to manage utilization and costs.

While there are no studies that compare costs between MA and the VHA, there are studies that compare costs between MA and TM. Some studies suggest that the federal government has struggled with the amount to pay MA plans, balancing adequate compensation to promote plan participation against overpayment. In 2016, it is expected to pay on average 2% more for an MA enrollee than the cost of a comparable TM beneficiary² (see Figure 1).

Figure 1. Medicare Payment to Medicare Advantage Plans as a Percentage of Traditional FFS Medicare Expenditures (Per Beneficiary)



However, the payment is even higher—17% higher by one estimate—relative to the cost that an MA plan incurs for health care services.³ MA plans can sometimes negotiate lower prices and often are associated with reduced utilization, frequently achieved by cost-sharing mechanisms, improved coordination of care, or stricter prior-approval processes.⁴ Despite this, if the VHA implements an MA-like system, costs may rise. The literature establishes

that MA is more costly per enrollee than TM and that TM is more costly than VHA (see PEPReC Policy Brief 2016 Vol. 1, No. 2). Thus, costs per Veteran will likely be higher in an MA-like system.

Quality of and Access to Care

Quality. Unlike the topic of cost, there have been studies that compare the quality of care among the VHA, MA, and TM. Studies have shown that patient health outcomes are better in the VHA than in MA⁵ and TM (see PEPRcC Policy Brief 2016 Vol. 1, No. 2 for TM and VHA comparisons). VHA survival rates are higher than MA rates for comparable patients. Figure 2 shows that Veterans are more likely than comparable patients in MA to receive preventive services and screenings as well as maintenance services.

Comparing MA and TM, studies indicate that MA has similar and sometimes better outcomes than TM, depending on patient conditions.⁶

Access. While it is possible that access to care is greater in a TM-like system than in the VHA (see PEPRcC Policy Brief 2016 Vol. 1, No. 2), it is unclear whether access in an MA-like system would be greater than in the VHA. The VHA has a limited number of hospitals and outpa-

tient clinics, though supplements access by paying for non-VHA care for some patients (e.g., under the Choice Act). MA plans restrict enrollees to provider networks (which may be narrow) and often require enrollees to get prior-approval or referrals for services. While these characteristics may help MA plans contain costs and achieve better patient outcomes (by choosing providers that provide high-value care at low cost), they can make it difficult for some enrollees to get care.⁷ Studies suggest access to care and patient experience with MA (relative to TM) may be worse for patients with more complex needs, mental disorders, lower-income, and less education.⁸ This raises the concern that access to the types of providers that Veterans often need would not be sufficient in an MA-like system.

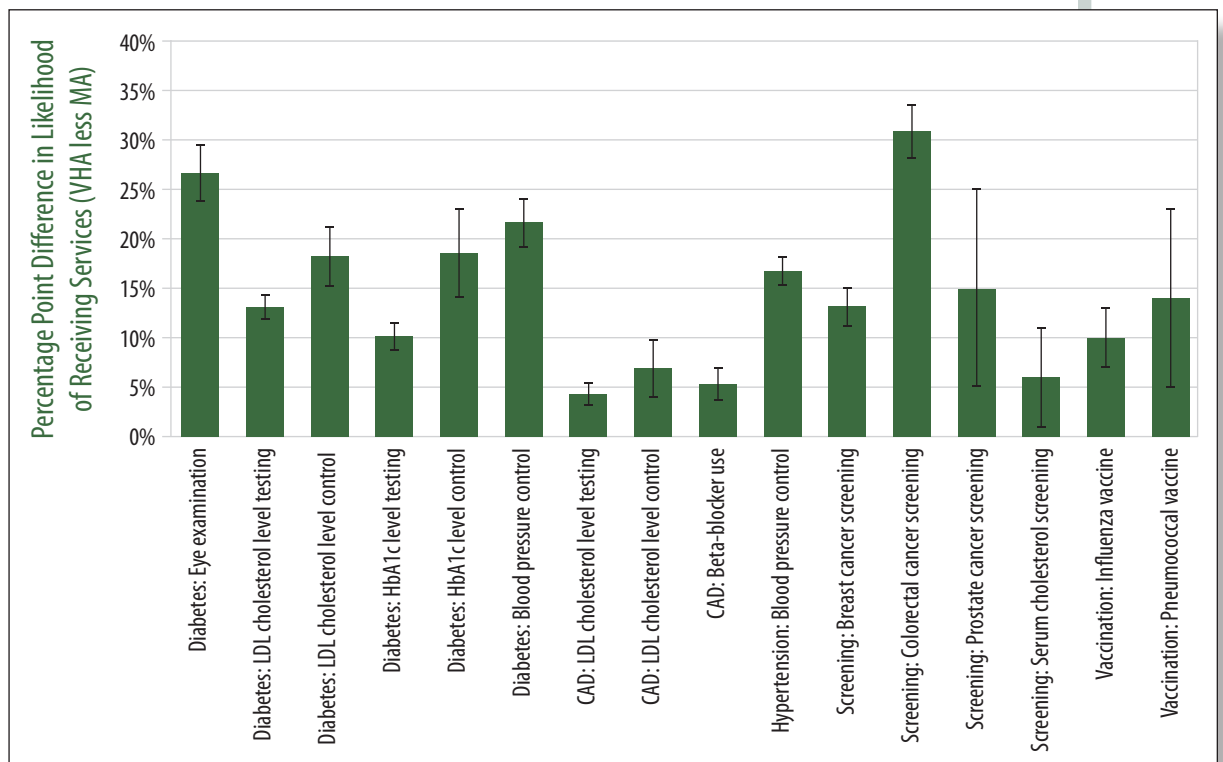
Implementation

As the VHA develops policies to expand its role of purchasing care and if it moves toward risk-based contracting, it will need to consider several issues. First, to maximize profit, private health plans aim to attract individuals whose costs are below payments to plans.⁹ Health plans can attract healthier, lower-cost individuals in a number of ways, for example, by narrowing their networks and limiting the supply of providers that certain high-cost patients need. It is not always evident how to risk adjust payments to reflect this risk selection, so there remains the likelihood that plans will be overpaid, as has been the experience in MA.

Second, insurers will only participate in regions where they can be profitable at the rates the VHA is willing to pay. This may leave some rural areas without plans, as has been the case in the predecessor to the MA program (Medicare+Choice). Therefore, the VHA may need to offer a public plan or fallback option in these areas. The VHA public plan could be similar to a fee-for-service system like TM, which is Medicare's fallback option, or the VHA could continue to provide services in its centers.

Third, there are a number of logistical issues to resolve. These include the creation of a rate setting process that includes risk adjustment; the specification and enforcement of minimum standards for qualifying health plans (e.g., the breadth of provider networks to address conditions that are prevalent among Veterans, like post-traumatic stress disorder); and the development of a system to collect data from non-VHA providers so that plan quality could be monitored and patient records could be transferred across plans and the VHA.

Figure 2. Likelihood of Receiving Preventive and Maintenance Services: the VHA versus MA



Conclusion

In conclusion, it is hard to make a compelling case for the VHA to move to risk-based contracting in the same style as Medicare Advantage. An MA-like system is likely to be more costly, at least in certain (typically rural) markets where plans will not participate without payments being above average fee-for-service costs. Quality of care has, historically, been higher in the VHA than in MA. Finally, because at-risk plans use narrow networks and other care management techniques, they may not provide greater access to care for the most vulnerable Veterans.

This, however, does not imply there is no role for risk-based contracting. Other approaches, like bundled payments or Accountable Care Organizations, may offer more attractive options for VHA purchased care.

Endnotes

¹ Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146).

² Newhouse, J. and McGuire, T. "How Successful is Medicare Advantage?" *Milbank Quarterly*. 92 (2) (2014): 351-394. McGuire, T., Newhouse, J., and Sinaiko, A. "An Economic History of Medicare Part C." *Milbank Quarterly*. 89(2) (2011): 289-332. Report to Congress: Promoting Greater Efficiency in Medicare. MedPAC (Medicare Payment Advisory Commission). (2007). Washington, DC., Ayanian, JZ, Landon, BE, Zaslavsky, AM, Saunders, R, Pawlson, LG, and Newhouse, JP. "Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare." *Health Affairs*. 32(7) (2013):1228-1235. Stevenson, DG, Ayanian, JZ, Zaslavsky, AM, Newhouse, JP, and Landon, BE. "Service use at the end-of-life in Medicare Advantage versus traditional Medicare." *Medical Care*. 51(10) (2013): 931-7.

³ Bhattacharya, J, Levin, Finkelstein, Einav, and Curto. "Public vs. Private Provision of Health Insurance: The Case of Medicare Advantage." *ASHEcon* (American Society of Health Economics) (2016).

⁴ Landon, BE, Zaslavsky, AM, Saunders, R, Pawlson, LG, Newhouse, JP, and Ayanian, JZ. "Analysis of Medicare Advantage HMOs compared with traditional Medicare shows lower use of many services during 2003-09." *Health Affairs*. 31(12) (2012):2609-2617.

⁵ Trivedi, A., Matula, S., Miake-Lye, I., Glassman, P., Shekelle, P., and Asch, S. "Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings." *Medical Care* 49(1) (2011).

⁶ "Actions Needed to Enhance CMS Oversight of Provider Network Adequacy." U.S. Government Accountability Office. Medicare Advantage GAO-15-710: Published: Aug 31, 2015. Publicly Released: Sep 28, 2015. Duggan, M., Gruber, J., Vabson, B.. "The Efficiency Consequences of Health Care Privatization: Evidence from Medicare Advantage Exits." National Bureau of Economic Research. October 2015: Working Paper No. 21650.

⁷ Steven C., Martino, MN, Elliott, A., Haviland, M., Saliba, D., Burkhart, Q., and Kanouse, DE. "Comparing the Health Care Experiences of Medicare Beneficiaries with and without Depressive Symptoms in Medicare Managed Care versus Fee-for-Service." *Health Services Research* 51(3), (2016): 1002-1020. Momotazu, R., Keohane, L., Trivedi, A.N., and Mor, V. "High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage And Joining Traditional Medicare." *Health Affairs*. 34 (10) (2015): 1675-1681. Elliott, N., Haviland, AM, Orr, N., Hambarsoomian, K., and Cleary, PD. "How Do the Experiences of Medicare Beneficiary Subgroups Differ between Managed Care and Original Medicare?" *Health Services Research*. 46(4) (2011): 1039-1058.

⁸ Rothschild, M. and Stiglitz, J. Equilibrium in competitive insurance markets: an essay on the economics of imperfect information. *The Quarterly Journal of Economics*. 90(4) (1976): 629-649.

⁹ McWilliams JM, Hsu J, Newhouse, JP. "New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage." *Health Affairs*. 31(12) (2012):2630-2640.

Figure Citations

Fig. 1: *Definition:* FFS: fee-for-service. *Source:* MedPAC's 2007-2016 reports titled "Report to Congress: Medicare Payment Policy."

Fig. 2: *Definitions:* VHA: Veterans Health Administration. MA: Medicare Advantage. LDL: low-density lipoprotein. CAD: coronary artery disease. Hb1Ac: glycosylated hemoglobin. *Sources:* Trevadi and Grebla (2011) provided the estimates for services related to diabetes, coronary artery disease, hypertension, breast cancer screening, and colorectal cancer screening. Salomeh et al. (2007) provided the estimates for prostate cancer screening, cholesterol screening, and vaccinations.

About PEPReC Policy Briefs

This evidence-based policy brief is written by the Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and VHA managers about the evidence regarding determinants of demand for VHA care within the broader health system and economy. PEPReC, the Partnered Evidence-based Policy Resource Center, is a QUERI-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.