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Opinions Commentary >> Fred Dunlap

Seeing the light

Medicare Advantage plans that coordinate care can thrive under reform

By most accounts, I should be fuming. When President Barack Obama signed into law historic healthcare reform in March, some would think I should have been among those full of angst, but I'm not—despite being chairman and CEO of a Medicare Advantage plan in six states.

Why am I not angry? With this legislation, Congress has taken action to address a perfect storm of problems threatening to bankrupt the Medicare program. Among the tailwinds driving Medicare to insolvency: a rising number of Medicare beneficiaries, increasing prevalence of chronic illness among the elderly, and growing spending associated with chronically ill beneficiaries. The confluence of these issues is causing tremendous and unsustainable escalation of costs in Medicare.

With the changes in this new law, Medicare plans will be increasingly focused on addressing these cost drivers and improving quality. This includes growing and refining a model of coordinated care that I've witnessed reduce costs and improve care for Medicare beneficiaries with chronic conditions such as diabetes and heart failure, and for those also on Medicaid. These are seniors with special needs who are costing our health system more than $300 billion every year, accounting for $8 out of every $10 spent by Medicare.

From now on, a Medicare plan's value will no longer be founded on its ability to pay claims and collect premiums. Rather, it will be measured by its focus on coordinated care and how it addresses potentially dangerous gaps in treatment, reduces unnecessary hospitalizations and improves clinical quality. All of this in return for payments now designed to equal what traditional Medicare would have paid for the same person.

It's simple in concept, but it will take a dogged commitment to quality and strategic understanding of what connects cost drivers to cost reduction to achieve.

Consider the cost to the U.S. healthcare system that comes from inadequate medication management—$170 billion in drug-related morbidity and mortality. Adherence to appropriate medication regimens in patients with chronic conditions is as low as 43%. Failure to adhere to these regimens is the source of up to two-thirds of hospital admissions. Counseling high-risk patients about their medications and alerting primary-care providers of gaps in therapy relative to those patients are significant investments, but can pay dividends in reducing costs.

Inefficiencies in transitional care—the care that occurs as a chronically ill patient leaves one setting for care in another—also consume a large chunk of healthcare spending. When transitions are done poorly, the consequences include medical errors and duplication of services that in turn often mean hospital readmissions. Recent studies estimate that more than half of all Medicare and Medicaid spending is related to hospital readmissions in some states.

Those who do these things well will be rewarded by reform. Those who do not will fail.

That's because health plans have focused more on scrutinizing hospital utilization rather than coordinating and improving care across multiple transition venues—whether hospital, skilled-nursing facility, outpatient primary care or the patient's own home. Many of these hospitalizations are preventable, and Medicare Advantage plans must ensure that their hospitalized members receive the necessary post-discharge care.

We also have work to do integrating services that address the behavioral and psycho-social issues related to chronically ill patients—in particular co-morbid depression, which affects up to 25% of the Medicare population. Depression results in more severe medical complications, worse outcomes and higher healthcare costs. Specific strategies to address it, including adequate social support, improving access to preventive care and taking an active role in health education and self-management, can produce considerable clinical and economic benefits.

All of this requires health plans to work with patients and healthcare providers in new and creative ways. Innovative models—such as physician house calls for chronically ill patients—can have a huge effect on quality and help patients and caregivers better understand their self-care needs. By bringing practitioners into the homes of high-risk patients, health plans identify treatable conditions sooner and help motivate patients to keep up with regular primary-care visits. Reporting visit findings back to the patient's community-based physicians in collaborative and consistent ways reliant on evidence-based medicine tightens bonds among members, their providers and the health plan. Indeed, the reform law encourages this very type of coordinated and community-based approach.

Those within the Medicare Advantage industry who do these things well will be recognized and rewarded under the new law. Those unable to do this will fail. New incentives will provide bonus payments for high-quality Medicare Advantage plans as well as those who offer high-quality plans in rural areas and other areas where access to healthcare is more challenging.

This is the lesson of healthcare reform for Medicare Advantage plans, and it is excellent news for our nation's chronically ill Medicare beneficiaries—especially when you consider the real-world healthcare needs of the sickest, most fragile beneficiaries and their cost to our healthcare system.

So, no, I'm not angry. I see great opportunity ahead to make Medicare Advantage better and more effective at reducing Medicare costs. The truth is that I, and others at my company, feel validated. <<

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