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HEALTH

Optum CMO: Doctors must take responsibility for patient outcomes

Our research finds that 'two-sided risk' Medicare Advantage plans benefited patients

By Ken Cohen

America's health system is buckling under the weight of several converging pressures: an aging population, high rates of chronic disease, a shortage of clinicians, and rising costs. The response to these challenges will determine the future of care in this country — and new evidence suggests the solution is rooted in how we deliver and pay for care.

A peer-reviewed study published in the American Journal of Managed Care by America's Physician Groups (APG), CareJourney, and Optum looked at whether health outcomes for dual-eligible Medicare and Medicaid patients (people who qualify for both Medicare and Medicaid) vary depending on the payment model they're treated under.

We examined health outcomes data under three different Medicare payment models: at-risk, or "two-sided risk" Medicare Advantage plans (where physician groups take full financial risk for patient care); fee-for-service (FFS) Medicare Advantage (where providers are paid per service by the Medicare Advantage plan insurer); and traditional Medicare (where providers are paid per service by the government).

In two-sided risk models, providers do everything in their power to more efficiently and proactively engage patients and build robust, multidisciplinary care teams (including both clinician specialists and nonclinicians) to deliver high-quality, evidence-based care.

In practical terms, this means primary care practices are always on to help ensure patients get appropriate preventive care; identify and address gaps in care ranging from housing and transportation to nutrition; and provide integrated support during vulnerable points of patients' health care journeys (e.g., after surgeries or hospital stays). While providers working within FFS constructs may intuitively understand the clinical advantages of two-sided risk approaches, the financial structure of FFS make the investments required to implement (much less sustain) them near impossible and constrain treatment to relatively reactive, episodic care.

Our substantial dataset encompassed 17 APG-member physician groups, representing more than 15,000 primary care providers contracted with 35 different Medicare Advantage health insurers and nearly 2 million patients.

Health outcomes were consistently better for patients cared for under the at-risk Medicare Advantage arrangement for dual-eligible patients, who generally have lower incomes and more complex health needs. This was true for at least 17 of 20 different health measures.

The most striking improvements were evident when comparing at-risk Medicare Advantage outcomes like acute inpatient admissions (24% fewer), 30-day readmissions (32% fewer), and avoidable emergency department visits (17% fewer) to traditional Medicare. These improvements demonstrate a particular strength and focus on identifying and addressing issues early on, before they escalate. That likely has something to do with the 33% reduction in preventable admissions for acute conditions and the 30% reduction in preventable admissions for chronic conditions seen in this study.

The study results aren't surprising. In fact, they make perfect sense. Providers under full-risk models are given more time and have the financial flexibility to utilize a broader and more coordinated care team whose work is informed by sophisticated analytic platforms

for population health risk stratification. This enables them to engage patients in ways that are meaningful to them and advance evidence-based practice across their patient panels.

To critics of Medicare Advantage, these results scramble the debate. Making the health care system work better for everyone doesn't come at the cost of physician autonomy. Rather, it comes by encouraging that autonomy more than ever before and broadening the role physicians play in proactively helping their patients lead healthier lives through better care coordination, patient engagement, and evidence-based practice. This is the best available opportunity to realign the incentives that hamstring our episodic, fee-for-service system and make significant strides in preventative care and chronic disease management.

This evidence makes a powerful case for scaling value-based care more widely, and has important policy implications to serve an older, sicker America as costs continue to rise. Some have criticized past Medicare Advantage research as biased, even research that underwent rigorous peer review before publication. As any researcher will tell you, no study is perfect. Often it leads to more research and new evidence, which drives progress and innovation in our health system. This is a field that deserves more research and more collaboration to identify and adapt promising solutions into new standards of care.

There's no time to lose. With a record number of Americans turning 65 this year, the time to advance valued-based care models, including at-risk Medicare Advantage options, is now. The sustainability of our health care system, and the health of our most vulnerable friends, family, and neighbors, depend on it.