THIRD WAY

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Executive Summary: Provide High-Cost Medicare Beneficiaries with Highly Valued Care

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To hear Eugene Allen tell it, he was nearly dead when he was wheeled into the Special Care Center in Atlantic City, New Jersey. He had just spent three months on a mechanical ventilator in the intensive care unit, unconscious most of the time. As a rule, Allen avoided doctors, so when his right leg swelled up, he continued his work as a chef and didn't seek care—until the blood clot traveled into his pulmonary artery and collapsed his lung. His chances at survival didn't look great; he also battled a hospital-acquired infection and weighed 480 pounds. But Allen is just the kind of patient for whom the Special Care Center is made. There, health care providers work to engage patients as partners in their care with a focus on lifestyle changes, such as diet and exercise. To help patients succeed, they receive unlimited, free access to the Center, health coaches to help keep them on track, and often receive reduced-cost medications. Despite his initial misgivings, Irma, Allen's health coach, was patient with him, helping him work through medication side effects and encouraging him to walk, up to 14 miles a week, which he credits with helping him lose 100 pounds.

This kind of care coordination and flexible benefit design could benefit millions of Medicare beneficiaries in the fee-for-service program. Medicare beneficiaries want and deserve highly valued care—care that is person-centered, convenient, efficient, and delivered in innovative ways to help each patient achieve their specific goals. But Medicare's administrators need to make explicit spending and health performance goals and be held accountable for achieving them. Doing so can save the federal government as much as $80 billion over 10 years.

This idea brief is one of a series of Third Way proposals that cuts waste in health care by removing obstacles to quality patient care. This approach directly improves the patient experience—when patients stay healthy, or get better quicker, they need less care. Our proposals come from innovative ideas pioneered by health care professionals and organizations, and show how to scale successful pilots from red and blue states. Together, they make cutting waste a policy agenda instead of a mere slogan.

What is Stopping Patients from Getting Quality Care?

Medicare is in the process of transforming itself from a passive bill payer to an active program manager. But this transformation will not be complete without a clear description of the spending and health goals that Medicare expects to achieve for beneficiaries and taxpayers—as well as accountability for achieving those goals. As a result of directives from Congress, the Centers for Medicare & Medicaid Services has created many great initiatives, but these efforts are missing a key piece—an overall strategy that will lead to the delivery of highly valued care. Highly valued care is individualized, convenient, and efficient care delivered in innovative ways to help each patient achieve their specific goals.

Where are Innovations Happening??

Large health plans, medical group practices, large employers, and even third parties provide effective examples for how Medicare can deliver highly valued care that improves beneficiary outcomes and reduces costs. For example:

- The Special Care Clinic in Atlantic City, New Jersey is exclusively available to workers who have or who are likely to have very high medical costs. These patients are incentivized to join the clinic with unlimited, free access. And the clinic is designed around providing very sick patients what they need, such as guaranteed same-day appointments and health coaches to help them meet their goals. During the clinic's first 12 months, patients' cost of care dropped by 25%.

- CareMore is an integrated health care company which offers Medicare Advantage plans and operates health centers that deliver care to members. CareMore provides many nonmedical services to improve patient compliance, including free transportation to and from its clinics, home visits to mitigate in-home fall hazards, and wireless monitoring devices to help patients track their weight or take medication. An "extensivist" manages care for frail and chronically ill patients, connecting a patient's hospital care with their outpatient care. The company reports medical costs that are 18% below the industry average.

- SCAN Health Plan serves high-cost Medicare beneficiaries through its Medicare Advantage special needs plans. SCAN offers a range of home- and community-based services to help beneficiaries live in their communities, such as home visits by case managers to help coordinate the health and social services a member may need to safely remain in their home. SCAN's efforts result in reduced readmission rates, high quality and member satisfaction ratings, and a 26% reduction in readmission to nursing facilities.

- Integra *ServiceConnect* is a non-provider, non-health plan service that connects individuals to the health care and social services they need. Integra partners with health plans, health systems, and government programs to improve health outcomes. By deploying teams of community health workers, Integra is able to find, engage, and connect with people who have high health care costs, helping them become invested in their health and health goals. One partnerships with a Medicare Advantage dual-eligible special needs plan yielded an 80% reduction in emergency room visits.

How Can We Bring Solutions to Scale?

In order to provide highly valued care to Medicare beneficiaries with the highest costs, Medicare's administrators need to make explicit goals on spending and health performance and be held accountable for achieving them. To codify this process, policymakers need to take the following four steps:

1. Congress should direct Medicare to develop and implement a management plan every two years for getting high-cost beneficiaries highly valued care. The plan should include both spending and health outcome goals.

2. Congress should tie the spending and health goals Medicare establishes in its management plan to performance criteria for Medicare administrators.

3. Congress should provide Medicare with the benefit design flexibility needed to meet the spending and health goals established under the management plan.

4. Congress should direct Medicare to improve payments to health plans for high-cost beneficiaries as part of the management plan.

5. Congress should require the Medicare management plan to encourage better anticipation of and care for high-cost beneficiaries in health plans.

Potential Savings

Research conducted by Avalere concluded that, for example, using a capitated payment rate 5% less than fee-for-service rates, managing care for high-cost beneficiaries would decrease federal spending by over $80 billion dollars over the 2015-2024 federal budget window. Using a capitated payment rate of 1% less than fee-for-service rates yields savings to the federal government of almost $17 billion for this same period, according to Avalere estimates.