

Policy Spotlight

New Federal Law and Rules Open Door for Integrated Care in Medicare Advantage

Overview

Recent policy actions by Congress and the Centers for Medicare & Medicaid Services (CMS) made significant changes to Medicare Advantage (MA), opening the door for health plan partnerships with community-based organizations (CBOs). On April 2, 2018, CMS released final policy and payment updates to the MA program through the 2019 Rate Announcement and Call Letter.¹ On February 9, 2018, President Trump signed the Bipartisan Budget Act of 2018, which included the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act. Both policy actions allow MA plans to expand the scope of the “primarily health-related supplemental benefit standard.” This expansion will effectively increase the number of allowable supplemental benefit options and provide MA enrollees with access to benefits and services that may improve their quality of life and health outcomes. To deliver supplemental benefits, such as transportation, nutrition services and more, MA plans may contract with CBOs, presenting a new opportunity for the Aging and Disability Networks.

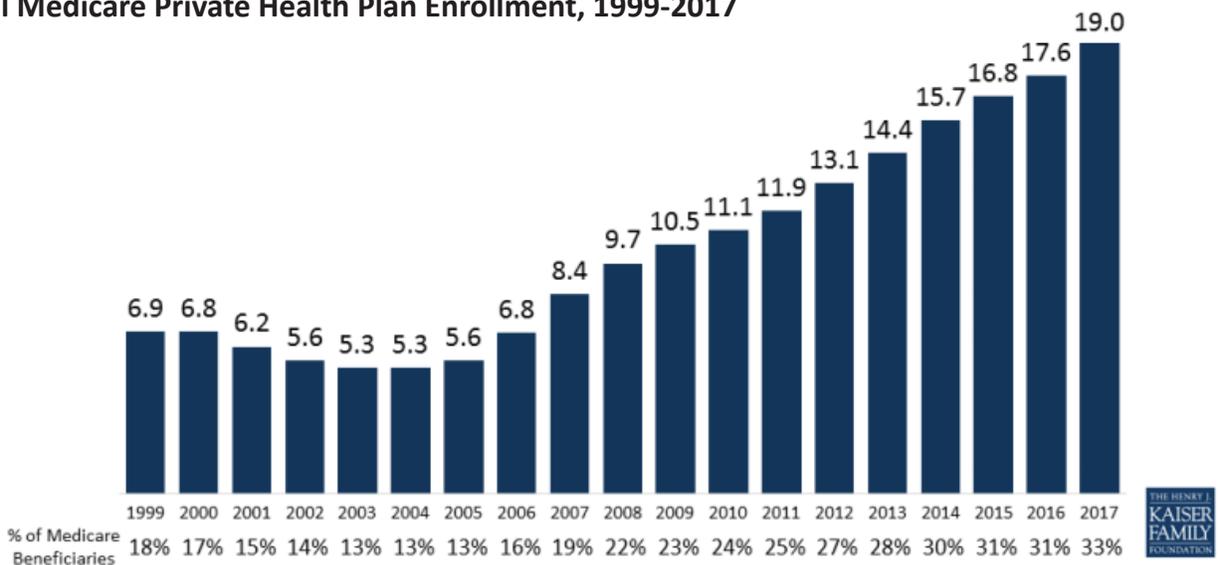
Medicare Advantage Plan Enrollment Trends

One-third of Medicare beneficiaries participated in Medicare Advantage in 2017, and this number is expected to rise. Since 2004, the number of

beneficiaries enrolled in private plans has more than tripled from 5.3 million (13 percent) to 19.0 million in 2017 (33 percent)² (Figure 1).

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2017



Note: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Source: Kaiser Family Foundation (2017). Medicare Advantage Fact Sheet.

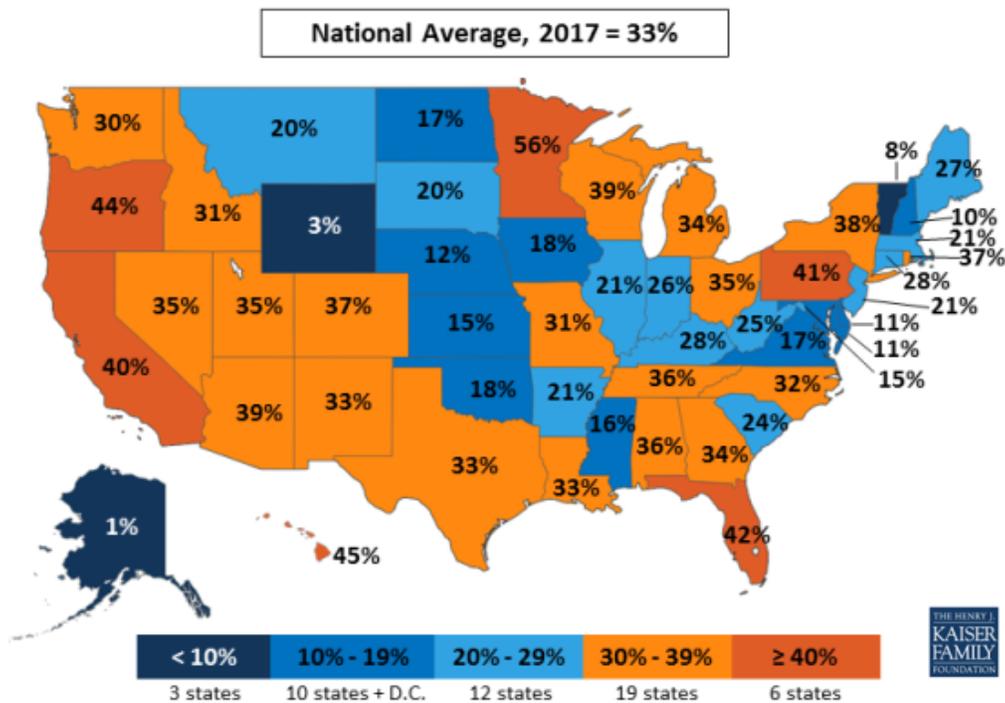
KFF authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

MA enrollment and plan penetration varies widely across the states, and by county, with some states having more than 40 percent of their Medicare beneficiaries in MA plans³ (Figure 2). Historically, this is because MA county rates are based on the relatively higher costs of beneficiaries in Medicare fee-for-service (FFS or Original Medicare) who have both Medicare Parts A and B. In addition, states that have had generally more managed care penetration overall (such as CA and OR) tend to have higher enrollment in MA. In

six states, 40 percent or more of Medicare beneficiaries are enrolled in an MA plan (CA, FL, HI, MN, OR and PA), and in Puerto Rico the rate is 74 percent. In three states (AK, VT and WY), fewer than 10 percent of all Medicare beneficiaries are in an MA plan (Figure 2). Only a few health plans, both nationally and in local markets, tend to dominate the MA market; UnitedHealth Group and Humana together accounted for 41 percent of enrollment in 2017.⁴

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by state, 2017



Note: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

Source: Kaiser Family Foundation (2017). Medicare Advantage Fact Sheet. KFF authors' analysis of CMS State/County Market Penetration Files, 2017.

Overview of Changes to Medicare Advantage

Under current rules, MA plans are allowed to offer supplemental benefits so that enrollees have access to more benefits and options than what they would receive under the Medicare FFS Program. MA plans use rebate dollars and plan premiums to fund these supplemental benefit offerings, which are limited by law to health care benefits. Until now, CMS has interpreted “supplemental health care

benefit” as “an item or service (1) not covered by Original Medicare, (2) that is primarily health-related and (3) for which the Medicare Advantage plan must incur a direct medical cost.”⁵ Previously, CMS has not allowed an item or service to be eligible as a supplemental benefit if the primary purpose includes daily maintenance.

The Final 2019 Advance Notice and Call Letter expands the scope of the primarily health-related supplemental benefit standard and the interpretation of uniformity. In this reinterpretation, CMS would allow supplemental benefits if they are used to “diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care

utilization.”⁶ Under the broader interpretation of uniformity in the Call Letter, supplemental benefits could be provided to all beneficiaries that meet certain health status criteria, as long as all members that meet those specifications can access the benefit. CMS will provide additional guidance to differentiate between the newly expanded supplemental benefits as defined by the CHRONIC Care Act and the Call Letter (Figure 3).

Figure 3
Timeline of Changes to Medicare Advantage

	2018 (no changes)	2019 (Call Letter applies)	2020 (CHRONIC Care Act applies)
Benefit Uniformity	Benefits must be uniform for all beneficiaries in plan	MA plans may tailor benefits for beneficiaries who are “similarly situated” and meet a set of clinical criteria	MA plans may tailor benefits for beneficiaries who are “similarly situated” and meet a set of clinical criteria CMS may offer waivers of benefit uniformity for benefits tailored to “chronically ill beneficiaries”
Supplemental Benefits	Must be offered uniformly to each enrollee in a plan	MA plans may tailor benefits for beneficiaries who are “similarly situated” and meet a set of clinical criteria	MA plans may tailor benefits for beneficiaries who are “similarly situated” and meet a set of clinical criteria CMS may offer waivers of benefit uniformity for benefits tailored to “chronically ill beneficiaries”

Source: Adapted from Better Medicare Alliance webinar. Medicare Advantage and Part D 2019 Final Rate Notice and Call Letter. April 5, 2018.

The CHRONIC Care Act builds upon several years of bipartisan work to improve care for the more than two-thirds of beneficiaries in the program today who have multiple chronic conditions. Passed by the Senate by unanimous consent on September 26, 2017, the new law received broad bipartisan support. It was driven by Senate Finance Committee Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR), who formed a Chronic Care Working Group, led by Senator Johnny Isakson (R-GA) and Senator Mark Warner (D-VA). According to statements released by their offices, these leaders and their staffs devoted hundreds of hours working with patient groups, health care providers and other experts, including n4a, to develop health policy that would both hold down long-term

health care costs and help patients and their families get the care they want and need. In addition, the new law adopts many of the policy recommendations put forward by the Bipartisan Policy Center regarding individuals with complex care needs.⁷

The CHRONIC Care Act redefines supplemental benefits as those that “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health-related benefits.” Plans may begin providing these benefits in 2020. In addition to broadening the definition of supplemental benefits, the CHRONIC Care Act also waives the uniformity requirement for supplemental benefits. Under the

previous uniformity requirement, MA plans were required to offer the same benefits to every beneficiary in their service area. The 2019 Final MA Call Letter allows MA plans to tailor supplemental benefits, such as cost sharing and deductibles, for beneficiaries who are clinically “similarly situated.” Waiving the uniformity requirement for supplemental benefits will allow MA plans to tailor services to address the needs of complex beneficiaries with certain chronic conditions, such as diabetes and chronic obstructive pulmonary disease, also known as COPD.

One barrier to offering supplemental benefits has long been that MA plans fund their supplemental benefits either by charging additional premiums or by using their rebate dollars, and are subject to a uniformity requirement. Rebate dollars are the difference between the MA plan’s “bid,” or estimated per-enrollee costs of providing Medicare Part A and B services, and the regional benchmark of Medicare FFS spending. If the benchmark is higher than the MA plan’s bid, the plan receives some of the difference as a “rebate” on top

of the bid amount. Rebates in some areas may not be large enough to finance supplemental benefits for all beneficiaries. Requiring uniformity was a barrier to offering benefits that would have been most valuable to a subset of beneficiaries, such as those with certain chronic conditions, because it would have been cost prohibitive to offer them to all plan members.

The CHRONIC Care Act makes additional changes to Medicare Advantage. It expands the Value-Based Insurance Design model, a model being tested by CMS’s Center for Medicare and Medicaid Innovation that allows MA plans to offer supplemental benefits or reduced cost sharing to beneficiaries with certain chronic conditions in order to better meet their needs with high-value services. It also permanently authorizes three types of Special Needs Plans (SNPs), which are special types of Medicare Advantage plans that enroll individuals with specific needs or chronic diseases, and enhances the integration of Dual Eligible SNPs (SNPs for dual eligible beneficiaries).

Implications for Integrated Care and Community-Based Organizations

By specifying that these benefits need not be “primarily health-related,” the new rules and law provide flexibility for MA plans to provide a broader set of benefits that address social determinants of health. This, in turn, creates significant opportunities for community-based organizations, who have long provided services that address health and function, such as home-delivered meals, home modifications (e.g., installing wheelchair ramps), transportation and evidence-based health promotion and disease management programs.

As new payment incentives with a sharper focus on health care outcomes and quality have begun to transform the health care sector, health care entities are increasingly contracting with CBOs to address the social needs of older adults and people with disabilities or chronic conditions. A recent Aging and Disability Business Institute survey of nearly 600 CBOs—including Area Agencies on Aging (AAAs), Centers for Independent Living, as well as faith-based organizations, service providers and others—revealed that over one-third (38 percent) of CBOs have a contract with a health care entity.⁸ The most common health care partners named were Medicaid Managed Care Organizations and hospitals/health systems, with

about 5 percent of respondents currently contracting with MA plans. The expansion of the definition of supplementary benefits should increase that percentage.

As enrollment continues to grow, MA plans are poised to provide integrated care to a growing number of beneficiaries across the country. These recently enacted changes signal policymakers’ increasing awareness that behavioral, environmental and social factors, as well as functional status, contribute significantly to health and health care spending.^{9,10} CBOs, such as AAAs, have decades of experience in providing the types of supplemental benefits that may be offered by the CHRONIC Care Act and the 2019 Call Letter, including nutrition services, home modifications/renovations, transportation, care management and evidence-based health promotion/disease prevention programs. Broadening the uniformity requirement for supplementary benefits allows MA plans to target these types of services to the subset of complex members whom they are most likely to benefit. In 2015, the 36 percent of Medicare beneficiaries with four or more chronic conditions accounted for 76 percent of total Medicare spending and 92 percent

of Medicare hospital readmissions.¹¹ Seventy-seven percent of these readmissions were for a small group of Medicare beneficiaries—15 percent—with six or more chronic conditions. Partnering with CBOs to provide supplemental social services and intensified case management could significantly improve health and quality of life for this population, while also reducing costs for the plan.

A growing body of research demonstrates the value of social services and supports in improving the health and well-being of people with chronic conditions and functional limitations. Several studies have found that home-delivered meals improve health outcomes and are associated with reduced nursing home use in older adults with less intensive health and long-term care needs.^{12,13} In addition, evidence-based disease management programs, such as the Chronic Disease

Self-Management Program and other self-management programs, have shown great success in improving health and alleviating symptoms such as fatigue, pain and shortness of breath.¹⁴ Falls prevention programs also present significant opportunities to address costs, with a recent study finding that \$29 billion in Medicare spending could be attributed to falls in 2015.¹⁵ Evidence-based health promotion and disease management programs have been shown to reduce incidence of falls, fear of falling, health care spending and hospitalizations.¹⁶ As of October 2016, all AAAs are required to provide these evidence-based programs, which address an array of chronic conditions as well as depression, help older adults with medication management and increase their physical activity.ⁱ Contracting with CBOs to provide these services would be greatly beneficial to complex beneficiaries in MA plans.

Partnering with Medicare Advantage Plans

CBOs have deep experience in providing person-centered services that address social determinants of health. Given this experience, they are excellent partners for MA plans seeking to address the broader social needs of their beneficiaries and improve their performance. Star Ratings, which provide publicly available ratings of MA plan performance, and the Health Effectiveness Data and Information Set (HEDIS) Measures, which are used by 90 percent of health plans and are important components of Star Ratings, are not yet tied to measures of integration of social services. However, there are many quality outcomes that can be improved by CBOs and the services that they provide, such as measures of chronic condition management and member experience. Star Ratings have a significant impact on plan enrollment and marketability. In 2016, plans that consistently earned four or more stars over the previous two years experienced 40.9 percent enrollment growth, compared to 0.9 percent for those that had consistently garnered three stars or fewer.¹⁷ Plans with higher Star Ratings also receive a larger rebate than those with lower ratings. CBOs should identify the measures that the plans in their areas could improve upon to build their case for contracting.

MA plans play a key role in delivery system reform, and the changes to their supplemental benefit rules present significant opportunities for partnership with CBOs. MA plans receive a set Per Member Per Month (PMPM) payment,¹⁸ which remains the same regardless of how many services the beneficiaries use, and are therefore incentivized to manage and improve the health of their clients as efficiently as possible. They will seek to partner with CBOs that are able to provide high-quality services at a competitive cost and can help improve their Star Ratings.

The CHRONIC Care Act and new MA rules are part of a larger effort to foster innovation in benefit design to better serve Medicare beneficiaries who have multiple chronic conditions. CBOs have an important role to play in the health care system, and should seek to partner with MA plans in their regions to provide supplemental services to complex beneficiaries. These partnerships will better enable MA plans to provide high-quality care to the growing number of Medicare beneficiaries across the country who enroll in Medicare Advantage.

i Title III D of the Older Americans Act provides grants to states and territories based on their share of the population aged 60 and older for programs that support healthy lifestyles and promote healthy behaviors. As of October 2016, OAA Title III D funds must be used to provide programs that meet a specific set of criteria, equivalent to the “highest-level” criteria of the former definition of evidence-based.

Notes

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