What's on the Horizon for Chronic Care Policy?

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ASA Roundtable

September 10, 2019

Why is this important?

- Need for LTSS Financing –
  - Lack of financing for LTSS – Medicaid accounts for 60 percent of annual LTSS expenditures. Private spending including out-of-pocket accounts for over 30 percent.
  - Medicare does not cover LTSS -- Medicare covers only 3 months of SNF and Home Health post-acute.
  - Medicare has previously not covered any non-medical benefits.

- Role of SDOH and functional limitations in medical utilization
  - Importance of addressing non-medical needs to improve clinical outcomes.
  - Clinicians need a broader set of tools to meet complex care needs.

- Potential for more integrated approaches to reduce health care spending

New flexible supplemental benefits incorporate some LTSS

CMS rules for 2019 plan year:

- Target benefit to specific subgroups of members
- Expand to "primarily health-related" benefits, such as:
  - Adult Day Care Services
  - Home-Based Palliative Care
  - In-Home Support Services
  - Support for Caregivers of Enrollees
- Specifically excludes meals in 2019

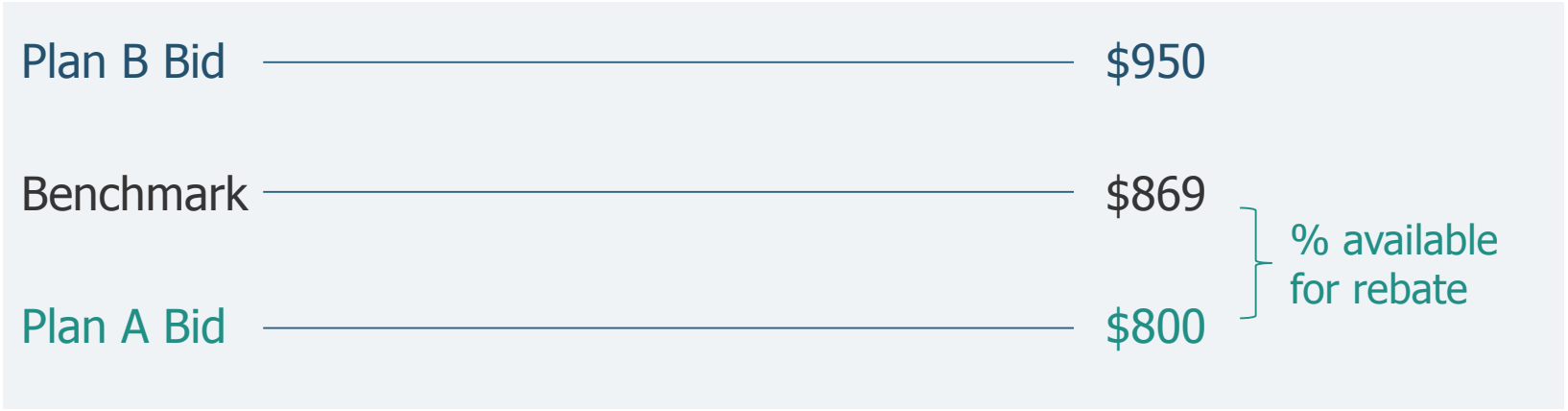
"Flexible" Supplemental Benefit – CY 2019

- Limited number of plans submitted bids in 2019.
- Plans that bid saw it as a pilot – an opportunity to test ideas.
- More planned to participate in 2020.
- Plans see value in the approach
  - Attracting complex care needs members with tools to effectively manage their care
  - Providing needed non-medical services and supports can help reduce avoidable medical utilization.
- Plans worry about adverse selection risk -- being the only game in town and attracting too many high-risk members without better risk adjustors.

MA Plan Perspective on New Supplemental Benefits

http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//LTQA-Report-on-MA-Flexible-Supplemental-Benefits-FINAL-11-9-18.pdf

Plan Pricing and Benefits

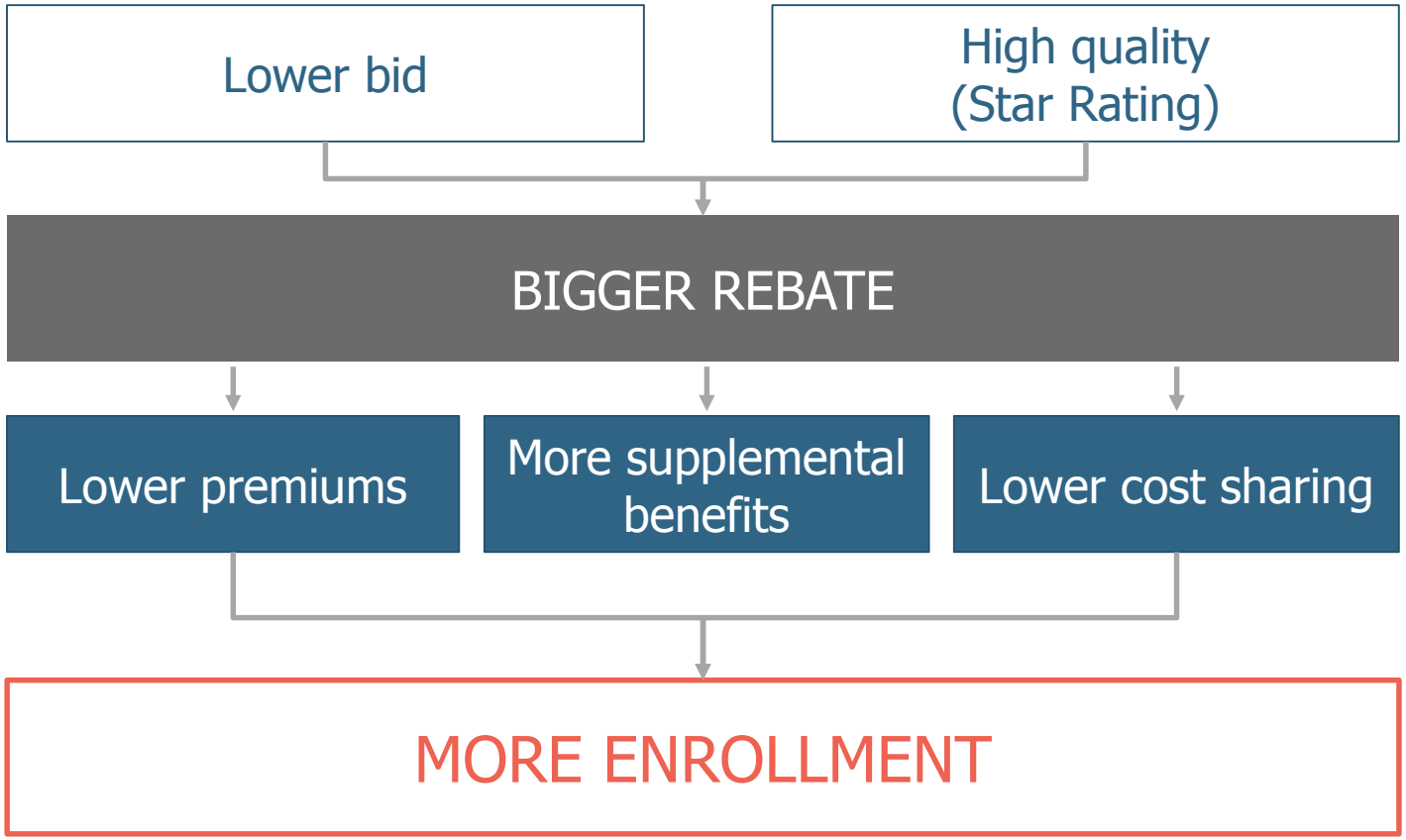


Plan A			Plan B		
Base Rate	=	$800	Base Rate	=	$869
Rebate	=	0.5* $69 = $34.5	Plan Premium	=	$81

Amount for reducing enrollee out of pocket spending & offering **supplemental benefits**

MORE ENROLLMENT

High Quality/Low Cost Plans Will Be More Competitive for Enrollment



Limitations of Using Supplemental Benefits

- Limited amount of money:
  - Rebate dollars (amount by which the plan bid is less than the CMS benchmark)
  - A function of the plan's quality "star rating" (which adjusts the rebate amount)
  - The need to offer universal supplemental benefits (e.g., vision, dental) that have a broad appeal for marketing

- Lack of continuity -- supplemental benefits can vary from year-to-year

Limitations of Using Supplemental Benefits

- Limited flexibility to build into a care plan
- A "benefit" is less flexible than a "clinical program" – has to be universally available to target population
- Challenges in marketing/communicating a targeted benefit.
  - Difficult to communicate the eligibility or benefit limits in PlanFinder or plan materials
  - Risk of misleading and attracting people to the plan who would not qualify for the benefit

Plan Comments to CMS for the 2020 Plan Year

- Plans asked for more clarity from CMS on kinds of benefits that CMS will approve
  - Communication of the criteria CMS is using
  - Better sense of how policy will evolve
- Plans wanted CMS to be less prescriptive and allow more flexibility for plans in designing benefits
  - Want to be able to incorporate Part D (drug) benefits
- Plans will be developing better evidence of the value of these benefits and a better way to price them

A Turning Point in Medicare Policy: Special Supplemental Benefits for the Chronically Ill

ANNE TUMLINSON INNOVATIONS

ltqa LONG-TERM QUALITY ALLIANCE

THE scan FOUNDATION

Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act

- The *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (CCA)* expands MA supplemental benefits to meet the needs of chronically ill beneficiaries
  - CCA special supplemental benefits for the chronically ill (SSBCI) must 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
  - Uniformity requirements are waived for SSBCI

CCA Definition of Chronically Ill Enrollee

- The law specifies the definition of a chronically ill enrollee as someone who:
  1. Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
  2. Has a high risk of hospitalization or other adverse health outcomes; and
  3. Requires intensive care coordination

Final 2020 MA Call Letter and April 24, 2019 Guidance

CMS clarifies what it means for enrollees to have one or more comorbid conditions but gives MA plans an unprecedented degree of flexibility to:

- Develop services they offer as SSBCI, so long as there is a reasonable expectation of improving and/or maintaining health;
- Target SSBCI as it relates to the individual enrollee's specific condition and needs;
- Address social determinants of health (SDOH); and
- Consider SDOH as one (but not the sole) factor in targeting benefits

CMS provides examples of non-primarily health related benefits such as pest control, structural home modifications, and transportation for non-medical needs

Sources: 1. CMS Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. April 1, 2019. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf; 2. CMS Guidance on Implementing Supplemental Benefits for Chronically Ill Enrollees. April 24, 2019. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

2020 SSBCI

- Plans have more flexibility than in 2019
- Building on 2019 offerings
- Healthcare tax paid in 2020 will impact funding available
- ROI and evidence are still critical components to determining if and which SSBCI to offer
- **Infrastructure to target and deliver remains top of mind:**
  - **MA Plans need strong community partnerships to implement SSBCI!**

Why "Principles?"

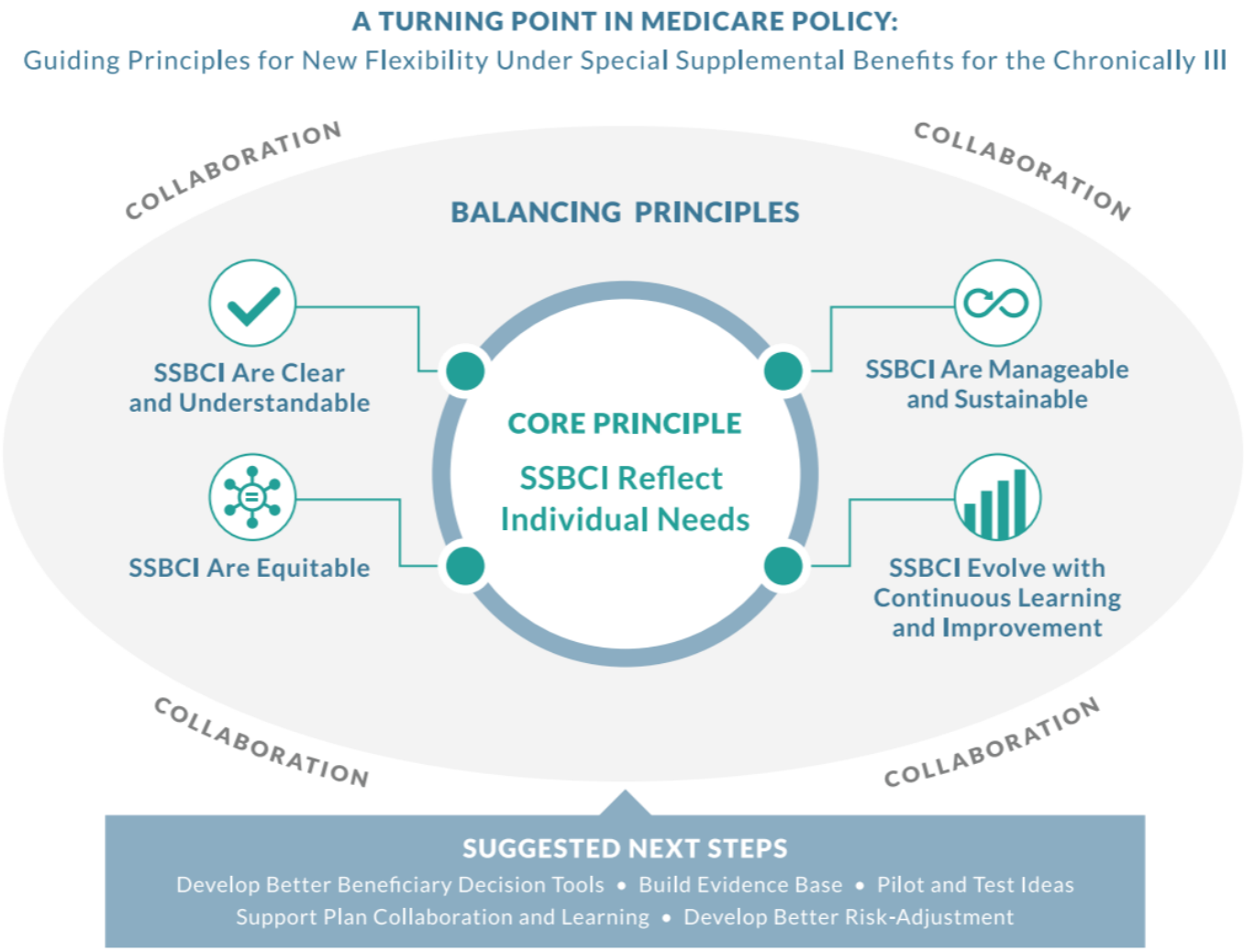
- SSBCI represent a turning point in Medicare policy.
- For the first time, Medicare allows coverage of non-primarily health related benefits through the Medicare Advantage program, as well as significant flexibility around who is eligible for these benefits and the services they receive.
- We need foundational principles that can inform regulation development, benefit design, and form the basis of a common language for everyone, including:
  - CMS and affiliates (OMB, ACL)
  - Health plans
  - Delivery systems
  - Advocates
  - Congress and affiliates (GAO, CRS)

Principles

- "a fundamental truth or proposition that serves as the basis for a system of belief or behavior or for a chain of reasoning"

- "a fundamental quality or attribute determining the nature of something; an essence"

A Turning Point in Medicare Policy



Core Principle: SSBCI Reflect Individual Needs

SSBCI flexibility –in benefit eligibility, types of services, and providers—allows Medicare Advantage plans to meet the individual needs of chronically ill beneficiaries.

- SSBCI flexibility supports the beginning of a path toward person-centeredness in Medicare.
- For the first time through SSBCI, chronically ill individuals may be covered by benefits that meet their specific needs according to their values and preferences, in the context of improving or maintain health.
- Medicare Advantage policy context limits SSBCI, their impact, and the ability of plans to meet comprehensive individual needs through these benefits.

Balancing Principle 1: SSBCI Are Clear and Understandable

Key stakeholders, including Medicare beneficiaries and their caregivers, providers, payers, enrollment counselors, and states understand SSBCI as well as its limitations and the circumstances under which they are available.

Additional Considerations:

- Key stakeholders should receive information about SSBCI that is explicit and clear, prevents confusion, and avoids unmet expectations about benefit eligibility, service levels and amounts, types of providers, and the timeframe under which benefits are potentially available. Information should be accessible to people who use assistive technology.
- Medicare beneficiaries and their family caregivers should be able to weigh tradeoffs of plan choices in a meaningful way. Meeting this principle will require new initiatives to promote stakeholder awareness and education, and initiatives to improve information that is available to the public for making decisions (e.g., Medicare Plan Finder).
- Medicare Advantage plans and CMS should ensure that Medicare beneficiaries are aware SSBCI can change or be eliminated from one plan year to the next.

Balancing Principle 2: SSBCI Are Equitable

Chronically ill Medicare Advantage enrollees receive SSBCI in a consistent, equitable, and nondiscriminatory manner that determines and meets individual need based on chronic illness and functional status.

Additional Considerations:

- Medicare Advantage plans should adopt specified criteria for eligibility that are administered consistently within a plan, based on chronic illness and functional impairment levels. This means that determination of need and subsequent authorization of services should be based on clear guidelines that ensure each case is evaluated within a Medicare Advantage plan on the same basis, according to the same process.
- Medicare Advantage enrollees, who otherwise meet eligibility criteria for SSBCI within a plan, should not be hampered in accessing benefits as the result of cultural or language barriers, use of assistive technology, disabilities, or health disparities. This goal should be balanced with avoiding unnecessary administrative burden on providers, plans, or enrollees.
- As CMS requires, Medicare Advantage plans are accountable for program integrity, quality, and access under SSBCI. Nothing about SSBCI should prevent Medicare Advantage enrollees from appealing denial of benefits.

Balancing Principle 3: SSBCI Are Manageable and Sustainable

Medicare program regulations and guidance, such as rate structures and quality measures, support Medicare Advantage plans in offering, managing, and sustaining their inclusion of SSBCI in MA plan benefit packages.

Additional Considerations:

- Policymakers should support SSBCI by refining and aligning quality measures, financial incentives, risk adjustment, and payment methods that ensure Medicare Advantage plans can meet identified, specified enrollee needs through these benefits.

Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement

The federal Department of Health and Human Services (HHS) and CMS, in conjunction with Medicare Advantage plans and other stakeholders, evaluate and measure the extent to which SSBCI are contributing toward meeting the needs of chronically ill enrollees and adapt SSBCI accordingly based on learnings.

Additional Considerations:

- HHS, CMS, and Medicare Advantage plans should be able to measure whether SSBCI are contributing toward meeting the needs of chronically ill Medicare Advantage enrollees. These services should be evaluated by socio-economic status, inclusive of income, race, disability, geography, and other demographic factors, to the extent possible with available data.
- Plans should have the opportunity to adapt and change their approach over time as they learn what works to meet individual needs.
- This principle will contribute to building an evidence base about what works in meeting individual need, which should inform delivery and future policy for the Medicare program, as a whole. It may require plans to submit information for independent third-party evaluation research that would be made publicly available. Such a mechanism would incorporate learnings among Medicare Advantage plans, consumers, and other stakeholders, and between Medicare Advantage plans and CMS.

Next Steps

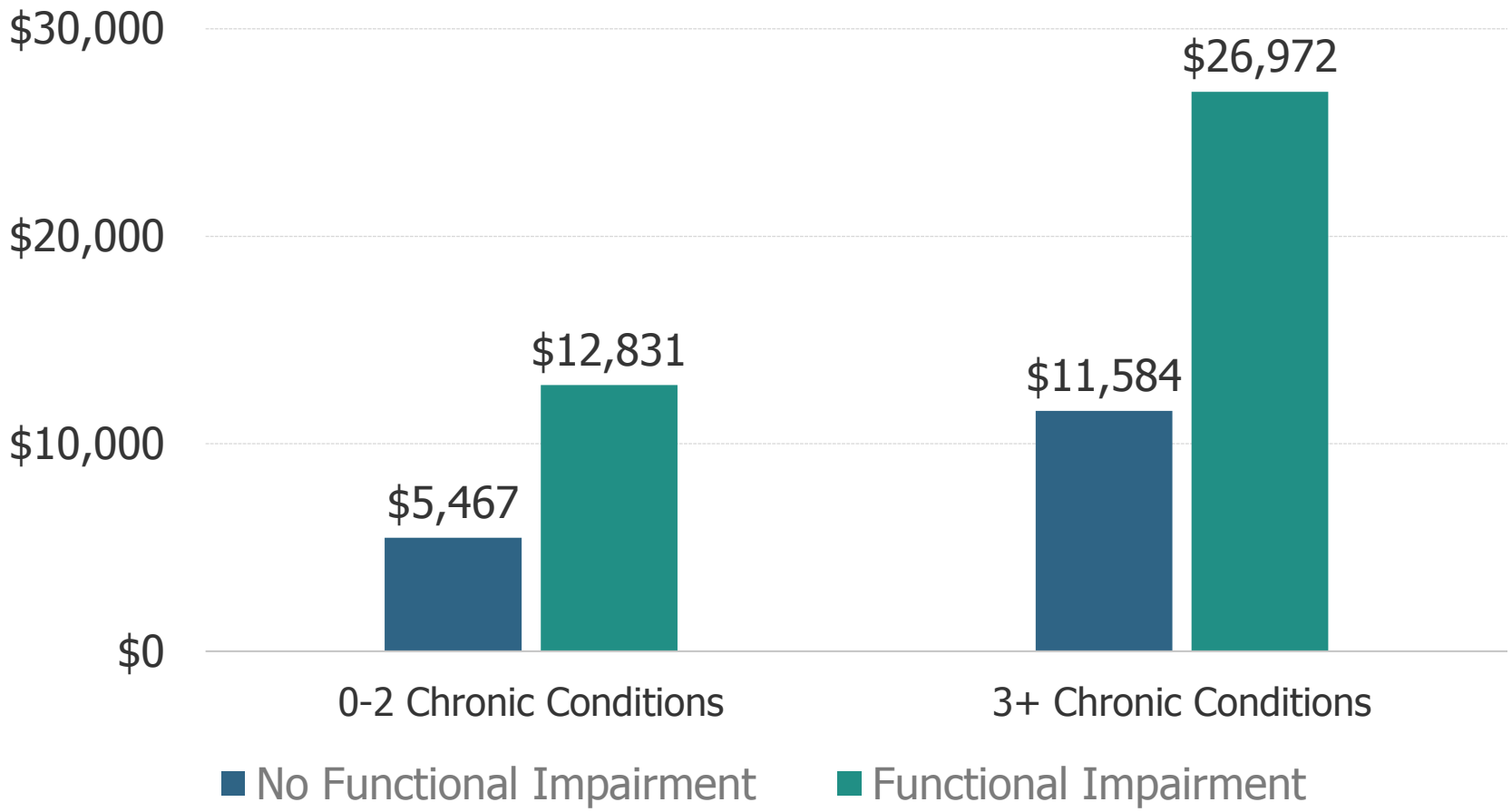
Balancing Principle 1: SSBCI Are Clear and Understandable	❑ Develop better beneficiary decision tools and information ❑ Increase beneficiary and family caregiver education ❑ Raise awareness
Balancing Principle 2: SSBCI Are Equitable	
Balancing Principle 3: SSBCI Are Manageable and Sustainable	❑ Develop better risk adjustment
Balancing Principle 4: SSBCI Evolve with Continuous Learning and Improvement	❑ Support plan collaboration and learning ❑ Build the evidence base ❑ Pilot and test ideas

Flexible Supplemental Benefits

Challenges:

- Challenges in marketing/communicating a targeted benefit.
- Limited flexibility to build into a care plan
- Actuarial challenges
- Network issues
- Determining eligibility and "amount" of benefit
- Uncertain how to measure success

Per Capita Medicare Spending, 2015



Note: Data is limited to fee-for-service Medicare beneficiaries living in the community
Source: 2015 MCBS linked to claims

Additional Emerging Opportunities in MA for Greater Flexibility

Medicare's New Flexibility in Medicare Advantage

- Other Options in Medicare Advantage: Plans are taking advantage of other initiatives that allow them to provide non-medical services and supports and address individual needs.

- Testing Limited Coverage of Non-Medical Services: Each of these approaches tests a provisional and limited gateway to providing care coordination and covering non-medical services and supports.
  - Each has a unique set of advantages and disadvantages,
  - Each provides a mechanism that may have some potential for expansion in the future.

Value Based Insurance Design (VBID): CMS Demonstration Program

- VBID Concept -- encourage plan enrollees to use specific preventive or clinically valuable services by reducing cost sharing for those preferred services aimed at improving outcomes and lowering medical costs.

- VBID Demonstration – CMS began testing use of VBID in managing care for enrollees with select chronic conditions in 2017.
  - The Demo gives MA plans flexibility to reduce cost sharing or adopt additional supplemental benefits for enrollees with specified chronic conditions.
  - Expanded for calendar year 2020: the VBID Demo is
    - available nationwide
    - expanded to include a range of new approaches, including offering "non-primarily health related" items or services for enrollees based on chronic condition or socio-economic status.

Quality Improvement Program (QIP): Clinical Programs

- Medical Loss Ratio: Federal law generally requires that health insurance plans use no-less-than 80 percent of the premium dollar they receive to provide health benefits or quality improvement activities (the "medical loss") and keep administrative costs and profits below 20 percent of premium.

- Rebate to Consumer: Any amount of administrative spending in excess of 20 percent has to be returned to the consumer or plan sponsor as a rebate.

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- Clinical Programs: MA plans can provide care management and a variety of non-covered services to individual beneficiaries as part of a "clinical program" aimed at quality improvement. They are not a "benefit."

…and beyond MA plans

- "Primary Cares" Initiative – the Centers for Medicare and Medicaid Innovation (CMMI) announced in April an initiative to provide incentives in traditional FFS Medicare for provider groups and other organizations to take financial risk for managing the care for beneficiaries with complex care needs.

- The initiative would enable these organizations to use similar "benefit flexibility" to provide non-medical services and supports that can reduce avoidable medical utilization. "

Final Thoughts on Financing LTSS

- Family caregiving is the foundation
  - Improve support for family caregivers and enable them to maintain a fundamental role

- Increase reliance on home- and community-based services – transform the way home care is provided to improve outcomes and reduce costs -- reduce avoidable hospital and institutional care.

- Strengthen individual preparation and responsibility:
  - Encourage savings and the use of accumulated assets, savings, and private insurance to cover a portion of LTSS costs

- Integrate LTSS and medical coverage in comprehensive, capitated plans – available through privately and publicly-financed integrated health plans

- Consider re-insurance of integrated health plans and other approaches that would cap and pool the risk of outliers with extended and expensive use of LTSS

Long-Term Quality Alliance (LTQA)

An alliance of national stakeholder organizations: payers, providers, and consumer and advocacy groups.

Promoting person-and family-centered, high-quality, integrated LTSS.

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