Medicare on the Move: New Insights and Opportunies

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The Evolving Health Care Landscape

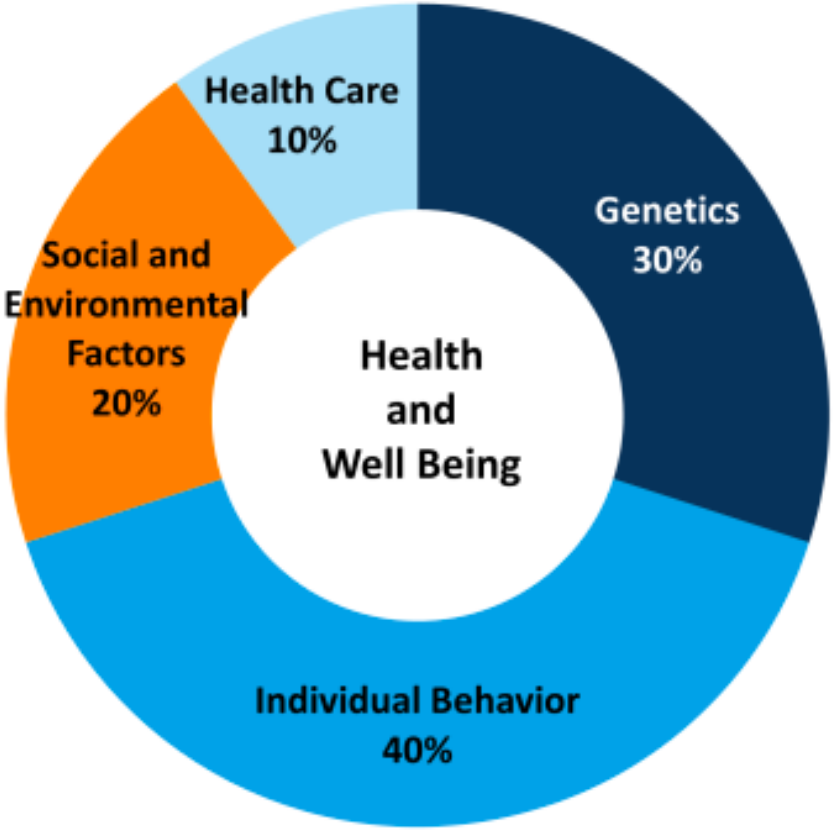
- Affordable Care Act, March 2010
  - Made affordable health care more available.
  - Supported innovative care delivery methods designed to lower costs.
- Medicare Access and CHIP Reauthorization Act (MACRA), April 2015
  - Changed the way physicians are reimbursed for Medicare services.
  - Introduced the Quality Payment Program, whereby physicians earn bonuses or face penalties based on their quality and cost performance measures.
- CHRONIC Care Act, Feb 2018
  - Advanced goals of integrated, person-centered care for adults with complex chronic care needs.
  - Allows MA plans to offer an expanded set of supplemental benefits to chronically ill enrollees starting in 2020.
- *Underlying Theme: Increase Quality and Reduce Total Costs

Shift Toward Value-Based Purchasing

- The current system is changing from Fee-For-Service to payment for outcomes.
- A Value-Based Purchasing system provides financial incentives for outcomes (Value)
- MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes
- In the past, there were real financial incentives to providers, when complications occur

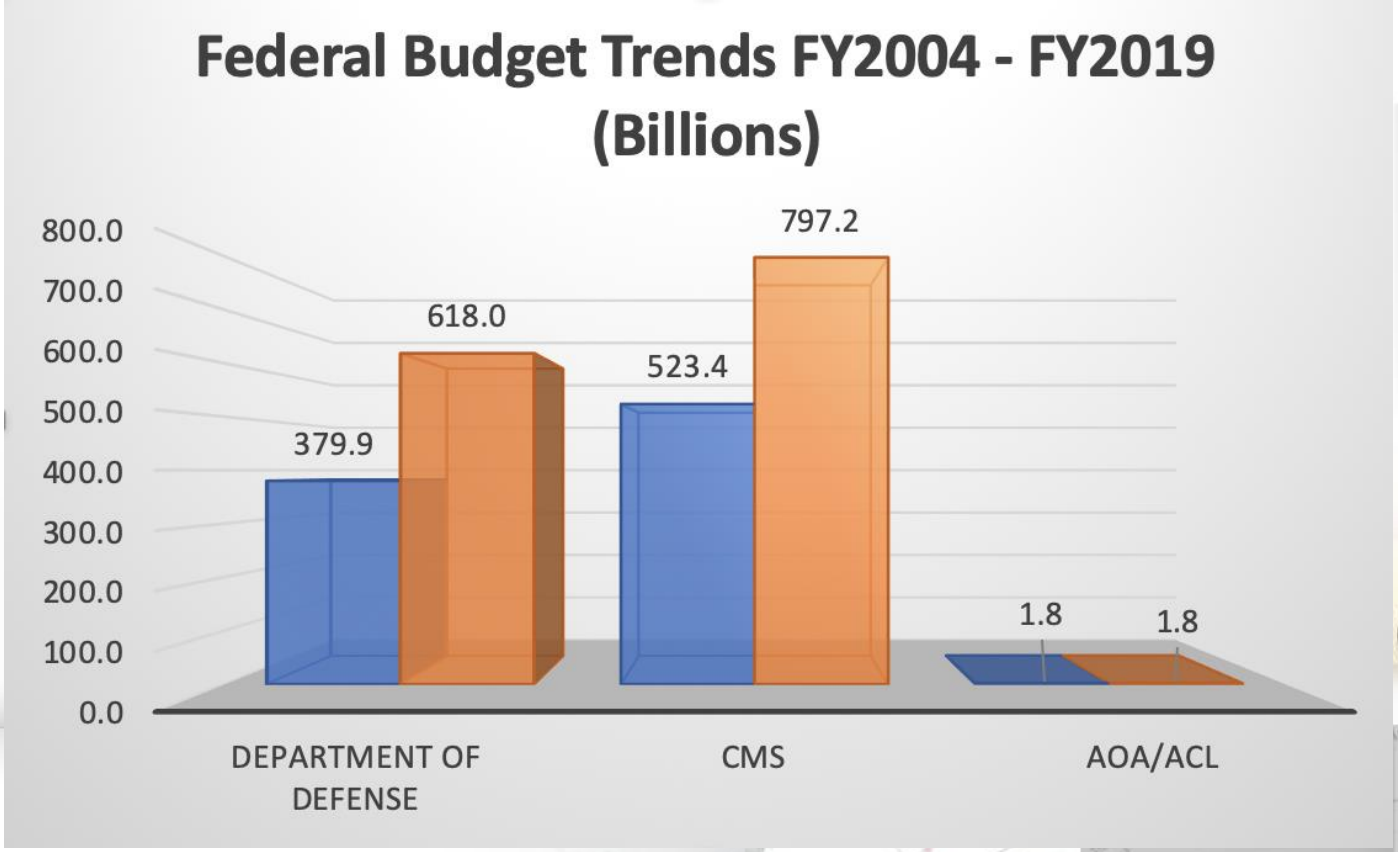
Figure 1

Impact of Different Factors on Risk of Premature Death

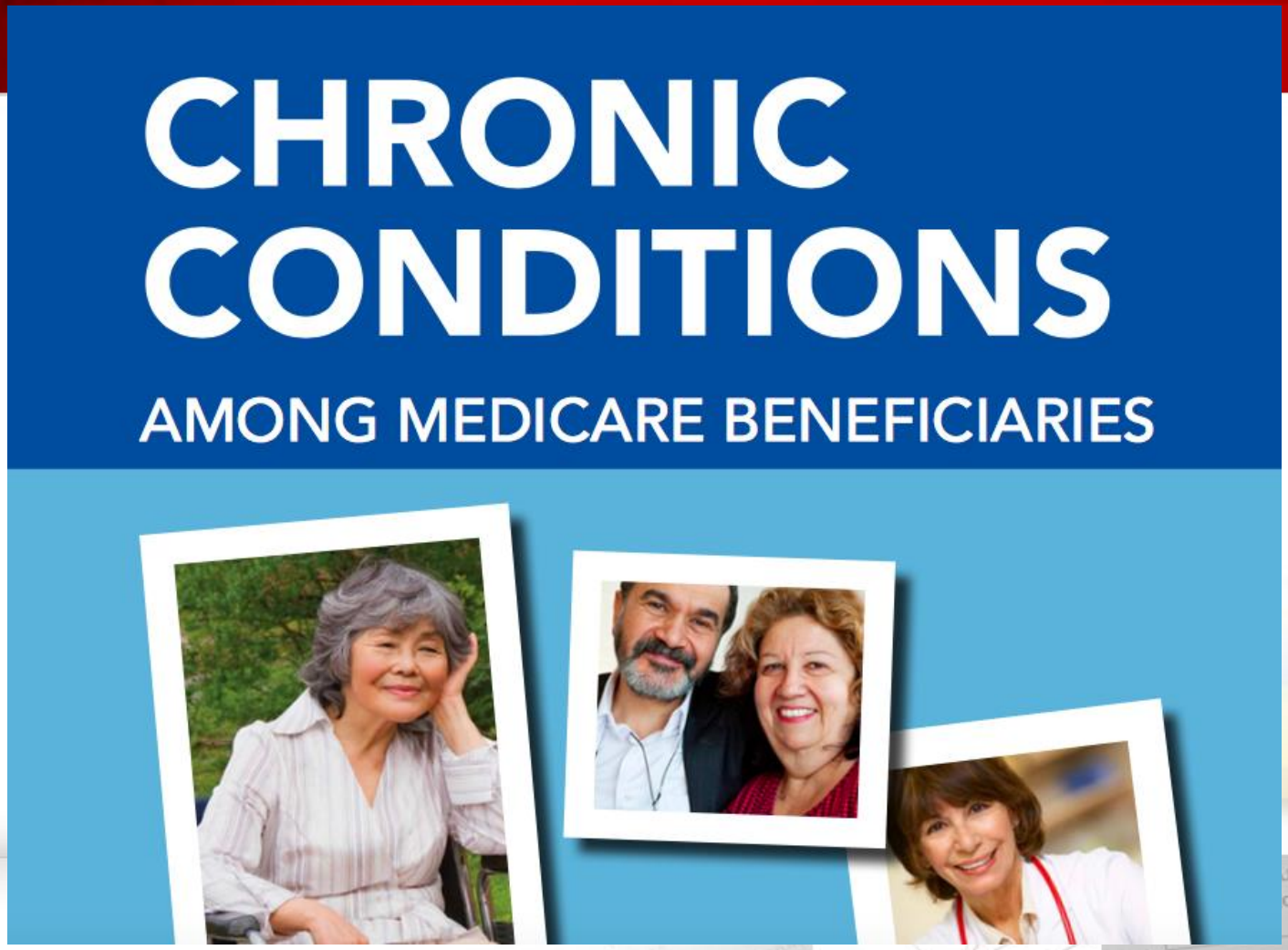


SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

Comparative Funding for Social Services



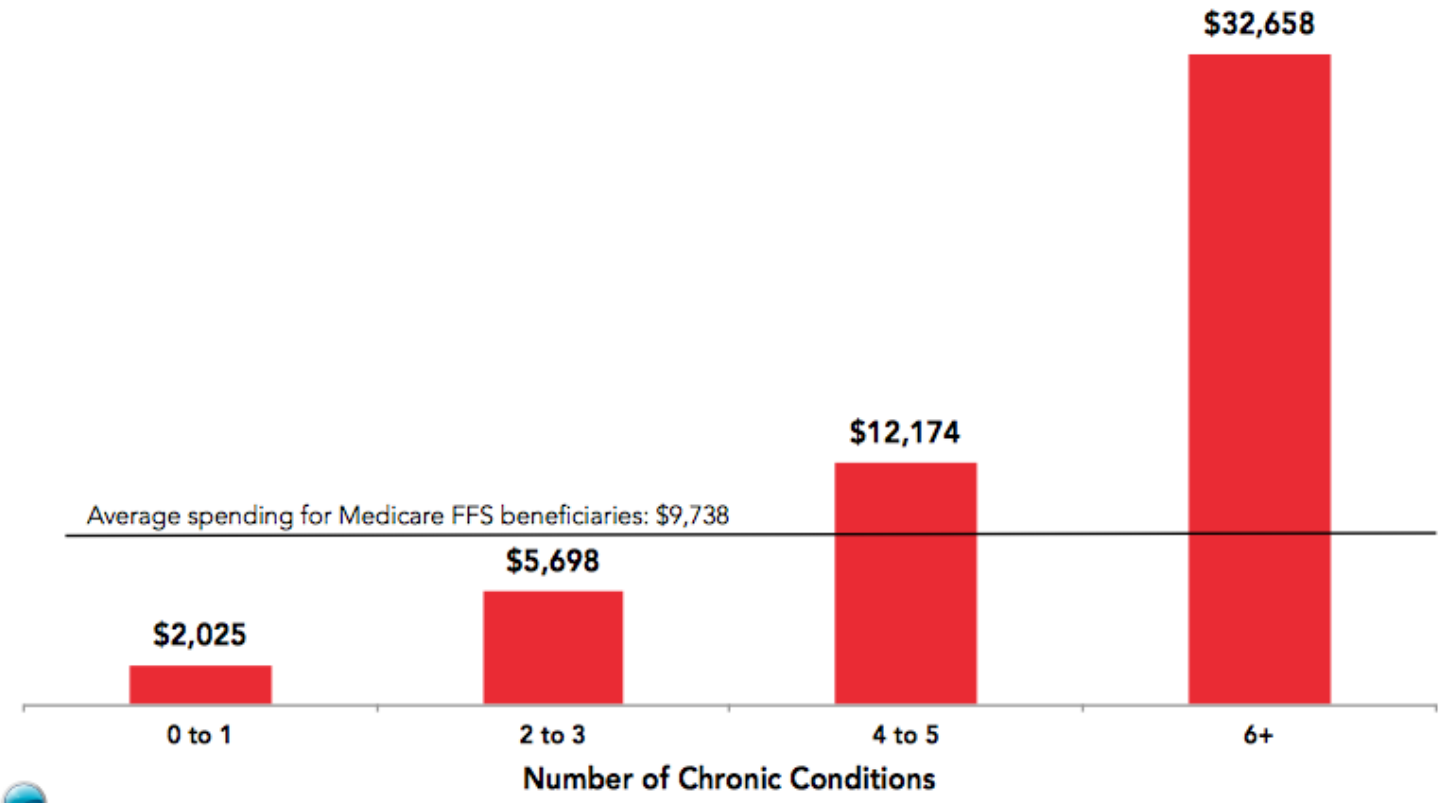
CMS Medicare Chartbook:



https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

Per Capita Expenditures increase as the conditions increase

Figure 3.1a *Per Capita Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*



Which Population has the most chronic disease?

- Most chronic conditions were more prevalent for dual-eligible beneficiaries
  - 72% of dual-eligible beneficiaries had two or more conditions
  - Dual eligible beneficiaries were 1.7 times as likely to have 6 or more chronic conditions
- 98% of readmissions, in 2010, were for Medicare beneficiaries with two or more chronic conditions
  - *CMS Chronic Conditions Among Medicare Beneficiaries, Chartbook – 2012 Edition. Available Online: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf*

Current State of Alternative Payment Models

- Accountable Care Organizations
  - Medicare Shared Savings
    - All MSSP ACOs must move to 2-sided risk in 2 years
  - Next Generation
- Bundled Payment for Care Improvement-Advanced
- CPC+
- *New Initiatives (CY 2020)
  - Direct Contracting / Primary Care Initiatives
  - Special Supplemental Benefits for the Chronically Ill

CPC+ Evaluation Report - 2019

MATHEMATICA
Policy Research

Independent Evaluation of Comprehensive Primary Care Plus (CPC+)

First Annual Report

April 2019

CPC+ 2019 Evaluation Report Key Finding

- https://downloads.cms.gov/files/cmmi/cpcplus-first-ann-rpt.pdf

  - "CPC+ **did not affect total Medicare expenditures** without enhanced CPC+ payments in 2017. After including CMS' enhanced CPC+ payments, and shared savings payments for practices that participate in the Medicare Shared Savings Program (SSP), the changes in **Medicare expenditures since baseline for beneficiaries in CPC+ practices were 2 to 3 percent higher than those for beneficiaries in comparison practices.** This is similar in size to the average care management fees practices received for Medicare FFS beneficiaries."

CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Examining the Potential Effects of Socioeconomic Factors on Star Ratings*

Center for Medicare

September 8, 2015

*The research presented is sponsored by CMS under contract HHSM-500-2013-00283G and performed by the RAND Corporation. The RAND Team included the work of Melony Sorbero, Ann Haas, Cheryl Damberg, Marc Elliott, and Susan Paddock.

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CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

Likelihood of Receiving Recommended Care or Outcomes

HEDIS Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Adult BMI Assessment	1.11***	0.93***
Rheumatoid Arthritis Management	0.85***	1.17***
Breast Cancer Screening	0.69***	0.72***
Controlling High Blood Pressure	0.99	1.02
Diabetes Care – Blood Sugar Controlled	0.68***	0.63***
Diabetes Care – Eye Exam	0.93***	0.68***
Diabetes Care – Kidney Disease Monitoring	0.93***	0.69***
Colorectal Cancer Screening	0.87***	0.47***
Osteoporosis Management in Women who had a Fracture	0.71***	0.56***
Plan All-Cause Readmissions#	0.87***	N/A&
Annual Flu Vaccine	0.85***	0.72***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
Measure is reverse-coded to make interpretation of Odds Ratio the same as other measures.
* Significant at p<0.05 ** Significant at p<0.01 *** Significant at p<0.001
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.
Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.
Black Odds Ratio indicates no significant effect.
& Not further adjusted for Disability. Readmissions is adjusted for factors that might be part of a person's reason for Disability.

WHAT DOES SYSTEM TRANSFORMATION LOOK LIKE?

Example

- 75 y/o Dual-Eligible female, lives alone in HUD subsidized senior housing
- History of falls. Socially isolated. Reduced nutritional intake.
- Admitted to the hospital post fall, requires knee replacement and post-discharge admission to SNF
  - Malnutrition, frail status extend SNF stay to 90 days

Impact of Social Determinants of Health

- 90+ days in a SNF = subsidized rent not paid to landlord
- Landlord can evict from subsidized housing due to non-payment with a 14 days notice
- Failure to respond to notice leads to eviction
- After 90 days, patient has no housing unit for discharge – transitions to long-term care
- Medicaid not aware of initial placement because Medicare was the initial payer

Comparative Costs

Category	Expense (AoA Data)
Nursing Home $253/day	$7,698/mo
Assisted Living $119/day + $500 for SNF Diversion Transitions	$3,628/mo + $500 = $4,128
Health Aide $20.50/hr/8hrs + $500 for SNF Diversion Transitions	$4,920/mo. + $500 = $5,420
Home Health	90 day bundle = $3,151.22

Source: Administration for Community Living/Administration on Aging. 2019. Available online: https://longtermcare.acl.gov/costs-how-to-pay/costs-of-care.html

SNF Diversion Return on Investment (ROI)

AHRQ	ROI Calculation
ROI =	Net financial returns from improvement actions / financial investment in improvement actions
Numerator: 90 day SNF Stay	$23,094 – ($3,151.22 + $500)
Denominator	$3,151.22 + $500
Calculation	$23,094 – $3,651.22/$3,651.22
ROI Result (Medicare/MA Plan)	5.32

Source: AHRQ Return on Investment Tool. 2019. Available online:

POLICY CHANGES TO ACHIEVE TRANSFORMATION

Bipartisan Budget Act of 2018

- Signed into law
- Includes the Chronic Care Act
- Changes required by the Bipartisan Budget Act of 2018 take effect beginning 2020, and subsequent plan years

Chronic Care Act -- SSBCI

Meals	Food and Produce
Transportation for Non-Medical Needs	Pest Control
Indoor Air Quality Equipment and Services	Social Needs Benefits
Complimentary Therapies	Services Supporting Self-Direction
Structural Home Modifications	General Supports for living

EXECUTIVE ORDERS

Executive Order on Protecting and Improving Medicare for Our Nation's Seniors

HEALTHCARE | Issued on: October 3, 2019

★ ★ ★

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. The proposed Medicare for All Act of 2019, as introduced in the Senate ("Medicare for All") would destroy our current Medicare program, which enables our Nation's seniors and other vulnerable Americans to receive affordable, high-quality care from providers of their choice. Rather than upend Medicare as we know it, my Administration will protect and improve it.

America's seniors are overwhelmingly satisfied with their Medicare coverage. The

Presidential Executive Order –October 3, 2019

- Executive Order signed at the Villages in Florida
- Mandates increased innovation in Medicare Advantage
- Increase in Value-Based Payment Models
- Mandates more innovation in MA plan Special Supplemental Benefits: Including payments to members
- Expands options for Tele-health
- Result:
  - Plans have reported that not having SSBCI makes their product less competitive.
  - Plans have reported that CMS instructed them to relook at their current SSBCI offering

MA Plan Bid Package

- Release of MA Rate Book (April)
- Initial Bid Submission (June)
- Bid must be certified by a qualified actuary
- MA plans must offer all items covered by Medicare Part A & B
- MA plans may offer additional benefits
  - Supplemental Benefits
  - Optional Benefits

CMS Guidance to MA Plans for SSBCI

- Memo dated April 24, 2019
- Broad discretion given to MA plans to develop items and services to be offered as SSBCI
- Service or item must have a reasonable expectation of improving or maintaining the health or overall functions of the chronically ill enrollee
- SSBCI is submitted as a separate proposal in the bid
- SSBCI approved can be disclosed at Open Enrollment
- Services can primarily address social determinants
- SSBCI is treated like traditional plan benefits – appeals, denials apply

EXAMPLES FROM THE FIELD

Alabama Experience after CMS CCTP Participation

- Two (2) Area Agencies on Aging (AAAs) participated in the CMMI Community Care Transitions Program (CCTP)
  - Southern Alabama Regional Council on Aging (SARCOA)
  - Top of Alabama Regional Council of Governments (TARCOG)
- Shared learning from CCTP provided to all AAAs
  - Medicaid approved State ADRCs to complete assessments and initiate enrollment for Medicaid Wavier, when persons are transitioning from acute care hospitals
  - SARCOA providing care transitions and chronic care management services for Medicare Providers in APMs / MIPS
- 2018: Medicaid Long-Term Services and Supports implemented under Medicaid Waiver in Alabama
  - 1 Vendor: Senior Select Health Plan

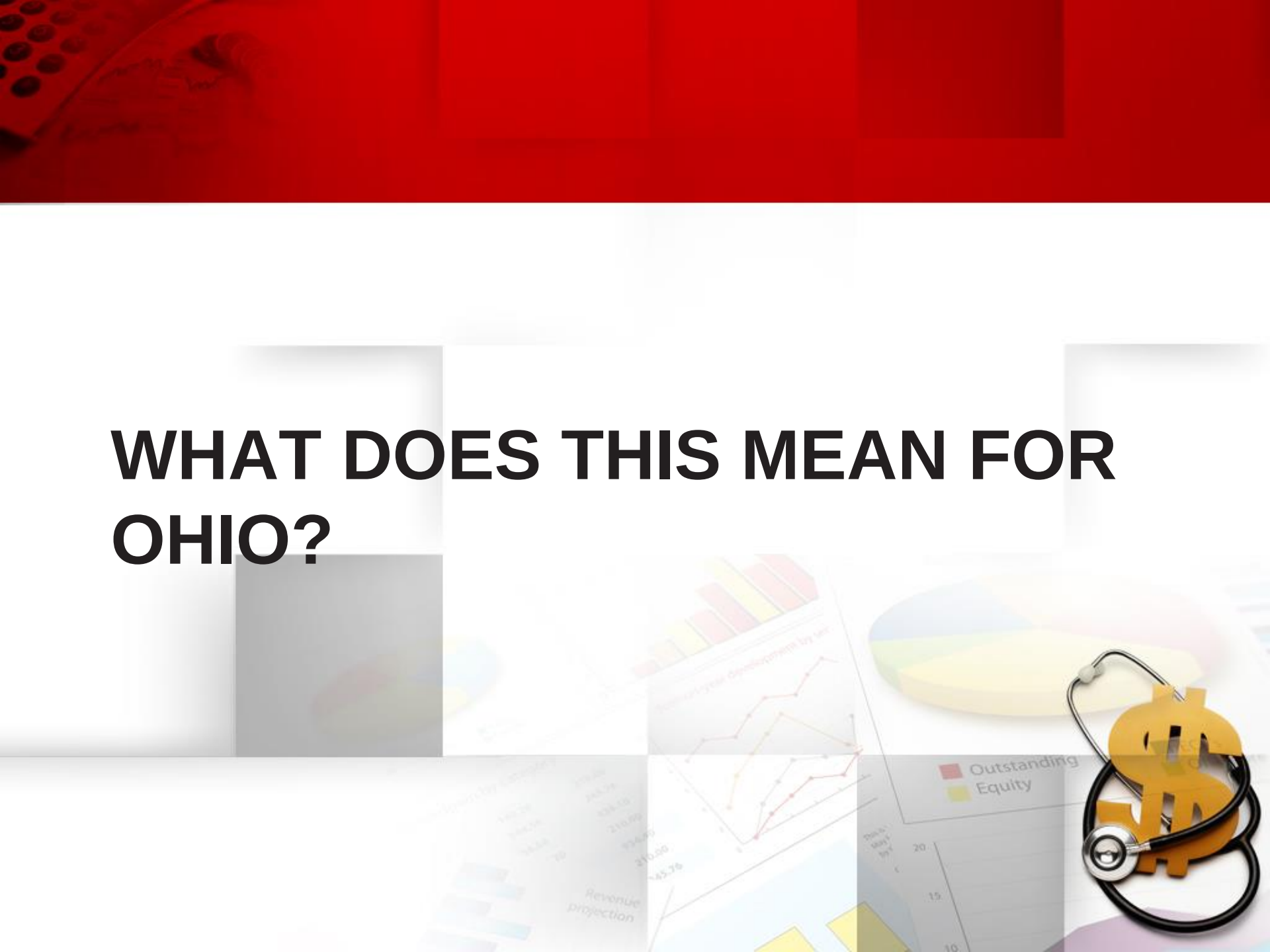
Western NY Experience

- Western New York Integrated Care Collaborative (WNYICC)
  - Network of CBOs serving Western New York
  - Erie & Niagara County AAAs, Meals on Wheels, Senior Centers, Catholic Charities, and independent home and community-based service providers
- WNYICC has secured an agreement with Independent Health Medicare Advantage Plan & Independent Health Chronic Disease Special Needs Plan (C-SNP),
- WNYICC Services
  - Post-discharge meals (Special Supplemental Benefit for Chronically Ill)
  - In-home care management
  - Diabetes Self-Management / MNT / Diabetes Prevention Program

MA Plan Contracts

- MA Plan
  - Care Management, Person-Centered Planning
  - Home-delivered Meals post discharge
- Pricing Model
  - 25% administrative mark-up for WNYICC as the coordinating entity providing access to the network of CBOs
    - Centralized invoicing, reporting, and network management
  - Full price of Meals and care management (CCM) based on Medicare fee schedule
  - Cost per meal $12.00 + Admin fee 25% = $15/Meal
  - Volume = All hospital discharges, ED observation visits, and SNF discharges (2 weeks covered)

WHAT DOES THIS MEAN FOR OHIO?



MA Plan Enrollment - September 2019

Enrolled	MA Plan
208,814	Aetna Life Insurance Company
193,832	Community Insurance Company (Anthem)
107,299	Unitedhealthcare Of Wisconsin, Inc.
61,772	Humana Wi Health Organization Insurance Corp
33,961	Medical Mutual Of Ohio
22,800	Summacare Inc.
628,478	Total

Primary Care Initiatives Overview

- CMMI 5 year demonstration: Beginning 2021
- Goal is to move one quarter of all providers into a value-based payment model
- Providers will have five different tracks to select from
- Providers will receive an up-front PMPM for all enhanced primary care
- Incentive:
  - Fixed up-front PBPM (per beneficiary per month) payments
  - 50% - 100% shared savings
  - Requires risk, with risk mitigation through stop-loss limits

NEW CMS ALTERNATIVE PAYMENT MODELS - 2021

Primary Care Initiatives Tracks

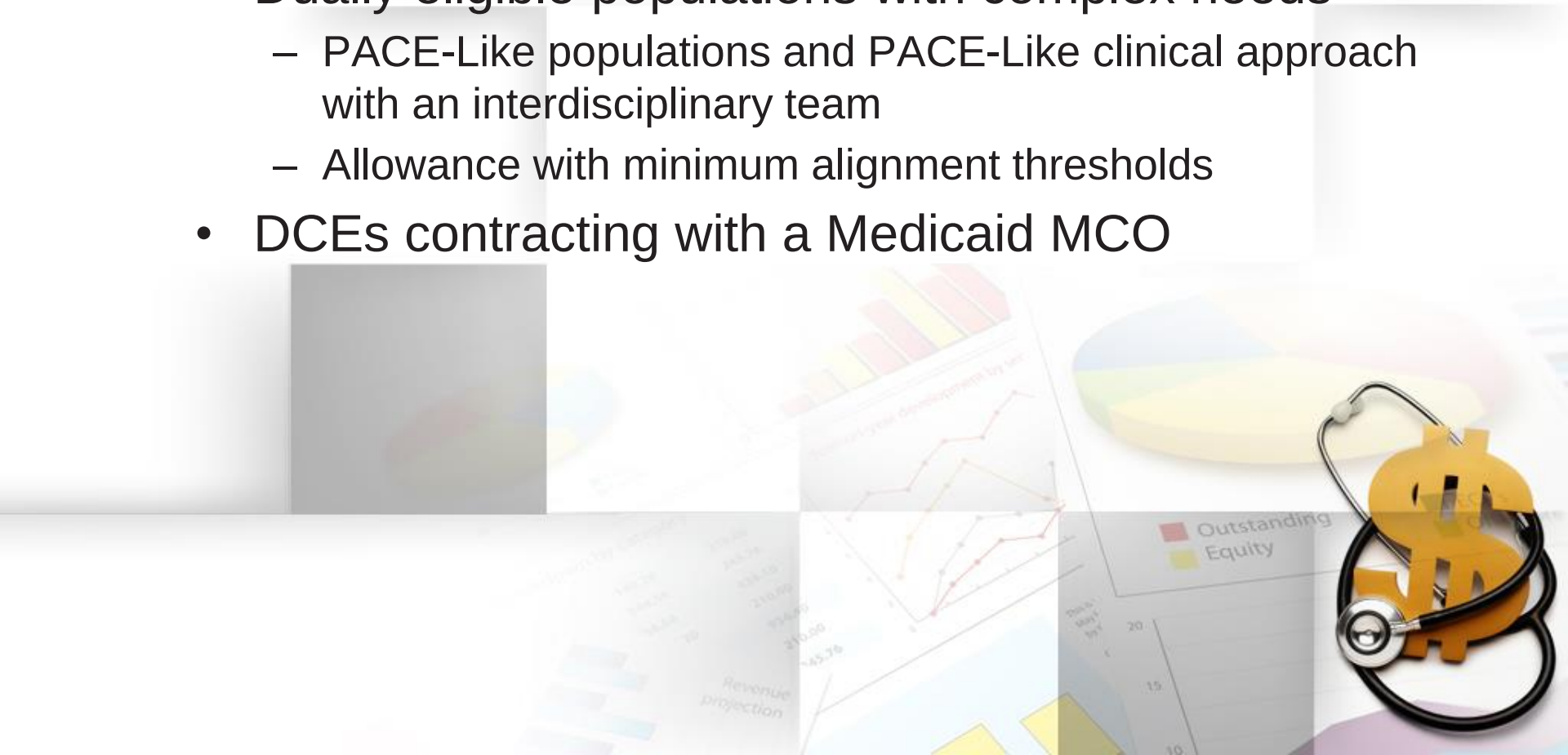
- Primary Care First
- Direct Contracting
  - Professional Population Based Payment (PBP)
  - Global Population Based Payment (PBP)
  - Geographic
  - Seriously Ill Populations (SIP)
  - Dual-Eligible Focused

Dually Eligible and Seriously Ill Population Focus

- Special consideration will be given to DCEs that express the desire to focus on the dually eligible, seriously ill population.
- DCEs can be a Medicaid MCO or entities that contract with a Medicaid MCO to align the dually eligible into the model.
- Alignment will allow the MCO to absorb full capitation for Medicare, and enhanced rate for Medicare care management, and Medicaid care management
  - Eligible for up to 100% shared Medicare savings

High Need Populations Considerations

- Complex chronic and seriously ill patients
- Dually eligible populations with complex needs
  - PACE-Like populations and PACE-Like clinical approach with an interdisciplinary team
  - Allowance with minimum alignment thresholds
- DCEs contracting with a Medicaid MCO



Benefit Enhancement and Payment Rule Waivers

- 3-Day SNF Rule Waiver
- Telehealth Expansion Waiver (No Geographic restriction. Services can occur in the home)
- Home Health Payment waiver that will allow for Home Health certification to be rendered by Nurse Practitioners
- Post-Discharge Home visits Rule Waiver
- Care Management Home Visits Rule Waiver

Questions

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