

Slide 1

The SCAN Foundation (logo)

CHRONIC Care Act: Making the Case for LTSS in Medicare Advantage Supplemental Benefits

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Slide 2 - Executive Summary

- New Medicare Advantage rules now allow insurers additional flexibility to offer long-term services and supports (LTSS) as supplemental benefits, and target these benefits to certain enrollees
- But, insurers and LTSS providers will experience a steep learning curve in working together to provide these new benefits
- This means each will have to learn a new language

Bottom Line: LTSS providers can help Medicare Advantage insurers develop new supplemental benefits but only if they learn what matters most to these organizations.

Slide 3 - How Medicare Advantage Insurers Compete

Slide 4 - Medicare Advantage Is One Health Insurance Option

Two options to choose from:

1. Medicare Fee-For-Service (“Original” Medicare)
Federal government pays directly for healthcare costs under
 - Part A: Hospital
 - Part B: PhysiciansIndividuals may choose to buy
 - Part D: Prescription Drugs

- Supplemental Insurance: Co-pays, deductibles, and other non-covered benefits under Medicare

2. Medicare Advantage

Private Insurance companies contract with the federal government to offer plans that pay for

- Part A: Hospital
- Part B: Physicians

Individuals usually choose to enroll in plans that also offer

- Part D: Prescription Drugs

Slide 5 – People Seek Relief from Out-of-Pocket Costs

Medicare Fee-For-Service (“Original” Medicare)

- Part A deductible: \$1340
- Part B annual deductible: \$183
- Part B coinsurance: 20%
- Monthly Part B premium (optional, varies by income)
- Monthly insurance premium for Prescription Drugs (Part D) (optional, varies by income and plan selection)
- Supplemental insurance premium (optional, covers out of pocket costs, varies by plan selection)

Medicare Advantage

- Monthly Part B premium
- Monthly health plan premium: varies by plan
- Deductibles and cost-sharing: varies by plan

Plans work to reduce these amounts to attract enrollees.

Source: www.cms.gov

Slide 6 – The Also Seek Coverage for Non-Covered Benefits

Medicare Advantage plans may cover these additional benefits

- Preventative care (always covered under MA)
- Dental

- Vision
- Podiatry
- Hearing exams and aides

New rules now allow plans to cover some types of LTSS

- Long-term services and supports

Slide 7 - Price and Benefits are Important in Competitive Marketplace

CALIFORNIA SNAPSHOT

Enrollment

41.3% of CA Medicare beneficiaries enrolled in Medicare Advantage

Competition

More than 60 insurers offering Medicare Advantage plans in California

Independent Physician Associations (IPA)

Heavily penetrated with IPAs, which provide services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis

Slide 8 – Insurers Compete on Pricing and Benefits

Plan B Bid - \$950

Benchmark - \$869

Plan A Bid - \$800 (The difference between the benchmark and Plan A Bid is the percentage available for rebate)

Plan A

Base Rate=\$800

Rebate= $0.5 * \$69 = \34.50

The rebate is the amount to be used for reducing enrollee out of pocket spending & offering supplemental benefits which can lead to more enrollment.

Plan B

Base Rate=\$869

Plan Premium=\$81

Slide 9 – High Quality/Low Cost Plans Will Be More Competitive for Enrollment

Flow chart description: A lower bid and High quality (star rating) lead to a bigger rebate which is used to lower premiums, provide more supplemental benefits, and/or lower cost sharing which in effect could lead to more enrollment.

Slide 10 – Risk Adjustment Examples

Lower risk patient

- Age: 65
- Diagnoses: Healthy
- Other Characteristics: Not low income
- Risk Score: 0.7
- Risk Adjusted Monthly Payment*: $869(\text{Base Rate}) \times 0.7 (\text{Risk Score}) = \608

Higher need patient

- Age: 89
- Diagnoses: Lung Cancer, Diabetes, Alzheimer's
- Other Characteristics: Eligible for Medicaid
- Risk Score: 2.8
- Risk Adjusted Monthly Payment*: $869(\text{Base Rate}) \times 2.8 (\text{Risk Score}) = \$2,433$

*Note: Intended to be an illustrative example. The final adjusted monthly payment to plan includes reduction for coding intensity that will reduce risk score.

Slide 11 – CMS Strict About How Health Plans Spend the Premium

Plans are required to spend at least 85% of premium on health care costs, quality improvement activities and supplemental benefits

Medical Loss Ratio (MLR) – 85% of Premium

- Traditional Benefits
- Quality Improvement Activities (Can include care management)
- Supplemental Benefits

Admin Loss Ratio (ALR) – 15% of Premium

- Profit (3-5%)
- Admin (10-12%)

Slide 12 – New Rules for Supplemental Benefits

Slide 13 – 2018 CMS Rules: New Benefit Flexibility in 2019

Benefit Uniformity

Old Rules: Plans must offer the same benefits to enrollees of the same plan.

New Rules: Now allowed to target benefits to groups of enrollees who have certain clinical diagnoses

Supplemental Benefits

Old Rules: Supplemental benefit must be primarily health-related, which means, in part, not for the purpose of “daily maintenance”

New Rules: Benefits are considered “primarily health-related” under a broader definition of the term

Slide 14 – “Primarily Health Related” Means:

Benefits

- Benefit must:
 - Diagnose, prevent or treat an injury
 - Compensate for physical impairments
 - Act to ameliorate the functional/psychological impacts of injuries or health conditions; OR
 - Reduce avoidable emergency or healthcare utilization
- Must be recommended by a licensed professional as part of a care plan
- NOT health-related: cosmetic, comfort, social determinant purposes

Services

- Examples:
 - Adult Day Care Services

- Home-Based Palliative Care
- In-Home Support Services
- Support for Caregivers of Enrollees
- Excluded for 2019: Meals

See April 27, 2018 CMS Guidance for full list

Source: Centers for Medicare & Medicaid Services. 2019 Medicare Advantage and Part D Rate Announcement and Call Letter.

Slide 15 – Congress Further Expanded Supplemental Benefit Flexibility Starting in 2020

- The Bipartisan Budget Act of 2018 authorizes supplemental benefits that have a reasonable expectation of improving or maintaining health or overall function of the chronically ill beneficiary, and do not have to be “primarily health related”
- Now allowed to target benefits to “chronically ill” enrollees

Signals new attitude about paying for LTSS with Medicare dollars but not a blank check

Slide 16 – The Challenges and Opportunities

Slide 17 - New Territory for CMS and Insurers

CMS Challenges

- Prevent replacement of other program funding
- Ensure clarity in marketing and plan comparability
 - Do consumers get what they think they’re getting?
 - Can they easily evaluate and compare plans?
- Consider implications for provider networks and contracting
- Competently evaluate insurer applications and bids

Insurer Challenges

- Application in the field is difficult
- Identify target population using existing data tools
- Determine how much “benefit” to provide

- Market and sell these benefits (e.g., How do you describe “adult day care”?)
- Develop new provider contracts, payment systems
- Estimate bid impact; enrollment impact

Slide 18 - Advice for LTSS Providers from Insurers

1. Start your outreach with independent physician practices
 - They are often in partnership with insurers
 - They are at risk for medical spending (i.e., receive capitated payments from insurers)
2. Approach insurers with your provider partners (e.g., hospitals)
 - Do you already deliver services through partnerships with other providers? Insurers are looking for operationalized programs
 - Go with that partner (e.g., hospital) to talk to the insurer about your outcomes and operations
3. If you are a small organization, use your size to your advantage
 - Insurers will contract with large organizations but you can be the “back-up” to help the insurer meet access and availability requirements
4. Communicate your capabilities
 - Offer social work services together with home care (i.e., insurers don’t want to deal with service problems)
 - Be prepared with data on your quality: assurances about safeguards, training, key competencies
 - Educate insurers on how your service is different from medical care (insurers won’t know!)

Slide 19 - Advice for LTSS Providers from Insurers (continued)

5. Demonstrate your ability to support good relationships between insurers and their enrollees (i.e., members)
 - Many insurers believe these new supplemental benefits could help them retain enrollees
6. Bring peer-reviewed studies to the conversation
 - Insurers will be skeptical of your data but will believe peer reviewed literature on programs similar to yours
7. Approach insurers with whom you already have a Medicaid contract

- This makes their contracting simpler
- 8. Consider how your services could fit into different programs
 - For example, home care can be part of a transitional care program or a respite care program
- 9. Don't forget the caregivers
 - CMS explicitly allows insurers to provide "Support for Caregivers"
- 10. Watch for new guidance from CMS for the 2020 rate year and be ready!

Slide 20 - Educate Insurers About Their Enrollees' LTSS Needs

MA enrollees need LTSS at same rate as fee-for-service

How many people have ADL Challenges?

Have difficulty with 1+ ADLs (Mild FI): Medicare Advantage - 34%, Medicare Fee-For-Service – 32%

Need help with 1+ ADLs (Moderate FI): Medicare Advantage - 12%, Medicare Fee-For-Service – 12%

Need help with 2+ ADLs (Severe FI): Medicare Advantage - 7%, Medicare Fee-For-Service – 7%
 Diagnosed with Cognitive Impairment: Medicare Advantage - 7%, Medicare Fee-For-Service – 7%

Diagnosed with 3+ Chronic Conditions: Medicare Advantage - 47%, Medicare Fee-For-Service – 45%

Note: Data excludes nursing home residents

Source: 2015 MCBS

Slide 21 - LTSS Need (Functional Impairment) Associated with High Rate of Hospital Use

Bar Graph: Average Medicare Inpatient Admissions (admits per 1,000 enrollees), 2015

Full Population – 260

No FI (No help or difficulty any ADL) – 190

Mild FI (Difficulty 1+ ADLs) – 410

Moderate FI (Help 1+ ADLs) – 570

Severe FI (Help 2+ ADLs) – 720

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

Slide 22 - Functional Impairment Associated with High Medical Costs

Bar Graph: Per Capita Medicare Spending, 2015

Full Population – \$10,507
No FI (No help or difficulty any ADL) – \$7,664
Mild FI (Difficulty 1+ ADLs) – \$16,436
Moderate FI (Help 1+ ADLs) – \$22,877
Severe FI (Help 2+ ADLs) – \$28,027

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

Slide 23 - Medicare Beneficiaries with Moderate Functional Impairment Are:

- 3x as likely to be age 80+
- 2x as likely not to have graduated high school
- 2x as likely to be low income
- 3x as likely to be enrolled in Medicaid
- 2x more likely to be diagnosed with Diabetes
- 3x more likely to be diagnosed with COPD
- 4x more likely to be diagnosed with CHF

Slide 24 - Moderate Functional Impairment Associated with High Medical Costs, Even for 3+ Chronic Conditions

Bar Graph: Per Capita Medicare Spending, 2015

0-2 Chronic Conditions and No Functional Impairment - \$5,567
0-2 Chronic Conditions with Functional Impairment - \$12,831
3+ Chronic Conditions and No Functional Impairment - \$11,584

3+ Chronic Conditions with Functional Impairment - \$26,972

Note: Data is limited to fee-for-service Medicare beneficiaries living in the community

Source: 2015 MCBS linked to claims

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Thank you

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Appreciation to Nicholas Johnson, FSA, MAAA for review and comments.

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Slide 26 – Let Us Know How We Did

Image 1: Screenshot of conference app on cellphone

Image 1 text: Select “surveys” from WHOVA home screen

Image 2: Evaluation form

Image 2 text: Look for a printed evaluation form in your program

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