HealthScape Advisors

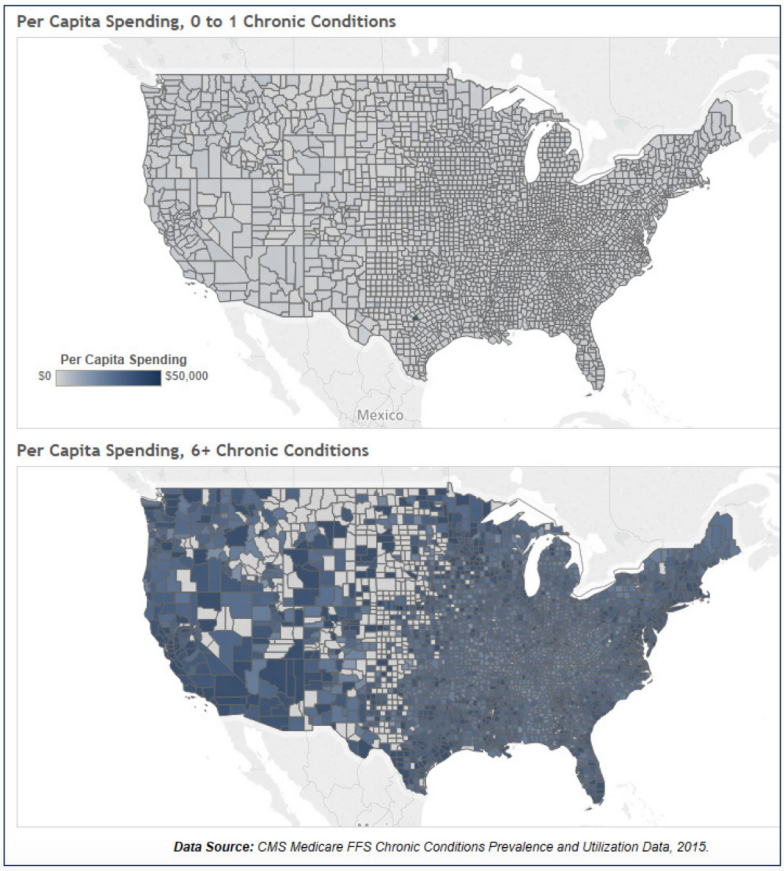
WHAT IS YOUR MEDICARE ADVANTAGE CHRONIC CARE STRATEGY?

Does your organization have a Medicare Advantage chronic care strategy? Now is the time for Medicare Advantage (MA) plans to consider how to best deliver and manage care for beneficiaries diagnosed with chronic conditions.

Nearly 150 million adults are living with at least one chronic condition in the United States. According to a recent RAND study, this chronically ill population accounts for hundreds of billions of dollars in healthcare spending annually and represents approximately 90% of total U.S. healthcare spending. This population will continue to grow as Baby Boomers age, since the prevalence of many chronic conditions increases with age. Does your organization have a plan to address this trend?

Chronic care strategies can have a significant impact on plan economics

The majority of MA plan medical spend is often driven by complex, co-morbid members that represent a much smaller percentage of total plan membership. Plans can derive significant value from implementing targeted care management strategies in close collaboration with the providers that serve them. Placing a broad emphasis on establishing a clearer understanding of patient-level economics will also help guide efforts toward populations that could benefit most from a higher-touch approach. Organizations can then stratify their chronic care populations, identifying the poly-chronic population that benefits the most from a focused model of care.



Couple these efforts with an enhanced focus on treatment and diagnostic completeness, and organizations may become well-versed in the delivery and management of care for the chronically ill population. Plans could become so proficient at managing chronic MA patients that they may choose to actively seek out these members through product design and network strategies of their MA plan or by leveraging market opportunities to provide more personalized care through innovative delivery models.

New and different ideas for how health plans could best serve the chronically ill Medicare population continue to surface, as regulators and legislators are beginning to focus on the provision of high quality, cost effective care. This focus represents an opportunity for MA plans with a mature chronic care strategy to be even more financially successful in future fiscal periods, if they are truly proficient at managing their chronic care populations.

The following key modifications to the historical approach of care delivery for this population should be considered by participating plans for operational and financial implications:

+ **Increased MA Product Flexibility**
+ **Increased Telehealth Utilization**
+ **Extension of Special Needs Plans (SNPs)**
+ **Implementation of a Focused Model of Care**

Several of these approaches are components of the CHRONIC Care Act, which was unanimously approved by the Senate Finance Committee in May. From a budgetary perspective, the CHRONIC Care Act received a favorable (net neutral) preliminary score from the Congressional Budget Office (CBO); this may clear a path for legislation to move forward, even with the political climate and the differing opinions related to healthcare reform. This bill was reported to the whole Senate for consideration in early August. In addition, the House Ways and Means Committee (HR 3727), as well as the House Energy and Commerce Subcommittee on Health (HR 1148), both recently approved legislation aimed at expanding Medicare coverage of telehealth services. Regardless of the status of pending legislation, MA plans should be aware of these potential policies, as they have broad implications for how care could be delivered to the Medicare population in future years.

How can these approaches to chronic care be impactful?

If enacted, these advancements in chronic care delivery offer significant opportunities to MA plans, but also require careful alignment of resources. Now is the time to consider the impact to your organization.

INCREASED MA PRODUCT FLEXIBILITY

MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN (MA-VBID):

MA plans are currently required to offer the same benefit package to all enrollees. The Center for Medicare and Medicaid Innovation (CMMI) is in the midst of testing the Medicare Advantage Value-Based Insurance Design (MA-VBID) model, which allows MA plans to provide supplemental benefits or reduced cost sharing to enrollees with specified chronic conditions, to test whether these changes can improve health outcomes and lower expenditures. The MA-VBID model is available for pilot in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania and Tennessee, and will expand to Alabama, Michigan and Texas in 2018. Currently, nine organizations are participating in the MA-VBID pilot.

Eligible plans in these states that are approved by CMS may elect to provide varied plan benefit designs for enrollees that exhibit specified chronic conditions: diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders, rheumatoid arthritis and dementia. The MA-VBID Model is expected to increase high-quality, cost-efficient care to improve enrollee health and reduce utilization of avoidable high-cost care for plans, beneficiaries and the Medicare program. The CHRONIC Care Act would expand the testing of the program to all states by 2020.

MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN (MA-VBID):

MA plans are currently required to provide the same supplemental benefits to all members of an MA plan. Beginning in 2020, the CHRONIC Care Act would allow MA plans greater flexibility in the supplemental benefits that they offer chronically ill members—and the ability to target supplemental benefits to specific chronically ill enrollees. Benefits must have a reasonable expectation of improving or maintaining overall health or function and are not limited to health-related services.

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Both the expansion of the MA-VBID program and flexibility in supplemental benefits introduce a great opportunity for MA plans to tailor plan design to target health needs of beneficiary populations for specific conditions. This results in an opportunity for plans to differentiate their products in the market and begin to deliberately attract the chronically ill beneficiaries that they are best positioned to manage.

INCREASED TELEHEALTH UTILIZATION

Currently, Medicare beneficiaries can receive telehealth services in certain geographic locations, settings of care and for a particular subset of Part B benefits. The CHRONIC Care Act would enable MA plans to include additional, clinically appropriate telehealth benefits in their annual bid amount, beyond those covered by Part B. In addition, expansion of telehealth services for patients presenting with stroke symptoms, as well as Medicare beneficiaries receiving home dialysis, are proposed in order to broaden access to specialist care. However, telehealth benefits could not be a substitute for meeting network adequacy requirements, and the beneficiary can determine whether to receive services via telehealth.

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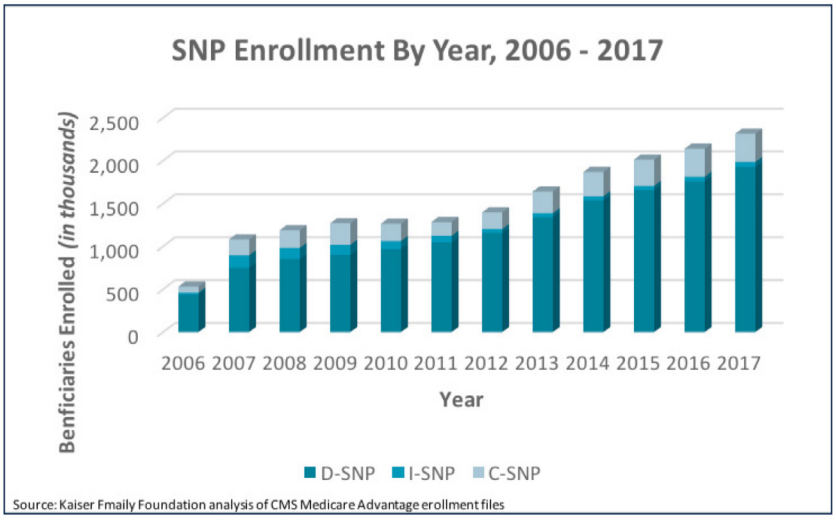
The potential expansion of telehealth within MA will increase the importance of establishing telehealth partnerships and may also impact the provider groups with whom MA plans prefer to contract. Although telehealth relationships cannot impact network adequacy requirements, telehealth capabilities may make some service areas more enticing when MA plan network adequacy is near the minimum required.

EXTENSION OF SPECIAL NEEDS PLANS (SNPS)

MA SNPs target enrollment to special needs beneficiaries by tailoring benefits to better meet the needs of the groups they serve. Currently, SNP authority has been extended through the end of 2018. The CHRONIC Care Act would permanently authorize these programs if certain requirements are met, such as those related to grievances and appeals procedures, long-term and behavioral health services, and additional care management requirements. The specific requirements vary by type of SNP (Dual Eligible SNP [D-SNP], Chronic Condition SNP [C-SNP], Institutionalized SNP [I-SNP]).



Source: Kaiser Fmaily Foundation analysis of CMS Medicare Advantage erollment files

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Enrollment in SNPs continues to grow each year. (See figure above.) Permanent authorization of the SNP program provides certainty for MA plans focused on the D-SNP, C-SNP and I-SNP populations, and may stimulate further investment and improvement in existing plans offered, as well as make entry into the market more attractive. In addition, while the current SNP landscape is dominated by national players, permanence of the program may attract more plans and create diversity (e.g., provider-owned plans).

IMPLEMENTATION OF A FOCUSED MODEL OF CARE

Focused models of care are an emerging best practice approach for the management of a select subset of chronic care beneficiaries—specifically, poly-chronic complex patients. Such models are characterized by multidisciplinary clinical teams—often led by physicians but inclusive of medical and psychiatric nurse practitioners, dietitians, and social workers, among other clinicians—that collaborate to provide the necessary primary care to the most chronically ill beneficiaries in the home setting. Successful models integrate behavioral and medical care, as well as offer on-demand access to care, creating a safety net that helps to minimize more costly emergent, urgent and institutionalized care.

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This model is not intended to replace the traditional primary care relationship; rather, it offers a collaborative approach to ongoing management in the patient's home via team-based approach. Such focused models of care show significant promise in improving quality of care, accuracy of risk assessment, and efficiency of care. These opportunities underscore the importance of the associated analytical capabilities to enable identification of the poly-chronic members who will benefit most from participation in such a focused program.

How can organizations seize the chronic care opportunity?

Regardless of future regulatory or legislative activity, the chronic care population should be a focus for MA plans.

IMPLEMENT MA CHRONIC CARE PATIENT- LEVEL ECONOMICS

+ Complete retrospective and prospective review of profitability to understand performance drivers
+ Identify sub-populations prime for quick wins, and implement targeted performance improvement strategies informed by both analytics and industry best practices
+ Review risk coding and capture processes to ensure accuracy and completeness

CUSTOMIZE BENEFITS & NETWORK DESIGN TO BETTER MANAGE MA CHRONIC CARE PATIENTS

+ Complete cost of care analytics to understand populations that your plan is best positioned to manage
+ Perform actuarial analyses to understand the potential impact of new benefit designs
+ Develop care model (e.g., virtual visits, group visits, integrated care teams)

ASSESS READINESS TO FOCUS ON MEMBERS WITH SPECIAL NEEDS

+ Determine readiness to engage in CMS model of care
+ Size the SNP market
+ Construct a business case for entering the SNP market, or establish a performance improvement plan for existing offerings
+ Determine provider network competency to handle SNP population
+ Develop internal organizational competencies necessary to successfully manage a SNP Plan

CONSIDER THE TELEHEALTH OPPORTUNITY

+ Execute a service area assessment to understand the need within your markets
+ Understand contracted provider capabilities in telehealth
+ Review state telehealth regulations
+ Determine strategy/ability to engage the members in telehealth programs
+ Evaluate partners for sub-specialization (e.g., stroke)

HEALTH SYSTEM CEO'S PERSPECTIVE

A Note from Senior Advisor Jack Friedman

Over the last twenty years, large and small health systems have been employing primary care physicians and/or acquiring local practices at unprecedented levels. More and more primary care groups are struggling to stand on their own, and employment seems to be an easier way to survive into the future. Once acquired, health systems need to focus on how to best enable primary care to stand on its own and become self-sustaining. Subsidies have been high over past years, and health systems are struggling to know how best to make primary care financially viable. This is why it is so important for health systems to move their primary care practices into Medicare Advantage (MA), where managing medically complex patients can yield far better financial results than traditional, fee-for-service Medicare.

Large, capitated medical groups that leaned into MA twenty years ago have deliberately moved their Medicare patients into MA, where they work diligently to do all of the things highlighted in this MA briefing. That begins with establishing a very close relationship with their medically complex patients, bringing them into the practice regularly to capture all of their conditions and diagnoses, attaching them to strong nurse care managers that are often embedded in the practice, monitoring their health regularly and doing all they can to reduce emergency room visits and soft medical admissions. When practices are at risk for MA members, they benefit enormously from reducing emergency room visits and hospital admissions. Traditional Medicare does not reward providers for this level of medical management, and that type of fragmented care model does not produce very good results.

Medicare Advantage offers integrated health systems and primary care medical groups a way to capture the value that they create by diligently managing the health and total healthcare costs of their complex patients. Those primary care medical groups that have committed to a managed model are earning up to 200-300% of traditional Medicare on these patients, because they reap the rewards when institutional costs are reduced. This is why it is so critical that health systems move these complex patients into MA sooner rather than later! The opportunity costs of leaving them in traditional Medicare are simply too high!

Think strategically about the MA chronic care population—HealthScape can help. For more information, contact us!

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