

Policy Spotlight

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

Overview

Two recent policy actions by Congress and the Centers for Medicare & Medicaid Services (CMS) have significantly changed Medicare Advantage (MA) and opened the door for community-based organizations (CBOs) to partner with health plans in order to provide better care to older adults. 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. On April 2, 2018, CMS released final policy and payment updates to the MA program through the 2019 Rate Announcement and Call Letter.¹ 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 some MA enrollees with access to benefits and services that may improve their quality of life and health outcomes. MA plans may contract with CBOs to deliver these supplemental benefits, such as transportation, nutrition services and more, presenting a new opportunity for the Aging and Disability Networks.

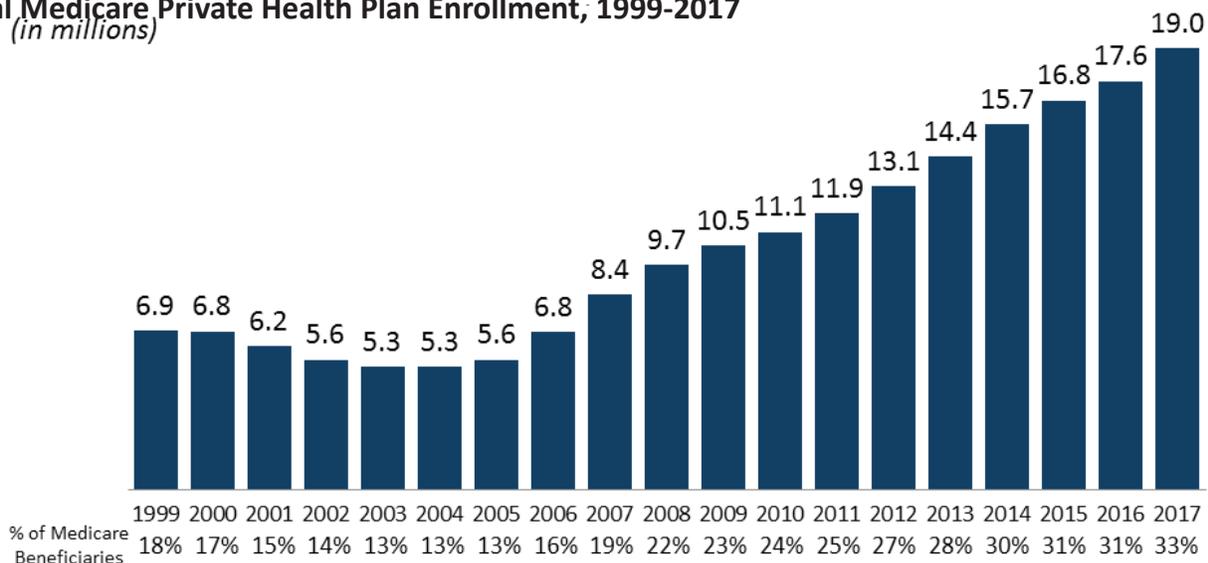
Medicare Advantage Plan Enrollment Trends

One-third of Medicare beneficiaries participated in Medicare Advantage and other Medicare private plans in 2017, and this number is expected to rise.

Since 2004, the number of Medicare 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
(in millions)



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.

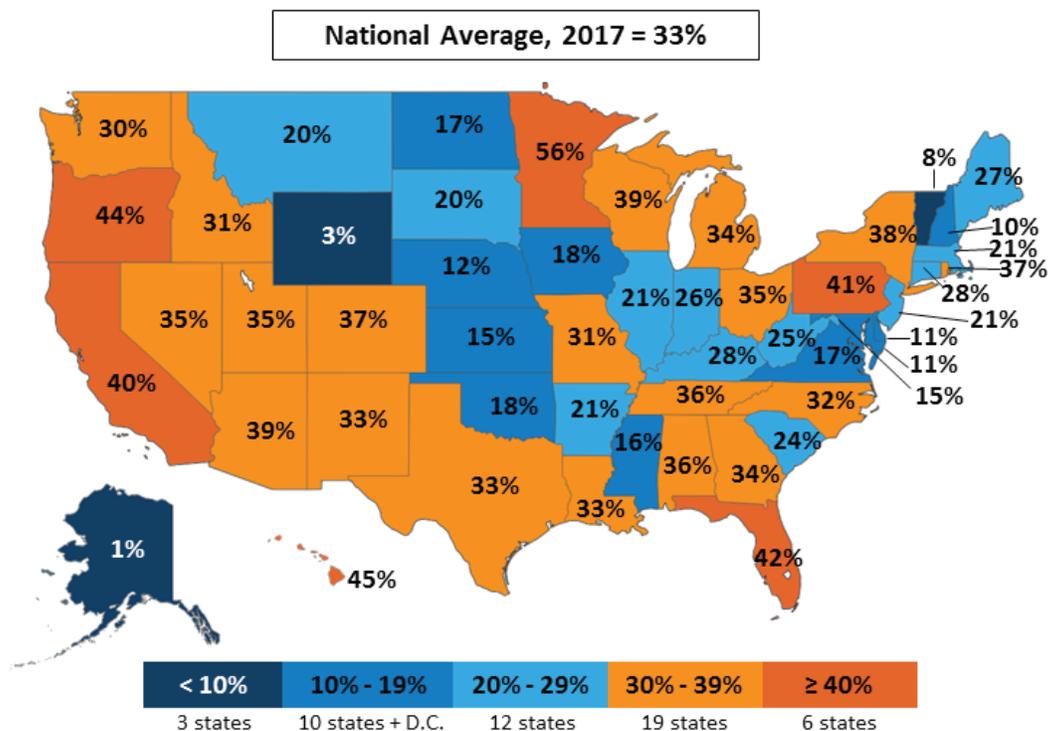
KFF authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

MA enrollment and plan penetration vary widely across states and counties, with more than 40 percent of Medicare beneficiaries in some states enrolled in private plans³ (Figure 2). Historically, this variation is because MA county rates are based on the relatively higher costs of beneficiaries enrolled in Medicare fee-for-service (FFS or Original Medicare) who have both Medicare Parts A and B. In addition, states with greater 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 MA plans (CA, FL, HI, MN, OR and PA), with the rate at 74 percent in Puerto Rico. In three states (AK, VT and WY), fewer than 10 percent of all Medicare beneficiaries are in an MA plan (Figure 2). A small number of 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 allows 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 may be provided to all

beneficiaries that meet certain health status criteria, as long as all members who meet those specifications can access the benefit. On April 27, 2018, CMS provided additional guidance on the uniformity requirement and the types of supplemental benefits that can be offered by MA plans.^{7,8} The CHRONIC Care Act will continue to go through a rulemaking process, during which CMS will create proposed rules regarding the implementation of the Act. Figure 3 illustrates the changes and timeline outlined in the Call Letter and CHRONIC Care Act.

Figure 3

Summary of Changes to Medicare Advantage under the 2019 Call Letter and the CHRONIC Care Act

	2019 (Call Letter applies) ⁹	2020 (CHRONIC Care Act applies)
Benefit Uniformity	Beginning on January 1, 2019, MA plans may tailor benefits for beneficiaries who are “similarly situated,” defined as all those who meet a specified set of clinical criteria.	Beginning on January 1, 2020, MA plans may tailor benefits for beneficiaries who are “similarly situated,” defined as all those who meet a specified set of clinical criteria. CMS may offer waivers of benefit uniformity for benefits tailored to “chronically ill beneficiaries.”
Supplemental Benefits	Definition of “primarily health-related” expanded to include benefits that 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. ¹⁰	“Primarily health-related” expanded to include benefits that 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. ¹¹ Plans may provide supplemental benefits 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.” ¹²
Beneficiaries	Benefits meeting the new health-related definition may be offered to any beneficiary, but plans must use ICD-10 codes to define conditions for targeting.	A chronically ill beneficiary, defined as one who the Secretary determines: “(I) 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; (II) has a high risk of hospitalization or other adverse health outcomes; and (III) requires intensive care coordination.”

Source: CMS Medicare Advantage and Part D 2019 Final Rate Notice and Call Letter; Bipartisan Budget Act of 2018; Better Medicare Alliance April 5, 2018 webinar.

The CHRONIC Care Act builds upon several years of bipartisan work to improve care for the more than two-thirds of currently enrolled Medicare beneficiaries who have multiple chronic conditions.¹³ Passed by Congress as part of the Bipartisan Budget Act in February 2018, 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 spent 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 receive 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.¹⁴

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.”¹⁵ Plans may begin providing these benefits in 2020. In addition to broadening the definition of supplemental benefits, the CHRONIC Care Act also allows the Secretary to waive 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.

A significant barrier to offering supplemental benefits has long been that MA plans fund these benefits either by charging additional premiums or by using their rebate dollars, and were subject to a uniformity requirement. Rebate dollars are the difference between the MA plan’s “bid,” or estimated per-enrollee costs of providing Medicare Parts 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 also expands the Value-Based Insurance Design (V-BID) model, which is currently being tested by CMS’s Center for Medicare and Medicaid Innovation, and 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. The Act also permanently authorizes three types of Special Needs Plans (SNPs), which are special types of Medicare Advantage plans that enroll individuals with specific needs. They include: Institutional SNPs (I-SNPs), for individuals in institutions; Dual Eligible SNPs (D-SNPs), for individuals enrolled in both Medicare and Medicaid; and Chronic Condition SNPs (C-SNPs), for individuals with chronic conditions.¹⁶ The Act also designates the Federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office) as the point of contact for D-SNP plans. In this role, the Medicare-Medicaid Coordination Office will create and disseminate resources for states that hope to use D-SNPs to better integrate care, and will establish grievance and appeals procedures for beneficiaries in D-SNP plans. The Act also creates new requirements for integration in D-SNPs, and for care management in C-SNPs.¹⁷

Implications for Integrated Care and Community-Based Organizations

Changes brought about by the CHRONIC Care Act and the 2019 Call Letter provide flexibility for MA plans to provide a broader set of benefits than has been available under previous law. As a result, CBOs, which have long provided services that address health and function, such as nutrition services, home modifications (e.g., installing wheelchair ramps), transportation and evidence-based health promotion and disease management programs, are presented with new opportunities for partnerships with health care entities.

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 more than one-third (38 percent) of CBOs have a contract with a health care entity.¹⁸ The most common health care partners named were Medicaid Managed Care Organizations and hospitals/hospital systems. Only about 5 percent of respondents with contracts currently have contracts with MA plans. The expansion of the definition of supplementary benefits could 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.^{19,20} CBOs, such as AAAs, have decades of experience in providing the types of supplemental benefits that may now be offered by MA plans under the CHRONIC Care Act and the 2019 Call Letter. Broadening the uniformity requirement for supplementary benefits

allows MA plans to target these types of services to the subset of members with complex health needs who are most likely to benefit from health-related services. In 2015, 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.²¹ 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 care management could significantly improve health and quality of life for this population, while also reducing costs for MA plans.

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.^{22,23} 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.²⁴ 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 2015.²⁵ Evidence-based health promotion and disease management programs have been shown to reduce incidences of falls, fear of falling, health care spending and hospitalizations.²⁶ As of October 2016, all AAAs are required to provide these and other evidence-based programs, which address an array of chronic conditions, including depression; improve medication management; and increase physical activity and mobility.²⁷ By contracting with CBOs to provide these services, MA plans can greatly improve the care of beneficiaries with complex needs.

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.

Partnering with Medicare Advantage Plans

CBOs have extensive 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.²⁸ Plans with higher Star Ratings also receive a larger rebate than those with lower ratings. CBOs should identify the measures that local MA plans 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,²⁹ which remains the same regardless of how many services 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 and/or complex care needs. 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 these 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.

Notes

1. Centers for Medicare & Medicaid Services (2018). 2019 Medicare Advantage and Part D rate announcement fact sheet, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02-2.html>
2. Kaiser Family Foundation. (2017). Medicare Advantage fact sheet. <https://www.kff.org/medicare/fact-sheet/medicare-advantage/>
3. Ibid.
4. Ibid.
5. Ibid.
6. Ibid.
7. Centers for Medicare & Medicaid Services (2018). Memo on Reinterpretation of “Primarily Health Related” for Supplemental Benefits. <https://www.dropbox.com/s/pee7o4igqye12ts/HPMS%20Memo%20Primarily%20Health%20Related%204-27-18.pdf?dl=0>
8. Centers for Medicare & Medicaid Services (2018). Memo on Reinterpretation of the Uniformity Requirement. <https://www.dropbox.com/s/Ockzmvvmhcjyt2z5/HPMS%20Memo%20Uniformity%20Requirements%204-27-18.pdf?dl=0>
9. The 2019 Call Letter applies to the 2019 plan year. CMS will release a new Call Letter for the 2020 plan year.
10. Centers for Medicare & Medicaid Services (2018), Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>
11. Ibid.
12. Bipartisan Budget Act of 2018, Public Law.115-123. <https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf>
13. Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html
14. Bipartisan Policy Center (2018). A policy roadmap for individuals with complex care needs. <https://bipartisanpolicy.org/library/a-policy-roadmap-for-individuals-with-complex-care-needs/>
15. Ibid.
16. Read which chronic conditions are approved to target for C-SNP enrollment here: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Chronic-Condition-Special-Need-Plans-C-SNP.html>

17. Ibid.
18. Kunkel, S.R., Straker, J.K., Kelly, E.M., & Lackmeyer, A.E. (2017). Community-based organizations and health care contracting: Research brief. Scripps Gerontology Center, Oxford, OH. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6182/Kunkel-Community-Based-percent20Organizations_12-2017.pdf
19. Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. County Health Rankings (2010). Different perspectives for assigning weights to determinants of health. <http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf>
20. Windh, J., Tumlinson, A., Mulcahy, J., Wolff, J., Willink, A., Kasper, J. & Atkins, G.L. Medicare spending on older adults who need long-term services and supports. <http://www.ltqa.org/medicare-spending-on-older-adults-who-need-itss/>
21. Centers for Medicare & Medicaid Services (2015). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html
22. Thomas, K.S., & Dosa, D. (2015). Results from a pilot randomized control trial of home-delivered meal programs. prepared for Meals on Wheels America. <https://www.mealsonwheelsamerica.org/theissue/research/more-than-a-meal/pilot-research-study>
23. Thomas K.S., & Mor, V. (2013). Providing more home-delivered meals is one way to keep older adults with low care needs out of nursing homes. *Health Affairs*, 32(10), 796-802.
24. National Council on Aging. National study of the Chronic Disease Self-Management Program: A brief overview <https://www.ncoa.org/resources/national-study-of-the-chronic-disease-self-management-program-a-brief-overview/>
25. Florence C.S., Bergen, G., Atherly, A., Burns, E., Stevens, J., & Drake, C. (2018). Medical costs of fatal and nonfatal falls in older adults. *Journal of the American Geriatrics Society*. DOI: 10.1111/jgs.15304.
26. Centers for Medicare & Medicaid Services (2013). Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. <http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf>
27. 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.
28. McKinsey Center for U.S. Health System Reform. (2016). Assessing the 2017 Medicare Advantage Star ratings. <https://healthcare.mckinsey.com/assessing-2017-medicare-advantage-star-ratings>
29. Aging and Disability Business Institute (2018). Resource Guide: *Pricing CBO Services in a New Health Care Environment* <https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/04/ADBI-resource-guide-Pricing-CBO-Services.pdf>

This publication was produced by the Aging and Disability Business Institute. Led by The National Association of Area Agencies on Aging (n4a) in partnership with the most experienced and respected organizations in the Aging and Disability Networks, the mission of the Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. The Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at www.aginganddisabilitybusinessinstitute.org.