Supporting the Needs and Personal Goals of the High-Need, High-Cost Population in Medicare Advantage

Driving Stakeholder Consensus and Policy Change in Medicare Advantage

BETTER MEDICARE
ALLIANCE

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BY BETTER MEDICARE ALLIANCE
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Overview

This report summarizes key discussion points from a July 2017 Better Medicare Alliance (BMA) convening, including specific actionable policy recommendations of innovations in care delivery for high-need, high-cost beneficiaries and how successful models in Medicare Advantage can be scaled to meet the needs of current and future beneficiaries.

BMA is a community of over 90 ally organizations and almost 300,000 beneficiaries, who — like the nearly 19 million beneficiaries who have chosen Medicare Advantage — share a commitment to a strong Medicare Advantage option. We believe that Medicare Advantage is an important part of the Medicare program. It represents a public-private partnership that addresses the needs of today's beneficiaries, while looking to technology and innovation to meet the needs of millions of future beneficiaries. Medicare Advantage's payment systems and flexibility are moving providers towards higher-value, higher-quality care, improving the health care experience for physicians and their patients.

BMA convened a group of approximately 60 thought leaders, including practitioners, researchers, health plans, community partners, and policymakers, to discuss how multi-stakeholder coordination in Medicare Advantage can best support the personal health and life goals of chronically ill beneficiaries in Medicare Advantage. The expectation of the convening was that together, these individuals would bring their experience and expertise to not only discuss the factors that were necessary to achieve better care, at a more affordable cost for HNHC beneficiaries, but reach agreement on a set of recommendations that could be offered to policymakers to improve care and achieve successful outcomes for these beneficiaries.

What Is Medicare Advantage?

Medicare Advantage, also called Part C, is an option within Medicare that allows Medicare-eligible seniors and beneficiaries with disabilities to choose a private plan to receive their Medicare benefits, instead of receiving coverage through Traditional Fee-For-Service (FFS) Medicare. Medicare Advantage plans are required to provide beneficiaries with all Part A (hospital insurance) and Part B (medical insurance) Medicare benefits. Beneficiaries can also choose to add a Part D prescription drug benefit to their Medicare Advantage plan.

Unlike FFS Medicare, Medicare Advantage plans are paid through a capitated (fixed monthly) payment system for each beneficiary. Medicare Advantage enables more benefits for beneficiaries since savings are applied to providing additional benefits, such as vision, hearing, dental, fitness programs, and reduced cost sharing. Medicare Advantage limits annual out-of-pocket expenses for beneficiaries. Medicare Advantage plans are required to report on quality metrics and receive an annual quality rating using the Star Rating System. Medicare Advantage plans receive incentive payments for high-quality performance.

Recent Enrollment Growth in Medicare and High Spending for Chronically Ill Beneficiaries Calls for Additional Emphasis on Addressing This Population's Needs
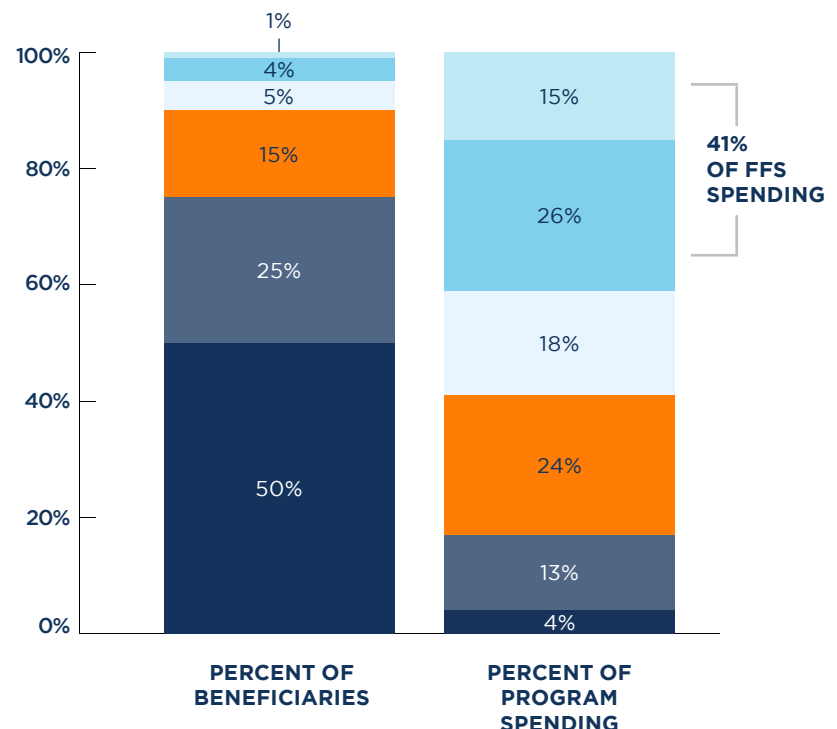
Medicare enrollment has risen by 5 to 13 percent per year over the past 10 years.[1,2] Total Medicare enrollment is projected to continue growing in the coming years – over the next 10 years, Medicare enrollment is projected to grow to 75 million beneficiaries, representing a 30 percent increase.[3] In particular, Medicare Advantage enrollment will continue rising as seniors are increasingly choosing Medicare Advantage over FFS Medicare. Medicare Advantage enrollment is projected to grow from 33 percent to 41 percent of all Medicare beneficiaries in 2027.[4]

CHRONICALLY ILL BENEFICIARIES ACCOUNT FOR A SIGNIFICANT PORTION OF TOTAL MEDICARE SPENDING

Chronically-ill beneficiaries, or high-need, high-cost (HNHC) beneficiaries, account for a significant portion of total Medicare spending. In fact, FFS Medicare beneficiaries with multiple chronic conditions account for 93 percent of total Medicare spending.[5] In FFS Medicare overall, the costliest 5 percent of beneficiaries accounted for 41 percent of annual spending in 2012, while the least costly 50 percent accounted for only 4 percent (see Figure 1).[6]

FIGURE 1

The Costliest 5 Percent of Beneficiaries Accounted for 41 Percent of Annual Spending in 2012[7]

PERCENT OF BENEFICIARIES

PERCENT OF PROGRAM SPENDING

41% OF FFS SPENDING

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MEDICARE ADVANTAGE IS UNIQUELY POSITIONED TO ADVANCE CARE FOR HNHC BENEFICIARIES WITH A FRAMEWORK THAT ENCOURAGES COORDINATED, PERSONALIZED CARE

Continued growth in Medicare and the ongoing importance of treating HNHC beneficiaries with multiple chronic conditions places greater importance on Medicare Advantage plans' ability to address this population's unique care needs. The HNHC population's care needs vary based on risk factors related to each beneficiary's health, medical, and social support needs. Medicare Advantage is a crucial policy vehicle for serving this population, because Medicare Advantage plans are designed to help beneficiaries better manage their health through coordinated and personalized care, compared to fragmented FFS Medicare coverage. However, several policies in Medicare Advantage today limit how plans tailor and personalize care, such as constraints in the current uniform benefit requirements and restrictions on supplemental benefit offerings.

ALIGNMENT EXISTS ACROSS STAKEHOLDERS ON THE NEED TO ADVANCE CARE FOR HIGH-NEED, HIGH-COST POPULATION IN MEDICARE ADVANTAGE

The convening started with an articulation of the needs of this HNHC population. With this foundation, the group considered promising care models for HNHC beneficiaries. Finally, the convening brought diverse stakeholder perspectives to bear on the future opportunities for Medicare Advantage by identifying policy barriers and potential solutions to best enable Medicare Advantage to serve HNHC beneficiaries. Importantly, the meeting highlighted broad agreement among stakeholders on the need to better tailor care for this HNHC population, incentivize continued collaborative innovation, and implement policy changes that can improve care for these chronically ill beneficiaries.

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Effective Programs Help High-Need, High-Cost Beneficiaries Overcome Challenges in Achieving Personal Health, Life Goals

HNHC BENEFICIARIES FACE MEDICAL AND SOCIAL HURDLES THAT CAN EXACERBATE ILLNESS IF NOT ADEQUATELY ADDRESSED

As a vulnerable population, HNHC beneficiaries face significant risks related to their health and daily living. How well providers and plans identify and address these risks impacts whether beneficiaries in this population achieve improvement in their health status and meet their own personal health and life goals. This includes enabling beneficiaries to live the way they want, such as living independently at home or staying engaged in the community. Helping HNHC beneficiaries achieve their personal goals acts as the central objective of any population-based intervention.

Chronically ill HNHC beneficiaries typically face two types of risk, which often overlap and can complicate care needs.

- First, HNHC beneficiaries commonly face medical risks, such as acute or advancing illness. Medical risks can be severe and immediate for HNHC beneficiaries, resulting in significant and sustained disruptions in daily living. Medical risks may also be compounded, requiring treatment regimens that rely on high degrees of care coordination across physician and caregiver teams.

- Second, HNHC beneficiaries face social risks, such as isolation, inadequate income, substandard housing, and poor access to nutritional food. Social risks pose an ongoing challenge for beneficiaries and their clinical providers, many of whom do not routinely interact with non-medical social support services and community resources. Yet, findings show that if not sufficiently addressed, social risks can exacerbate existing medical-related vulnerabilities or hamper the progress of an ongoing treatments.
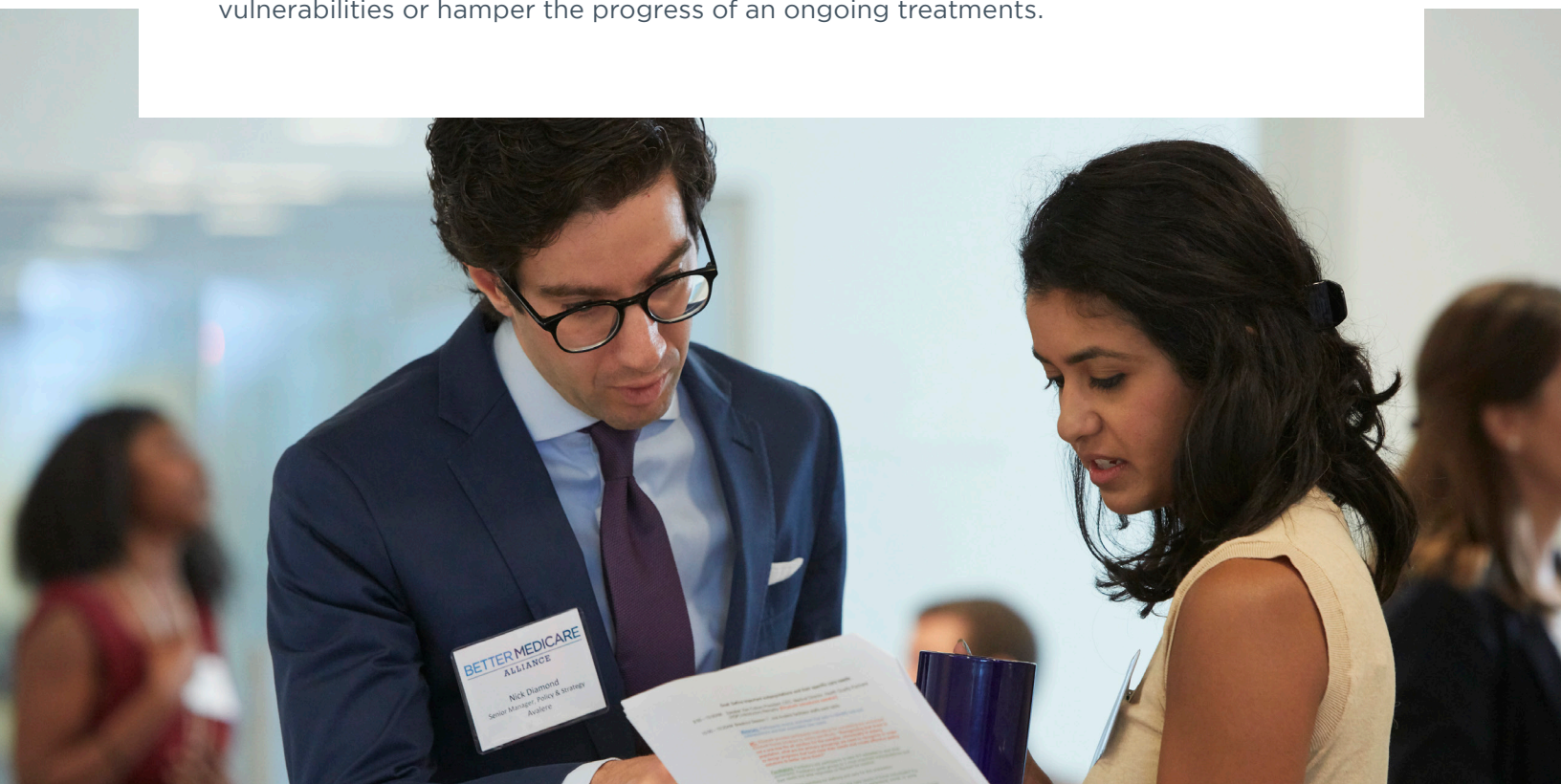
Figure 2 illustrates potential medical and/or social risks that a beneficiary may face and the need to mitigate these risks to enable beneficiaries to live the life they want.

Patients Are At-Risk Based on Medical, Social Risk Factors

Patient

Medical Risks

Behavioral Health / Substance Abuse Disorders

Declining Functional Capabilities

End-of-Life Status

Acute Illness

Advancing Illness

Social Risks

Insufficient Caregiver Support

Isolation

Lack of Nutritious Foods

Financial Challenges

Inadequate Housing

Patient Needs

Access to Care (medical care, providers, treatment)

Engagement in Care Management

Community Integration

Care Coordination

Social Supports

Technology to Enable Effective Care

Educated Providers

Patient Goals

TARGETED PROGRAMS CAN TAILOR SUPPORTS FOR PATIENTS AT VARYING LEVELS OF RISK TO ACHIEVE PERSONAL HEALTH AND LIFE GOALS AND IMPROVE HEALTH

Identifying HNHC beneficiaries can be improved by including patients who are recognized early, as having "rising-risk". High-risk patients are known to have significant medical or social needs, or both, that tend to cause or worsen chronic conditions. High-risk patients require robust and regular medical and social support services to make progress toward complying with clinical recommendations and achieving their personal health and life goals. In contrast, rising-risk patients require active management of their individual chronic conditions to minimize the chance that they become high-risk. Like high-risk patients, rising-risk patients require access to medical and social support services, and can benefit from a comprehensive preventive strategy that includes varying degrees of interventions.

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Enabling HNHC beneficiaries to achieve their personal goals requires not only adequate management of these risks, but also a tailored, personalized approach that accounts for each beneficiary's unique needs. Standard, clinical settings and staff often lack resources to address non-clinical needs. In addition, there are constraints from coverage rules that do not enable providers to sufficiently account and plan for the unique characteristics, personal goals, and individual capabilities of HNHC beneficiaries. Meanwhile, hyper-categorization based on standardized patient profiles risks losing sight of the person-centered approach required to care for this population.

HNHC beneficiaries need a variety of medical and/or social supports, tailored to their unique individual needs, in order to achieve their personal goals and actively engage in behavior changes and compliance to protocols that are necessary to slow disease progression and improve health status. While supports offered from program to program serve patients at varying levels of risk (rising-risk or high-risk) in different ways, any set of supports should be designed to help HNHC patients achieve their individual health and life goals. Figure 3 demonstrates examples of key program components targeted to address the medical and social needs of high- and rising- risk patients according to their unique needs in order to reach their ultimate goals for their health and daily life. For example, a high-risk patient may require ongoing care support from caregivers to manage multiple chronic conditions, while a rising-risk patient may benefit from transportation stipends for his or her caregivers to ensure timely physician visits.
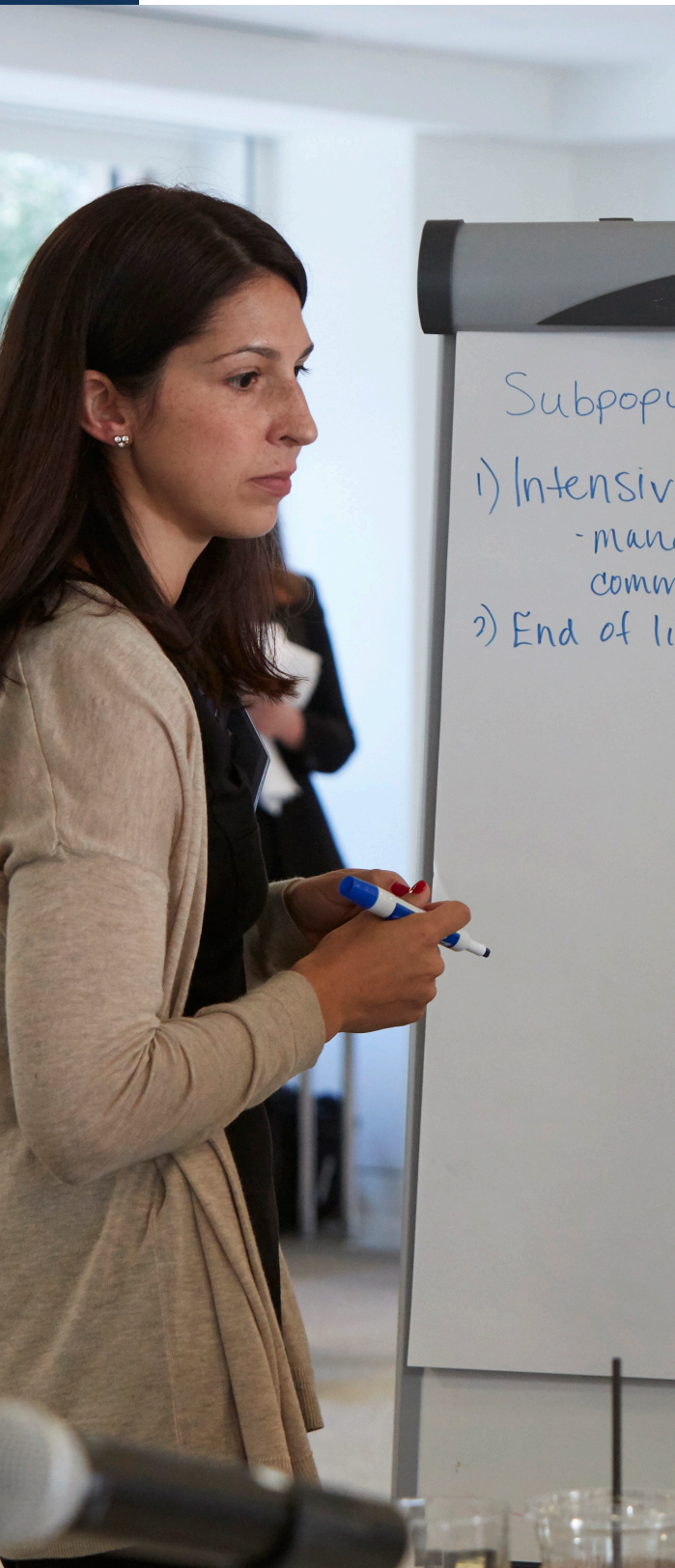
FIGURE 3

Targeted Programs Support Patients at Varying Levels of Risk to Achieve Personal Health and Life Goals

Examples of Potential Program Support for At-Risk Patients

LEVEL OF RISK	CAREGIVER SUPPORT	MEDICATION MANAGEMENT	TELEHEALTH SERVICES	
HIGH-RISK PATIENT Has multiple chronic conditions and is home-bound	Caregivers provided ongoing education and live support for managing one's care	Medication management for many drugs	Telehealth visits and continuous monitoring	**Patient Goals**
RISK-RISING PATIENT Has 2 chronic conditions and is with limited transportation	Caregiver is provided stipend to transport loved one to medical appointments	Medication management to support adherence to 2 drugs	Telehealth checkups with doctor as needed	

Whether a HNHC beneficiary achieves his or her personal goals often depends on caregiver support. Caregivers play critical roles in the daily lives of HNHC beneficiaries and generally serve as an indispensable part of the care team. Like patients, caregivers also require their own support to assist their loved ones with navigating care decisions, such as resources focused on the phases of their loved one's care journey.

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The development of effective, scalable programs and policy interventions does not presuppose an understanding of HNHC beneficiaries' risks. The ultimate success of any such program or policy, turns on whether it can be appropriately tailored to meet the unique needs and personal goals of HNHC beneficiaries. The current Medicare Advantage policy environment offers a stable foundation for tailoring benefits for this population which, with diverse stakeholder input, can be further refined to evolve with the care needs of the population.

Promising Care Models Already Exist for the High-Need, High-Cost Medicare Population

VARIOUS PROGRAMS HAVE EMERGED FOCUSED ON THE SPECIFIC CARE NEEDS OF THE HIGH-NEED, HIGH-COST POPULATION

Given variation across sub-populations and risk factors, no single program or model can sufficiently address all care needs of the HNHC population. As a result, many programs have emerged to serve the specific care needs of various sub-populations. Examples of such programs include the Healthy Living Center of Excellence[8] in Massachusetts, Lehigh Valley Health Network's Street Medicine Program[9] in Pennsylvania, and Meals on Wheels America[10] (nationwide), described further below (see Figure 4).

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FIGURE 4

Various Programs Have Emerged for the High-Need, High-Cost Population

HEALTHY AGING CENTER OF EXCELLENCE	LEHIGH VALLEY HEALTH STREET MEDICINE PROGRAM	MEALS ON WHEELS AMERICA
• Collaboration of community-based organizations, aging service providers, healthcare systems, government agencies, and payers in Massachusetts • Focuses on key aspects of caring for HCHN individuals, including chronic disease management, nutrition, regular physical activity, and fall prevention and management	• Delivers primary and urgent healthcare services to homeless individuals in Leigh Valley, Pennsylvania • Provides services wherever the patient is located (e.g., shelters, soup kitchens, under bridges, in the woods) • Does not charge patients for care, medications, or laboratory tests	• Supports more than 5,000 community-based senior nutrition programs nationwide • Delivers nutritious meals, friendly visits, and safety checks to seniors living at home • Serves as instant feedback loop between the patent and provider or caregiver

EFFECTIVE PROGRAMS SERVING HIGH-NEED, HIGH-COST BENEFICIARIES SHARE ESSENTIAL COMPONENTS

While programs can vary in many respects, effective programs tend to share a set of core characteristics that help HNHC beneficiaries achieve their health and life goals (see Figure 5). Characteristics include behavioral health service integration, social supports via partnerships with community-based services, and well-coordinated care.

FIGURE 5

Effective Programs Share Core Characteristics

CREATE COMMITTED CARE TEAMS	Deliver coordinated person-centered care by ensuring committed leadership, fostering team-oriented culture across clinical teams, and aligning financial incentives across providers and payers
REDEFINE CARE DELIVERY AND SUPPORTS	Deliver specialized care via redefining site of care, offering telehealth services, and providing medical supports (medication management or modification), in-home supports (home modifications), and social supports (food, housing, transportation)
INTEGRATE BEHAVIORAL HEALTH SERVICES	Offer and integrate behavioral health services with medical care for individuals with mental health conditions and substance abused disorders
ASSURE QUALITY CARE AND MONITORING	Design real-time feedback loop from care site to provider or caregiver and integrate w monitoring
UTILIZE PATIENT DATA	Build strong health IT foundation to identify at-risk patients, advance care coordination, and develop specialized prevention and intervention programs

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ORGANIZATIONAL, FINANCIAL, AND INFRASTRUCTURE ISSUES IMPACT PROGRAM SCALABILITY

Not surprisingly, the characteristics that make for an effective program also reflect potential challenges. How programs respond to these challenges impacts their scalability and the number of HNHC patients they can help. Generally, organizational, financial, and infrastructure-related barriers present the greatest challenges to program scalability, including insufficient buy-in and commitment within an organization, lack of funding, and inadequate access to relevant data (see Figure 6).

FIGURE 6

Organizational, Financial, and Infrastructure Issues Are Among the Highest Priority Barriers in Scaling Effective Programs for High-Need, High-Cost Beneficiaries

ORGANIZATIONAL	FINANCIAL	INFRASTRUCTURE
• Lack of investment and buy-in across internal stakeholders • Insufficient partnership and alliance development (i.e., between plans/providers and community-based organizations) • Lack of care coordination across various providers and caregivers	• High programmatic costs, including administrative resources to implement and sustain a program • Minimal financial incentives for robust investment under current Medicare reimbursement structure • Uncertainty around continued funding for government-run initiatives (State Health Insurance Assistance Program)	• Ill-equipped IT infrastructure and investment for identifying sub-populations and their specific care needs • Need for regular patient monitoring, particularly via tele-monitoring • Lack of behavioral health integration with medical care.

# Cross-Stakeholder Consensus Is Driving Change in the Policy Landscape

Discussion during the convening underscored the importance of cross-stakeholder support for the current direction of changes in the policy landscape that enhance care for chronically ill HCHN beneficiaries. In particular, stakeholders expressed strong support for policy changes called for in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017[11] (the "Act"), including:

- Giving Medicare Advantage plans greater flexibility in providing supplemental benefits for chronically ill beneficiaries;

- Expanding existing programs that have made an impact on care for chronically ill Medicare Advantage beneficiaries, such as Special Needs Plans (SNPs) and the Value-Based Insurance Design Model and

- Allowing Medicare Advantage plans to offer and receive payment for additional telehealth benefits.

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BUILDING ON STAKEHOLDER CONSENSUS REQUIRES COMPREHENSIVE ACTION

Moving forward, other areas warrant further stakeholder attention and collaborative action to continue efforts to improve care for HNHC beneficiaries.

- First, stakeholders at the convening expressed the need to enhance education for HNHC beneficiaries and their caregivers. They called for improvements in the materials and strategies in use. CMS should engage in robust, consumer-friendly, and culturally appropriate outreach and to improve the information and ease of use of written and online information to beneficiaries.

- Second, stakeholders at the convening recognized that, given the goal to transition to value-based care in Medicare, Medicare Advantage plans are uniquely positioned to deliver high quality care to HNHC beneficiaries. CMS has the opportunity to provide incentives to drive expansion of value based care, such as fostering alignment of FFS Medicare-focused value-based programs and Medicare Advantage quality measures, and ensuring that providers in Medicare Advantage value-based contracting that meet qualifications for APM to be counted toward APM thresholds for those providers.
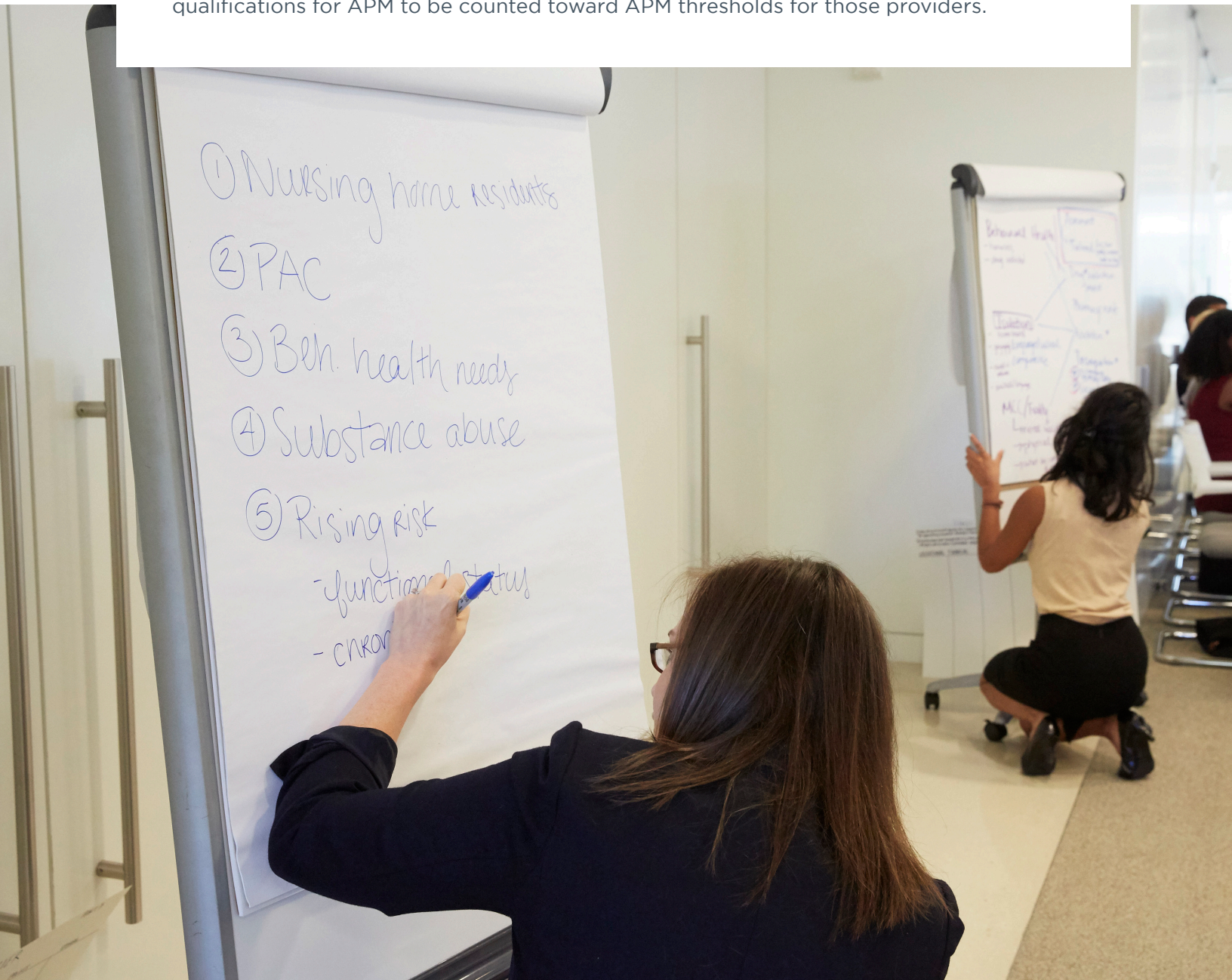
HIGH-NEED, HIGH-COST BENEFICIARIES AND THEIR CAREGIVERS NEED ENHANCED EDUCATIONAL RESOURCES TO MAKE MORE INFORMED DECISIONS RELATED TO THEIR CARE

Education on the option of Medicare Advantage and the potential benefits of care coordination for HNHC individuals should include the myriad stakeholders, including beneficiaries, caregivers, commercial payers, Medicaid managed care plans, and providers. Engaging stakeholders is essential to ensuring these beneficiaries know they have the choice of such plans. While Medicare offers many educational resources for HNHC beneficiaries and their caregivers, targeted improvements to these materials, related to the benefits that would better serve this population's needs is especially important. Specific improvements include:

- Enhanced education, particularly for first-time Medicare enrollees, on the differences between FFS Medicare and Medicare Advantage would ease the transition for HNHC beneficiaries by better enabling them to weigh and choose desired benefits based on their needs.

- Reinstating seamless conversion, where CMS can permit plans to enroll their commercial beneficiaries, including beneficiaries receiving care through a Medicaid Managed Care Organization, in a comparable Medicare Advantage plan, subject to a beneficiary opt-out. Seamless conversation would ease the transition to Medicare, while ensuring HNHC beneficiaries receive high quality, personalized care. As part of reinstating seamless conversion, CMS should engage in multi-stakeholder dialogue around adequate consumer protections to implement concurrently.

- Specific enhancements to the "Welcome to Medicare" packet, such as the inclusion of detailed information on SNPs, would provide valuable information for the growing population of frail and chronically-ill seniors.

- Augmenting Plan Finder resources would enable a more personalized beneficiary experience. For example, Plan Finder does not allow beneficiaries to input medical needs to estimate out-of-pocket costs, so it can be difficult to weigh various plan options for some beneficiaries. Additionally, Plan Finder does not display the total cost of FFS Medicare with Medigap (i.e., Part B premiums) for beneficiaries. By failing to display the total cost, beneficiaries are unable to make an apples-to-apples comparison between FFS Medicare and Medicare Advantage options. What's more, Plan Finder would benefit from displaying specific plan prices, rather than an average across plans, to enable easier beneficiary choice.

- Expansion of the number and availability of counselors who can engage directly with beneficiaries would better ensure consumers know and understand their options and the best choice for them. Ensuring sufficient funds for State Health Insurance Assistance Program (SHIP) is critical. The President's Fiscal Year 2018 Budget proposes to eliminate funding for SHIP.[12] Congress should maintain funding for SHIP and other education-related programs for the HNHC population as an important means to enable these high-need, high-risk individuals have access to the care they need.

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FURTHER INCENTIVES FOR VALUE-BASED CARE WOULD ENHANCE QUALITY OF CARE FOR HIGH-NEED, HIGH-COST BENEFICIARIES IN MEDICARE ADVANTAGE

The transition from volume to value has been a central theme in delivery reform, and spans across government and private payers. Medicare Advantage can enable this transition in a way that best serves the specific care needs of HNHC beneficiaries. While most government initiatives to incentivize and reward high value care across all populations have focused on FFS Medicare, further enabling alignment between FFS Medicare and Medicare Advantage in this area would enhance the quality of care that HNHC Medicare beneficiaries receive.

EXPANSION OF THE QUALITY PAYMENT PROGRAM WOULD FOSTER ALIGNMENT IN THE DRIVE TOWARD VALUE-BASED CARE

Notably, the Quality Payment Program (QPP) is expected to hasten the transition toward value-based care in Medicare, especially through Advanced Alternative Payment Models (APMs). Medicare Advantage plans are partnering with clinicians in risk-based arrangements to improve health outcomes across all populations, including the HNHC population. However, the QPP currently rewards clinicians with bonus payments only for risk-based payments that they receive under FFS Medicare.

Expansion of the QPP to allow clinicians' contracts with Medicare Advantage plans that meet the criteria to be Qualifying Advanced APMs would further incentivize high value care for HNHC beneficiaries. More broadly, expanding the scope of the QPP would foster consistency across federal programs in the drive toward value-based care. Integrating Medicare Advantage into Advanced APMs sooner would recognize and support the important work providers are engaged in through risk-based Medicare Advantage contracts.

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ADDITIONAL OPPORTUNITIES EXIST TO INCENTIVIZE CARE MODELS THAT TARGET THE NEEDS OF HIGH-NEED, HIGH-COST BENEFICIARIES

Under its statutory authority, the Centers for Medicare & Medicaid Services (CMS) could develop a demonstration project through the Center for Medicare & Medicaid Innovation (CMMI) that would incentivize Medicare Advantage plans to provide high value care by participating in risk-based contractual arrangements with providers. Broadly, the demonstration would encourage Medicare Advantage plans to enter into innovative value based relationships with providers.

Under this demonstration, CMMI would evaluate cost and quality metrics based on key value-based considerations. The demonstration could evaluate the extent of alignment with FFS Medicare goals, such as the broader goals of the QPP. Importantly, the demonstration could evaluate whether priority care goals for the HNHC population are achieved, such as inclusion of care focused on gap areas like behavioral health and in-home services, and the presence and degree of care coordination. As part of this effort, the demonstration could incentivize and measure achievement of these priority goals through reforms to the Star Rating System. This type of demonstration could test potential ways to evolve quality measures to better reflect patient needs, quality of care, and health care outcomes.

Conclusion

While great progress has been made in tailoring care in Medicare for the HNHC population, work remains. Given the increased understanding among policymakers of the importance of addressing the needs and related costs of health care for HCHN individuals, this is an opportune moment to support and strengthen strategies that work. There was widespread stakeholder consensus at the convening that advancing high quality care tailored to the health needs and personal life goals of HNHC beneficiaries must be a high priority for policymakers.

The thought leaders, practitioners, plans, and government representatives at the convening further agreed that Medicare Advantage offered the right framework for improved care for this population of beneficiaries. They were unified in calling for policymakers, plans, practitioners, and community partners to coalesce around successful, scalable programs and enact policy interventions that enable Medicare Advantage to provide the comprehensive, patient-centered care that enables HNHC beneficiaries to achieve their health and personal goals. With its emphasis on the provision of coordinated, well managed, high quality care to Medicare beneficiaries, Medicare Advantage is uniquely positioned to deliver innovative care solutions for the HNHC population.

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Resources

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Better Medicare Alliance is the leading coalition on Medicare Advantage.

Our mission is to build a healthy future by advocating for a strong Medicare Advantage. As a community of experts, we're leading the way on health care through research, advocacy, and grassroots organization. Together, we're creating a path forward for innovative, modern health care.

For more information, please visit **www.bettermedicarealliance.org.**

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