BETTER MEDICARE
ALLIANCE

WHITE PAPER

SEPTEMBER 9, 2016

THE VALUE OF MEDICARE ADVANTAGE: PIONEERING COMMUNITY PARTNERSHIPS TO IMPROVE HEALTH OUTCOMES

Between 2011 and 2030, roughly 10,000 seniors in America will become eligible for Medicare every day, presenting challenges and opportunities for the health care system.[1] The growing demand for health care services increases the need for innovative community partnerships enabled by Medicare Advantage (MA).

Community partnerships help seniors age "in place"; outside of traditional health care settings. MA plans and providers are bridging gaps in health care delivery by actively engaging in partnerships with community-based organizations to meet the health and social needs of Medicare beneficiaries to improve outcomes and slow disease progression.

This White Paper:

- Explains how MA plans and providers are bridging gaps in health care delivery by actively engaging in partnerships with community-based organizations to meet the needs of Medicare beneficiaries.
- Highlights examples of effective partnerships connecting MA beneficiaries to community-based services, including healthy food through Meals on Wheels America, exercise and diabetes prevention through the YMCA, and community nursing through Health Quality Partners. These partnerships provide beneficiaries with resources to improve transitions of care, manage chronic conditions and receive care at home.
- Identifies ways in which policymakers can support innovative community partnerships, with specific emphasis on services targeted to beneficiaries with multiple chronic conditions in order to slow disease progression.
- Offers policy proposals which include: increasing flexibility in MA plan design, expanding the definition of supplemental benefits in MA, expanding reimbursement options for the home and community as a site of care, and promoting public-private partnerships in MA.

This white paper builds on the Better Medicare Alliance (BMA) Congressional Hill Briefing "*The Value of Medicare Advantage: Pioneering Community Partnerships to Improve Health Outcomes,*" which can be viewed online. Presentations from this briefing can be downloaded on the BMA website.

COMMUNITY PARTNERSHIPS IMPROVE CARE

According to the Office of Disease Prevention and Health Promotion, community-based programs play a critical role in preventing diseases, improving health and enhancing quality of life. Community-based programs are designed to reach people outside of traditional health care settings.[2] Value-based health care delivery models are providing new incentives to lower readmission rates, identify alternatives to long-term care facilities and utilize the home and community as a site of care. MA plans and providers are bridging gaps in health care delivery by actively engaging in partnerships with community-based organizations to meet the health and social needs of Medicare beneficiaries.

Leveraging the home and community as a site of care increases opportunities to provide care, improve care coordination and bridge gaps in care. Through the MA framework, health plans and community partners design evidence-based initiatives to offer coordinated care, disease management, and interventions that include social wellness, nutrition, exercise support, and other services critical to improving beneficiary health. These partnerships make health care services more accessible to disabled and senior beneficiaries covered by Medicare.

In the United States, chronic disease is now the major determinant of longevity and quality of life. Chronic disease is also a key driver of health service utilization and cost. Preventing the onset and progression of chronic diseases is essential for improving population health. Health and economic experts warn the increasing prevalence of chronic disease and the aging of the population present a growing challenge for

the nation's health care system. MA is at the forefront of developing and incentivizing early intervention, care coordination, and a patient-centered approach to care to address these concerns and achieve better outcomes for beneficiaries.

Community partnerships in MA can help bridge gaps in care and address the social determinants of health, which studies show have a significant impact on health outcomes. There is an estimated 20-year gap in life expectancy between the most and least advantaged populations in the U.S.[3] Key social determinants of health include social support, food, and transportation. Health issues, particularly for those with multiple chronic conditions, cannot be fully addressed without appropriately fulfilling Maslow's basic Hierarchy of Needs: food, water, warmth, rest, and security.[4] Social determinants of health must be considered as a factor in a beneficiaries' ability to get the care they need. An aging population increases the urgency to meet the needs of the whole person through a patient-centered approach to care.

MEDICARE ADVANTAGE PROVIDES FRAMEWORK FOR COMMUNITY PARTNERSHIPS

MA provides a comprehensive framework to develop effective community partnerships through a patient-centered approach to care. The capitated system in MA enables health plans and providers to move beyond traditional health care benefits to address beneficiaries needs. MA plans provide all of the traditional benefits in Traditional Fee-for-Service (FFS) Medicare, with flexibility to address additional health care needs. This capitated system incentivizes health plans to better coordinate care, prevent avoidable hospitalizations, and provide patient-centered, integrated care. MA plans can leverage community-based organizations to take a holistic view of the patients' health care needs.

Patients with multiple chronic conditions particularly benefit from the MA approach to health care. An example of this incentive at work occurred when a health plan noticed a beneficiary was consistently seeking care at an emergency room without a corresponding medical issue. After some investigation, the plan realized the beneficiaries' food stamps did not last the full month, leaving the beneficiary hungry and seeking meals at the end of each month. The health plan acted to ensure the beneficiary had adequate food by contacting a local organization to provide meals as needed.

Incentives in the MA program are aligned to promote innovative ways to provide comprehensive care to beneficiaries and link individuals to services that improve their health. Health plans and providers identify needs, resources, and expertise in the community and conduct population health analysis to ensure investments are improving health outcomes. This White Paper details multiple examples of effective partnerships connecting MA beneficiaries to community-based services, including healthy food through Meals on Wheels America, exercise and diabetes prevention through the YMCA, and community nursing through Health Quality Partners.

This White Paper also identifies ways policymakers can support innovative community partnerships. Such efforts should include services targeted to beneficiaries with multiple chronic conditions to slow disease progression. Policy proposals include increasing flexibility in MA plan design and expanding the definition of supplemental benefits. Both of these policies could allow MA plans to connect beneficiaries with the health care and resources that will produce the best outcomes. Expanding reimbursement options for the home and community as a site of care would also increase innovation as MA continues to form public-private partnerships to meet patient's needs. Policymakers could also prioritize demonstrations and other research initiatives to identify programs that produce improved outcomes that can be incorporated into the core benefits of Medicare.

MEALS ON WHEELS AMERICA COMMUNITY PARTNERSHIP WITH MEDICARE ADVANTAGE

Adequate nutrition plays a critical role in the health of an individual. As a result, community partnerships in MA have focused on ensuring seniors have access to healthy food to both improve health outcomes and reduce hospital readmissions. Meals on Wheels America (MOWA) is the oldest and largest national organization supporting the more than 5,000 community-based senior nutrition programs across the country that are dedicated to addressing senior hunger and isolation. MOWA partners with MA plans to achieve their mission of empowering local community programs to improve the health and quality of life of the seniors they serve to prevent hunger and isolation. Older adults are at risk of malnutrition and can become more vulnerable when recovering from a hospitalization. It is estimated that 50% of the seniors who enter the hospital are already malnourished when they arrive.

PROGRAM OVERVIEW

Strong evidence suggests home-delivered meals have a positive impact on the nutritional well-being of older, homebound persons. The once-weekly delivery of frozen meals has emerged as a cost-effective way to provide seniors with nutrition assistance post-hospitalization. In this model, participants are provided the full week's meals in one bulk delivery weekly following a hospitalization. MOWA partnered with the Humana FeelGoodFood™ Program to provide 135,000 MA seniors in 36 states with a one-time delivery of 10 frozen meals and follow-up calls.

RESULTS

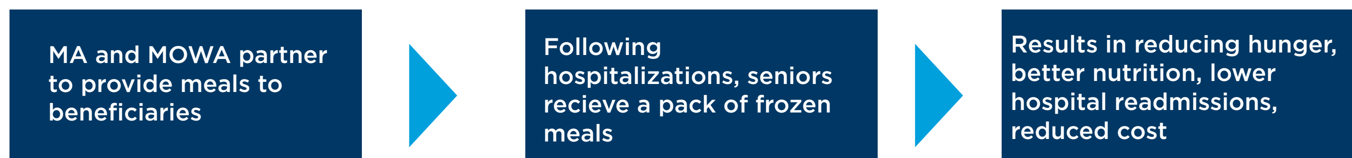
The MOWA program has shown measurable results:

• When a pack of 10 healthy frozen meals was provided to a beneficiary through a discharge planning program after a hospitalization, lower hospital readmissions occurred.

• The discharge planning program yielded overall health care savings averaging 31% per member per month for the first month following discharge.

• Additionally, the discharge planning program led to fewer post-discharge costs, fewer hospital inpatient days and admissions, and referral opportunities for about 30% of recipients for ongoing services.

MOWA's partnership with MA connects beneficiaries to healthy meals through the community to improve overall health and prevent hospitalizations.



NEXT STEPS

MOWA makes the case for expanding community partnerships to provide seniors with healthy meals. A recent research study released by the organization called More Than a Meal, found seniors who receive daily, home-delivered meals, in-home visits and safety checks are likely to experience the greatest improvements in their health and quality of life. Seniors who received the home-delivered meal services experienced improvements in mental health, self-rated health, reductions in the rate of falls and decreases in worry about being home alone. On an almost daily basis, MOWA is receiving calls from MA case managers. Meals on Wheels targets seniors who are significantly more vulnerable than the average American senior. MOWA has proposed enhancing MA by allowing doctors to prescribe meals when needed and improving the hospital discharge planning process to ensure an individual has access to food when they get home.

A SENIOR WHO RECEIVES DAILY-DELIVERED MEALS EXPERIENCES THE GREATEST IMPROVEMENTS IN HEALTH AND QUALITY OF LIFE COMPARED TO A SENIOR WHO RECEIVES FROZEN, WEEKLY-DELIVERED MEALS OR NO MEALS AT ALL.

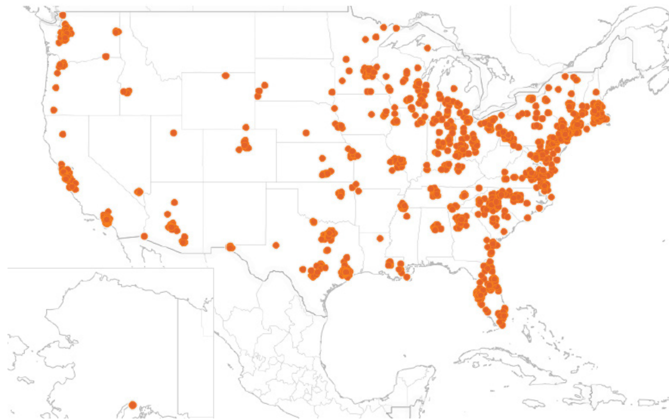
YMCA COMMUNITY PARTNERSHIP WITH MEDICARE ADVANTAGE

Staying active can boost the mental and physical health of Medicare beneficiaries. The YMCA of the USA (YMCA) is working with MA plans across the country to combat diabetes through community partnerships with local YMCA's and empowering seniors with the tools to slow disease progression. The YMCA is focused on programs that help to promote healthy spirit, mind and body for all. As a national, community-based charity, the YMCA has developed needed services, while also serving as a delivery system for a range of home and community-based interventions. The YMCA's Diabetes Prevention Program (YMCA's DPP) is consistent with the YMCA's mission of working side-by-side with neighbors to make sure that everyone - regardless of age, income or background - has the opportunity to learn, grow and thrive. The YMCA's DPP is one of the largest programs of its kind, with 1,600 program sites in 47 states; the Centers for Disease Control and Prevention (CDC) verifies the quality of any organizations that are delivering their own DPP consistent with standards set by the CDC. The need for the DPP is clear, about 30 million Americans have type 2 diabetes, resulting in two deaths every five minutes in the U.S. It is estimated that one of every three Medicare dollars is attributed to diabetes and associated illnesses. Additionally, 86 million Americans have prediabetes, which is essentially a diagnosis of having a high risk of developing diabetes.

PROGRAM OVERVIEW

The YMCA's DPP has been brought to national scale in the past 6 years. In 2012, a few years into scaling the YMCA's DPP, the YMCA received funding from the Center for Medicare and Medicaid Innovation to enroll eligible Medicare beneficiaries who have high risk for diabetes in a program that could decrease their risk for developing serious diabetes-related illnesses. Between February 2013 and June 2015, the YMCA enrolled 7,804 beneficiaries in FFS Medicare and MA in the DPP program. Participants attended weekly meetings with a lifestyle coach to learn strategies for long-term dietary change, appropriate physical activity, and behavior changes to control weight and decrease the risk of type 2 diabetes. After the initial weekly training sessions, participants could attend monthly follow-up meetings to help maintain healthy behaviors. Participants demonstrated high levels of engagement in the program – 83 percent of the beneficiaries attended at least four core sessions. As the map on page 5 illustrates, by the end of April 2016 the YMCA's DPP reached national scale. Along with other DPP providers, the YMCA is positioned to be a strong partner to MA plans.

YMCA's Diabetes Prevention Program National Footprint



Source: YMCA Diabetes Prevention Program Fact Sheet, April 2016

RESULTS

The YMCA program has shown measurable results:

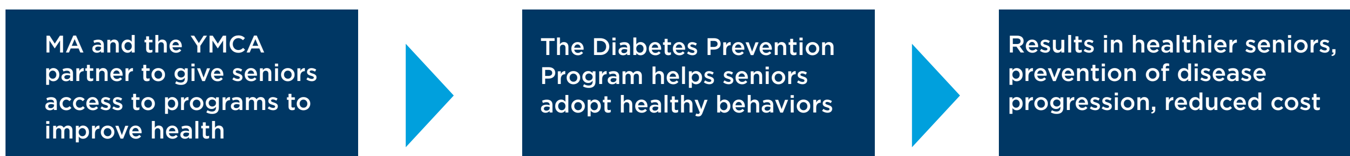
• Through an analysis of the DPP data, the Centers for Medicare and Medicaid Services (CMS') Office of the Actuary determined the program is likely to reduce expenditures if made available to eligible Medicare beneficiaries.

• The YMCA's DPP pilot program was delivered by 17 YMCA's in 8 states. About one-third of these participants were covered by MA plans.

• The program has proven cost savings of 5:1 return, saving an estimated $2,650 over 15 months per beneficiary.

• Beneficiaries who attended at least one core session lost an average of 7.6 lb., while beneficiaries who attended at least four core sessions lost an average of 9 lb.

The YMCA's DPP is a prime example of the outcomes that can be achieved through community partnerships with MA plans. In 2016, U.S. Department of Health and Human Services (HHS) certified that the YMCA's DPP would reduce net Medicare spending. The HHS Secretary announced an expansion of the program. This was the first time a preventive service model from the Innovation Center within CMS became eligible for inclusion in the Medicare program. In the Medicare Physician Fee Schedule CMS proposed expanding the YMCA DPP program using a 12-month CDC approved curriculum. CMS proposed allowing any organization recognized by the CDC to be eligible to apply for enrollment in Medicare after January 1, 2017. Proposed CMS reimbursements would be heavily weighted toward achievement of weight loss over the first six months, and no payments would be available after the first six months without achievement of the minimum weight loss goals.



NEXT STEPS

MA plans, health systems, and physicians across the country will be involved in expanding the DPP. More than 30 commercial health plans have been important partners in the success of the YMCA's DPP. By early 2016, more than 60 YMCAs had received claims-based reimbursements for the YMCA's DPP. The health plans reimburse the YMCA using value-based contracting, which means the YMCA is only reimbursed when outcomes are achieved. Moving forward, the program will be integrated into Medicare and then MA. YMCA's can function as a Management Services Organization to provide administrative, business and technological services to enable local YMCA's to receive payments for delivering the program. Allowing Medicare to reimburse for the DPP will make it easier to expand the program to more beneficiaries in MA moving forward.

HEALTH QUALITY PARTNERS COMMUNITY PARTNERSHIP WITH MEDICARE ADVANTAGE

Health Quality Partners (HQP) is a quality improvement organization in Doylestown, Pennsylvania dedicated to improving the experience of health care for patients, their families, and providers by sending nurse care managers into beneficiary's homes to manage chronic conditions. Through a community-based model of advanced care management, HQP accomplishes their mission of improving the health of vulnerable populations, supporting primary care, and increasing the value of our health care system. In the U.S., chronic disease is now the major determinant of longevity and quality of life. Chronic disease is also a key driver of health service utilization and cost. HQP works to prevent the onset and progression of chronic disease to improve population health.

PROGRAM OVERVIEW

Starting in 2002, HQP participated in the Medicare Coordinated Care Demonstration, a national demonstration project sponsored by CMS to reduce hospitalizations and health care costs, and improve health outcomes for high-risk Medicare beneficiaries. HQP focused on identifying high-risk patients and working to meet their needs through comprehensive in-home assessments, frequent in-person visits, group education and behavior change classes, and coordination of care between providers. The project led to the development of a model of community-based nurse care management that incorporates well-established, evidence-based interventions designed to help reduce cardiovascular and geriatric risks for Medicare beneficiaries with chronic health conditions.

Since the CMS demonstration project ended, HQP has implemented the program for Aetna MA enrollees. The program offered to MA members with certain chronic health conditions provides an individualized approach to assessing beneficiaries' personal health risks. The HQP support services are designed to improve senior's health, independence, and quality of life. Benefits for participating in the program include personalized health assessments, one-on-one meetings with a nurse care manager, access to healthy workshops and individualized care to help manage health conditions.

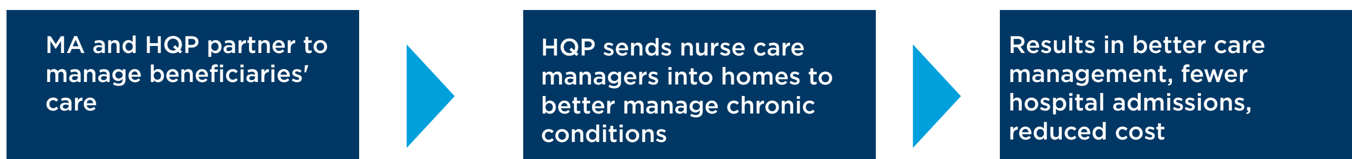
HQP works with Aetna's MA plan by serving patients selected by diagnosis, utilization, and the health plans risk scoring methodology. Aetna identifies participants for the program by identifying physicians' offices that treat a large number of Aetna MA members. HQP then reviews claims data and identifies members in need of additional services due to chronic illness. Plan members within that group chose to participate. HQP develops risk profiles for those members, generates medical record reviews in primary care offices, and utilizes frequent data feeds from Aetna related to hospital and facility admissions, lab values and claims. This information is used to prioritize outreach efforts to members with the highest risk. Nurses coordinate with care managers at Aetna to discuss the best care for patients because as one Senior Clinical Lead at HQP said, "they know us and we know them."

The HQP Model

RESULTS

The HQP program has shown measurable results:
• The demonstration project ended in 2014, showing a 10 percent reduction in hospitalizations and improved 2 and 5-year survival rates.[5]
• Through the HQP community partnership with Aetna, hospitalizations have been reduced 17-20%, and costs have been reduced 16-18%.
• High-risk members who agreed to participate received more individually focused assessments and interventions. These interventions included more monitoring, education and counseling, and coordinating additional community health and social services.
• A Senior Clinical Lead at HQP said, "I can't imagine some of these patients navigating the health system without us. I so believe in what we do."

The community partnership between HQP and Aetna is a good example of how MA plans can utilize patient data and care coordination by nurse care managers to target additional care to the most vulnerable patients to achieve better health outcomes and cost savings.



NEXT STEPS

While HQP currently operates in Pennsylvania, the model could have a large-scale impact on the health system. The HQP community-based interventions in collaboration with primary care providers and specialists help mitigate health risks. The Washington Post profiled HQP and highlighted how home as the site of care can prevent hospitalizations by managing chronic conditions. With the continued focus of moving from volume to value through a more risk-bearing value-based Medicare system, HQP is well positioned to scale their person-centered, population-relevant and accountable model to clinical practices across the U.S.

THE FUTURE OF COMMUNITY PARTNERSHIPS & POLICY RECOMMENDATIONS

MA is pioneering the use of effective community partnerships for beneficiaries by focusing on prevention, early intervention, disease management, and filling-in gaps in health care. The capitated payment system gives MA plans the ability to design benefits that provide crucial supplemental care in addition to core Medicare benefits to meet patient's needs. Health plans and providers use this flexibility to innovate and integrate care by identifying needs and then connecting the resources and expertise available in the community to the beneficiary to meet those needs. As our nation's health care system is challenged to meet the needs of a rapidly aging population, it is important for policymakers to do more to encourage the growth of effective community partnerships in MA to provide effective care for Medicare beneficiaries.

Policy Recommendations:

- **Increasing flexibility in MA plan design to encourage benefits that are more effectively tailored to meet individual patient needs.**
- **Expand the definition of supplemental benefits in MA to include services that address barriers to better health outcomes, such as physical activity, transportation, and nutrition.**
- **Expand coverage options for the use of the home and community as a site of care.**
- **Promote public-private partnerships between MA plans and the community by identifying and sharing best practices.**
- **Prioritize demonstrations and other research initiatives to identify programs that produce improved outcomes that can be incorporated into the core benefits of Medicare. Such efforts should be particularly targeted to beneficiaries with multiple chronic conditions most likely to benefit from slowing disease progression.**

FLEXIBILITY IN PLAN DESIGN

A way to address the unique health care needs of each beneficiary is to allow flexibility in health plan design. Allowing MA plans to vary benefit structure based on the chronic conditions of an individual could improve health outcomes by making treatments easier to access and more coordinated. MA plans could provide additional supplemental benefits, reduce the cost of preventive services and adjust the provider network to include the most effective care team. Effectively tailoring care and cost-sharing to the beneficiaries' unique needs could slow disease progression. In order to connect a beneficiary with the most effective individualized care, flexibility in health plan design is potentially highly beneficial.

EXPAND SUPPLEMENTAL BENEFITS

The definition of supplemental benefits in MA should be broadened to improve beneficiaries access to care that addresses chronic conditions and the social determinants of health. Currently, if MA plans are able to provide care at a lower cost than FFS Medicare, the MA plan can put a percentage of the difference towards supplemental benefits. However, supplemental benefits must fit into a rigid definition of health-related benefits. This definition does not take into account the unique needs of each beneficiary. Beneficiaries often do not have access to innovative solutions that may address issues like hunger, physical activity or transportation needs. With an expanded definition of supplemental benefits, MA plans could reimburse needed services provided by innovative non-profit organizations that offer well documented benefits like home delivered, nutritious meals, or new, innovative efforts such as allowing clinicians to write "prescriptions" for services to address hunger or utilizing registered dietitians to reach seniors through telehealth visits. Identifying seniors with chronic diseases and socio-economic challenges and then finding ways to address those needs means enabling coverage for health related supplemental benefits to slow their disease progression.

OFFER COVERAGE FOR COMMUNITY-BASED CARE

Expanding coverage options for MA to use the home and community as a site of care will help facilitate partnerships to fill in gaps. Engaging residents at home or in the community can serve as effective ways to deliver services. Community support for seniors can facilitate home health care, caregiver support and access to resources like healthy meals or free transportation. These support systems can help seniors avoid long-term care facilities and hospitalizations. As the Medicare system transitions from volume to value, the divisions between health care and community services will continue to dissipate as providers are incentivized to get seniors the right care, at the right place and the right time.

PROMOTE PUBLIC-PRIVATE PARTNERSHIPS

Across the country, community support organizations provide critical services for seniors and people with disabilities. These organizations also provide opportunities for partnerships to better integrate community based services with the delivery of medical care. Promoting public-private partnerships between MA plans and community partners helps ensure services are appropriate to local communities with attention to cultural, racial or ethnic differences, and helps identify best practices. Every community is different and public-private partnerships are important to connect beneficiaries with high-value care. MA plans are uniquely positioned to identify quality community resources and drive best practices. Technology offers increased opportunities for aggregating resources, coordinating care and analyzing outcomes to replicate community partnerships that work. MA plans provide a framework to expand successful community partnerships to improve the health and well-being of Medicare beneficiaries.

PRIORITIZE SUCCESSFUL DEMONSTRATIONS AND RESEARCH

CMS is implementing demonstrations that identify innovative ways to enhance quality, efficiency and patient safety in Medicare. For example, the YMCA DPP model was integrated into the larger Medicare program through Section 1115A of the Social Security Act, which established the Center for Medicare and Medicaid Innovation (CMMI) within CMS. CMMI is designed to test innovative payment techniques and service delivery models and allow the HHS Secretary to expand the scope of successful models. Another example of an innovation in progress is a pilot CMS announced in January 2016, to provide funding to address beneficiaries' health-related social needs in Medicare and Medicaid. The goal of the pilot is to connect beneficiaries' unmet health-related social needs with community-based services. The pilot will test three scalable approaches to addressing health-related social needs and linking those social needs with medical and community services, which include community referrals, community service navigation, and community service alignment. This pilot and other CMS research programs can help identify best practices in community partnerships.

MA is leading the way in facilitating partnerships that improve beneficiaries' access to community services. Improving flexibility in plan design, supplemental benefit options, site of care coverage, public-private partnerships and successful demonstrations will help promote and improve community partnerships. Policymakers, stakeholders, and communities must continue to work together to remove barriers for health plans and providers so Medicare beneficiaries can gain access to the resources that enhance their overall health and well-being.

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[2] *Healthypeople.gov. Educational and Community-Based Programs. Accessed August. Web.*
[3] *Murray CJL, Michaud CM, McKenna MT, Marks JS. US patterns of mortality by county and race: 1965–94. Cambridge: Harvard Center for Population and Development Studies, 1998. Web.*
[4] *Rebecca Leibowitz. "Food or meds? Find out what your patients' priorities are." Advisory Board. August 19, 2013. Web.*
[5] *Jelena Zurovac, Greg Peterson, Cara Stepanczuk, Randy Brown. Mathematica Policy Research Report. Evaluation of the Medicare Coordinated Care Demonstration: Interim Impact Estimates for the Health Quality Partners' Program. November 17, 2014. Web.*

Better Medicare Alliance | The Better Medicare Alliance (BMA) is the leading coalition of nurses, doctors, employers, aging service agencies, advocates, retiree organizations, and beneficiaries who support Medicare Advantage as an option under Medicare. Medicare Advantage offers quality, affordability and simplicity, with enhanced benefits to more than 17 million Medicare beneficiaries across the United States of America. BMA works to ensure the sustainability and stability of Medicare Advantage through information, research, education, and united support among stakeholders to strengthen this important coverage for seniors and people with disabilities.