BRIEF

Approaches to Cancer Coverage and Care in Medicare Advantage

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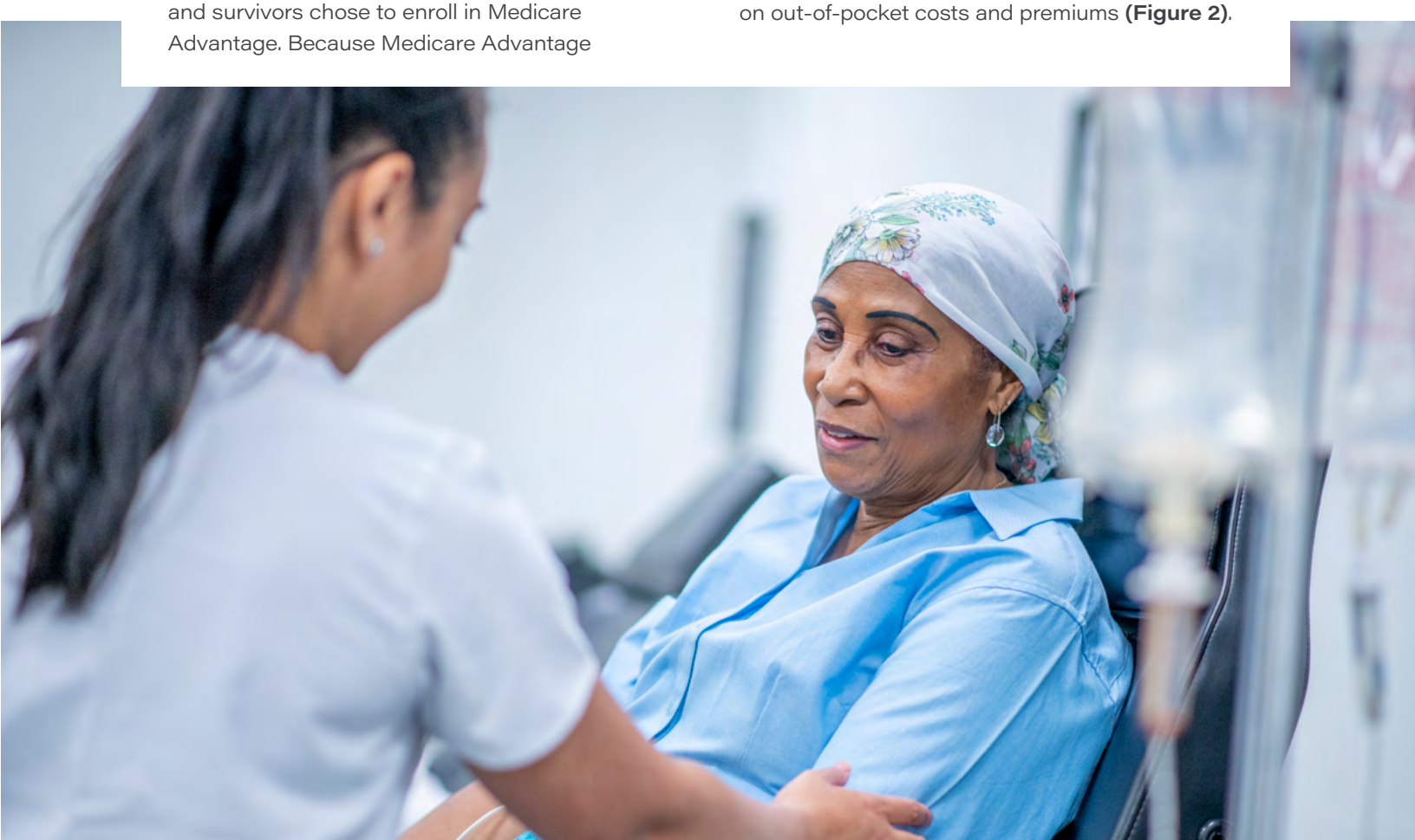
Analysis by ATI Advisory for:

BETTER MEDICARE ALLIANCE

Background

Over 20 million Medicare beneficiaries are cancer patients or survivors. As the second leading cause of death in the United States, cancer's impact is widespread, and half of men and one third of women will receive a diagnosis in their lifetime.[1] The Medicare program pays more than an estimated $200 billion a year on cancer treatment, which is projected to increase as the number of Medicare beneficiaries grows rapidly from 62 million in 2020 to 78 million in 2030 and 84 million in 2040.[2,3] President Biden recognized the importance of this issue by establishing the White House Cancer Moonshot's goal of cutting the U.S. cancer death rate at least 50 percent over the next 25 years and improving the experiences of people and their families living with and surviving cancer.

In 2019, 37 percent of Medicare cancer patients and survivors chose to enroll in Medicare Advantage. Because Medicare Advantage plans receive a capitated payment to provide comprehensive coverage, plans are incentivized to provide high-quality and cost-effective health care. These private health plans have the flexibility to implement innovative health care programs that are especially important to cancer patients and survivors. The fee-for-service (FFS) Medicare program, through Parts A and B, spends, on average, 38 percent more on beneficiaries who have received a cancer diagnosis in their lifetimes compared to beneficiaries who have not.[4] Based on quantitative analyses performed by ATI Advisory, Medicare Advantage performs comparably to FFS Medicare on a variety of quality measures while limiting the cost burden of health care experienced by beneficiaries. Cancer patients and survivors in Medicare Advantage spend, on average, over $2,000 less than the annual amount FFS Medicare beneficiaries spend on out-of-pocket costs and premiums **(Figure 2)**.



Overview and Implications*

BMA engaged ATI Advisory (ATI) to perform qualitative analysis on how the Medicare Advantage program services both cancer patients and survivors. ATI Advisory conducted policy reviews, data analytics, and stakeholder interviews to understand how the Medicare Advantage program serves both cancer patients and survivors. This brief describes approaches Medicare Advantage plans report taking to tailor benefits, programs and interventions to cancer patients' and survivors' needs. Informed by interviews, the brief provides an on-the-ground view of the strategies two Medicare Advantage Plans, an integrated delivery system that includes a Medicare Advantage product, a provider organization, and a cancer-focused health company report using to serve cancer patients. The most promising of these include an emphasis on screening and internal risk assessments to detect disease as early as possible in its progression, care management that simplifies care navigation, and palliative care that addresses whole-person needs and preferences in cancer care.

* Differences between the Medicare Advantage and FFS Medicare programs that are statistically significant at a p-value of 0.05 using the Balanced Repeated Replication method are marked with an asterisk (*). All differences between the two programs described in prose are statistically significant.

Medicare Coverage of Cancer Care Services

The Medicare program covers a variety of medically necessary services for cancer patients. Medicare Advantage is required to offer the same services as FFS Medicare but has the flexibility to offer additional benefits as well. As a result, Medicare Advantage plans are allowed to fill gaps in traditional Medicare services **(Figure 1)**. Medicare Advantage program and demonstration design allows plans to implement flexible solutions, relevant to cancer care, across preventative care, therapy programs, and hospice, like through the newly piloted Hospice Value Based Insurance Design (VBID) model.

Figure 1: Cancer-related Allowable Benefits in FFS Medicare and Medicare Advantage

Allowable Benefit	FFS Medicare	Medicare Advantage
Cancer Screenings, if authorized by Congress or recommended by the U.S. Preventive Services Task Force (USPSTF)[1]	✓	✓
Medically Necessary Treatments	✓	✓
Palliative Care	✓	✓
Advanced Care Planning	✓	✓
Telehealth	Temporary[2]	✓
Transitional Hospice Care		Through Hospice VBID
Hospice Supplemental Benefits		Through Hospice VBID
Cancer Screenings During In-home Health Risk Assessments (HRAs)[3]		✓
Financial Navigation		✓
Care Management		✓
Transportation		✓
Non-medical supports such as housing, food, and caregiver respite		✓

**Note: Medicare Advantage plans may, but are not required to, offer supplemental benefits or benefits through Hospice VBID.*

[1] Bipartisan legislation to change this coverage, "The Medicare Multi-Cancer Early Detection Screening Coverage Act," has been introduced in both the U.S. House and Senate. This bill would provide CMS with additional authority to determine appropriate Medicare coverage of new diagnostic technologies, without requiring Congressional authorization or a USPSTF recommendation.

[2] During the COVID-19 Public Health Emergency (PHE), waivers allowed FFS Medicare to reimburse more services for all beneficiaries (i.e., even those in urban areas) rendered remotely. For more on telehealth flexibilities, see the ATI Advisory and BMA report: Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19.

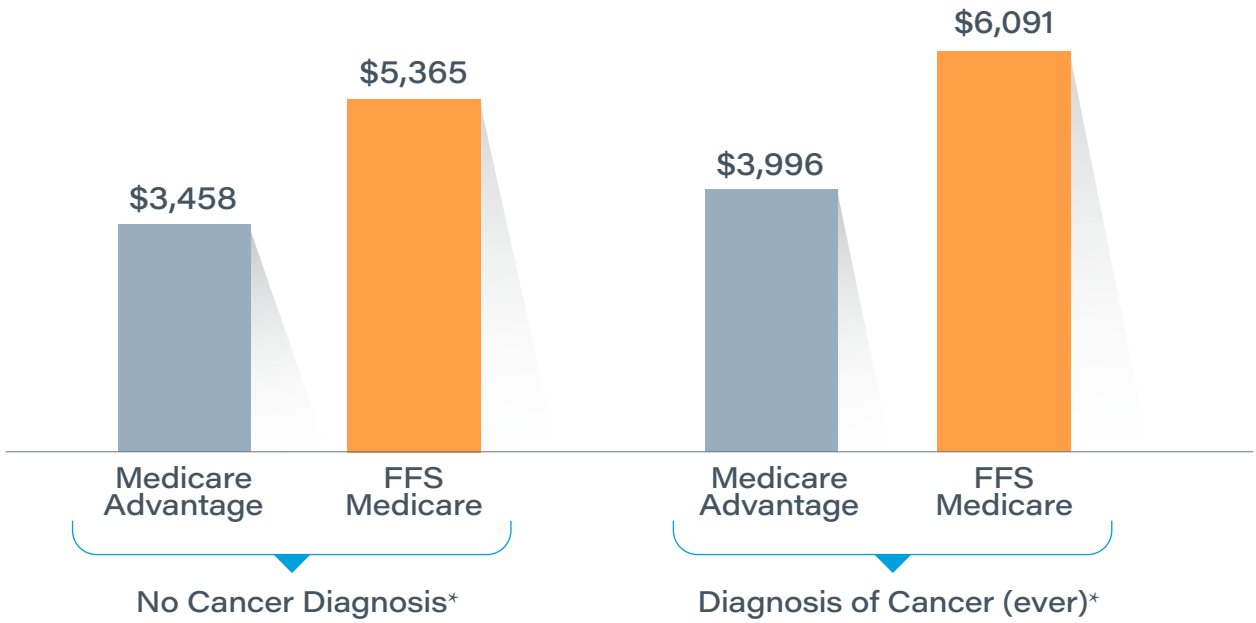
[3] During in-home HRAs, clinicians may ask whether patients have cancer and can perform colorectal cancer screenings during the visit.

Provider Networks

Beneficiaries with FFS Medicare may seek treatment from any provider who accepts Medicare. In Medicare Advantage, beneficiaries generally may use providers with whom the plan contracts to be part of its network. Although beneficiaries with Medicare Advantage are less likely than FFS beneficiaries to seek care at academic medical centers for cancer treatment,[5] interviewees felt that seeking cancer treatment from community providers rather than an academic medical center facilitates a greater diversity of options for beneficiaries in determining the provider of their choice. While interviewees acknowledged that community-based cancer care can be less well coordinated than academic medical center treatment, Medicare Advantage plans often dedicate care coordination resources to these members.

The Medicare Advantage program allows plans to "buy down" and reduce enrollee premiums and cost sharing with rebate dollars. In these scenarios, the Medicare Advantage program allows plans to provide comprehensive benefits with lower patient cost-sharing. This, in turn, has resulted in statistically significantly lower spending on premiums and out-of-pocket costs among Medicare Advantage patients with and without a cancer diagnosis over their lifetimes, when compared to those in FFS Medicare **(Figure 2)**. Based on data survey respondents report, this lower spending is reflected in the proportion of Medicare Advantage beneficiaries who are cost burdened ("cost burden" is defined as spending over 20 percent of income on health care costs). Among beneficiaries with a cancer diagnosis, 15 percent of Medicare Advantage beneficiaries are cost burdened compared to 23 percent of FFS Medicare beneficiaries (data not shown).

Figure 2: Average Total Spending (Premium + Out-of-Pocket Costs) per Enrollee by Cancer Status



Core Cancer Care Interventions in Medicare Advantage

To understand Medicare Advantage approaches to addressing cancer coverage and care, ATI conducted interviews with six organizations that included two Medicare Advantage plans, an integrated delivery system that includes a Medicare Advantage product, a provider organization, a cancer-focused health care company specializing in care coordination, and an advocacy organization.

Interviewees reported core cancer-related interventions that include screening for early identification of cancers and, for those with cancer, enhanced care management and care navigation services, as well as access to advanced care planning and palliative care. Interviewees also described value-based care models that align provider payment with innovative care delivery models for cancer patients.

Screening & Proactive Identification

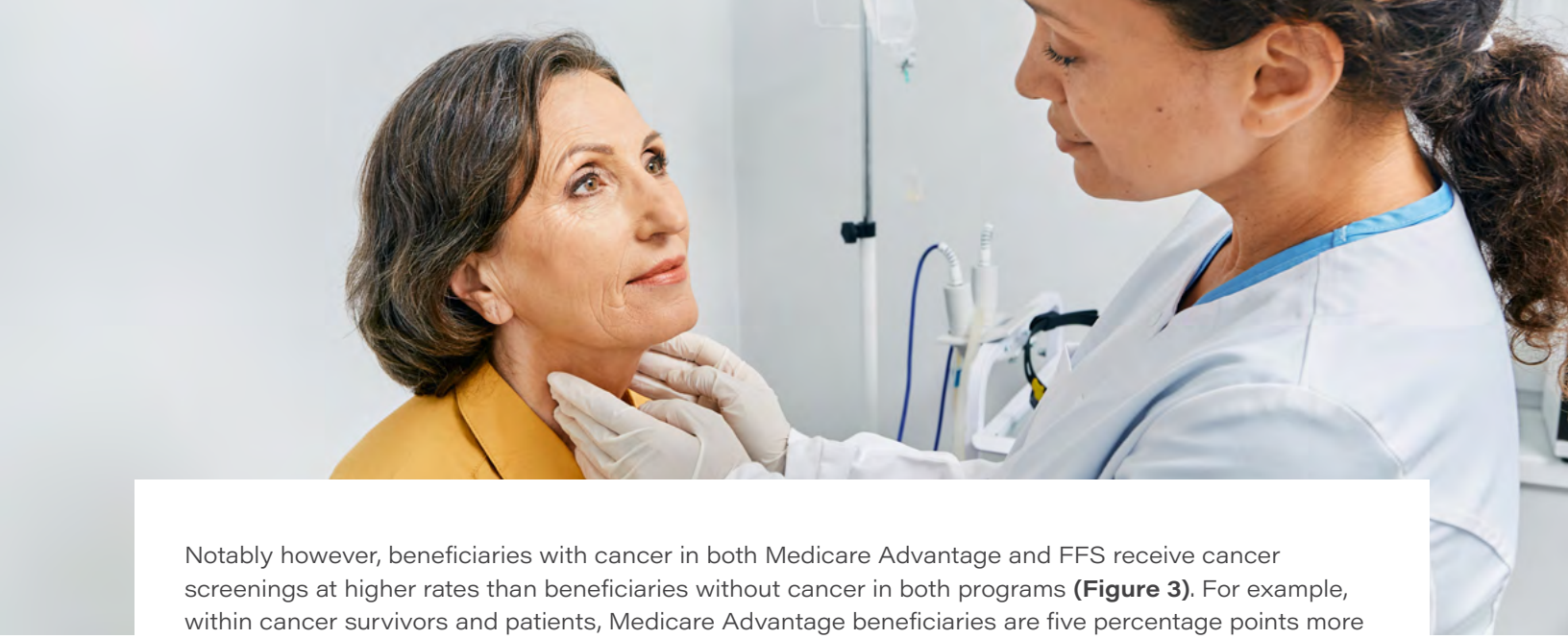
As risk-bearing entities, Medicare Advantage plans rely on care management programs, leverage data to predict need, and screen individuals through more frequent touchpoints than typically occur in FFS Medicare, such as through the Health Risk Assessment (HRA) process. Screening for conditions like cancer allows Medicare Advantage plans and providers to identify cancers or potential cancers sooner, ideally improving outcomes and reducing cost of care in the long term.

Health Plan Case Studies: Assessing for Current or Former Cancer Status and Implications for Risk Stratification

A **large, national health plan** includes questions about current and former cancer status in their HRA. Both current cancer and remission status escalates an enrollee to a higher-risk stratification category with elevated care management. Additionally, the plan's HRA includes questions about past family medical history; family history of cancer or other cancer risk factors may inform the enrollee's appropriate cancer screening cadence.

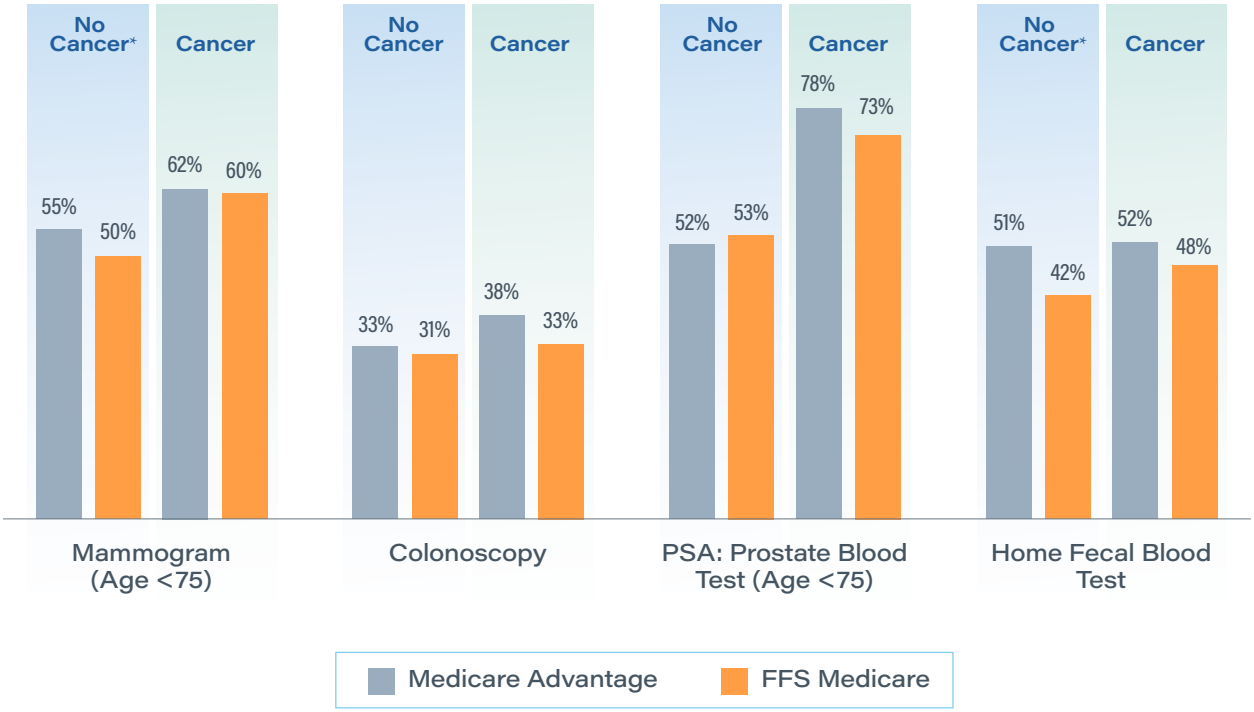
A different **large, national health plan** includes questions about current cancer status on their in-person and standard HRAs. While remission status is not explicitly discussed in their HRA, the health plan may have claims information on previous cancer diagnoses. Current cancer diagnosis is incorporated into the health plan's inpatient predictive model, which estimates the enrollee risk for an inpatient event within the next six months. If an enrollee qualifies as high-risk within the inpatient predictive model, the plan will deploy targeted care management to address unmet needs and prevent the admission.

Compared to FFS Medicare, beneficiaries in Medicare Advantage are as likely or more likely to have received key cancer screenings within the past year **(Figure 3)**. Among Medicare beneficiaries who have never received a cancer diagnosis, those in Medicare Advantage are significantly more likely to receive a mammogram and home fecal blood test in the past year compared to FFS Medicare beneficiaries.



Notably however, beneficiaries with cancer in both Medicare Advantage and FFS receive cancer screenings at higher rates than beneficiaries without cancer in both programs **(Figure 3)**. For example, within cancer survivors and patients, Medicare Advantage beneficiaries are five percentage points more likely to receive a Prostate Specific Antigen (PSA) blood test to help detect prostate cancer. Regardless of Medicare program affiliation, beneficiaries with cancer are likely to have more established touchpoints with the health care system and understand the importance of cancer screenings, and therefore are more likely to have been screened in the past year.

Figure 3. Cancer Screening Utilization in Past Year by Cancer Status and Program[4]



[4] Analyses of mammogram use are limited to individuals identifying as female who are younger than 75. The U.S. Preventive Services Task Force (USPSTF) concluded that there is not adequate evidence to recommend mammograms for those older than age 75. Analyses of PSA blood test use are limited to individuals identifying as males who are younger than 75. The USPSTF recommends against PSA screening for individuals over the age of 70.

> *"On a macro-level, people have a tendency to think of a screen as a simple test. But, for lung cancer for example, you can have a negative, positive, in between, or something else result."*
>
> ***- Study Interviewee***

Interviewees emphasized the importance of engaging providers, patients, and enrollees in proactive identification of cancers through recommended screenings. At each stage in the process – identifying the need for a screening, receiving the screening itself, communicating the results, and interpreting the results to determine next steps – both provider and enrollee must remain engaged to ensure the intended outcome is achieved. Provider organizations and health plans have developed and implemented strategies for communicating with beneficiaries about the importance of screening. For example, one health plan interviewee spoke of sending enrollees at-home colorectal cancer screening kits during the height of the COVID-19 pandemic to mitigate lower than usual screening rates due to the public health emergency.

Care Management & Care Navigation

Through screening and risk stratification processes, Medicare Advantage beneficiaries with cancer are likely to qualify for more intensive care management programs. Care management services differ by Medicare Advantage plan, but typically involve an interdisciplinary care team with an established care manager lead who coordinates an enrollee's clinical, behavioral, pharmacological, and social needs. Care managers can help connect enrollees to alternative medicine benefits, like physical and occupational therapy and acupuncture. One interviewee also mentioned the importance of care managers evaluating an enrollee's informal caregiving supports and the caregiver's needs.

Medicare Advantage Plan & Provider Case Studies: Emphasis on Addressing Social Needs

Both health plans and providers recognize the importance of addressing social needs in overcoming barriers to improve outcomes for chronic conditions like cancer. Medicare Advantage plans typically offer services that include social supports beyond those offered through FFS Medicare in two ways: a plan's filed supplemental benefits or the plan's care model. Interviewees highlighted the following examples:

- A **large, national health plan** spoke about the importance of health literacy when trying to address the clinical and psychosocial aspects of cancer, indicating that most beneficiaries present at a third to eighth grade reading level.
- An **integrated delivery system** that includes a Medicare Advantage product highlighted the importance of social daycares for mitigating social isolation among patients and enrollees.
- A **provider organization** that services Medicare Advantage enrollees offers a variety of social services that vary depending on facility but include social support, transportation, meals, art therapy, wigs, and cosmetic support.
- A **cancer-focused health care company** that works with Medicare Advantage plans started offering nutrition services as part of their suite of clinical services and has since expanded the offering to address outstanding social determinants of health needs.

> *"When a patient goes in with esophageal cancer, what types of foods can they truly stomach without suffering significant weight loss or not being able to tolerate the next therapy?"*
>
> ***- Study Interviewee***

Care coordination and navigation is especially critical for cancer patients, many of whom must navigate a new array of providers who may not have direct lines of communication to each other. Medicare Advantage beneficiaries utilizing community-based providers, rather than receiving their cancer care at an academic medical center, may particularly benefit from the care coordination and navigation assistance available from health plans and providers. Navigators help beneficiaries traverse and understand the complex systems of care they are exposed to, including the coverage for their treatment and available financial assistance.

> *"One of the fundamental beliefs that we have is creating that centralized point of contact using our patient-care coordination team… [which helps] navigate patients through appointments, provide them access to services, and navigate through all the different aspects of their cancer care."*
>
> ***- Study Interviewee***

Palliative Care

Given the chronic nature of cancer and the discomfort associated with many of its treatments, palliative care, or care focused on providing relief from the symptoms and stress of an illness, is especially important during cancer treatment.[6] Palliative care refers to care designed to ease symptoms of serious illnesses, like cancer, and improve beneficiaries' daily quality of life. Palliative care can accompany treatments to cure a serious illness.[7] Two interviewees, a Medicare Advantage plan and a cancer-focused health care company, spoke of the importance of palliative care for their patients:

- The **Medicare Advantage plan** offers a palliative care model. The organization utilizes predictive analytics to identify patients with serious illness that may be appropriate for palliative care. Patients who participate in the palliative care model receive care both telephonically, via a social worker, and in the home, via a nurse practitioner. The organization relies more heavily on the telephonic model for patients in rural areas. The palliative model team is overseen by a palliative care physician. Because the provider organization is owned by a health plan, the two entities have better data connectivity and communication than non-integrated health plans and providers. The two entities have bidirectional data feeds that include medical and pharmacy claims, chemotherapy orders, and biomarker information, among other data.
- The **cancer-focused health care company** spoke of the importance of coordination with Medicare Advantage plans, which often have their own supportive care teams or in-network palliative care physicians. The organization has partnered with their health plan clients on the importance of patient education and communication regarding palliative care. Historically, health plans have required assistance beyond simply identifying patients for palliative care through algorithms and notifying them of their eligibility for palliative care services. This is often not an effective way to communicate with

Advanced Care Planning Case Study: Innovative Solution

Advanced care planning (ACP) involves a discussion between a patient and their provider about the patient's health care wishes if they become unable to make decisions about their health care. ACP discussions may involve talking about advance directives, like living wills or health care power of attorney.

One interviewee, a **provider organization** that services Medicare Advantage enrollees, reported that they use an app-based solution to allow providers to document ACP discussions within the electronic health record (EHR). This interoperability for ease of documentation has been an effective tool in increasing rates of completion of ACP. However, the interviewee said that the app was not available to all providers in the system due to varying EHRs and compatibility issues. The provider organization does not have enough financial resources available to expand the solution beyond its current pilot markets.

patients about why they might choose to receive palliative care. Now, the organization engages patients in conversations about palliative care on the front end, emphasizing that palliative care can be received in conjunction with current treatment, which has resulted in improved uptake of palliative care services.

Innovative Care Models for Cancer Care within Medicare Advantage

Several interviewees are engaged in innovative and/or value-based care models for cancer care, like utilization of capitated payments or leveraging incentive or bonus payments to encourage providers to make appropriate cancer screening and treatment decisions. Interviewees also spoke of their experience with oncology medical homes, or medical homes where an oncologist is the central coordinator of a patient's care.[8] This includes iterating on the completed Oncology Care Model (OCM), and CMS recently accepted applications for the Enhancing Oncology Model (EOM). The EOM targets Medicare providers as Model participants, but involves a multi-payer structure, where Medicare Advantage plans can apply and reimburse participating providers at the same amount as FFS Medicare for delivery of EOM services.[9] Multi-payer models that are inclusive of both FFS Medicare and Medicare Advantage, like OCM and EOM, are valuable innovation opportunities for CMS to improve cancer care for all Medicare beneficiaries. Despite this, interviewees agreed that CMS' longstanding support of value-based cancer care demonstrations was an important lever for moving the cancer field in general towards value-based care. Additionally, the EOM model requires participants to develop a health equity plan and screen patients for health-related social needs, which sets important precedents for the cancer field.[8]

Case Study: Capitated Model Design of a Cancer-Focused Health Care Company

A **cancer-focused health care company** leverages a capitated model with some health plans, including Medicare Advantage plans. Like Medicare Advantage plans themselves that are incentivized to provide high-value care under capitated payments, the company receives a capitated payment from the plans to provide comprehensive high-value cancer care management. As such, the company takes on financial risk for the services they provide, seeking to ensure that savings generated through high-quality, coordinated care outweigh costs. The company recognizes, however, that not all provider organizations are ready to take on the same level of financial risk. Therefore, the company is prepared to work with providers at different points along the value-based spectrum, with the goal of supporting clients towards the eventual shift to value-based care.

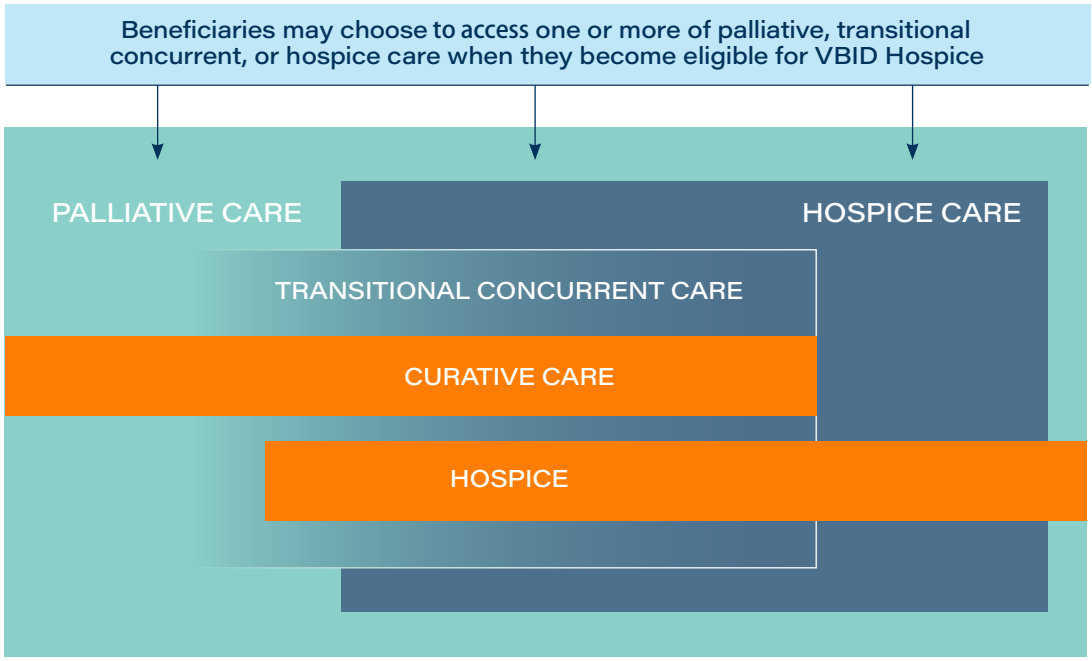
The company uses data to support providers with an online dashboard of key metrics profiling their patient populations with cancer. The company's goal is to align providers along a value-based care model and to price their solution such that it reduces the actuarial risk for the health plan. In this way, they ensure that providers save money compared to a FFS model, while also ensuring that providers are not financially disincentivized to provide care.

> *"In a lot of these markets where [provider] groups aren't willing to work with a capitated entity or provider at this point, we work with them on still helping manage their cost structure and improve their quality of care with the idea that down the road eventually, we fundamentally believe that capitation or a high value-based care environment will prevail in the U.S. That seems to be the way things are moving. That has become a methodology of allowing us to help providers get oriented to the new market, without inserting ourselves and saying, 'You have to do this now,' because we know how sensitive it can be going into a new market and talking to new providers."*
>
> ***- Study Interviewee***

Medicare Advantage Value-Based Insurance Design (VBID) Model – Hospice Component

Traditionally, hospice benefits have been carved out of Medicare Advantage. But, in 2021, CMS piloted the Hospice VBID model, which allows participating Medicare Advantage plans to take on financial responsibility for hospice services providing access to and coordinating both palliative and hospice care.[10] In traditional FFS Medicare, beneficiaries must elect to end curative treatment for their terminal diagnosis (they may continue to receive treatment for other diagnoses). The Hospice VBID model enables Medicare Advantage plans to allow transitional concurrent care, where beneficiaries receive both curative care and hospice services at the same time for a set period, such as 60 days (Figure 4). Health plans may also offer hospice supplemental benefits, for example, eliminating cost sharing for hospice medications and inpatient respite care.[11] The goal of the Hospice VBID model is to improve beneficiary health and reduce costly complications stemming from poorly managed chronic conditions, socioeconomic barriers, and poor care coordination.

Figure 4. Spectrum of Services Available Within VBID Hospice Component[12]



FFS Medicare has innovated in this space as well; the Medicare Care Choices Model, which ended in 2021, similarly allowed for patients to receive curative treatment for their terminal illness concurrently with hospice services. Medicare Advantage remains a strong platform for innovation and improvement in this space.

Looking Ahead

As of 2019, over one in three Medicare cancer patients and survivors were enrolled in Medicare Advantage, which serves an estimated 7.4 million beneficiaries with a history of cancer.[4] The Centers for Disease Control and Prevention estimates that between 2015 and 2050, the total number of cancer cases in the U.S. will increase by almost 50 percent due to growth and aging of the population.[13] Furthermore, the largest increase in cancer prevalence is anticipated among the Medicare population – those who are aged 75 years or older. As the proportion of Americans experiencing and surviving cancer continues to grow, it is important that Medicare continue to adapt its available benefits and supports for cancer patients and survivors. The Medicare Advantage program, with its incentives and flexibilities to deliver innovative, high-value care, is well-positioned to meet this challenge.

This report demonstrates that Medicare Advantage provides cancer patients and survivors with preventative and screening care at similar or higher rates than FFS Medicare. This analysis also reflects insights learned from Medicare Advantage plans, an integrated delivery system with a Medicare Advantage plan, provider organizations, and a cancer-focused health care company regarding the coverage and care that they provide to cancer patients and survivors under Medicare Advantage. Innovative solutions for this population include holistic palliative care models, supplemental benefits to address social needs, and stratification models that take cancer status into account for determining appropriate care management resources. New care models and processes such as these in Medicare Advantage will be crucial to achieving the White House Cancer Moonshot. Policymakers should continue to learn from and iterate on these innovative models, as part of the broader effort to improve care and coverage experiences for all Medicare beneficiaries.

Methods

To understand how Medicare Advantage plans meet the needs of enrolled cancer patients and survivors, ATI Advisory conducted interviews with two Medicare Advantage Plans, an integrated delivery system that includes a Medicare Advantage product, a provider organization, a cancer-focused health company, and an advocacy organization.

These qualitative interviews are complemented with analytics from the 2019 Medicare Current Beneficiary Survey (MCBS). Using the MCBS, ATI Advisory examined health care costs for individuals and cancer screening rates. The cancer patients and survivors cohort includes beneficiaries who reported any cancer diagnosis in their lifetime, excluding skin cancer. Because the prevalence of skin cancer is high and the five-year survival prognosis for skin cancer is 93 percent, the experiences of beneficiaries with skin cancer may differ from those who received other cancer diagnoses.

Statistical significance was measured at a p-value of 0.05 using the Balanced Repeated Replication method. All data differences between Medicare Advantage and FFS Medicare discussed in prose are statistically significant.

Full MCBS methods are available at:
https://atiadvisory.com/wp-content/uploads/2022/04/2019-MCBS-Analysis-Research-Methods-April-2022.pdf

Acknowledgments

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