HealthScape Advisors

EXECUTIVE BRIEFING

Is Change Good for the Medicare Advantage Market?

With Medicare Advantage (MA) and Part D plans entering the final stretch for 2019 bid submission, each has undoubtedly spent a significant amount of time thinking about change. In April, CMS released the final policy and payment updates for these programs through its 2019 Rate Announcement and Call Letter. Enhancing benefit flexibility, with the goal of improving health outcomes and empowering beneficiaries, was a central theme of the finalized policy updates. How will these updates impact participating plan bids and future operations?

Weeks before, Congress passed a Bipartisan Budget Act (BBA 2018) which also incorporated elements of the CHRONIC Care Act aimed at beginning to transform the way that chronically ill members receive care. These provisions will also impact MA plans in future years.

HealthScape highlights some of the changes poised to have the most significant impact on MAOs below.

Introduction

Post CMS release of the 2019 rule-making, the primary changes grabbing most of the headlines are a higher than expected increase to average payments from 1.84 percent in the proposed rule to 3.4 percent in the final rule, as well as confirmation of the increased use of encounter data to 25 percent for 2019, decreasing RAPS to 75 percent. These changes will have a significant impact on Medicare Advantage Organization (MAO) financials and operating decisions; however, HealthScape believes that several policy-focused regulatory and legislative changes should receive equal consideration given their potential impact in 2019 and beyond:

Expansion of Health-Related Supplemental Benefits

CMS revised its interpretation of statutes regarding health-related supplemental benefits to allow for coverage if such benefits 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 healthcare utilization." Historically, items or services were not eligible for coverage if their primary purpose included daily maintenance. This change is intended to increase beneficiary access to services that may improve quality of life and overall health outcomes, covering items like shower safety bars or portable wheelchair ramps and in-home support services such as meal preparation.

Uniformity Flexibility

CMS will allow MAOs increased flexibility in the supplemental benefits offered to beneficiaries with similar, specific medical criteria as long as these similarly situated individuals are treated uniformly. Plans will be able to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer different deductibles based on health status or disease state. This flexibility is meant to provide plans with the opportunity to better manage healthcare services.

Impact

The increased flexibility afforded to MAOs by these provisions creates opportunity for organizations that respond strategically. Plans can establish coverage and engagement models that better support, identify, and manage chronically ill members, with expanded benefits and more categories of coverage than before, while doing so in a targeted, cost effective fashion. Benefits could be tailored to enhance coverage for support services critical for members with particular conditions (such as in-home supports for members living with multiple sclerosis), or even tailored based on geography (such as enhanced transportation or telemedicine benefits for rural members) to ensure access to care.

Through our data analytics and subsequent work with clients, we have seen the expense associated with failing to effectively manage chronic populations, as well as witnessed models of care beginning to successfully engage members and bend the cost curve. In our experience, 25-30% of MA members have multiple HCCs. As many as 10-15% of members have four or more chronic conditions, with medical loss ratios (MLR) that easily exceed 120% in cases where care is not well managed. More concerning is the membership population with six or more chronic conditions (approximately 5% of members), which can have MLRs in excess of 190%. Although they represent a small portion of overall membership, the multiple HCC population is a driver of significant financial pressure for MAOs, creating the need to establish better means of managing the population.

HealthScape has been privileged to work with organizations beginning to make strides in this area; MAOs are establishing programs to help ensure effective, efficient care upfront, such as centers of excellence for the treatment of particular conditions, as well as programs aimed at ensuring targeted post-care follow-up, such as in-home practitioner visits or support services to help maximize compliance and minimize readmissions. The expansion of health-related supplemental benefits and uniformity flexibility provisions adopted by CMS represent another opportunity for MAOs to think about how to structure programs to best serve their polychronic population.

We expect MAOs to demonstrate caution in adoption of this new flexibility, especially in 2019, with CMS providing fairly limited guidance on how plans can implement. However, we do recommend that plans examine how this change could be beneficial for subpopulations of beneficiaries within their overall MA book business.

Enhanced Patient Engagement Through Data Access

Although not a requirement for 2019, CMS is signaling a focus on ensuring beneficiary access to their health information in future years. The agency is encouraging organizations to provide data release platforms that enable members to access claims data and transfer such data to other trusted applications, service providers, or research programs, citing CMS Blue Button 2.0 as a minimum standard.

Impact

Organizations should begin to evaluate their ability to securely provide MA members with access to their health data, identify any significant capability gaps preventing roll-out of such member tools, and plan a path forward to ensure access. In addition to compliance with future CMS regulations, members want greater ownership and control of their own health information. A truly user-friendly approach to providing this access could become a short-term differentiator (before becoming table-stakes in the longer-term).

EGWP Payment

CMS finalized a 100% phase-in to using only individual market plan bids to calculate the benchmark ratios used to set EGWP payments, with adjustments based on the proportion of beneficiaries enrolled in PPOs vs HMOs between individual market plans and EGWPs. CMS is expected to request comments on modifications for 2020, including additional adjustments for regional and rural/local PPOs.

Impact

Although this methodology update is expected to have a slightly negative impact on EGWP payment, we believe that the group MA market continues to represent a future growth opportunity. Even though retiree coverage is decreasing nationally, employers are actively seeking new retiree solutions to help control costs, and MA plans can offer greater value to employers through managing care savings not available in group Medicare supplemental plans. As a result, employer group retirees enrolling in MA grew over 15% from 2016 to 2017. This methodology update is unlikely to change demand for improved management of care over time in a market that is less price sensitive than individual MA; as such, HealthScape continues to encourage organizations to reevaluate the opportunity that could be associated with placing a greater focus on the EGWP market. Plans can sharpen their pencils as they consider future bids and proposals and still achieve organizational guiding principles for participation.

Permanent Authorization of Special Needs Plans (SNPs)

The BBA permanently authorized SNPs and introduces regulatory changes to strengthen the program in the long-term. Beginning in 2020, chronic condition SNPs (C-SNPs) will be required to meet more stringent care management provisions; by January 1, 2022 (and every five years afterwards), CMS must also update the list of conditions eligible for participation in a C-SNP and must include HIV/AIDS, end-stage renal disease, and chronic and disabling mental illness to ensure the inclusion of beneficiaries that would benefit most from the program. Dual-eligible SNPs (D-SNPs) will also be subject to additional Medicare – Medicaid integration requirements. By 2021, D-SNPs will be required integrate Medicare and Medicaid long-term services and supports and/or behavioral health services as well as adopt unified grievances and appeals processes.

Impact

Permanent authorization provides certainty regarding the future of these specialized MA plans, leading organizations to be increasingly willing to make the investments necessary to successfully operate a SNP and qualify for enhanced reimbursement. HealthScape encourages organizations to review their existing, traditional MA membership base and associated cost/utilization, potential new enrollees, as well as their internal capabilities over time, to understand if participation makes sense. A similar membership segmenting exercise will benefit existing SNPs in evaluating their current performance and identifying new opportunities to better manage care within other chronic care populations in future years.

Expansion of Telehealth Coverage

Beginning in plan years 2020 and beyond, MAOs will be authorized to offer telehealth benefits for services available under Part B and identified as clinically appropriate to be furnished by a physician that is not in the same location as the enrollee. HHS must solicit public comment by November 30, 2018 regarding the types of telehealth services and benefits (including supplemental benefits such as remote health monitoring or secure messaging) that should be covered.

Impact

Organizations should evaluate their existing telehealth capabilities now, establishing the necessary relationships and contracts, and start to strategize regarding their offerings, especially in rural or underserved areas.

HEALTHSCAPE CAN HELP.

We are experts in the Senior Market, having completed 130+ Medicare-related engagements and 85+ MA-specific engagements since our inception.

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