BIPARTISAN POLICY CENTER

Improving Care
for
High-Need, High Cost Medicare Patients

Roundtable on Quality Care for People with Serious Illness

National Academy of Medicine
April 27, 2017

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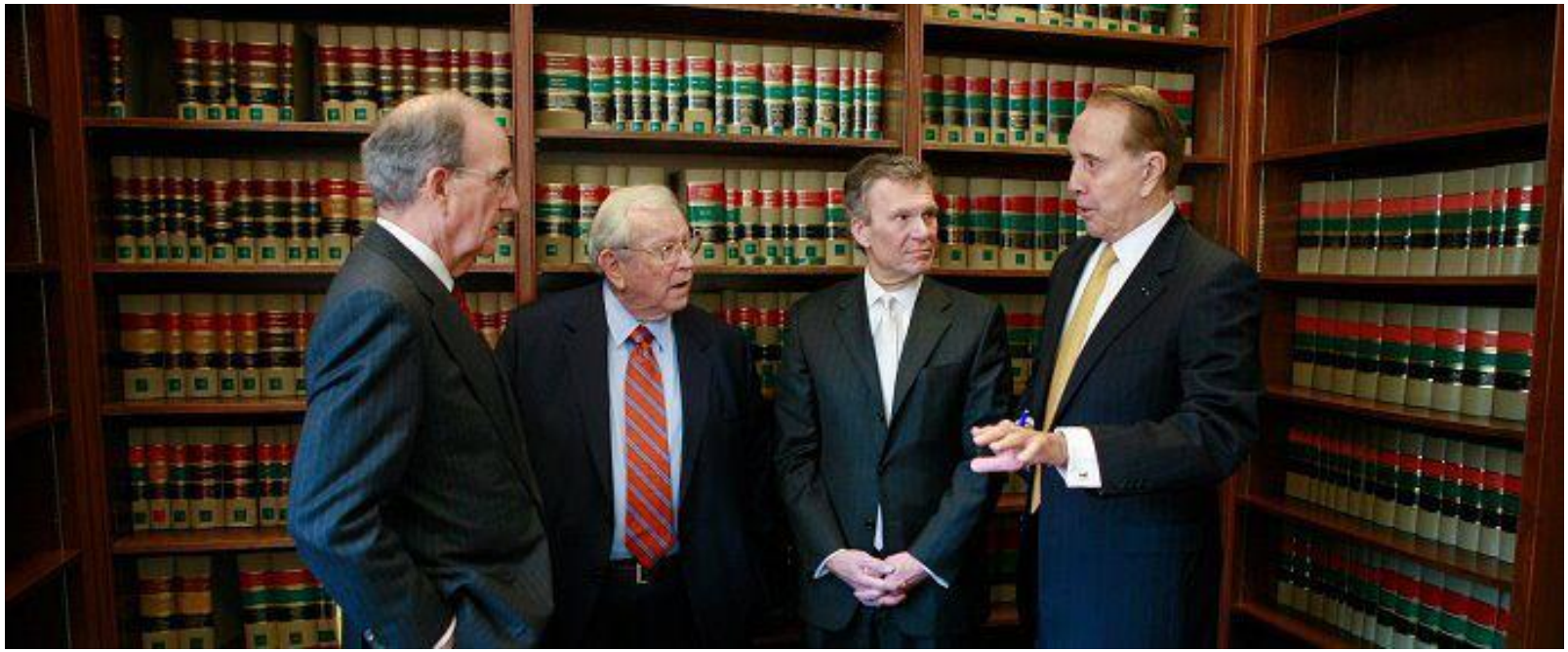
SVP Bipartisan Policy Center

bipartisanpolicy.org

Founded in 2007 by former Senate Majority Leaders

George Mitchell, Howard Baker, Tom Daschle, and Bob Dole



A non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation and respectful dialogue. With projects in multiple issue areas, BPC combines politically-balanced policymaking with strong, proactive advocacy and outreach.

BPC Health Project Leaders – Long-Term Care Initiative

Former U.S. Senate Majority Leader, Senator Tom Daschle (D-SD)*

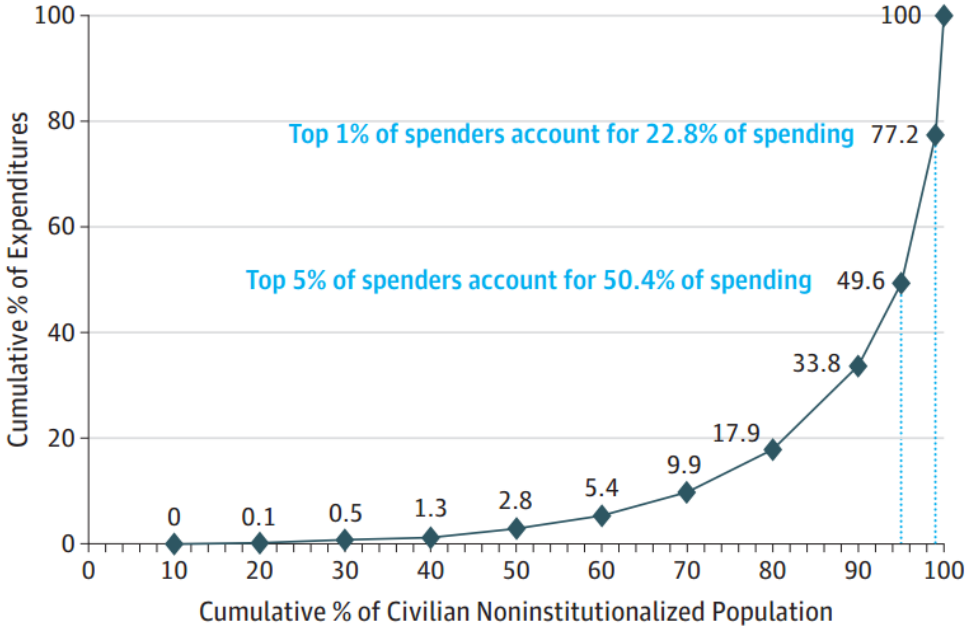
Former U.S. Senate Majority Leader, Senator Bill Frist (R-TN)*

Former Governor and HHS Secretary Tommy Thompson

Former CBO/OMB Director Alice Rivlin; Senior Fellow, Center for Health Care Policy, Brookings Institution

*** Steering Committee, NAM's Vital Directions for Health and Health Care Initiative**

Distribution of Personal Health Care Spending in US Civilian Noninstitutionalized Population, 2014



In 2014, the top 1% of health care spenders accounted for 22.8% of total health care spending and the top 5% of health care spenders accounted for 50.4% of total health care spending. Data are from the Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.[28]

Mandatory Expenditures

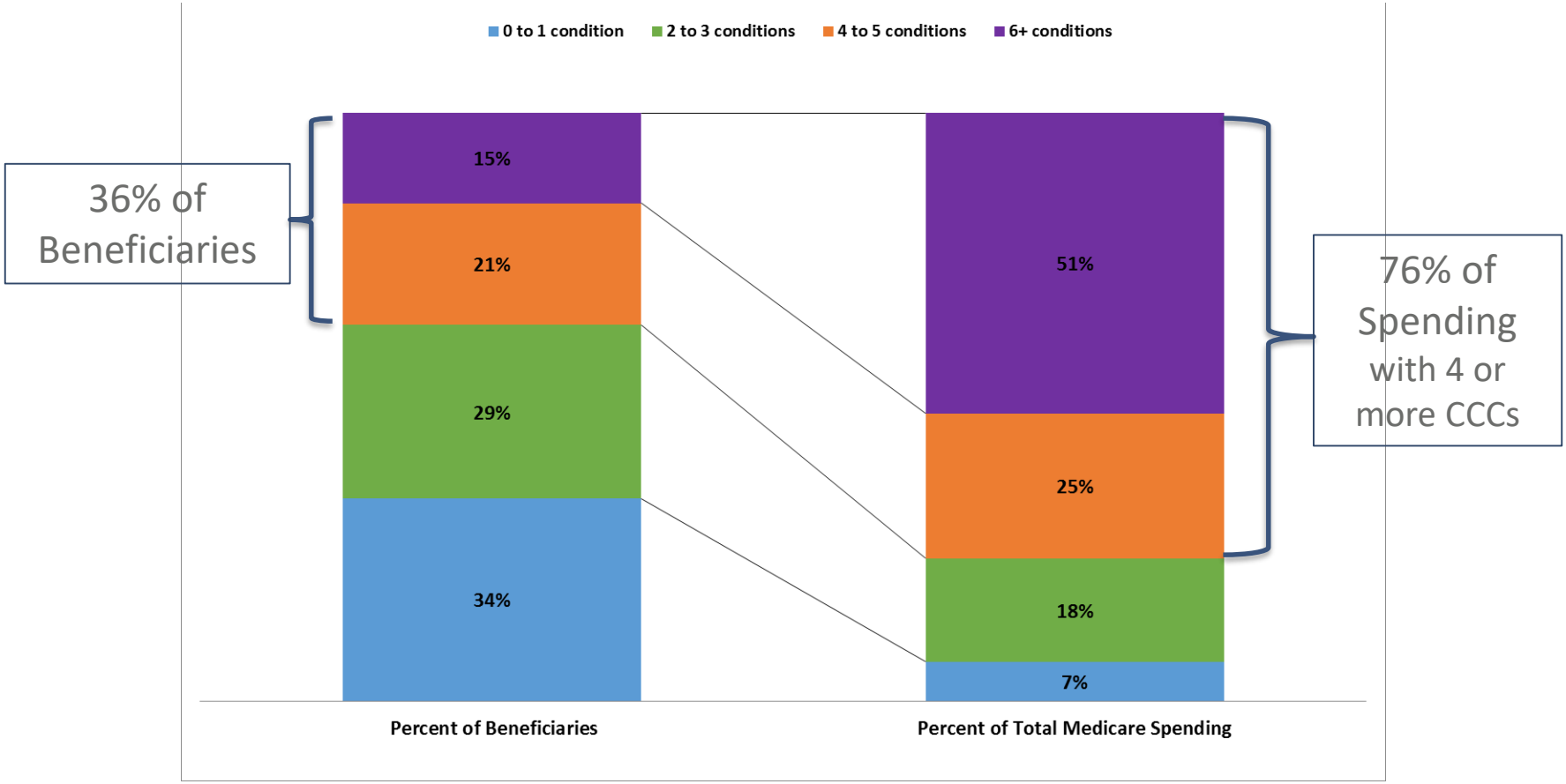
(Outlays by FY, Billions of Dollars)

	2015	2017	2027	Avg. Annual Growth 2017-2027
Medicare	634	705	1,402	7.2%
Medicare Offsetting Receipts	-94	-113	-237	7.7%
Medicaid	350	389	650	5.3%
Health Insurance Subsidies	38	51	106	7.8%
Children's Health Insurance Program	9	15	6	-8.7%
Total Major Health Care	937	1,047	1,927	6.3%
Total Federal Mandatory Spending	2,299	2,484	4,305	5.6%
Health Care as % Total Mandatory	41%	42%	45%	---

GDP projected to increase 3.9% annually over the decade.

Source: Congressional Budget Office. The Budget and Economic Outlook: 2017 to 2027; January 2017.

Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2015

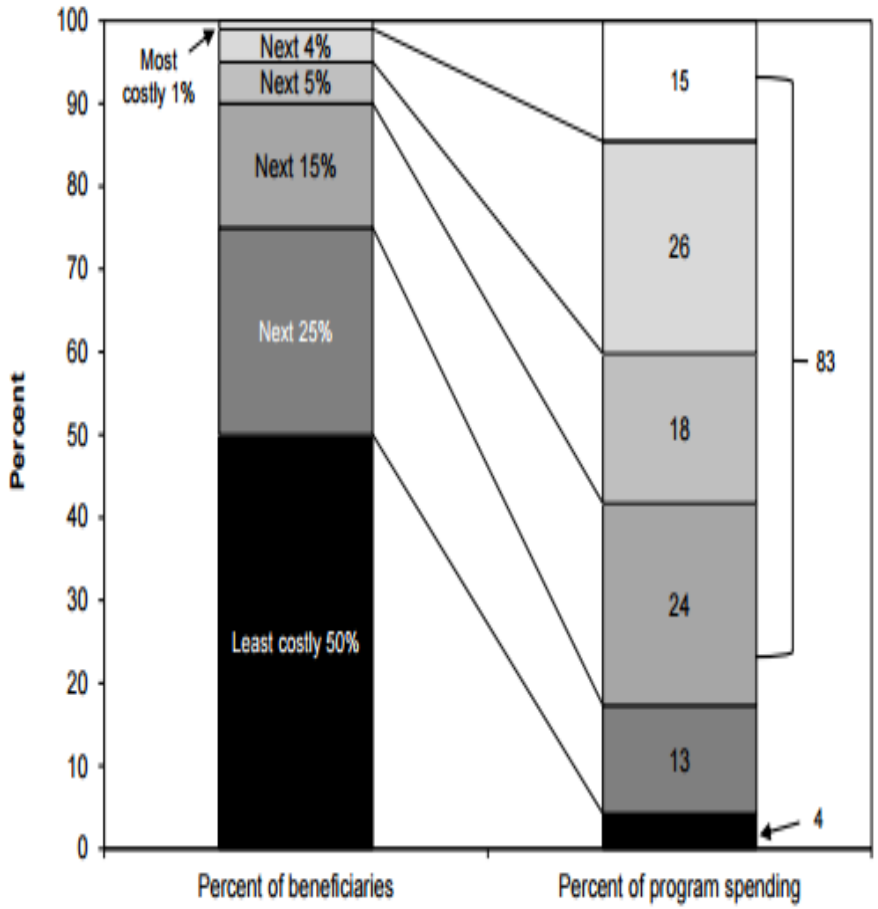


Source: CMS 2015

High-Need, High Cost Medicare Patients

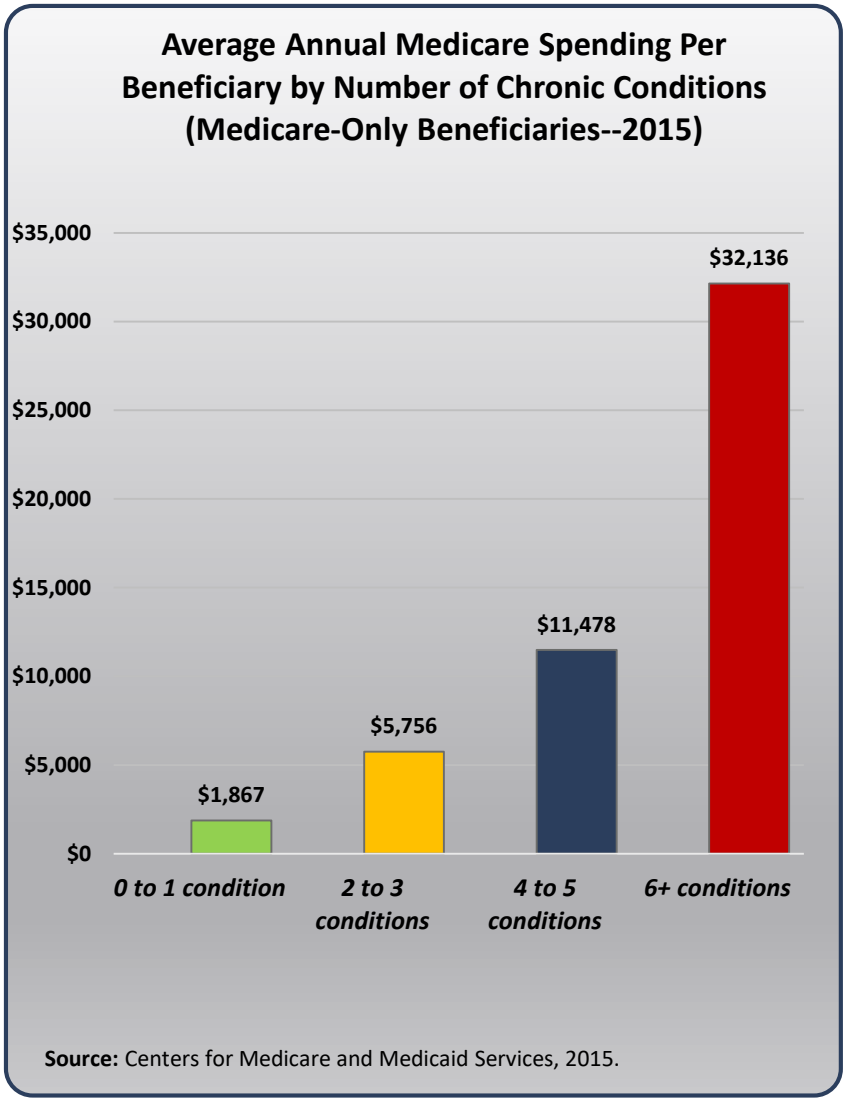
- Medicare spending is highly concentrated amongst a small slice of the overall beneficiary population.
- The costliest 10 percent of beneficiaries accounted for 59 percent of Medicare FFS costs.
- Least costly 50 percent of the beneficiaries accounted for only 4 percent of Medicare FFS program spending.
- The strongest predictors of beneficiary costs are **chronic conditions** and **functional/cognitive impairment**.

Concentration of Medicare Spending Among Costliest Beneficiaries, 2012

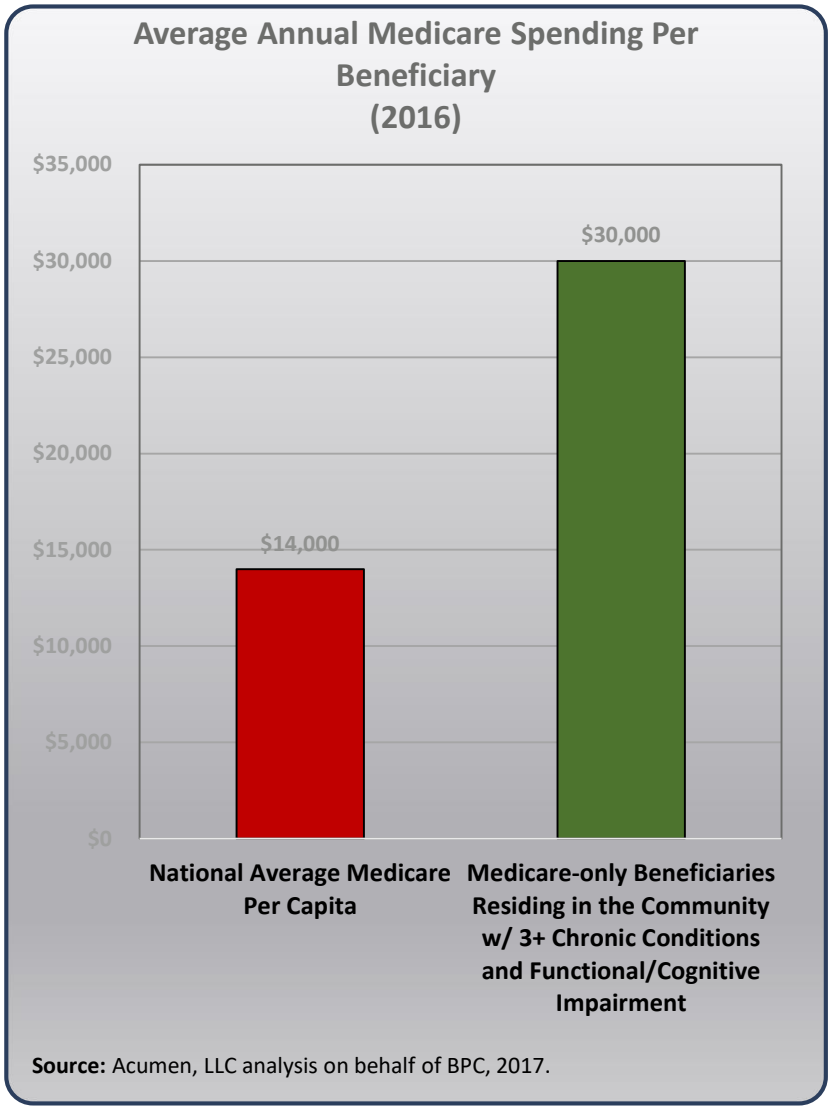


Source: Medicare Payment Advisory Commission, 2016.

Chronic Conditions & Functional or Cognitive Impairment Impact on Spending



Source: Centers for Medicare and Medicaid Services, 2015.



Source: Acumen, LLC analysis on behalf of BPC, 2017.

BPC Work on High-Need Populations

- **BPC has focused on two distinct high-need, high-cost populations in 2016/17**:
  - Medicare/Medicaid "Dual-Eligible" Individuals
  - "Medicare-only" Beneficiaries Who Have 3+ Chronic Conditions *and* Functional/Cognitive Impairment
- **Both populations share common features and outcomes:**
  - High prevalence of hospitalizations, hospital readmissions, and emergency dept. visits
  - Significant behavioral health needs
  - Substantial assistance required in performing Activities of Daily Living (e.g. transferring in/out of bed, bathing, dressing)
- **Policy challenges for dual-eligible care models**: the non-medical supports are covered, as Medicaid benefits, but *integration* of Medicaid and Medicare benefits not seamless.
- **Policy challenges for Medicare-only models**: *lack of flexibility* and *financial incentives* to provide non-Medicare-covered social supports—even where supports has been shown to reduce high-cost hospital episodes.

BPC REPORTS – FINANCING & DELIVERY OF LTSS

Enrollment of Dual-Eligible Beneficiaries in Certain Plan Types

Total Dual-Eligible Beneficiaries (June 2015)	10.3 Million
Total D-SNP Enrollment (June 2015)	1,693,593
Total MMP Enrollment (June 2015)	354,904
Total PACE Enrollment (September 2015)	33,003
Combined D-SNP/MMP/PACE Enrollment	20.2% of Dual–Eligible Population

Source: Centers for Medicare and Medicaid Services.

Dually Eligible: Delivery Reform Recommendations

September 2016

- **Special-Needs Plans (SNPs)**
  - Permanent Authorization of Medicare Advantage D-SNPs.
  - Plans fully integrated (FIDE-SNP) by Jan. 1, 2020. (Single managed care organization.)
- **Financial Alignment Initiative**
  - Demonstrations should be deficit neutral over 5 years, rather than annual savings.
  - Permit new states to enter into demonstrations as they are ready.
  - Full financial integration – Permit Medicare and Medicaid dollars to be combined.
  - Greater shared savings to incentivize states to integrate care.
- **Combine Regulatory Authority in the Medicare Medicaid Coordination Office**
- **New Regulatory Structure based on Demonstrations**
  - Model 3-way contract.
  - Plans must be seamless to beneficiaries and providers (single enrollment process, claims forms, benefit cards, case managers, plan point-of-contact).
  - Align Medicare and Medicaid grievance and appeals processes and overlapping benefits.
  - Benefit flexibility based on reasonable necessary standard for patients with multiple chronic conditions and functional limitation or cognitive impairment, provided part of a care plan and not used for enrollment.

Issues for High-Need, High-Cost "Medicare-Only" Population

- In February 2017, BPC issued a preliminary report outlining regulatory and payment policy barriers to integration of social supports into care models serving chronically ill Medicare-only beneficiaries.
- Care models addressed in report included Medicare Advantage (MA), Accountable Care Organizations (ACOs), and patient-centered medical homes.
- Barriers identified in preliminary report include:
  - **"Uniform Benefit" Requirements—**Prohibit MA plans from targeting Supplemental Benefits to high-risk enrollees.
  - **Health-Related Benefit Requirements**—MA rules mandate that Supplemental Benefits must be "primarily health-related."
  - **Program Integrity Issues**—Current program integrity waiver rules lack clarity for ACOs and medical homes seeking to offer social supports for free.
  - **MLR Rules**—Prohibit MA plans from counting certain free/no-charge social supports toward medical loss ratio.
  - **Lack of Financing**—Some non-Medicare-covered supports are too costly to finance within existing MA rebates and/or ACO shared savings payments, particularly when Medicare's risk adjustment model under-predicts the actual Medicare costs of chronically ill enrollees.

BPC Recommendations for High-Need, High-Cost "Medicare-Only" Population

- **BPC's final recommendations:**
  - Reforming MA "uniform benefit" requirement to allow targeting of supplemental benefits toward frail and chronically ill enrollees, as part of person-centered care plan.
  - Allowing MA plans to offer supplemental benefits that are not "primarily health-related," so long as they are part of person-centered care plan for a chronically ill beneficiary.
  - Allowing MA plans to count costs of non-covered (non-supplemental benefit) supports towards MLR, when supports are provided to beneficiary at no charge.
  - Reforming Medicare's risk adjustment model to account for a beneficiary's frailty.
  - Developing new quality measures that will financially incentivize MA plans and ACOs to provide non-Medicare-covered social supports.
  - Clarifying program integrity rules to allow for ACOs and medical homes to provide non-Medicare-covered supports to high-risk beneficiaries for free.
- All recommendations designed to provide flexibility to allow MA plans and Medicare providers to furnish or finance non-Medicare-covered supports that are part of person-centered care plan for a Medicare-only beneficiary with 3+ chronic conditions and functional or cognitive impairment.

Common Features Between BPC Recommendations and "Chronic Care Act of 2017"

	CHRONIC Care Act	BPC April 2017 Recommendations	BPC September 2016 Recommendations
Allowing MA Plans to Target Supplemental Benefits to Chronically Ill Enrollees	✓	✓	
Waiving the Restriction that Limits MA Supplemental Benefits to "Primarily Health-Related" Services	✓	✓	
Clarifying that Certain ACOs and Medical Homes Can Provide Non-Medicare-Covered Social Support Services for Free		✓	
Improving the Accuracy of the Risk Adjustment Model for MA Plans and ACOs		✓	
Establishing New Quality Measures to Assess the Integration of Medical Services with Non-Medical Social Supports		✓	
Making the CMS Medicare-Medicaid Coordination Office the Focal Point for Dual-Eligible Issues	✓		✓
Permanently Authorizing D-SNPs in Conjunction with New Requirements for D-SNPs to Integrate Certain Medicare/Medicaid Benefits	✓		✓
Integrating Medicare/Medicaid Grievance and Appeals Processes within D-SNPs	✓		✓
Revising and Improving the Structure of the Financial Alignment Initiative for Dual-Eligible Beneficiaries			✓
Developing a New Three-Way Contract Model for Integrated Care for Dual-Eligible Individuals			✓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