Session 2
Medicare and Medicare Advantage Health Plans

Patty Blake, MA, MBA
August 10, 2015
Medicare and Medicare Advantage

Patty Blake
President, Senior Products
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Overview

- Summary of key messages
- What is Medicare and who is eligible?
- Medicare and Medicare Advantage: differences and similarities
- How is Medicare evolving?
- What are the implications for physicians?
Significant growth in the Medicare population and rising Medicare costs are driving the need for change in the federal Medicare program.

Nearly one third of all Medicare beneficiaries are now enrolled in private Medicare Advantage plans where their care is being managed.

The traditional fee for service Medicare program is evolving using many approaches borrowed from Medicare Advantage plans.

CMS has aggressive goals to shift from fee for service to value based payments for physicians and hospitals by 2018.

As a result, physicians and physician practices must adapt and evolve the way they care for people with Medicare.

These changes will drive further change in the broader healthcare system.
Insurance Coverage in the U.S.

17%, (54M) of the population is covered by the federal Medicare program.

Total Population (est.) 321.3M

Note: Total adds to >100%, 10M + are covered by both Medicare and Medicaid and are double counted

Sources: Kaiser Family Foundation 2013, adjusted for current Medicare and Medicaid enrollment, 2015 exchange enrollment
Who is Eligible for Medicare?

- 54 million people in U.S.
- Must be age 65+ and have paid into the Medicare system through payroll tax, or
- Disabled, or have ESRD, or ALS
- 16% are under 65 and disabled
Growth in the Medicare Eligible Population

The silver tsunami is coming. By 2030 over 19% of the population will be age 65+. The 85+ population is projected to increase from 5.7 million in 2011 to 14.1 million in 2040. Is the healthcare system ready?
The Basics of Medicare

Most people over age 65 qualify for Medicare, but Medicare has many gaps (out of pocket costs) for which people seek additional coverage.

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Part D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/Institutional</td>
<td>Medical</td>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Benefits</td>
<td>• Inpatient hospital w/ lifetime max</td>
<td>• Physician services</td>
</tr>
<tr>
<td>• Skilled Nursing Facility*</td>
<td>• Outpatient care**</td>
<td>• Prescription drugs according</td>
</tr>
<tr>
<td>• Home Health</td>
<td>• Preventive services</td>
<td>to a plan formulary</td>
</tr>
<tr>
<td>• Hospice</td>
<td>• PT,OT, DME</td>
<td></td>
</tr>
<tr>
<td>Patient Payment</td>
<td>• Hospital deductible $1,260 plus</td>
<td>• $147 annual deductible</td>
</tr>
<tr>
<td>• Hospital deductible $1,260 plus</td>
<td>coinsurance days 61+</td>
<td>then 20% coinsurance</td>
</tr>
<tr>
<td>• SNF days over 20 $157/day</td>
<td></td>
<td>No out of pocket max.</td>
</tr>
<tr>
<td>• No out of pocket max.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility/Cost</td>
<td>• Free to qualified individuals who have paid in while working</td>
<td>• $104.90/mo. adjusted +/- by income</td>
</tr>
<tr>
<td>* Medicare does not cover long term care</td>
<td>•</td>
<td>• People w/ higher incomes pay supplemental premium, low income may pay no premium</td>
</tr>
<tr>
<td>** Does not cover dental, eyeglasses, hearing aids</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Medicare does not cover long term care
** Does not cover dental, eyeglasses, hearing aids
Options for People with Medicare

Original Medicare (Part A and Part B)
Is operated by the government and government subcontractors.

Medicare Advantage (Part C)
Is operated by private companies approved by Medicare.

Part A
helps with hospital costs.

Part B
helps with doctor and outpatient care.

Part C
plans combine hospital costs, doctor and outpatient care in one plan.

Part D
helps pay for prescription drugs.

Part D
is available in Medicare Advantage plans. Some plans offer built-in drug coverage. Other plans treat it as an optional add-on.

Medicare Supplement Insurance Plans
cover some costs not covered in Parts A & B.

Additional benefits
are often included, such as vision and hearing services.
# Medicare vs. Medicare Advantage

Medicare Advantage plans have provider networks and actively manage care of their members. Plans utilize various payment mechanisms to engage providers including global payment.

<table>
<thead>
<tr>
<th>Care Delivery &amp; Management</th>
<th>Traditional Medicare</th>
<th>Medicare Advantage Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any Medicare provider</td>
<td>• Health plan HMO or PPO network</td>
<td></td>
</tr>
<tr>
<td>• 400+ ACOs managing care and quality for 8M beneficiaries, others may be unmanaged</td>
<td>• Population management; care and quality management programs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Payment</th>
<th>• Predominantly fee for service but, evolving to value based</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACOs may share in surplus or deficit vs. a target</td>
<td>• Plans paid risk adjusted monthly payment per member</td>
</tr>
<tr>
<td></td>
<td>• Plans use various payment mechanisms including global payment and value based</td>
</tr>
<tr>
<td></td>
<td>• Provider organizations may assume partial or full financial risk</td>
</tr>
</tbody>
</table>
# Medicare vs. Medicare Advantage Coverage Comparison

## Why do people choose Medicare Advantage?

<table>
<thead>
<tr>
<th></th>
<th>Original Medicare</th>
<th>Tufts Medicare Preferred HMO Saver Rx/Basic Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Premium</strong></td>
<td>Part B Premium</td>
<td>$0* premium Plus Part B Premium</td>
</tr>
<tr>
<td><strong>Medical Deductibles</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Annual Medical out-of-pocket maximum</strong>*</td>
<td>No limit</td>
<td>$3,400</td>
</tr>
<tr>
<td><strong>Primary Care Doctor Office Visits</strong></td>
<td>20% coinsurance after Medicare Part B deductible</td>
<td>$20/$15 copay</td>
</tr>
<tr>
<td><strong>Annual Physical</strong></td>
<td>Not covered</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Specialist Office Visits</strong></td>
<td>20% after Medicare Part B deductible</td>
<td>$40/$30 copay</td>
</tr>
<tr>
<td><strong>Referrals Required</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>20% after Medicare Part B deductible (no worldwide coverage)</td>
<td>$65 copay (worldwide coverage)</td>
</tr>
<tr>
<td><strong>Annual Routine Vision and Hearing Exams</strong></td>
<td>Not covered</td>
<td>$40/$30 copay for one routine vision exam and for one routine hearing exam every calendar year</td>
</tr>
<tr>
<td><strong>Part D Prescription Drugs</strong></td>
<td>Not covered; must purchase stand-alone drug plan</td>
<td>Included: Prescription deductible and copays vary by tier</td>
</tr>
<tr>
<td><strong>Annual Wellness Allowance/ Fitness and Nutritional Counseling Allowance</strong></td>
<td>Not covered</td>
<td>Up to $150 reimbursement for fitness classes, nutritional counseling, and wellness programs</td>
</tr>
<tr>
<td><strong>Annual Eyewear Benefit</strong></td>
<td>Not covered</td>
<td>Up to $150 reimbursement in network</td>
</tr>
</tbody>
</table>

*Saver Rx plan available in Barnstable, Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk and Worcester Counties. Basic Rx plan available in Hampden and Hampshire Counties. Other plans are also available in these counties.

**Comprised of all your medical copays/coinsurance—your out of pocket costs will never exceed this amount.
Growth in Medicare Advantage

Medicare Advantage plans have become increasingly popular with 31% of eligibles enrolled nationally. In some states 45% or more are enrolled.

Figure 1
Total Medicare Private Health Plan Enrollment, 1999-2015

In millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
</tr>
<tr>
<td>2000</td>
<td>6.8</td>
</tr>
<tr>
<td>2001</td>
<td>6.2</td>
</tr>
<tr>
<td>2002</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>5.3</td>
</tr>
<tr>
<td>2004</td>
<td>5.3</td>
</tr>
<tr>
<td>2005</td>
<td>5.6</td>
</tr>
<tr>
<td>2006</td>
<td>6.8</td>
</tr>
<tr>
<td>2007</td>
<td>8.4</td>
</tr>
<tr>
<td>2008</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>10.5</td>
</tr>
<tr>
<td>2010</td>
<td>11.1</td>
</tr>
<tr>
<td>2011</td>
<td>11.9</td>
</tr>
<tr>
<td>2012</td>
<td>13.1</td>
</tr>
<tr>
<td>2013</td>
<td>14.4</td>
</tr>
<tr>
<td>2014</td>
<td>15.7</td>
</tr>
<tr>
<td>2015</td>
<td>16.8</td>
</tr>
</tbody>
</table>

% of Medicare Beneficiaries

18% 17% 15% 14% 13% 13% 13% 16% 19% 22% 23% 24% 25% 27% 28% 30% 31%

NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.
Given the unique needs and challenges of managing care for Medicare beneficiaries our model centers on collaboration with organized and engaged physician groups.

We are selective about the physician groups we contract with.

- Organized or integrated with strong primary care orientation
- Strong physician leadership
- Possess some managed care infrastructure
- Willing to engage in the critical elements of senior care management
- Willing to assume accountability for cost and quality of care
Tufts Health Plan provides resources, programs and support that enable PCPs to focus time on and be rewarded for reducing morbidity and improving health.
Since the Affordable Care Act, Medicare has started to move toward value based provider payments by adopting or piloting mechanisms used by health plans. CMS recently set a goal of tying 50% of all payments to doctors and 85% of all payments to hospitals to quality by 2018.
What are the Implications for Physicians?

- Increasing enrollment in Medicare Advantage plans
- Medicare shifting toward value based payments

What do these changes mean for physicians?

What does it take to be successful in managed Medicare?
Cost and Utilization Comparison

Medicare patients consume a disproportionate share of health care resources and will likely consume a disproportionate share of your time.

<table>
<thead>
<tr>
<th></th>
<th>Employer/ Commercial</th>
<th>Medicare</th>
<th>Dual Eligible Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ave Total Medical and Pharmacy Cost pmpm</td>
<td>$377</td>
<td>$836</td>
<td>$2,275</td>
</tr>
<tr>
<td>Inpt. Hospital Admits/1000</td>
<td>32</td>
<td>233</td>
<td>388</td>
</tr>
<tr>
<td>SNF Admits /1000</td>
<td>1.7</td>
<td>93</td>
<td>221</td>
</tr>
<tr>
<td>Ave physician visits per member/ year</td>
<td>3.5</td>
<td>7.7</td>
<td>12.6</td>
</tr>
<tr>
<td>Ave # Prescriptions/year</td>
<td>13.3</td>
<td>47.5</td>
<td>75.4</td>
</tr>
</tbody>
</table>

Source: Tufts Health Plan 2014
Population Management

The health and wellness of Medicare eligibles varies greatly. To manage their care a segmentation approach is critical.

- **Active & Well (~15%)**
  - No Chronic conditions
  - Emphasis on engagement and prevention
  - Monitor gaps in care
  - Annual wellness exam

- **Average Chronic (45%)**
  - 1 - 2 chronic conditions
  - Ave # of prescriptions
  - Engage in disease management
  - Screen and monitor for change
  - Monitor gaps in care

- **Multi-Chronic (~38%)**
  - 3 -5 chronic conditions
  - Multiple medications
  - High risk for admission/readmission
  - Enroll in care management
  - Monitor closely and frequently

- **Frail & Complex (~2%)**
  - 10+ prescriptions
  - Multiple conditions
  - Advanced illness
  - Comprehensive support of an interdisciplinary team
  - Care in home or institution

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**Low Touch/ Lower Cost**

**High Touch/Higher Cost**
# What Does it Take to Practice Successfully in Managed Medicare?

| Physician Leadership | • Develop, implement and refine processes, protocols and infrastructure to support effective care delivery, care management and engagement of physicians and other providers.  
• Practice redesign to accommodate needs of senior patients (access, longer appointments, 24/7 for some)  
• Build and maintain strong referral relationships (specialists, SNF, home health) |
| --- | --- |
| Care Management | • **Integrated Care Management**: work as part of an interdisciplinary team that includes care managers, behavioral health clinicians, pharmacists, social workers etc. to facilitate comprehensive patient management across the continuum  
• **Population management**: early identification of high risk patients. Provide the right care to the right patients at the right time.  
• **Transition Management**: Planning and oversight of transitions from hospital to SNF to home to prevent complications & readmissions  
• **Geriatric condition programs**: fall prevention, dementia, end of life, palliative care  
• **Providing care in SNF, nursing home or patient’s home if needed** |
| Incentive Structures | • PCPs incented and see the direct impact of effective cost and quality performance  
• Rewards shared with non-PCP providers who are critical to successful performance (e.g. hospital, specialists) |
| Data and Systems | • Patient care management supported by integrated EMR and care management tools  
• Actionable data at the point of care  
• Population analytics  
• Cost, utilization and quality performance results shared with physicians |
The Medicare program is evolving from fee for service to value based payment adopting many tenets of managed care while enrollment in Medicare Advantage plans is growing.

With significant growth in the senior population, caring for people with Medicare will be a major part of physician’s practice.

As a result of these trends, all players in the healthcare system will need to adapt and develop capability to be accountable for the cost and quality of the care they provide.
Appendix
What do plans do to manage chronic illnesses?

- Formal programs to provide support for families or informal caregivers: 42%
- Nurse hotline programs: 79%
- Use of clinical pharmacists to educate enrollees: 82%
- Use health managers to monitor patients and provide counseling: 82%
- Nurse telephone visits: 91%
- Coordinating care with multiple physicians: 91%
- Provider alerts, summary data on care gaps, or adherence to medications: 97%
- Help to access social services: 97%
- Teaching chronic disease self-management: 100%

Christopher Tompkins, Health Affairs Blog, April 2013
Survey of Medicare Advantage Plans

What services and supports do plans provide to frail elderly members?

- Remote home monitoring: 56%
- In-home visits by social workers: 69%
- Medication management alerts: 75%
- Link patients with support groups: 84%
- Self-management sessions with care managers: 88%
- In-home visits with clinicians to develop and monitor care plans: 88%
- Assessing safety of home environments: 91%
- Coordinate care with PCPs using care managers: 100%
- Arrange access for community services: 100%