Tufts Health Care Institute

Practicing Medicine in the Era of Health Reform

Session 2

Medicare and Medicare Advantage Health Plans

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August 10, 2015

Medicare and Medicare Advantage

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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?

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Summary of Key Messages

- 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.

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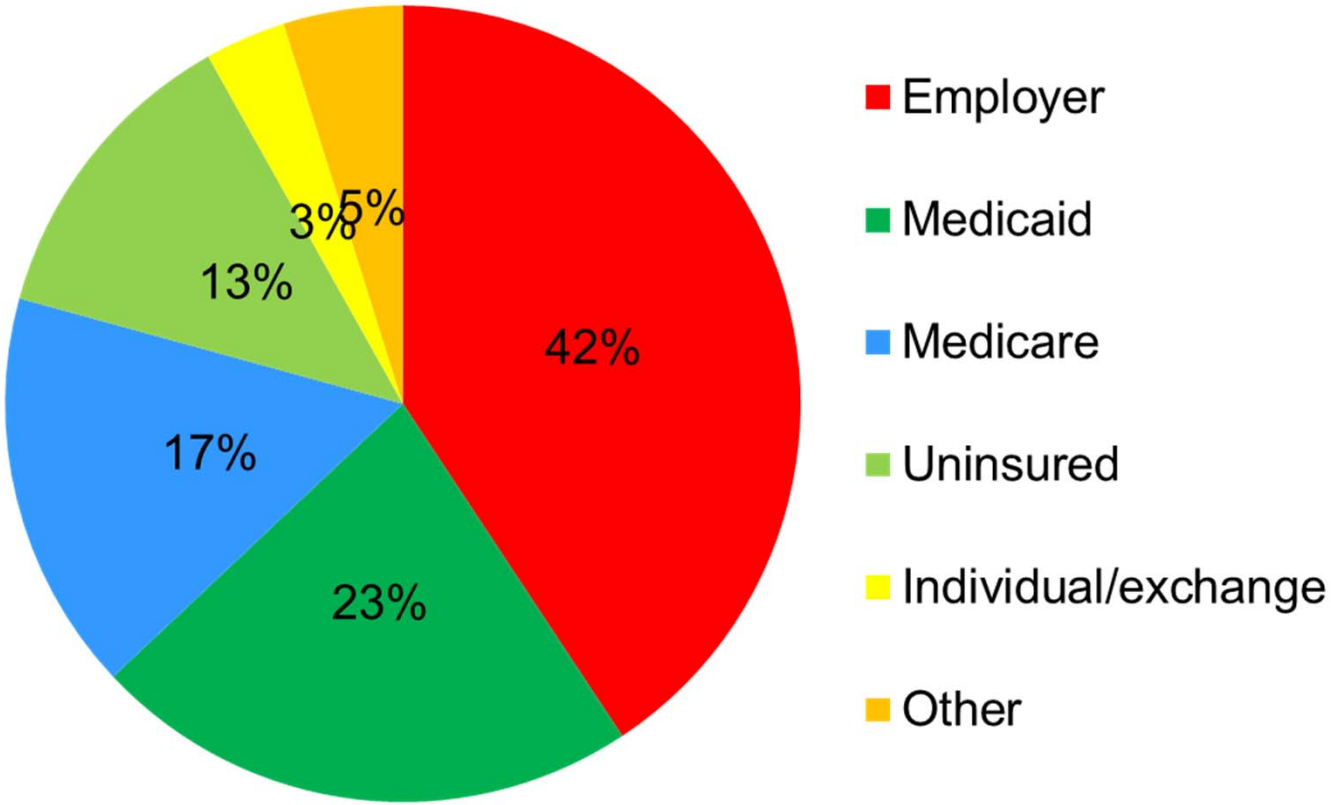
Insurance Coverage in the U.S.

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

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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






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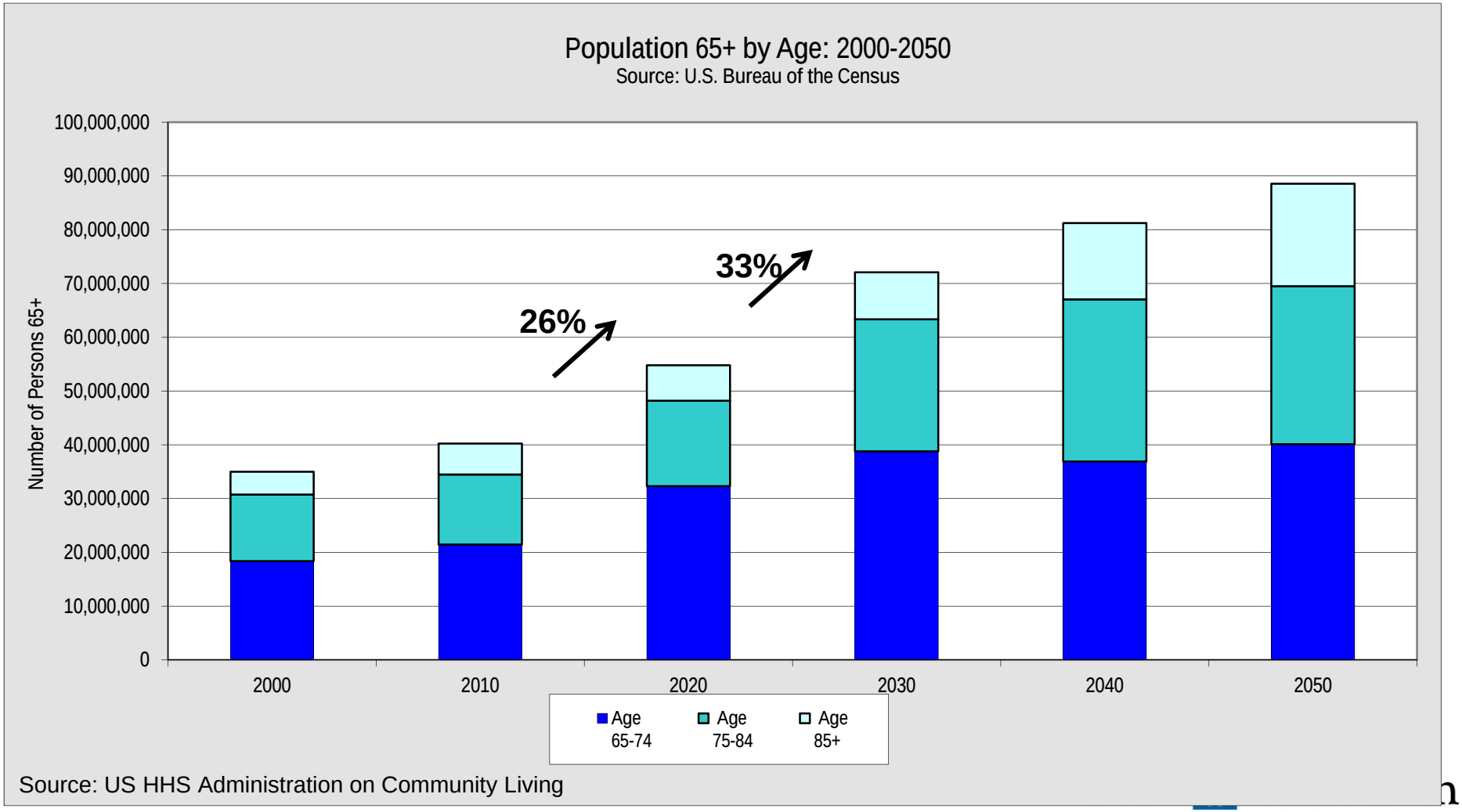
Growth in the Medicare Eligible Population

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?



Source: US HHS Administration on Community Living

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.

	Part A Hospital/ Institutional	Part B Medical	Part D Prescription Drugs
Benefits	• Inpatient hospital w/ lifetime max • Skilled Nursing Facility* • Home Health • Hospice	• Physician services • Outpatient care** • Preventive services • PT,OT, DME	• Provided by private plans • Prescription drugs according to a plan formulary
Patient Payment	• Hospital deductible $1,260 plus coinsurance days 61+ • SNF days over 20 $157/day • No out of pocket max.	• $147 annual deductible then 20% coinsurance • No out of pocket max.	• Cost sharing or copay • Coverage gap from $3600 of coverage until spending reaches $4700 OOP.
Eligibility/ Cost	• Free to qualified individuals who have paid in while working	• $104.90/mo. adjusted +/- by income	• Monthly plan premium • People w/ higher incomes pay supplemental premium, low income may pay no premium

* Medicare does not cover long term care
** Does not cover dental, eyeglasses, hearing aids

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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.

OR

Part A
helps with hospital costs.

Part B
helps with doctor and outpatient care.

Standard

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

Part D
helps pay for prescription drugs.

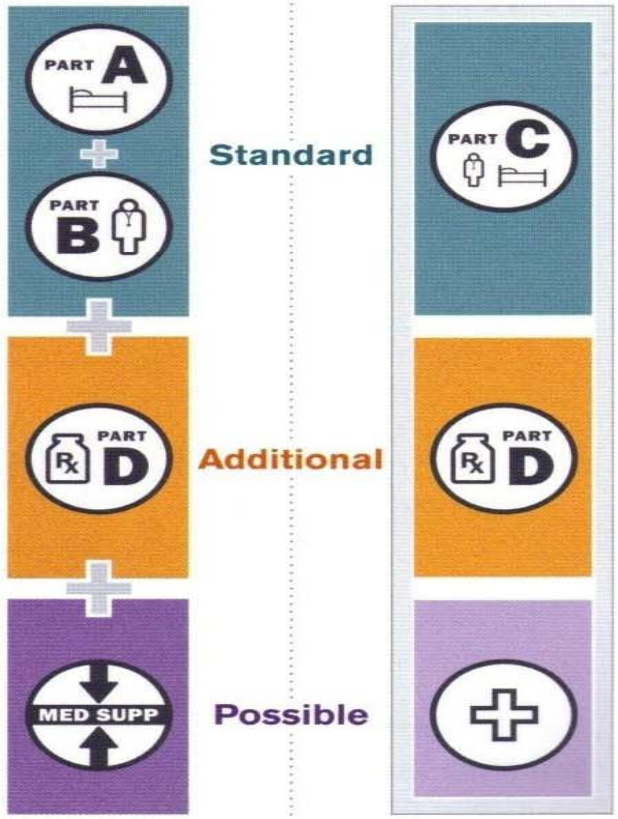
Additional

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.

Possible

Additional benefits
are often included, such as vision and hearing services.



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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.

	Traditional Medicare	Medicare Advantage Plan
Care Delivery & Management	• Any Medicare provider • 400+ ACOs managing care and quality for 8M beneficiaries, others may be unmanaged	• Health plan HMO or PPO network • Population management; care and quality management programs
Provider Payment	• Predominantly fee for service but, evolving to value based • ACOs may share in surplus or deficit vs. a target	• Plans paid risk adjusted monthly payment per member • Plans use various payment mechanisms including global payment and value based • Provider organizations may assume partial or full financial risk

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Medicare vs. Medicare Advantage Coverage Comparison

Why do people chose Medicare Advantage?

	Original Medicare	Tufts Medicare Preferred HMO Saver Rx/Basic Rx
Monthly Premium	Part B Premium	$0* premium Plus Part B Premium
Medical Deductibles	Yes	No
Annual Medical out-of-pocket maximum* **	No limit	$3,400
Primary Care Doctor Office Visits	20% coinsurance after Medicare Part B deductible	$20/$15 copay
Annual Physical	Not covered	$0 copay
Specialist Office Visits	20% after Medicare Part B deductible	$40/$30 copay
Referrals Required	No	Yes
Emergency Care	20% after Medicare Part B deductible (no worldwide coverage)	$65 copay (worldwide coverage)
Annual Routine Vision and Hearing Exams	Not covered	$40/$30 copay for one routine vision exam and for one routine hearing exam every calendar year
Part D Prescription Drugs	Not covered; must purchase stand-alone drug plan	Included: Prescription deductible and copays vary by tier
Annual Wellness Allowance/ Fitness and Nutritional Counseling Allowance	Not covered	Up to $150 reimbursement for fitness classes, nutritional counseling, and wellness programs
Annual Eyewear Benefit	Not covered	Up to $150 reimbursement in network Up to $90 reimbursement out of network

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.*

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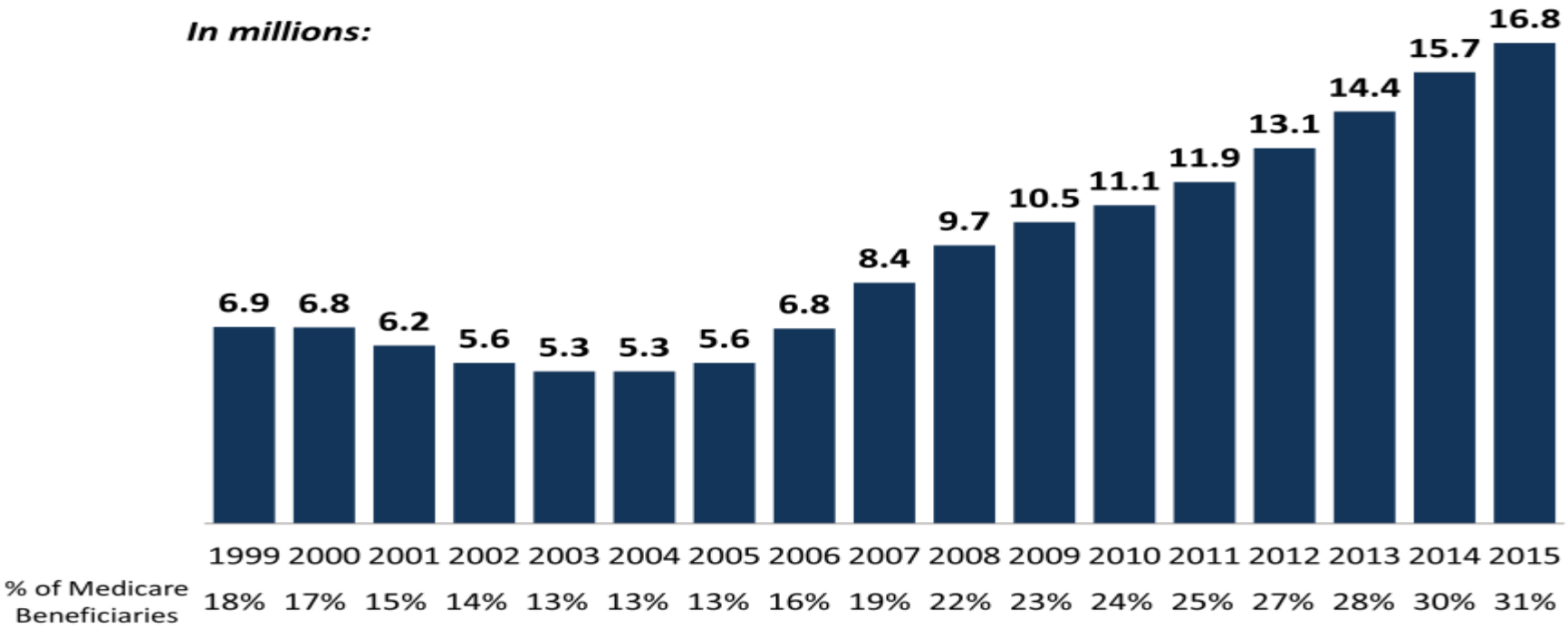
Growth in Medicare Advantage

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



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2015, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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Tufts Health Plan Medicare Advantage Model

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

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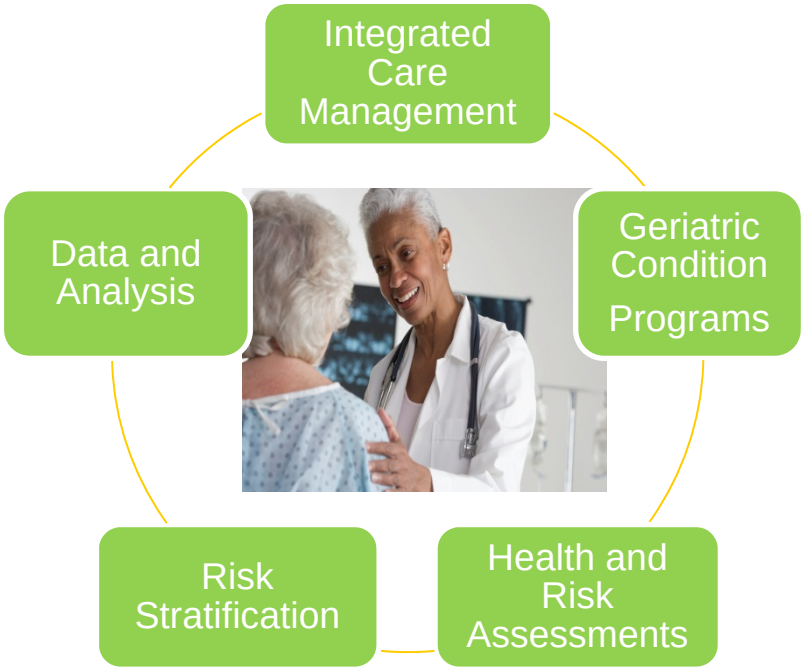
Health Plan Support to Physician Practices

Tufts Health Plan provides resources, programs and support that enable PCPs to focus time on and be rewarded for reducing morbidity and improving health.



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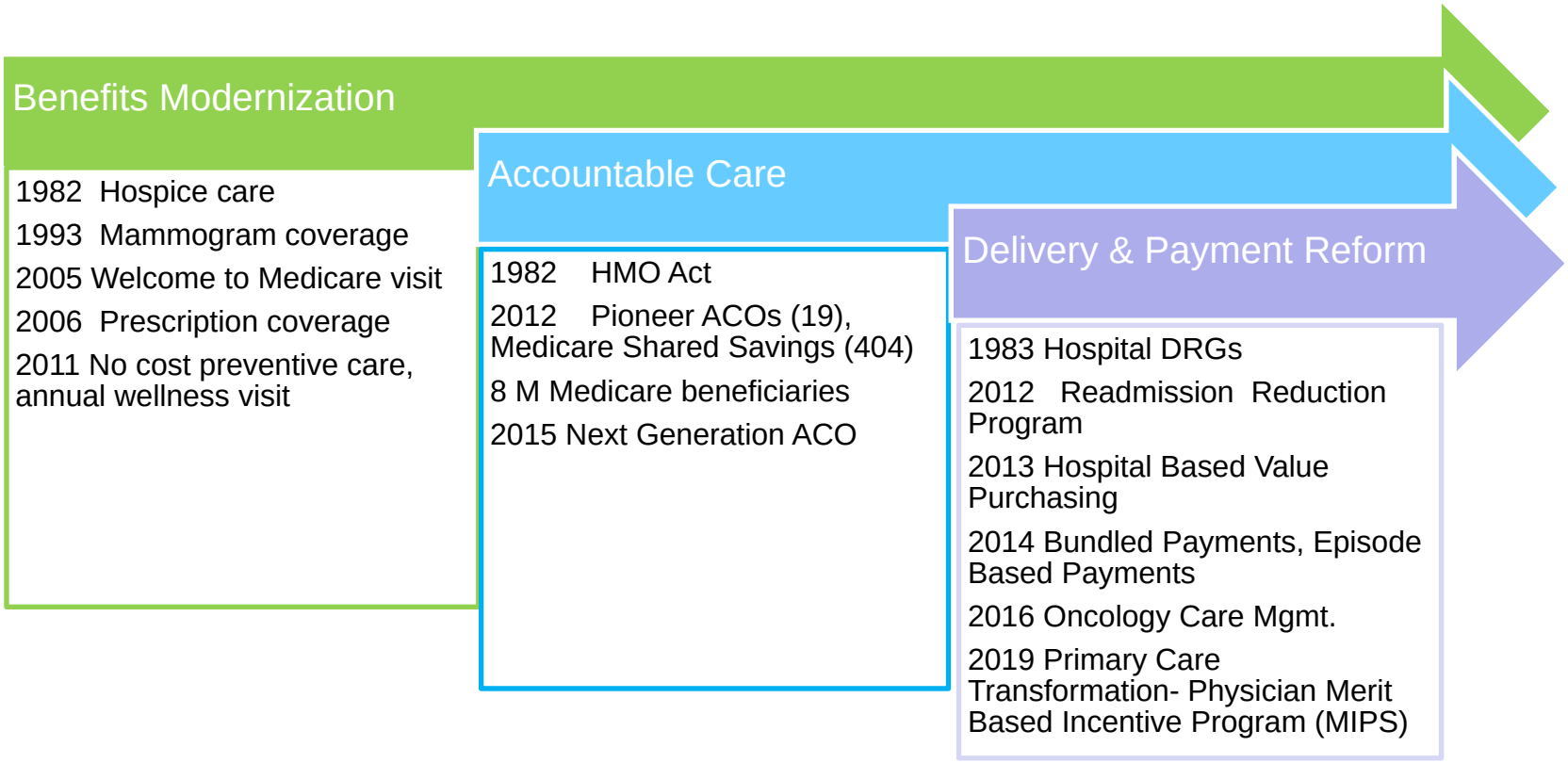
Evolution of Medicare Program

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.



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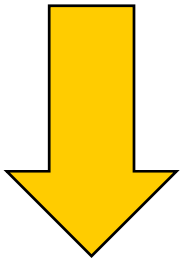
What are the Implications for Physicians?

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?

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Cost and Utilization Comparison

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

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

Source: Tufts Health Plan 2014

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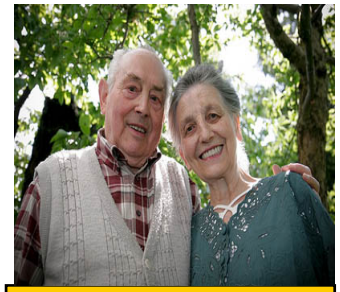
Population Management

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

Low Touch/ Lower Cost → **High Touch/Higher Cost**

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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 Take Away

- **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.**

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Appendix

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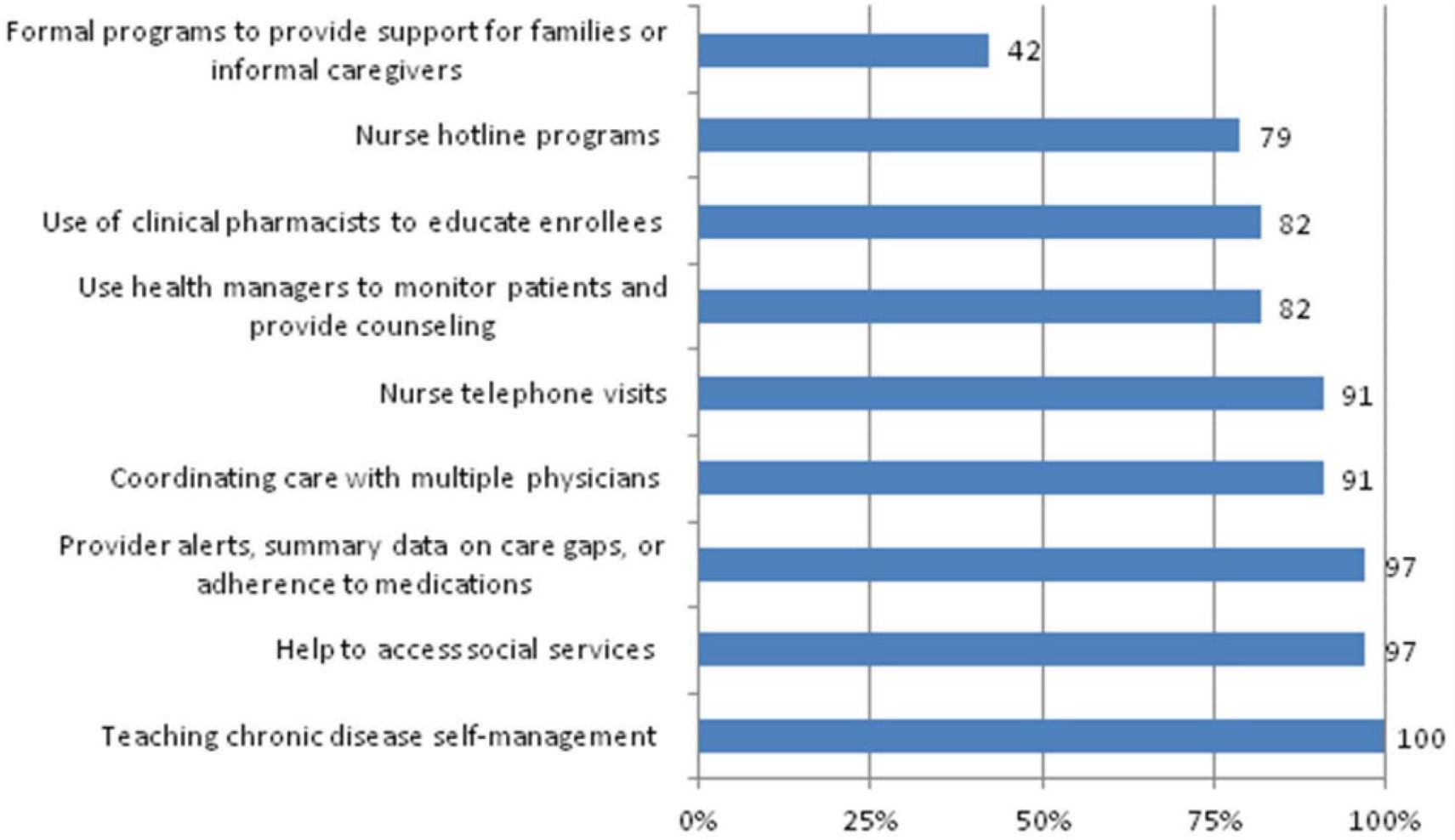
Survey of Medicare Advantage Plans

What do plans do to manage chronic illnesses?



Christopher Tompkins, Health Affairs Blog , April 2013

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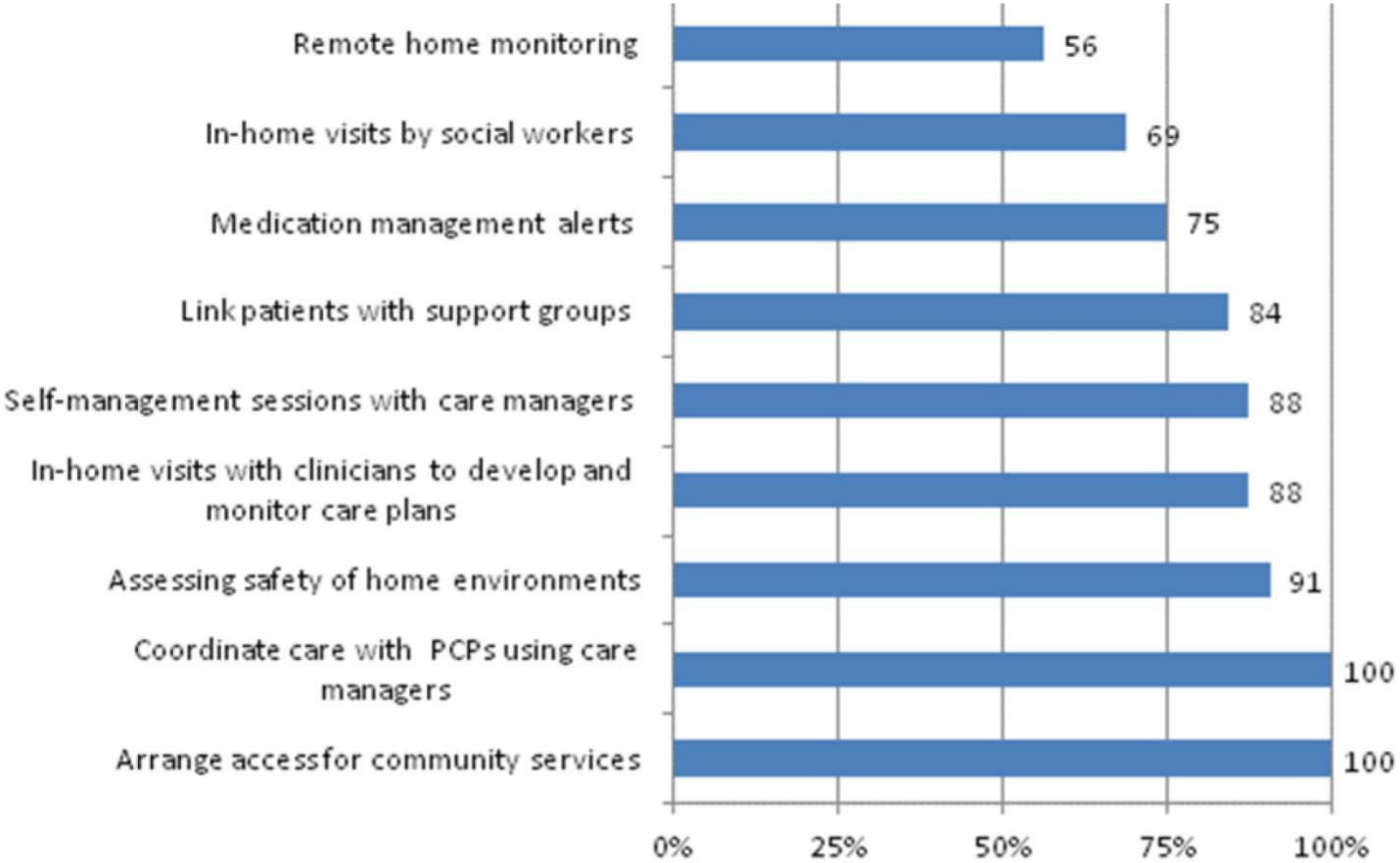
Survey of Medicare Advantage Plans

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



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