Next Steps in Chronic Care

Expanding Innovative Medicare Benefits

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. Our work focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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The SCAN Foundation advances a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

Glossary of Acronyms

ACO	Accountable Care Organization
ADLs	Activities of Daily Living
APM	Alternative Payment Model
BBA	Bipartisan Budget Act of 2018
CC	Chronic Condition
CCM	Chronic Care Management
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPC+	Comprehensive Primary Care Plus
CPT	Current Procedural Terminology
D-SNP	Dual Eligible Special Needs Plan
FFS	Fee-for-Service
HCC	Hierarchical Condition Categories
HHS	Department of Health and Human Services
MA	Medicare Advantage
MCBS	Medicare Current Beneficiary Survey
MDPP	Medicare Diabetes Prevention Program
MSSP	Medicare Shared Savings Program
PUF	Public Use File
SNF	Skilled Nursing Facility
SSBCIs	Special Supplemental Benefits for the Chronically Ill

Executive Summary

Over the last six years, the Bipartisan Policy Center's Health Project has developed policy recommendations to improve access to services, improve quality, and lower the cost of care for those with complex care needs, including those with chronic conditions. These efforts have focused on recommendations to: (1) improve the integration of care for Medicare-Medicaid beneficiaries, or "dual-eligible" individuals; (2) improve flexibility in Medicare Advantage (MA) so that plans can target supplemental benefits to patients with multiple chronic conditions; (3) improve the availability of care at home and in the community for those with serious illness; (4) improve the financing and delivery of long-term services and supports; and (5) better integrate clinical health and behavioral health services. Congress enacted many of these recommendations as part of the Bipartisan Budget Act of 2018 (BBA), while others have been implemented through regulations or other agency guidance.

Since enactment of the BBA, BPC has monitored its implementation and hosted public events and private roundtable discussions with expert stakeholders to better understand how best to improve care for those with chronic conditions. Based on those efforts, BPC provided comments to the Centers for Medicare and Medicaid Services (CMS) on the integration of care for dual-eligible individuals and on the targeting of supplemental benefits for those with chronic conditions.

Recognizing the need to continue efforts to improve care for those with chronic conditions, this report makes recommendations in three areas:

I. Providing greater authority to CMS to integrate services for Medicare-Medicaid beneficiaries;

II. Improving on the BBA provisions allowing MA plans to offer special supplemental benefits for individuals with chronic illness; and

III. Improving care for those with chronic conditions in Medicare fee-for-service through accountable care organizations, primary care models, and chronic care management.

MEDICARE-MEDICAID INTEGRATION

BPC's 2016 report, Improving Care for Individuals Dually Eligible for Medicare and Medicaid, outlined the challenges Medicare-Medicaid beneficiaries face and the benefits of integrating the two programs. CMS has made considerable progress in integrating Medicare and Medicaid services, most recently announcing new demonstration authority for states. While the agency has aligned many conflicting program requirements, challenges remain. Providing regulatory authority and resources to CMS would support agency efforts to further improve alignment of the two programs and make technical assistance available to states to assist in alignment efforts.

In addition, integration requires a commitment of additional state Medicaid expenditures, particularly as states seek to better coordinate care for homeless populations and those with mental illness. Finally, integration of the Medicare and Medicaid programs could be furthered by giving the secretary of the U.S. Department of Health and Human Services (HHS) authority to incorporate discrete components of the financial alignment demonstrations into existing care models outside the demonstrations.

Congress should:

A. Permit shared savings by allowing states to retain a portion of Medicare savings attributable to integration of services. These resources will help states offset the initial Medicaid investment in services and infrastructure. In return, states would agree to remove state-level barriers to alignment by coordinating Medicaid open enrollment with Medicare's annual open enrollment period;

B. Increase funding to the State Health Insurance Assistance Program to help Medicare-Medicaid beneficiaries better understand the options available to them in order to make informed choices;

C. Make funds available to the HHS secretary to coordinate alignment through the use of technical-assistance teams, similar to those used as part of the financial alignment demonstration for states that do not have expertise or resources;

D. Direct the HHS secretary to convene a working group composed of state agency officials; consumer advocacy representatives; private health insurance plans with experience integrating clinical health, behavioral health, and long-term services and supports; and other relevant experts to develop uniform standards appropriate for both Medicare and Medicaid, rather than continuing separate standards. As part of this alignment, Congress should provide limited authority to CMS to implement changes agreed on by the working group in the following areas:

   1. Care management standards for clinical health, behavioral health, and long-term services and supports;
   2. Network adequacy standards appropriate for Medicare-Medicaid beneficiaries, with beneficiary access as the primary focus;
   3. Unified standard materials for marketing, plan notices, and other member materials;
   4. A process for joint oversight of plans by CMS and states; and
   5. Alignment of Medicare and Medicaid measures, including measures of access to care by patient care setting; beneficiary experience in navigating the integrated program; and appropriateness of financial incentives among plans, providers, states and the federal government.

SPECIAL SUPPLEMENTAL BENEFITS FOR INDIVIDUALS WITH CHRONIC ILLNESS: MEDICARE ADVANTAGE

Under the BBA, Congress provided authority for MA plans to offer special supplemental benefits for the chronically ill (SSBCIs) that are not primarily health-related beginning in January 2020. These benefits must have a reasonable expectation of improving or maintaining an individual's health or function (for example, the ability to perform normal activities of daily living, such as bathing and dressing). Under HHS guidance, plans may determine what benefits to offer, subject to approval by the secretary. SSBCIs are financed within existing Medicare payments to plans. As a result, there is no added cost to enrollees or to the federal government. Under agency guidance, plans may offer benefits such as medically tailored, home-delivered meals beyond those already permitted in MA; non-medical transportation; fresh produce; and services supporting self-direction, home modifications, or other benefits. Under the BBA, Congress included a requirement that the General Accounting Office report on benefits offered and the impact of those benefits. While that report will prove instructive, a longer study is needed to determine whether this new flexibility will be successful in improving care for those with complex needs.

Advocacy groups, as well as some plans and providers, have raised concerns about the implementation of SSBCIs. Concerns include the adequacy of consumer information about the benefits, whether they qualify, and whether providers will have the information they need to provide referrals for services. These groups have also raised concerns about marketing practices that could cause Medicare-Medicaid beneficiaries—who already have reduced cost-sharing and Medicaid benefits through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid fee-for-service (FFS)—to enroll in an MA plan, resulting in a loss of benefits.

Congress should:

A. Direct the HHS secretary to establish standard language for marketing materials that clarifies that coverage of an SSBCI benefit is not guaranteed and to establish standards for member materials that describe the availability of SSBCIs once individuals are enrolled. Congress should also direct the secretary to revise agent and broker training and testing guidelines to include training on these benefits;

B. Require MA plans to to develop materials for providers that make them aware of SSBCIs, the conditions under which services are covered, and where to direct patients for services, if not available through the referring provider;

C. Require MA plans to quantify and report outcomes to CMS on SSBCIs offered in a format and time frame established by the secretary;

D. Direct CMS to review and compile evidence provided by MA plans, to publish periodic reports on outcomes, and to make data available to researchers to help build an evidence base on the effectiveness of covered non-medical services; and

E. Increase funding for State Health Insurance Assistance Programs, which assist Medicare beneficiaries in understanding the full range of choices available to them.

IMPROVING CHRONIC CARE SERVICES IN MEDICARE FEE-FOR-SERVICE

BPC's Health Project has long advocated for increased enrollment in MA and has supported alternative payment models (APMs), such as accountable care organizations (ACOs), to improve value in the U.S. health care system. In MA or in APMs with two-sided risk, providers may retain a portion of savings and are responsible for excess costs. The payment model creates disincentives to covering services that add costs unless they reduce overall health spending.

Half of individuals with complex needs are enrolled in MA, while half receive health care services through Medicare FFS. For those receiving care under Medicare FFS, either by choice or because MA plans offering SSBCIs are not available, there are opportunities to improve care for and offer similar non-medical benefits to individuals with chronic conditions. The availability of these services is particularly critical in rural areas, where there is limited market penetration by MA plans.

In traditional Medicare Part B FFS and non-risk-based APMs, in which providers are not responsible for total cost of care, there is the potential to pass added costs along to Medicare beneficiaries in the form of higher cost-sharing, higher premiums, or added costs to taxpayers for the federal government's share of Medicare Part B spending.

While Congress should provide authority to the HHS secretary to approve coverage of non-medical benefits for individuals with chronic illness in Medicare FFS, it should be done through APMs, such as ACOs and primary care models, as well as for individuals receiving chronic care management (CCM) services. To address concerns about increased costs and utilization of services, coverage of non-medical benefits should be subject to conditions, including strong evidence of efficacy and cost-effectiveness.

Congress should:

A. Provide authority to the HHS secretary to identify and authorize coverage and payment of evidence-based non-medical benefits for patients with chronic conditions if:

    1. Peer-reviewed evidence demonstrates that the benefit improves or maintains health or function for a specific subset of patients with certain chronic conditions and/or functional limitations;

    2. The CMS Office of the Actuary certifies that coverage of the defined benefit for the defined population would result in no net increase in Medicare spending; and

    3. The chronic condition is being managed by an ACO, a comprehensive primary care model, through CCM, or through other payment or delivery models that include a care management component.

B. For any new evidence-based benefits for the chronically ill, the secretary should make available to Medicare providers list of suppliers in the geographic area in which they provide services.

C. Eliminate the beneficiary co-pay for CCM services covered under Medicare, since the benefit covers provider-to-provider communications outside an office visit and are not obvious to the beneficiary;

D. Expand the list of qualified health providers that can bill for CCM services to include licensed clinical social workers practicing within the scope of their licenses;

E. Direct the HHS secretary to develop a uniform functional assessment tool and define the conditions under which providers would perform the assessment to facilitate eligibility determination for non-medical services. Determination will be based on both chronic conditions and functional status;

F. Direct the secretary to establish criteria for organizations that would be eligible to provide non-medical services identified by the secretary in traditional Medicare FFS. The secretary should also establish monitoring programs to minimize fraud, waste, and abuse; and

G. Direct the secretary to examine potential modifications to the risk-adjustment model to ensure more accurate predictions of medical expenses for Medicare beneficiaries with functional limitations. The secretary should consider the appropriateness of developing a tool that can determine eligibility and assess risk.

ANALYSIS OF BUDGETARY IMPLICATIONS ASSOCIATED WITH A HYPOTHETICAL SUPPLEMENTAL BENEFIT

BPC contracted with Ananya Health innovations to help define Medicare patient cohorts that could potentially be eligible for SSBCIs and to estimate the budgetary effects of an evidence-based, non-medical benefit narrowly tailored to certain patients with chronic conditions. Through this analysis BPC hoped to illustrate the potential for offering non-medical benefits in Medicare FFS for individuals with chronic conditions. For the complete analysis, see the Appendix.

Based on evidence that medically tailored meals can reduce hospital readmissions for certain patients post-discharge from the hospital, the analysis identified 11 chronic conditions: (1) congestive heart failure; (2) depression; (3) diabetes; (4) emphysema, asthma, or chronic obstructive pulmonary disease; (5) Alzheimer's disease or other diagnosis of dementia; (6) osteoporosis; (7) other heart condition; (8) paralysis; (9) Parkinson's disease; (10) rheumatoid arthritis; and (11) stroke. BPC defined "eligible individuals" as Medicare beneficiaries with two or more of these conditions and one or more functional limitations (deficits in activities of daily living). The benefit, defined as seven days of medically tailored home-delivered meals, would be made available to patients who meet eligibility criteria and would be provided post-discharge from the hospital.

Full participation could lead to 575,408 eligible beneficiaries, with 1,012,590 eligible inpatient stays and 9,719 fewer readmissions attributable to the supplemental benefit. The literature suggests other utilization offsets, including reduced emergency-department visits and skilled nursing facility (SNF) stays, which would result in additional savings attributable to the same supplemental benefit. BPC's data source did not include emergency-department utilization rates for the analytic cohorts. The health care system could achieve significant reductions in SNF benefits, especially in conjunction with supplemental benefits that include medically-tailored meals and home visits that include clinical monitoring, social support, and early intervention as needed.

According to the simulation, the aggregate cost of full participation among eligible beneficiaries would be $101,258,974 (or $175.98 per person). The gross savings due to reduced readmission rates would be $158,606,687, resulting in a net savings of $57,347,713. Most of the net savings come from the subgroup who incur several hospitalizations, while beneficiaries with a single inpatient stay would incur incremental costs from the meals program but have no readmissions to avert. All of the subgroups could potentially have additional savings due to averted emergency department visits or SNF stays under a national program with tailored supplemental benefits. In this simulation, the ratio of savings to cost for the hypothetical supplemental benefit was 1 to 57; that means, on average, every dollar spent on the meals program would result in $1.57 in savings.

This analysis illustrates that the HHS secretary could potentially identify a defined benefit for specific cohorts of patients in Medicare FFS that does not result in net outlays to the Medicare program. Additional analysis will be required to develop actual projections of costs and savings to the Medicare program, including further specification of non-medical benefits for those with chronic illness and more refined assumptions about targeting, realistic participation, gaming, and operational details like market prices.

CONCLUSION

Federal policy affecting individuals who require complex care continues to improve. Congress and CMS have taken steps to better integrate Medicare and Medicaid services for dual-eligible individuals. There are, however, additional steps that Congress or the administration can take.

As MA plans begin to target non-medical benefits to patients with chronic conditions, it will be important to collect information on what services are covered and for whom, to assess the impact of these benefits on individuals and on the Medicare program, and to make sure that beneficiaries understand that these benefits are not guaranteed to all Medicare enrollees.

Given the high percentage of Medicare beneficiaries with chronic illness, Congress should extend similar benefits to those in Medicare FFS. In providing that authority, Congress must be cognizant that MA plans and full-risk APMs have incentives to lower cost and utilization of unnecessary services. Non-risk based APMs and CCM services require safeguards to ensure that these non-medical benefits are evidence-based, targeted, and do not result in a net increase in beneficiary cost-sharing, in premiums, or in additional costs to taxpayers.

Introduction

Over the last six years, the Bipartisan Policy Center's Health Project has developed policy recommendations to improve access to services, improve quality, and lower the cost of care for those with complex care needs, including individuals with chronic conditions. These efforts have focused on recommendations to: (1) improve the integration of care for Medicare-Medicaid beneficiaries, or "dual-eligible" individuals;[2] (2) improve flexibility in Medicare Advantage (MA) to allow plans to target supplemental benefits to patients with multiple chronic conditions;[3] (3) improve the availability of care at home and in the community for those with serious illness;[4,5] (4) improve the financing and delivery of long-term services and supports;[6] and (5) better integrate clinical health and behavioral health services.[7] Congress enacted many of these recommendations into law[8,9,10] while others have been implemented through regulations or other agency guidance.[11,12,13,14] As those policies were put into place, BPC monitored the implementation process and worked toward the best outcomes for those individuals with complex care needs.[15,16,17]

Recognizing the need to continue efforts to improve care for those with chronic conditions, this report makes recommendations in three areas:

I. Providing greater authority to the Centers for Medicare and Medicaid Services to integrate services for Medicare-Medicaid beneficiaries;

II. Improving on the Bipartisan Budget Act of 2018 (BBA) provisions allowing MA plans to offer special supplemental benefits for individuals with chronic illness; and

III. Improving opportunities for those with chronic conditions in Medicare fee-for-service through accountable care organizations, primary care models, and chronic care management.

Medicare-Medicaid Integration: Improving Care for Beneficiaries

BPC's August 2016 report, Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid, outlined the challenges Medicare-Medicaid beneficiaries face and recommended: (1) permanently authorizing Dual-Special Needs Plans (D-SNPs); (2) giving the Medicare-Medicaid Coordination Office regulatory authority over D-SNPs; (3) aligning the Medicare and Medicaid grievance and appeals processes; and (4) expanding opportunities for states to align payment and delivery models. Congress enacted all of these recommendations as part of the BBA or through subsequent agency actions.[18,19,20,21]

The Centers for Medicare and Medicaid Services (CMS) have made considerable progress in the integration of Medicare and Medicaid services, most recently announcing new demonstration authority for states. As part of this effort, CMS has improved coordination of care through Fully Integrated Dual Eligible Special Needs Plans, as well as other plans and initiatives designed to make it easier for states that have not yet integrated care. While the Medicare-Medicaid Coordination Office has announced a second round of opportunities for states, the U.S. Department of Health and Human Services (HHS) has also indicated the need for additional authority and resources to better align Medicare and Medicaid services.[22]

While HHS has been able to align many conflicting program requirements through demonstration authority, providing additional resources and regulatory authority to CMS would support agency efforts to further align the two programs and make technical assistance available to states that most need it.

In addition, integration requires a commitment of additional state Medicaid funding to address provider shortages, as states seek to better coordinate care for homeless populations, particularly for those with mental illness. Finally, integration of the Medicare and Medicaid programs could be advanced by giving the HHS secretary authority to incorporate discrete components of the financial alignment demonstrations into existing care models.

Recommendations

Congress should:

A. Permit shared savings by allowing states to retain a portion of Medicare savings attributable to integration of services. These resources will help states offset the initial Medicaid investment in services and infrastructure. In return, states would agree to remove state-level barriers to alignment by coordinating Medicaid open enrollment with Medicare's annual open enrollment period;

B. Increase funding to the State Health Insurance Assistance Program to help Medicare-Medicaid beneficiaries better understand the options available to them in order to make informed choices;

C. Make funds available to the HHS secretary to coordinate alignment through the use of technical-assistance teams, similar to those used as part of the financial alignment demonstration for states that do not have expertise or resources;

D. Direct the HHS secretary to convene a working group composed of state agency officials; consumer advocacy representatives; private health insurance plans with experience integrating clinical health, behavioral health, and long-term services and supports; and other relevant experts to develop uniform standards appropriate for both Medicare and Medicaid, rather than continuing separate standards. As part of this alignment, Congress should provide limited authority to CMS to implement changes agreed on by the working group in the following areas:

    1. Care management standards for clinical health, behavioral health, and long-term services and supports;
    2. Network adequacy standards appropriate for Medicare-Medicaid beneficiaries, with beneficiary access as the primary focus;
    3. Unified standard materials for marketing, plan notices, and other member materials;
    4. A process for joint oversight of plans by CMS and states; and
    5. Alignment of Medicare and Medicaid measures, including measures of access to care by patient care setting; beneficiary experience in navigating the integrated program; and appropriateness of financial incentives among plans, providers, states and the federal government.

Special Supplemental Benefits for the Chronically Ill: Medicare Advantage

Under the BBA, Congress provided authority for MA plans to offer special supplemental benefits for the chronically ill (SSBCIs) that are not primarily health-related to patients beginning in January 2020. These benefits must have a reasonable expectation of improving or maintaining health or function (for example, the ability to perform normal activities of daily living, such as bathing and dressing). Under HHS guidance, plans may determine what benefits to offer, subject to approval by the secretary.[23]

Under current law, as part of a basic package, MA plans may offer supplemental benefits, which are provided to all enrollees. Those benefits are provided at no extra charge to enrollees and are financed by the difference between a plan's bid to CMS to cover Medicare benefits and the maximum amount that Medicare will pay to MA plans (known as the "benchmark"). Plans may also offer optional benefits for which beneficiaries pay higher premiums. Because SSBCIs are considered part of the basic benefits, they are financed through existing Medicare payments to plans.[24,25] As a result, there is no added cost to enrollees or to the federal government. Among the examples of SSBCIs cited by CMS, plans may offer benefits such as medically tailored home-delivered meals, beyond those already permitted in MA; food and produce; non-medical transportation; pest control; indoor-air-quality equipment and services; and services supporting self-direction, home modifications, and other benefits.[26]

Emerging evidence suggests that health plans can improve population health by serving non-medical needs. In one HHS study, researchers found that high-performing MA D-SNPs were able to reduce emergency department visits and hospitalizations through referral or direct provision of services for those who needed assistance with housing, food, and transportation.[27] Although similar studies exist, most are limited in scope and are unclear on whether these successes can be spread and scaled. Building a stronger evidence base will be necessary to expand the availability of non-medical benefits in Medicare fee-for-service. Under the BBA, Congress included a requirement that the Government Accountability Office report on benefits offered and the impact of those benefits. While that report will prove instructive, a longer study is needed to determine whether this new flexibility will be successful in improving care for those with complex needs.

One advantage of permitting MA to offer SSBCIs is that plans and providers can test benefits to determine their effectiveness in improving health or functional status for patients with chronic conditions and assess whether there are any added or reduced costs to the federal government or beneficiaries. These fully capitated plans provide opportunities to test the use of SSBCIs to see if they can reduce more costly inpatient stays or other avoidable events in Medicare—a primary BPC goal.

Recommendations

Congress should:

A. Direct the HHS secretary to establish standard language for marketing materials that clarifies that coverage of an SSBCI benefit is not guaranteed and to establish standards for member materials that describe the availability of SSBCIs once individuals are enrolled. Congress should also direct the secretary to revise agent and broker training and testing guidelines to include training on these benefits;

B. Direct the HHS secretary to develop materials for providers that make them aware of SSBCIs, the conditions under which services are covered, and where to direct patients for services, if not available through the referring provider;

C. Require MA plans to quantify and report outcomes to CMS on SSBCIs offered in a format and time frame established by the secretary;

[a] Notably, in California (one of the Financial Alignment Demonstration states), The SCAN Foundation and multiple partners developed the My Care, My Choice online tool that assists Medicare-Medicaid beneficiaries.

D. Direct CMS to review and compile evidence provided by MA plans, to publish periodic reports on outcomes, and to make data available to researchers to help build an evidence base on the effectiveness of covered non-medical services; and

E. Increase funding for State Health Insurance Assistance Programs, which assist Medicare beneficiaries in understanding the full range of choices available to them.

Discussion

Advocacy groups, as well as some plans and providers, have raised concerns about the implementation of SSBCIs.[28] Concerns include the adequacy of consumer information about the benefits, whether they qualify and whether providers will have the information they need to issue referrals for services. These groups have also raised concerns about marketing practices that could cause Medicare-Medicaid beneficiaries—who already have reduced cost-sharing and Medicaid-covered services through MA D-SNPs and Medicaid —to enroll in an MA plan, resulting in a loss of benefits. These are valid concerns that CMS or Congress should address.

BPC's original recommendations to expand non-medical benefits in MA included a number of safeguards that CMS did not adopt. To limit the improper use of this benefit and encourage enrollment, BPC proposed that plans be prohibited from marketing SSBCIs, since there is no guarantee that potential enrollees will meet the plan requirements to qualify for the benefits.[29] BPC also recommended that plans be required to use functional assessments and/or individualized care plans, in concert with diagnosis, to ensure appropriate targeting of benefits. These earlier recommendations were safeguards intended to prevent questionable marketing practices and to ensure appropriate targeting.[30]

Finally, while the policy to expand non-medical benefits was designed to improve care for individuals with chronic conditions, it is important to remember that MA plans once offered benefits such as golf-club memberships to encourage enrollment of low-risk Medicare beneficiaries. Recent agency guidance citing examples of allowable SSBCIs could be viewed as promoting exercise to prevent functional decline; however, they bring to mind past practices to select risk that were deemed inappropriate by Congress.[31] To prevent this, SSBCIs should be subject to congressional and agency oversight. Failure to conduct such oversight could result in a backlash among policymakers, prompting a rollback of the flexibility afforded to improve care for those with chronic conditions.

[b] Separate from BPC's efforts, a broad coalition of stakeholders has released Guiding Principles for New Flexibility Under SSBCI, common principles and priorities to assure that the new flexibility is balanced with appropriate guardrails to protect beneficiaries, providers, Medicare Advantage plans, and the Medicare program overall.

Improving Chronic Care Services in Medicare Fee-for-Service

In 2019, the trend of new retirees enrolling in MA continued. According to CMS, MA enrollment grew to 22.4 million in 2019, a 32 percent increase over 2015.[32] A growing number of Medicare beneficiaries in fee-for-service (FFS) receive care through alternative payment models (APMs). As of 2018, Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) covered 10.5 million Medicare beneficiaries, accounting for 27 percent of those in FFS.[33] Comprehensive Primary Care Plus (CPC+) medical homes, either as freestanding practices or as part of a larger ACO, served more than 15 million beneficiaries.[34]

BPC's Health Project has long advocated for increased enrollment in MA and supports APMs, such as ACOs, to improve value in the health care system. This view is embodied in BPC's earlier work by the Debt Reductions Task Force, co-chaired by former Senator Pete Domenici and former Director of the Congressional Budget Office Director Alice Rivlin, in 2011, as well as BPC's subsequent policy recommendations by former Senate Majority Leaders Tom Daschle and Bill Frist, Domenici, and Rivlin in 2013. Collectively, these leaders have emphasized the need to move away from traditional Medicare FFS toward MA and other APMs, to shift from volume-driven care to value-driven care, and BPC remains committed to this goal.

Half of beneficiaries with complex needs receive health care services through FFS,[35] and, according to the Kaiser Family Foundation, those choosing to remain in FFS have had historically higher spending than those who enroll in MA.[36] For those receiving care under Medicare FFS, either by choice or because MA plans offering SSBCIs are not available, these numbers underscore the need to seek solutions in traditional Medicare FFS.

The availability of targeted non-medical benefits for the chronically ill (referred to as "non-medical benefits") is particularly critical in rural areas, where MA plans have limited market penetration. According to the most recent data from the National Center for Health Statistics, 27.7 percent of respondents living in rural areas report having two or more chronic medical conditions.[37] Compounding matters, 11.4 percent of rural respondents report being in fair or poor health, compared with 8.6 percent of those in metropolitan areas.[38]

In traditional Medicare Part B FFS and non-risk-based APMs, in which providers are not responsible for the total cost of care, there is potential for added costs to be passed along to Medicare beneficiaries in the form of higher cost-sharing and premiums, and to taxpayers for the federal government's share of higher Medicare Part B spending.

While Congress should provide authority to the HHS secretary to approve coverage of non-medical benefits for individuals with chronic illness in Medicare FFS, it should be done through APMs, such as ACOs and primary care models, as well as for individuals receiving chronic care management (CCM) services. To address concerns about increased costs and utilization of services, coverage of non-medical benefits should be subject to conditions, including strong evidence of efficacy and cost-effectiveness.

Recommendations

Congress should:

A. Provide authority to the HHS secretary to identify and authorize coverage and payment of evidence-based non-medical benefits for patients with chronic conditions if:

   1. Peer-reviewed evidence demonstrates that the benefit improves or maintains health or function for a specific subset of patients with certain chronic conditions and/or functional limitations;
   2. The CMS Office of the Actuary certifies that coverage of the defined benefit for the defined population would result in no net increase in Medicare spending; and
   3. The chronic condition is being managed by an ACO, a comprehensive primary care model, through CCM, or through other payment or delivery models that include a care management component.

B. For any new evidence-based benefits for the chronically ill, the secretary should make available to Medicare providers a list of suppliers in the geographic area in which they provide services;

C. Eliminate the beneficiary co-pay for CCM services covered under Medicare, since the benefit covers provider-to-provider communications outside an office visit and are not obvious to the beneficiary;

D. Expand the list of qualified health providers that can bill for CCM services to include licensed clinical social workers practicing within the scope of their licenses;

E. Direct the HHS secretary to develop a uniform functional assessment tool and the conditions under which providers would perform the assessment to facilitate eligibility determination for non-medical services. Determination will be based on both chronic conditions and functional status;

F. Direct the secretary to establish criteria for organizations that would be eligible to provide non-medical services identified by the secretary in traditional Medicare FFS. The secretary should also establish monitoring programs to minimize fraud, waste, and abuse; and

G. Direct the secretary to examine potential modifications to the risk-adjustment model to ensure more accurate predictions of medical expenses for Medicare beneficiaries with functional limitations. The secretary should consider the appropriateness of developing a tool that can determine eligibility and assess risk.

Discussion

IDENTIFYING EVIDENCE-BASED BENEFITS

Under the Medicare program, Congress provides statutory authority for coverage of broad categories of services, and the HHS secretary makes coverage decisions about specific items and services within each category, either at a national level or through regional carriers. Within those categories, items and services must be reasonable and necessary for the diagnosis or treatment of an illness or injury.[39]

One challenge associated with expanding the availability of non-medical benefits is the somewhat limited body of evidence to support the coverage of these benefits as a way to improve outcomes and lower utilization of more expensive inpatient care. Yet some studies are emerging, particularly in the areas of medically tailored meals and community health workers.[40,41] As MA plans gain experience offering SSBCIs, the data collected could prove useful in increasing an evidence base to support the expansion of services, which will be critical for application to traditional Medicare coverage.

While an expansion of non-medical benefits to Medicare FFS would require congressional action, it is impractical to require Congress to enact legislation for these targeted benefits each time evidence becomes available, particularly when services are indicated for a very specific group of individuals based on health or function. HHS has used the Center for Medicare and Medicaid Innovation (CMMI) to test coverage of services and to expand coverage under Medicare through demonstrations. In 2017, for example, CMS began covering Medicare Diabetes Prevention Program (MDPP) services, which included beneficiary eligibility criteria, payment structure, supplier requirements, and compliance standards.[42]

While the HHS secretary could use a similar structure to advance coverage of evidence-based non-medical benefits in Medicare FFS, it is not practical or efficient to conduct demonstrations for each intervention as evidence becomes available for specific subpopulations.

A better option would be to provide authority to the secretary to expand the availability of evidence-based benefits, with similar safeguards relating to improving care and lowering costs, subject to certification by the CMS Office of the Actuary. Under this approach, the secretary could recommend coverage of a specific item or service for a defined population, and coverage would be subject to certification by Medicare's actuary, who in turn would determine if the evidence shows that the cost of the benefit would not add to the net cost of the Medicare program or would result in reduced spending over time.

In MA or in APMs with two-sided risk, in which providers may retain a portion of savings and are responsible for excess costs, there are disincentives to the coverage of services that add costs unless they result in an overall reduction in health spending. In traditional Medicare Part B FFS and non-risk-based APMs, in which providers are not responsible for total cost of care, there is the potential for added costs to be passed along to Medicare

beneficiaries in the form of higher cost-sharing and premiums, and to taxpayers for the federal government's share of higher Medicare Part B spending. Targeting of benefits is discussed in greater detail in the next sections.

The Role of Functional Assessment

Increasingly, experts agree that diagnosis alone does not give a full picture of a patient's need for services or the cost of providing care and that functional assessment is an important factor.[43,44] SSBCIs, as applied to MA, must have a reasonable expectation of improving or maintaining health or function. In establishing eligibility for MDPP services, for example, CMS defined clinical criteria for eligibility based on existing evidence.

Unlike the MDPP services, which are designed to prevent the onset of a condition, determining eligibility for non-medical services will necessitate having access to information on patient functional status, including cognitive function. For example, the need for minor home modifications or transportation, respite care for a caregiver, and other services that are traditionally provided for those who need long-term services and supports has historically depended on the level of independence of the beneficiary.[45,46] As a result, services could vary based on individual functional status and, if provided in Medicare FFS, would require the use of a uniform functional assessment tool to ensure that individuals meet the criteria for eligibility of a benefit and that similarly situated individuals are treated equally.

A variety of tools and instruments are currently available and used in the marketplace. Clinicians routinely employ standardized questions and validated assessment tools to screen for clinical and behavioral drivers of poor health, such as alcohol dependency, decompensated heart failure, and depression, yet there is no uniform assessment tool in use across providers or payers. Private insurers typically use proprietary tools for screening and assessing patient risk and the need for services; Accountable Health Communities employ the CMMI-developed Health-Related Social Needs Screening Tool;[47] and Federally Qualified Health Centers use their own Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool.[48] States may also require functional assessment to determine home and community service eligibility. If coverage were based on both chronic conditions and functional assessment, a uniform assessment tool would need to be developed. In developing this tool, CMS should look to existing tools. California, for example, requires Medicaid managed care plans to include 10 core questions in the health risk assessment that address both functional and social needs.[49]

While CMS has done a significant amount of work in the area of functional assessment, there is no single agreed-upon assessment tool. In 2014, Congress passed the Improving Medicare Post-Acute Care Transformation Act (IMPACT).[50] While the focus of the work done by CMS was to develop quality measures for post-acute care, the work required creating standards to assess functional status, cognitive function, and the changes in functional status in both areas. More recent efforts by the National Quality Forum seek to measure function among those with serious illness.[51] Today, CMS uses Hierarchical Condition Categories (HCC) to make risk-adjusted payments in MA.[52] Most recently, CMS has proposed incorporating a frailty adjuster, which takes into account severity of illness and can improve risk adjustment; however, evidence shows that functional assessment is a better predictor of cost and medical needs.[53,54,55,56] In addition to the need of a uniform functional assessment tool to determine eligibility for non-medical benefits in fee-for-service Medicare, experts have also suggested that the use of functional status could be an important factor in improving risk adjustment.[57,58]

Service Providers

Another consideration for coverage of non-medical benefits in Medicare FFS is the importance of identifying qualified providers or suppliers. Similar to the MDPP benefit, the secretary could set standards for community-based organizations, or other types of entities, to provide covered benefits.[59] HHS took this approach in defining medical suppliers qualified to offer MDPP. Value-based models are best structured for supporting the provision of non-medical services to individuals with chronic conditions. Critical to making non-medical services available is the link to case-management services.

PAYMENT AND DELIVERY MODELS THAT SUPPORT CHRONIC CARE MANAGEMENT

Alternative Payment Models

CMS has demonstrated a commitment to aligning health care payment and delivery. The agency is providing financial incentives through recent initiatives that expand and support two-sided risk arrangements. In exchange for increased responsibility for quality and spending that exceeds expected costs, providers are given greater flexibility to achieve improved health outcomes. Alternative payment models include ACOs and the CPC+ model, as well as other new initiatives. At the same time, CMS is promoting chronic care management by updating and expanding codes under the physician fee schedule.

FFS primary care models focus on population health and rely heavily on care coordination to avoid acute care costs. Despite an inherent focus on patient-centered care, these risk-based models have faced barriers to fully integrating services, some of which have been addressed by CMS. One challenge associated with the provision of non-medical services that are not covered by Medicare, is financing of those services.

The 2019 "Pathways to Success" rule released by CMS adopts many earlier BPC recommendations for improving ACOs, including enabling elective beneficiary enrollment,[60] offering prospective beneficiary attribution, and expanding telehealth services.[61] These actions highlight CMS's intention to expand the use of risk-sharing arrangements for models with a focus on population health.

CMS and the HHS Office of the Inspector General have used waivers to support integrated care. For example, the patient incentive waiver for the MSSP allows ACOs to provide in-kind items and services to beneficiaries as long as the service is reasonably connected to medical care and offers preventive or improved care management.[62] Services that support care management can be funded through ACO shared-savings income, but those requiring substantial up-front investment are unlikely to be offered due to a lack of resources. Notably, CMS explicitly prohibits financial incentives, such as waiving or reducing patient cost-sharing. For example, an ACO may arrange for transportation to a provider office visit or pharmacy, but it may not reimburse costs of travel initiated by the patient.

The CPC+ model is supported by a prospective payment structure, including care management and incentive payments based on the complexity of attributed beneficiaries. In contrast to ACOs, the CPC+ model lacks the waiver flexibility afforded to ACOs. Program integrity rules prevent providers from furnishing non- Medicare-covered supports and services at no charge to the beneficiary. Providing non-medical services could violate the federal anti-kickback statute and the beneficiary inducements' civil monetary penalty. These laws prohibit providers from offering rewards or remuneration to induce beneficiaries to receive services.[63] While necessary for preventing fraud, these laws may also interfere with the provision of effective and justifiable services that support patient-centered care.

A Patient Incentive Waiver, similar to that under the MSSP, would ensure the legality of providing in-kind services for CPC+ practices that are not in MSSP ACOs. CMS released the first annual performance evaluation for CPC+ in April 2019. Participating practices stated that the prospective payments, meant to assist in the financing of up-front investments necessary for care-coordination services, were crucial to providing care-coordination services yet remained insufficient for some practices. This highlights concerns about the viability of offering non-medical services for certain high-need, high-cost Medicare-only individuals under this model. Should CMS grant a Patient Incentive Waiver, funding will require further consideration, as CMS designed current prospective payments to help support investments in care-coordination activities, rather than finance additional social services and supports.

Assuring Appropriate Risk Adjustment

Considering the substantial investment in a comprehensive care model, quality measures should also capture efforts to incorporate these services, using either shared savings or incentive payments, within existing ACO and CPC+ financial structures. Importantly, CMS should structure quality measures in a way that rewards the appropriate provision of services without encouraging overuse. This is described by the work of the National Quality Forum Serious Illness Initiative that aims to effectively capture efforts to screen patients and use functional assessment tools as part of care-coordination activities.[64] Provided that CMS defines quality measures appropriately, risk-based models with greater levels of social support and service integration should be rewarded.

The successful delivery of non-medical benefits depends on enhanced risk stratification to ensure appropriate financing. CMS uses the HCC model to capture the variable costs of providing care to a particular patient population. However, the CMS-HCC risk-adjustment model is known to underpredict costs by 29 percent for the highest-cost Medicare beneficiaries and overpredict expenses by up to 62 percent for the lowest-cost beneficiaries.[65] In neglecting to adequately capture costs, while heavily influencing reimbursement rates, risk-based models working against a benchmark have found themselves under-financed to adequately care for patients with complex needs. In response, many ACOs have developed methods to more narrowly target services though population segmentation. Supporting this trend, the National Quality Forum's Serious Illness Initiative is evaluating how functional assessment tools are being evaluated as a means to to more optimally target services.[66] This enables a more effective assignment of resources to address the significant variability of high-need, high-cost beneficiaries.[67] In accordance with the 21st Century Cures Act, CMS has updated the risk-adjustment methodology for 2020 by implementing the alternative payment condition count model. This should more accurately capture spending for high-cost beneficiaries, particularly with respect to the addition of dementia to the list of conditions.

Two-sided-risk ACOs and some primary care practices may see value in providing non-medical services as part of a comprehensive care plan. In a 2016 study, researchers found that ACOs frequently provided non-health-related services as a means of addressing patients' social needs.[68] However, the acceleration of two-sided risk in 2019 may negatively impact the ability of ACOs to offer non-medical benefits. Ultimately, the successful delivery of non-medical benefits through FFS models, such as CCM services and APMs, will depend on enhanced risk stratification and appropriate financing. However, under a process that permits the expansion of Medicare to include non-medical services, those services would be included as a Medicare-covered service in payment.

New Models

In a proposal submitted to the Physician-Focused Payment Model Technical Advisory Committee, the American Academy of Family Physicians highlighted barriers to care-coordination and management activities under the current episodic reimbursement structure, which bases payment on services rather than on patient health status.[69] The academy described a means "to support continuous, longitudinal, and comprehensive care across settings and providers."[70] The proposal is reflected in the recently announced CMMI Primary Care First model as part of the "Primary Cares Initiative." The initiative builds on the success of the CPC+ model and enables direct contracting to support providers in care coordination and to better address the complex needs of the chronically ill.[71]

Chronic Care Management and Related Services

While not an APM, participation in CCM and related services could be another means of accessing non-medical services. Case-management services are an essential attribute of caring for patients with complex needs, and, in recent years, CMS has acknowledged the importance of CCM services for these individuals. Use of CCM codes to oversee patients can be used as a point of access for newly available non-medical services. Historically, care management was considered part of a bundle of services provided during a physician's office visit. However, CMS recognizes that this approach resulted in payment disparities.[72] New codes developed over the last five years include specific non-face-to-face CCM codes, complex care management services, and transitional care management services. When combined with new codes for remote patient monitoring, communication technology-based services, and interprofessional internet consultation, CCM codes provide a range of reimbursement options for qualified health professionals who want to better manage care for their patients with complex needs.

In 2015, Medicare began paying separately for CCM services furnished to Medicare patients with multiple chronic conditions. Like many Medicare-covered outpatient services, clinical staff may provide CCM services under the direction of a billing practitioner on an "incident to" basis, an integral part of services provided by the billing practitioner. Beginning in 2019, CMS distinguished between CCM services provided by (1) clinical staff under the supervision of a billing provider (current procedural terminology [CPT] 99490), which includes 20 minutes of clinical staff services, including 15 minutes of physician time for supervision of clinical staff; and (2) a qualified health provider (CPT 99491), which includes direct care by physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants.[73] CMS defines clinical staff as employees of or contractors to the billing provider.[74] The ability to provide services is subject to state law, licensure, and scope of practice. For more complex cases, providers may bill under a complex care management code that better accounts for the time and cost of providing services to those with multiple chronic conditions. For more on available reimbursement opportunities in FFS, see Table 1.

Table 1: Chronic Care Management and Related Codes, Medicare Physician Fee Schedule 2019

Description	Code	Billing Provider	National Payment Amount*
Chronic Care Management, 20 minutes	99490	Clinical staff directed by a physician or other qualified health care professional; includes 15 minutes of physician time for supervision of clinical staff	$42.17 PMPM
Chronic Care Management, 30 minutes	99491	Physician or other qualified health professional	$83.97 PMPM
Complex Care Management, 60 minutes	99487	Clinical staff directed by a physician or other qualified health care professional (employees and consultant)	$92.98 PMPM
Complex Care Management each additional 30 minutes	99489	Clinical staff directed by a physician or other qualified health care professional, billed with code 99489 for each additional 30 minutes	$46.49 PMPM
Chronic Care Remote Physiologic Monitoring	99453	Initial set-up and patient education on use of equipment	$19.46 (one time)
Chronic Care Remote Physiologic Monitoring	99454	Remote monitoring of physiologic parameter(s) every 30 days, initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$64.15 PMPM
Remote physiologic monitoring treatment management services, 20 minutes	99457	Clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	$51.54 PMPM
Psychiatric Care Management, 70 minutes	99492	Initial psychiatric collaborative care management	$162.18 (First month)
Psychiatric Care Management, 60 minutes	99493	Subsequent psychiatric collaborative care management	$129.38 PMPM
Psychiatric Care Management, each additional 30 minutes	99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month	$67.03 PMPM
Transitional Care Management, 14-day	99495	Transitional care management for 30 days commences on day of discharge; must include a face-to face visit within 14 days of discharge	$166.50
Transitional Care Management, 7-day	99496	Transitional care management for 30 days commences on day of discharge. Must include a face-to face visit within 7 days of discharge.	$234.97
Interprofessional Internet Consultation, 5 minutes	99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician	$37.48
Interprofessional Internet Consultation, 30 minutes	99452	Interprofessional telephone/internet/electronic health record referral service(s)	$37.48

**Payment amount listed is for services provided in a non-hospital-based provider office. Amount varies by Medicare administrator contractor locality.*

According to CMS, CCM is a primary care service that "contributes to better health and care for individuals," and while most frequently billed by primary care providers, in certain circumstances it may be provided by specialists.[75] CMS notes that CCM is not within the scope of practice for limited license providers, such as psychologists, podiatrists, or dentists. Primary care providers may refer to or consult with these providers to manage care; however, separate codes exist for behavioral health integration.[76]

CCM services may be provided to Medicare beneficiaries with two or more chronic conditions whose conditions are expected to last at least 12 months or until the death of the patient. The conditions must place the patient at significant risk of death, acute exacerbation of the condition, or functional decline.[77] As with other Part B services, patients have a 20 percent coinsurance.

Despite this progress, health care providers were somewhat slow to use these codes during the first year of availability. According to a July 2017 article in the *Journal of General Internal Medicine*, practitioners surveyed reported challenges associated with providing CCM services under Medicare.[78] Among the challenges cited: (1) the lack of personnel available to develop care plans; (2) documentation resulted in duplicate data entry between electronic health records and care management software, although many of the providers were able to purchase add-on software that permitted them to track case management; (3) the requirement to obtain written beneficiary consent and collect a co-pay for services that are not performed during a regular office visit; and (4) whether payment is adequate.

CMS has addressed some of these issues. As part of the 2019 physician fee schedule, CMS noted efforts to streamline requirements to avoid duplication of documentation; added a billing code to better reflect the time spent by a qualified health provider directly performing care management services, as opposed to services performed by clinical staff; and permitted verbal rather than written consent from patients.[79] CMS also noted that, although many commenters had requested the elimination of the 20 percent beneficiary co-payment, CMS did not have the authority to make that change.[80]

Analysis of Budgetary Implications Associated with a Hypothetical Supplemental Benefit

BPC contracted with Ananya Health Innovations (Ananya Health) to help define Medicare patient cohorts that could potentially be eligible for SSBCIs and to estimate the budgetary effects of an evidence-based, non-medical benefit narrowly tailored to certain patients with chronic conditions. Through this analysis, BPC hoped to illustrate the potential for non-medical benefits to be offered in Medicare FFS for individuals with multiple chronic conditions. For the complete analysis, see the Appendix.

Based on evidence that medically tailored meals can reduce hospital readmissions for certain patients post-hospital discharge, the analysis identified 11 chronic conditions: (1) congestive heart failure; (2) depression; (3) diabetes; (4) emphysema, asthma, or COPD; (5) Alzheimer's disease or other diagnosis of dementia; (6) osteoporosis; (7) other heart condition; (8) paralysis; (9) Parkinson's disease; (10) rheumatoid arthritis; and (11) stroke. BPC defined "eligible individuals" as Medicare beneficiaries with two or more of these conditions and one or more functional limitations (deficits in activities of daily living). The "benefit," which BPC defined as seven days of medically tailored home-delivered meals, would be made available to patients meeting eligibility criteria and provided post-hospital discharge.

Full participation could lead to 575,408 eligible beneficiaries, 1,012,590 eligible inpatient stays, and 9,719 fewer readmissions attributable to the supplemental benefit. The literature suggests other utilization offsets, including reduced emergency-department visits and skilled nursing facility (SNF) stays, would lead to additional savings attributable to the same supplemental benefit. BPC's data source did not include emergency department utilization rates for the analytic cohorts. Achieving significant reductions in SNF benefits might be considered especially in conjunction with supplemental benefits that include medically tailored meals and home visits with clinical monitoring, social support, and early intervention as needed.

According to the simulation, the aggregate cost of full participation among eligible beneficiaries would be $101,258,974 (which is $175.98 per person). The gross savings due to reduced readmission rates would be $158,606,687, resulting in a net savings of $57,347,713. Most of the net savings would come from the subgroup with several hospitalizations, while beneficiaries with a single inpatient stay would incur incremental costs from the meals program but have no readmissions to avert. All of the subgroups could potentially have additional savings due to averted emergency-department visits or even SNF stays under a national program with tailored supplemental benefits. In this illustration, the ratio of savings to cost for the hypothetical supplemental benefit was 1 to 57; hence, on average, every dollar spent on the meals program resulted in $1.57 in savings.

This analysis illustrates that the HHS secretary could potentially identify a defined benefit for specific cohorts of patients in Medicare FFS that does not result in net outlays to the Medicare program. Additional analysis will be required to develop actual projections of costs and savings to the Medicare program, including further specification of non-medical benefits for those with chronic illness and refined assumptions about targeting, realistic participation, gaming, and operational details, such as market prices. Also, as noted, from a policy perspective, it would be necessary to limit eligibility for these benefits to patients both meeting the condition criteria defined by the secretary and those receiving care coordination, through APMs or care management services, that includes a functional assessment.

Conclusion

Federal policy that affects individuals who require complex care continues to improve. Congress and CMS have taken steps to better integrate Medicare and Medicaid services for dual-eligible individuals. There are, however, additional steps that Congress or the administration can take.

As MA plans begin to target non-medical benefits to patients with chronic conditions, it will be important to collect information on which services are covered, who is receiving them, and the impact of these benefits on individuals and on the Medicare program. It will also be critical to ensure that beneficiaries understand that CMS is not guaranteeing these benefits to all Medicare enrollees.

Given the high percentage of Medicare beneficiaries with chronic illness, Congress should extend similar benefits to those in Medicare FFS. In providing that authority, however, Congress should be cognizant that, while MA and APMs that share in risk have incentives to lower cost and the use of unnecessary services, for other APMs and CCM services provided outside of an APM, safeguards should be put in place to ensure that these non-medical benefits are evidence-based, targeted, and do not result in a net increase in beneficiary cost-sharing, premiums, or additional costs to taxpayers.

Appendix

Analysis in Support of Special Supplemental Benefits for Medicare FFS Beneficiaries with Chronic Illness Provided by Ananya Health

BPC has made a series of recommendations to improve the health and functional status for chronically ill beneficiaries, to prevent avoidable adverse outcomes for these individuals, and to generate savings for the Medicare program. BPC's recommendations address SSBCIs for beneficiaries covered by original Medicare and call for additional efforts by the HHS secretary to better define eligibility, assess the specific needs of this population, and identify evidence-based benefits that could prove beneficial. It would be helpful if policymakers would define and empirically illustrate the types of beneficiaries who could potentially qualify for SSBCIs, their relevant needs and circumstances, and potential scenarios leading to cost savings.

This issue brief describes the results of the analysis conducted in support of BPC's efforts to improve the welfare of chronically ill Medicare beneficiaries through the availability of SSBCIs. The objectives of the analyses were to:

- Define and describe six Medicare patient cohorts who could potentially be eligible for specific supplemental benefits based on general criteria related to chronic conditions and functional limitations, as well as other specific considerations;
- Identify and quantify possible opportunities to reduce or offset costs and usage for the patient cohorts;
- Incorporate estimates of the likely cost of one specific supplemental benefit as part of empirical illustrations of the cost versus savings of a benefit;
- Estimate scenarios of scaled programs—such as the total number of plausible users of the selected benefit multiplied by the suggested average cost per person—to produce aggregate total additional spending and net savings; and
- Derive estimates of the likely cost and plausible impact of a specific supplemental benefit to illustrate cost versus savings of a benefit.

Data Sources and Methods. Ananya Health used the 2016 Medicare Current Beneficiary Survey (MCBS) Public Use File (PUF) to identify the Medicare patient cohorts for analyses, and to identify the subsets covered under the original (that is, "fee-for-service," or FFS) Medicare program. Ananya Health included all beneficiaries who indicated that they enrolled in original Medicare for the whole year or any part of the year. By including beneficiaries who only enrolled for part of the year in the analysis, Ananya Health could ensure more complete estimates of the possible incremental costs of any new SSBCIs as well as any offsetting savings the Medicare program might capture.

In addition to the MCBS, Ananya Health incorporated information from other published sources in order to determine baseline cost, utilization patterns, and estimates of the affected sizes related to the selected benefit: that is, home delivery of meals to qualified beneficiaries immediately following discharge from inpatient hospital stays.

Ananya Health defined the patient cohorts based on BPC's recommendation that beneficiaries who had at least two chronic conditions and one functional limitation potentially be offered SSBCIs. The MCBS includes questions about a number of chronic conditions. Ananya Health selected a subset of 11 chronic conditions for the cohort analyses in consultation with the BPC project team and based on the plausible relevance of SSBCIs to avoid adverse utilization events and costs in the presence of co-occurring functional limitations:

1. Congestive heart failure (ever);
2. Depression (ever);
3. Diabetes (told on two or more visits);
4. Emphysema/asthma/COPD (ever);
5. Alzheimer's or dementia diagnosis (ever);
6. Osteoporosis/soft bones (ever);

7. Other heart condition—for example, valve/rhythm (ever);
8. Paralysis complete/partial (ever);
9. Parkinson's disease (ever);
10. Rheumatoid arthritis (ever); and
11. Stroke/brain hemorrhage (ever).

Ananya Health calculated the frequency counts of beneficiaries who reported having each of the chronic conditions, and then proceeded to form heterogeneous cohorts comprising all beneficiaries who had two or more of the 11 selected chronic conditions.

In addition, the MCBS asks respondents about their functional limitations, including instrumental activities of daily living and activities of daily living (ADL). Ananya Health presents descriptive details of the eventual patient cohorts for many different functional limitations; however, Ananya Health defined the cohorts based on a variable provided in the MCBS PUF, which indicates whether the beneficiary has zero, one, two, three, or four ADLs.

Ananya Health defined the general patient cohort as those beneficiaries who had any two or more of the 11 chronic conditions listed above, plus one or more ADL. Ananya Health then layered additional criteria on top of this baseline cohort in order to identify five additional subsets of potential interest:

- **Patient Cohort 1:** Beneficiaries enrolled in original Medicare (age or disability) for any part of the year who reported having any two or more of the 11 identified chronic conditions, and at least one ADL.
- **Patient Cohort 2:** Beneficiaries in Cohort 1 who also had an inpatient (IP) stay any time during the year.
- **Patient Cohort 3:** Beneficiaries in Cohort 2 who indicated that they had difficulty eating solid foods because of dental issues.[81]
- **Patient Cohort 4:** Beneficiaries in Cohort 1 who indicated that they had difficulty eating solid foods because of dental issues.
- **Patient Cohort 5:** Beneficiaries in Cohort 1 who indicated they relied on forms of transportation for medical appointments other than being driven.
- **Patient Cohort 6:** Beneficiaries in Cohort 1 who indicated living in a single-person household—that is, living alone.

For these six cohorts, Ananya Health also calculated demographic characteristics, such as age band, gender, rural/urban, race, income, education, and marital status. In addition, Ananya Health calculated usage profiles for these cohorts using data from the MCBS PUF. The MCBS PUF provides the following utilization data for each beneficiary: IP stays, outpatient visits, office visits, SNF stays, home health, and hospice visits. The MCBS PUF does not include data on emergency-room visits.

Results

This section shows results that describe the potential beneficiary groups who could be eligible for supplemental benefits based on criteria related to the presence of chronic conditions and functional limitations. Exhibit 1 shows the 11 selected chronic conditions, which serve as input into the criterion that patients have (two or more) chronic conditions. Each of the 11 conditions is a prevalent problem for different numbers of beneficiaries. Basing eligibility for supplemental benefits on rarer conditions would limit their availability, as well as the specter of increased costs to the Medicare program. For example, Parkinson's disease (N=131) and Alzheimer's or dementia (N=412) had the lowest prevalence rates in the MCBS FFS sample. Expanding criteria to include additional chronic conditions, as done in this exploratory study, would increase potential access to supplemental benefits to larger and more diverse patient cohorts.

Exhibit 1: Selected Chronic Conditions for Medicare FFS Beneficiaries

Chronic Condition	Sample Size
Congestive heart failure (ever)	703
Depression (ever)	2,395
Diabetes (told on two or more visits)	2,167
Emphysema/asthma/COPD (ever)	1,803
Alzheimer's or dementia (ever)	412
Osteoporosis/soft bones (ever)	1,455
Other heart condition (e.g., valve/rhythm) (ever)	2,616
Paralysis complete/partial (ever)	298
Parkinson's disease (ever)	131
Rheumatoid arthritis (ever)	1,309
Stroke/brain hemorrhage (ever)	917

Exhibit 2 shows further steps in the formation of patient cohorts intended for this analysis. In addition to the sample sizes for patient groups reporting each of the 11 selected conditions, Exhibit 2 shows the respective sample sizes for subgroups with each of the individual "anchor" conditions plus any one or more of the 11 chronic conditions. For example, 655 of the 703 beneficiaries with congestive heart failure also have at least one of the other chronic conditions and thus meet the criterion of two or more chronic conditions. The right side of Exhibit 2 describes the functional limitations anchored in each of the 11 chronic conditions for each of the respective sub-cohorts. For example, 40 percent of the sub-cohort who have congestive heart failure (and at least one other chronic condition) reported having no functional limitation defined as an ADL. That means 60 percent of that sub-cohort had one or more ADLs, which corresponds to the proposed criterion for eligibility to supplemental benefits. Exhibit 2 shows that those 60 percent of the sub-cohort with congestive heart failure comprised 33 percent with one or two ADLs, and 27 percent with three or four ADLs.

Exhibit 2: Selected Chronic Conditions and Functional Limitations

Anchor Chronic Condition (CC) Name	Overall Anchor CC Cohort Size	Anchor CC + Any Other CC Sub-cohort Size	No ADL	1 or 2 ADLs	3+ ADLs
Congestive heart failure (ever)	703	655	40%	33%	27%
Depression (ever)	2,395	1,892	46%	30%	24%
Diabetes	2,167	1,671	53%	27%	20%
Emphysema/asthma/COPD (ever)	1,803	1,525	51%	29%	20%
Alzheimer's or dementia (ever)	412	370	29%	30%	41%
Osteoporosis/soft bones (ever)	1,455	1,191	50%	29%	21%
Other heart condition (e.g., valve/ rhythm) (ever)	2,616	2,035	54%	29%	17%
Parkinson's disease (ever)	131	119	29%	28%	44%
Paralysis complete/partial (ever)	298	270	27%	30%	43%
Rheumatoid arthritis (ever)	1,309	1,121	44%	31%	25%
Stroke/brain hemorrhage (ever)	917	799	43%	30%	27%

Below are a series of exhibits that describe the six patient cohorts meeting potential criteria related to eligibility for supplemental benefits (and introduced earlier).

Demographic Characteristics of Selected Cohorts

In this section, Ananya Health describes the demographic characteristics of the selected cohorts, including age, gender, income, education, and geographic location (metropolitan versus non-metropolitan). Exhibit 3 shows the counts of beneficiaries in the sample that correspond to the six cohorts described in the "Data Sources and Methods" section and the gender breakdown of each patient cohort.

As a reference, of the 6,576 sampled beneficiaries with any one or more of the 11 chronic conditions, 44 percent were male and 56 percent were female. There were 1,939 beneficiaries in Cohort 1 who met the basic criteria for supplemental benefits: that is, two or more of the chronic conditions and one or more of the ADLs; of those beneficiaries, 36 percent were male and 64 percent were female. Of the six analytic cohorts, the largest percentage of male beneficiaries (41 percent) was in Cohort 5, which included reports of transportation difficulties (normally driven to doctor visits). The smallest percentage of male beneficiaries (28 percent) was in Cohort 6, which included reports of living alone.

Exhibit 3: Patient Cohorts Based on Selection Criteria: Gender

		Gender	
Cohort definition (FFS for any part of the year)	**Count**	**Male**	**Female**
Any of the 11 CCs	**6,576**	44%	56%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	36%	64%
Cohort 2: Cohort 1 Plus IP Stays	**508**	34%	66%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	37%	63%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	36%	64%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	41%	59%
Cohort 6: Cohort 1 Plus Living Alone	**627**	28%	72%

Exhibit 4 shows the reported incomes of beneficiaries in each of the patient cohorts, using a dichotomy of less or more than $25,000. The highest percentages of beneficiaries with lower incomes (about two-thirds) were in cohorts that reported experiencing food difficulties (Cohorts 3 and 4) or living alone (Cohort 6).

In addition to income Ananya Health also examined the distribution by educational attainment. Exhibit 5 shows the education levels achieved by beneficiaries in the cohorts. Cohorts with reported food difficulties (Cohorts 3 and 4) tended to have lower educational achievement, which coincides with findings shown in Exhibit 4, as one would expect given that in general income and education are known to be correlated.

Exhibit 4: Patient Cohorts Based on Selection Criteria: Income

		Income	
Cohort definition (FFS for any part of the year)	Count	< $25,000	>= $25,000
Any of the 11 CCs	**6,576**	45%	55%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	56%	44%
Cohort 2: Cohort 1 Plus IP Stays	**508**	55%	45%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	66%	34%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	67%	33%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	53%	47%
Cohort 6: Cohort 1 Plus Living Alone	**627**	67%	33%

Exhibit 5: Patient Cohorts Based on Selection Criteria: Education

		Education		
Cohort definition (FFS for any part of the year)	Count	Less than high school	High school or vocational, technical, business	More than high school
Any of the 11 CCs	**6,576**	19%	36%	45%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	25%	37%	38%
Cohort 2: Cohort 1 Plus IP Stays	**508**	27%	37%	35%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	35%	34%	30%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	31%	37%	31%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	21%	36%	43%
Cohort 6: Cohort 1 Plus Living Alone	**627**	23%	36%	40%

Exhibit 6 shows the residence locations of beneficiaries based on metropolitan versus non-metropolitan areas. Cohorts with reported food difficulties, (Cohorts 3 and 4) at around one-third, tended to have slightly higher percentages of individuals living in non-metropolitan areas, although the patterns are fairly similar across all six cohorts.

Exhibit 6: Patient Cohorts Based on Selection Criteria: Living in Metropolitan or Non-Metropolitan Areas

		Location	
Cohort definition (FFS for any part of the year)	**Count**	**Metro area**	**Non-metro area**
Any of the 11 CCs	**6,576**	71%	29%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	70%	30%
Cohort 2: Cohort 1 Plus IP Stays	**508**	71%	29%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	67%	33%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	67%	33%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	70%	30%
Cohort 6: Cohort 1 Plus Living Alone	**627**	71%	29%

Exhibit 7 shows the marital status of beneficiaries in the respective cohorts. Cohort 6 (living alone) differs the most from other cohorts with more than half (54 percent) widowed and only 5 percent married.

Exhibit 7: Patient Cohorts Based on Selection Criteria: Marital Status

		Marital Status			
Cohort definition (FFS for any part of the year)	**Count**	**Married**	**Widowed**	**Divorced/ separated**	**Never Married**
Any of the 11 CCs	**6,576**	47%	26%	16%	12%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	38%	32%	18%	11%
Cohort 2: Cohort 1 Plus IP Stays	**508**	37%	37%	17%	9%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	34%	33%	22%	10%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	34%	32%	23%	11%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	39%	28%	22%	10%
Cohort 6: Cohort 1 Plus Living Alone	**627**	5%	54%	29%	13%

Exhibit 8 shows beneficiaries' age group, with the highest percentages over 75 (more than 60 percent) among Cohorts 2 and 3, which included an IP stay, and Cohort 6 (living alone). Cohort 4, with food difficulties, had the highest percentage under age 65 (32 percent). Exhibit 9 shows the distribution of cohorts by race. The highest percentages of Hispanics were among cohorts with reported food difficulties (Cohorts 3 and 4).

Exhibit 8: Patient Cohorts Based on Selection Criteria: Age Group

		Age Group		
Cohort definition (FFS for any part of year)	**Count**	**<65**	**(65 -75)**	**>=75**
Any of the 11 CCs	**6,576**	20%	29%	50%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	25%	20%	55%
Cohort 2: Cohort 1 Plus IP Stays	**508**	18%	19%	63%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	25%	14%	61%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	32%	19%	49%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	28%	26%	46%
Cohort 6: Cohort 1 Plus Living Alone	**627**	17%	21%	62%

Exhibit 9: Patient Cohorts Based on Selection Criteria: Race

		Race			
Cohort definition (FFS for any part of the year)	**Count**	**Non-Hispanic white**	**Non-Hispanic black**	**Hispanic**	**Other**
Any of the 11 CCs	**6,576**	77%	10%	7%	6%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	73%	11%	9%	7%
Cohort 2: Cohort 1 Plus IP Stays	**508**	74%	11%	9%	6%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	72%	8%	12%	9%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	69%	12%	10%	9%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	75%	11%	8%	6%
Cohort 6: Cohort 1 Plus Living Alone	**627**	75%	12%	7%	6%

Utilization Patterns for Selected Cohorts

The following tables show the utilization rates by service type for each patient cohort: (a) office visits; (b) outpatient visits; (c) SNF stays; and (d) IP hospital stays. Generally, these patient cohorts had frequent office and outpatient visits during the year. Except for Cohort 2, which required an IP stay, about one-fifth to one-quarter of beneficiaries in the other cohorts had at least one IP hospital stay. Most of the patients in this cohort did not have any SNF stays.

Exhibit 10: Utilization Rates by Service Type: Cohort 1 (2+ CCs plus 1+ADL)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	224	11.6%	11.6%
16 to 20 office visits	210	10.8%	22.4%
11 to 15 office visits	335	17.3%	39.7%
6 to 10 office visits	468	24.1%	63.8%
1 to 5 office visits	491	25.3%	89.1%
No office visit	211	10.9%	100.0%
Total	**1,939**	**100%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	1,551	80.0%	80.0%
No	388	20.0%	100.0%
Total	**1,939**	**100%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	43	2.2%	2.2%
One stay	113	5.8%	8.0%
No stay	1,783	92.0%	100.0%
Total	**1,939**	**100%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	46	2.4%	2.4%
Three stays	32	1.7%	4.0%
Two stays	95	4.9%	8.9%
One stay	326	16.8%	25.7%
No stay	1,440	74.3%	100.0%
Total	**1,939**	**100.0%**	

Exhibit 11: Utilization Rates by Service Type: Cohort 2 (Cohort 1 plus IP stay)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	98	19.3%	19.3%
16 to 20 office visits	80	15.7%	35.0%
11 to 15 office visits	106	20.9%	55.9%
6 to 10 office visits	108	21.3%	77.2%
1 to 5 office visits	92	18.1%	95.3%
No office visits	24	4.7%	100.0%
Total	**508**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	474	93.3%	93.3%
No	34	6.7%	100.0%
Total	**508**	**100.0%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	43	8.5%	8.5%
One stay	109	21.5%	29.9%
No stay	356	70.1%	100.0%
Total	**508**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	46	9.1%	9.1%
Three stays	32	6.3%	15.4%
Two stays	95	18.7%	34.1%
One stay	326	64.2%	98.2%
No stay[82]	9	1.8%	100.0%
Total	**508**	**100.0%**	

Exhibit 12: Utilization Rates by Service Type: Cohort 3 (Cohort 2 plus food difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	31	16.9%	16.9%
16 to 20 office visits	26	14.2%	31.1%
11 to 15 office visits	42	23.0%	54.1%
6 to 10 office visits	36	19.7%	73.8%
1 to 5 office visits	38	20.8%	94.5%
0: No office visit	10	5.5%	100.0%
Total	**183**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	168	91.8%	91.8%
No	15	8.2%	100.0%
Total	**183**	**100.0%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	16	8.7%	8.7%
One stay	34	18.6%	27.3%
No stay	133	72.7%	100.0%
Total	**183**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	20	10.9%	10.9%
Three stays	10	5.5%	16.4%
Two stays	36	19.7%	36.1%
One stay	113	61.7%	97.8%
No stay	4	2.2%	100.0%
Total	**183**	**100.0%**	

Exhibit 13: Utilization Rates by Service Type: Cohort 4 (Cohort 1 plus food difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	76	10.4%	10.4%
16 to 20 office visits	73	10.0%	20.4%
11 to 15 office visits	125	17.1%	37.4%
6 to 10 office visits	169	23.1%	60.5%
1 to 5 office visits	197	26.9%	87.4%
0: No office visit	92	12.6%	100.0%
Total	**732**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	575	78.6%	78.6%
No	157	21.4%	100.0%
Total	**732**	**100.0%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	16	2.2%	2.2%
One stay	35	4.8%	7.0%
No stay	681	93.0%	100.0%
Total	**732**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	20	2.7%	2.7%
Three stays	10	1.4%	4.1%
Two stays	36	4.9%	9.0%
One stay	113	15.4%	24.5%
No stay	553	75.5%	100.0%
Total	**732**	**100.0%**	

Exhibit 14: Utilization Rates by Service Type: Cohort 5 (Cohort 1 plus transportation difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	118	12.2%	12.2%
16 to 20 office visits	103	10.7%	22.9%
11 to 15 office visits	172	17.8%	40.7%
6 to 10 office visits	251	26.0%	66.7%
1 to 5 office visits	226	23.4%	90.2%
0: No office visit	95	9.8%	100.0%
Total	**965**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	774	80.2%	80.2%
No	191	19.8%	100.0%
Total	**965**	**100.0%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	11	1.1%	1.1%
One stay	37	3.8%	5.0%
No stay	917	95.0%	100.0%
Total	**965**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	16	1.7%	1.7%
Three stays	8	0.8%	2.5%
Two stays	38	3.9%	6.4%
One stay	145	15.0%	21.5%
No stay	758	78.5%	100.0%
Total	**965**	**100.0%**	

Exhibit 15: Utilization Rates by Service Type: Cohort 6 (Cohort 1 plus living alone)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	85	13.6%	13.6%
16 to 20 office visits	64	10.2%	23.8%
11 to 15 office visits	115	18.3%	42.1%
6 to 10 office visits	153	24.4%	66.5%
1 to 5 office visits	149	23.8%	90.3%
No office visit	61	9.7%	100.0%
Total	**627**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	515	82.1%	82.1%
No	112	17.9%	100.0%
Total	**627**	**100.0%**	
C) SNF stays	**Counts**	**Utilization Category Rates**	**Cumulative**
Two stays	13	2.1%	2.1%
One stay	42	6.7%	8.8%
No stay	572	91.2%	100.0%
Total	**627**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	12	1.9%	1.9%
Three stays	8	1.3%	3.2%
Two stays	27	4.3%	7.5%
One stay	110	17.5%	25.0%
No stay	470	75.0%	100.0%
Total	**627**	**100.0%**	

ANALYSIS OF MEDICALLY TAILORED MEALS FOLLOWING AN IP STAY

Next, Ananya Health considers the illustration of a supplemental benefit matched to one of the patient cohorts. Specifically, Ananya Health considers a hypothetical benefit comprising meals delivered to beneficiaries who were discharged following an IP stay for a period of approximately seven days. In this illustration, Ananya Health applies that supplemental benefit to Cohort 3, which meets the general criteria of two or more chronic conditions plus one or more ADLs and adds an additional criterion that the patient must have difficulties related to meals.

Exhibit 16 shows the step-by-step logic that results in a count of the IP readmissions that might be attributable to the intervention comprising the meals delivered to eligible beneficiaries. The left side of the table repeats the information provided earlier in Exhibit 12 regarding the number of IP stays reported by patients in this cohort.

The remainder of the table illustrates the application of the delivered-meals benefit. Because this cohort has characteristics that match the eligibility criteria for this hypothetical benefit, all of the patients would qualify at least once for the meals program.[c] Each of those patients will be eligible for the meals benefit according to the number of IP stays they reported for that year. For example, the 113 patients who reported one IP stay would be eligible for 113 instances of delivered meals. Other patients in the cohort who had more IP stays that year would be eligible for delivered meals more than once. For example, the 20 patients with four or more stays would be eligible for approximately 100 instances in the aggregate, based on the assumption of an average of five IP stays for that subgroup. Similarly, the other subgroups would be eligible for meals more than once based on the total number of IP stays they reported for that year.

While a patient would be eligible for the meals program with each IP stay, a main hypothesized effect of the meals program is to reduce the probability of readmission. Exhibit 16 shows the count of readmissions targeted by the intervention. For example, the 36 patients who had reported IP stays had 72 IP stays in the aggregate, 36 of which are considered index admissions and not avoidable by the IP-triggered meal program, while the other "second" admission of the year might be a readmission that also might be averted. Ananya Health drew from the literature an estimate that 17.1 percent of Medicare IP discharges result in readmissions.[83] In other words, every 100 admissions would spawn about 17 additional IP stays. Ananya Health applied that estimate of 17.1 percent to the number of IP stays observed after the initial or index stay of the year in order to estimate the number of readmissions occurring absent the meals program. Ananya Health also drew from the literature an estimate that 13 percent of readmissions can be averted by delivering meals to patients following hospital discharges.[84] The result shown at the right of Exhibit 16 is the hypothetical number of readmissions adverted by the supplemental meals benefit.

Exhibit 17 shows an aggregate incremental cost of the meals program of $31,000 for the sample or $175.98 per participant, which is based loosely on estimates of program costs drawn from the literature.[85] This example uses $100 per patient/discharge, which could be modified based on actual specifications and applicable prices. The corresponding averted readmission yield is $49,340 in savings and $17,840 in net savings, which is about $99.66 per participant in the supplemental benefits.

Exhibits 18 and 19 are identical conceptually to Exhibits 16 and 17, respectively, except that the numbers are extrapolated from the MCBS sample to the national Medicare population. The basic inputs in the extrapolations are the same, including the underlying utilization rates and assumptions about effect sizes from the hypothetical supplemental benefit. Also, the same are the estimates of cost, savings, and net savings per person. The extrapolations merely scale the case volumes to provide national estimates of results that might pertain if the supplemental benefit was used by all eligible beneficiaries covered by original Medicare at any time during the year.

Exhibit 18 shows simulated results for a hypothetical supplemental benefit involving medically tailored meals following an IP stay. Full participation might lead to 575,408 eligible beneficiaries, 1,012,590 eligible IP stays, and 9,719 fewer readmissions attributable to the supplemental benefit. The literature suggests other utilization offsets, including reduced emergency-department visits and SNF stays, which would be additional savings attributable to the same supplemental benefit. The data source did not include emergency-department utilization rates for the analytic cohorts. Achieving significant reductions in SNF benefits should be considered especially in conjunction with supplemental benefits that include medically tailored meals and home visits that include clinical monitoring, social support, and early intervention as needed.

Exhibit 19 presents national estimates based on the sample data shown previously in Exhibit 16. The aggregate cost of full participation among eligible beneficiaries would be $101,258,974 (which is $175.98 per person). The gross savings due to reduced readmission rates would be $158,606,687, resulting in a net savings of $57,347,713. Most of the net savings come from the subgroup with several hospitalizations, while

[c] The count of four patients with "no stay" reflects discrepancies within the source and MCBS data. Ananya kept the four patients in order to keep running counts of patients in this cohort consistent; however, Ananya does not use them in these calculations of averted readmissions.

beneficiaries with a single IP stay would incur incremental costs from the meals program but have no readmissions to avert. All of the subgroups could potentially have additional savings due to averted emergency-department visits or even SNF stays under a national program with tailored supplemental benefits. In this illustration, the ratio of savings to cost for the hypothetical supplemental benefit was 1 to 57; on average, every dollar spent on the meals program resulted in $1.57 in savings.

Exhibit 16: Readmissions Averted by Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Inpatient Stays Current Yr	Counts	Admission Category Rates	Cumulative	# Meals Eligible Pts	# Meals Eligible Pt-Admissions	# Subsequent Admits Targetted by Intervention	Expected Re-admit Rate (Literature)	# Expected Re-Admits w/o Intervention	Rate Re-Admit Averted by Food (Angel 2018=13%)	#Re-Admit Averted by Meals
Four or more stays	20	10.9%	10.9%	20	100	80	17.1%	14	13.0%	1.78
Three Stays	10	5.5%	16.4%	10	30	20	17.1%	3	13.0%	0.44
Two Stays	36	19.7%	36.1%	36	72	36	17.1%	6	13.0%	0.80
One Stay	113	61.7%	97.8%	113	113	-	0.0%	-	0.0%	-
No Stay	4	2.2%	100.0%	-	-	-	0.0%	-	0.0%	-
	183	**100.0%**		**179**	**315**	**136**		**23**		**3**

Exhibit 17: Aggregate Cost, Savings, and Net Savings from Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Inpatient Stays Current Yr	Counts	Admission Category Rates	Cumulative	Meals Cost per Post-IP Discharge	Cost Saving: (Martin 2018: average cost per readmission of $16,320 per high-risk patient)	Net Saving	Comments
Four or more stays	20	10.9%	10.9%	10,000	$29,023	$19,023	Best Saving
Three Stays	10	5.5%	16.4%	3,000	$7,200	$4,256	Good
Two Stays	36	19.7%	36.1%	7,200	$13,061	$5,861	Good
One Stay	113	61.7%	97.8%	11,300	$-	**($11,300)**	No Saving, All Cost
No Stay	4	2.2%	100%	-	$-	$0	
	183	**100.0%**		**31,500**	**$49,340**	**$17,840**	
				175.98	**$275.64**	**$99.66**	
				Save/Cost Ratio	**1.57**		

Exhibit 18: National Estimates of Readmissions Averted by Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Inpatient Stays Current Yr	Counts	Admission Category Rates	Cumulative	# Meals Eligible Pts	# Meals Eligible Pt-Admissions	# Subsequent Admits Targetted by Intervention	Expected Re-admit Rate (Literature)	# Expected Re-Admits w/o Intervention	Rate Re-Admit Averted by Food (Angel 2018=13%)	#Re-Admit Averted by Meals
Four or more stays	64,291	10.9%	10.9%	64,291	321,457	257,166	17.1%	43,975	13.0%	5,716.79
Three Stays	32,146	5.5%	16.4%	32,146	96,437	64,291	17.1%	10,994	13.0%	1,429.20
Two Stays	115,725	19.7%	36.1%	115,725	231,449	115,725	17.1%	19,789	13.0%	2,572.56
One Stay	363,246	61.7%	97.8%	363,246	363,246	-	0.0%	-	0.0%	-
No Stay	12,858	2.2%	100.0%	-	-	-	0.0%	-	0.0%	-
	588,266	**100.0%**		**575,408**	**1,012,590**	**437,182**		**74,758**		**9,719**

Note: The patients with "no stay" reflect discrepancies within the source and MCBS data. Ananya kept those patients in order to keep running counts of patients in this cohort consistent; however, Ananya does not use them in these calculations of averted readmissions.

Exhibit 19: National Estimates of Aggregate Cost, Savings, and Net Savings from Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Inpatient Stays Current Yr	Counts	Admission Category Rates	Cumulative	Meals Cost per Post-IP Discharge	Cost Saving: (Martin 2018: average cost per readmission of $16,320 per high-risk patient)	Net Saving	Comments
Four or more stays	64,291	10.9%	10.9%	32,145,706	$93,298,051	$61,152,345	Best Saving
Three Stays	32,146	5.5%	16.4%	9,643,712	$23,324,513	$13,680,801	Good
Two Stays	115,725	19.7%	36.1%	23,144,908	$41,984,123	$18,839,215	Good
One Stay	363,246	61.7%	97.8%	36,324,648	$-	**($36,324,648)**	No Saving, All Cost
No Stay	12,858	2.2%	100.%	-	$-	$0	
	588,266	**100.0%**		**101,258,974**	**$158,606,687**	$57,347,713	
				175.98	**$275.64**	**$99.66**	
				Save/Cost Ratio	**1.57**		

Discussion

In this issue brief, BPC and Ananya used publicly available data, combined with assumptions drawn from the literature, in order to illustrate the possible size and characteristics of Medicare beneficiary populations who could become eligible for supplemental benefits. Exhibit 20 shows national estimates of the number of beneficiaries covered under original Medicare for any part of the year and belonging to any of the six analytic cohorts defined in this study.

Exhibit 20: Patient Cohorts Based on Selection Criteria: Estimated National Eligible Population Sizes

Cohort definition (FFS for any part of the year)	Count
Any of the 11 CCs	**26,083,966**
Cohort 1: 2+CCs Plus 1+ADLs	**7,049,507**
Cohort 2: Cohort 1 Plus IP Stays	**1,750,611**
Cohort 3: Cohort 2 Plus Food Difficulties	**588,266**
Cohort 4: Cohort 1 Plus Food Difficulties	**2,688,098**
Cohort 5: Cohort 1 Plus Transportation Difficulties	**3,931,686**
Cohort 6: Cohort 1 Plus Living Alone	**2,209,976**

Ananya described each of these cohorts in terms of demographic and socioeconomic characteristics, as well as utilization rates reported in the MCBS survey. Ananya chose Cohort 3 to illustrate a type of supplemental benefit involving medically tailored meals delivered after discharge from an inpatient stay. Based on simple assumptions drawn from the literature, Ananya was able to illustrate potential positive net savings due to reduced readmission rates. Actual projections would require specification of a benefit, and refined assumptions about targeting, realistic participation, gaming, and operational details, including market prices. Meanwhile, policymakers and analysts can consider potential supplemental benefits in light of the eligibility criteria and resulting beneficiary populations described in this issue brief.

Endnotes

1 For a full list of examples provided by CMS, see: Kathryn Coleman, CMS Memorandum: "Implementing Supplemental Benefits for Chronically Ill Enrollees," Centers for Medicare and Medicaid Services, April 24, 2019.
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6 Bipartisan Policy Center, *Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times*, July 2017.
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12 U.S. Department of Health and Human Services, "What Is Medicare Part C?"
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