Medicare Advantage Plan Engagement Tips

The Trusted Voice for Aging

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LeadingAge Resources To Support Medicare Advantage Plan Engagement

Medicare Advantage Plan Engagement Toolkit Resources	Purpose of Resource
Medicare Advantage and SNP 101	This document provides context on the Medicare Advantage program.
Medicare Advantage Supplemental Benefits Explained	This document provides an overview of and update on Medicare Advantage supplemental benefits policies and opportunities.
Medicare Advantage Engagement Strategy Checklist	This document highlights key questions to direct your organization's education and preparation activities.
Medicare Advantage Plan Engagement Tips	This document provides an overview of new opportunities to engage health plans and an overview of how to prepare your organization.
Step-by-Step Guide to Understanding Medicare Advantage Activity in Your Market	This document provides instructions for identifying Medicare Advantage enrollment and penetration in your organization's market.
Telling Your Story Template	This editable document provides a template for your organization to insert information on your services and value that you can provide to Medicare Advantage health plans.
Contracting Tools and Templates	This set of information provides sample contracts and exhibits, as well as editable tools to populate with your organization's information to track contracts.
Glossary of Terms and Acronyms	This document provides a comprehensive list of terms, acronyms and definitions related to managed care and alternative payment models.

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Medicare Advantage Plan Engagement Tips: Outline

How to Use This Resource:

- Understand new Medicare policy changes that create opportunities to engage Medicare Advantage plans around supplemental benefits.
- Know the capabilities that your organization needs to support Medicare Advantage health plans.
- Learn how to target Medicare Advantage plans.

Sections in This Resource:

- Medicare Advantage 101
- New Opportunities in Medicare Advantage for Non-Medical Service Providers
- Why Medicare Advantage Plans Care About Your Population
- Demonstrating Your Organization's Capabilities
- Creating Your Organization's Targeting and Outreach Strategy

Medicare Advantage 101

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What is Medicare Advantage?

Medicare Advantage is a private health insurance option for older adults. Under Medicare Advantage, private health plans create a one-stop shop for what can often be less expensive insurance.

Older adults have two Medicare options to choose from:

Medicare Fee-For-Service ("Original" Medicare)

Federal government pays directly for healthcare costs under:

- Part A: Hospital
- Part B: Physicians

Individuals may choose to add onto the basic Medicare benefit:

- Part D: Prescription Drugs
- Supplemental Insurance: Covers cost-sharing, non-covered benefits under Medicare.

Medicare Advantage

Private insurance carriers contract with the federal government to offer plans that pay for:

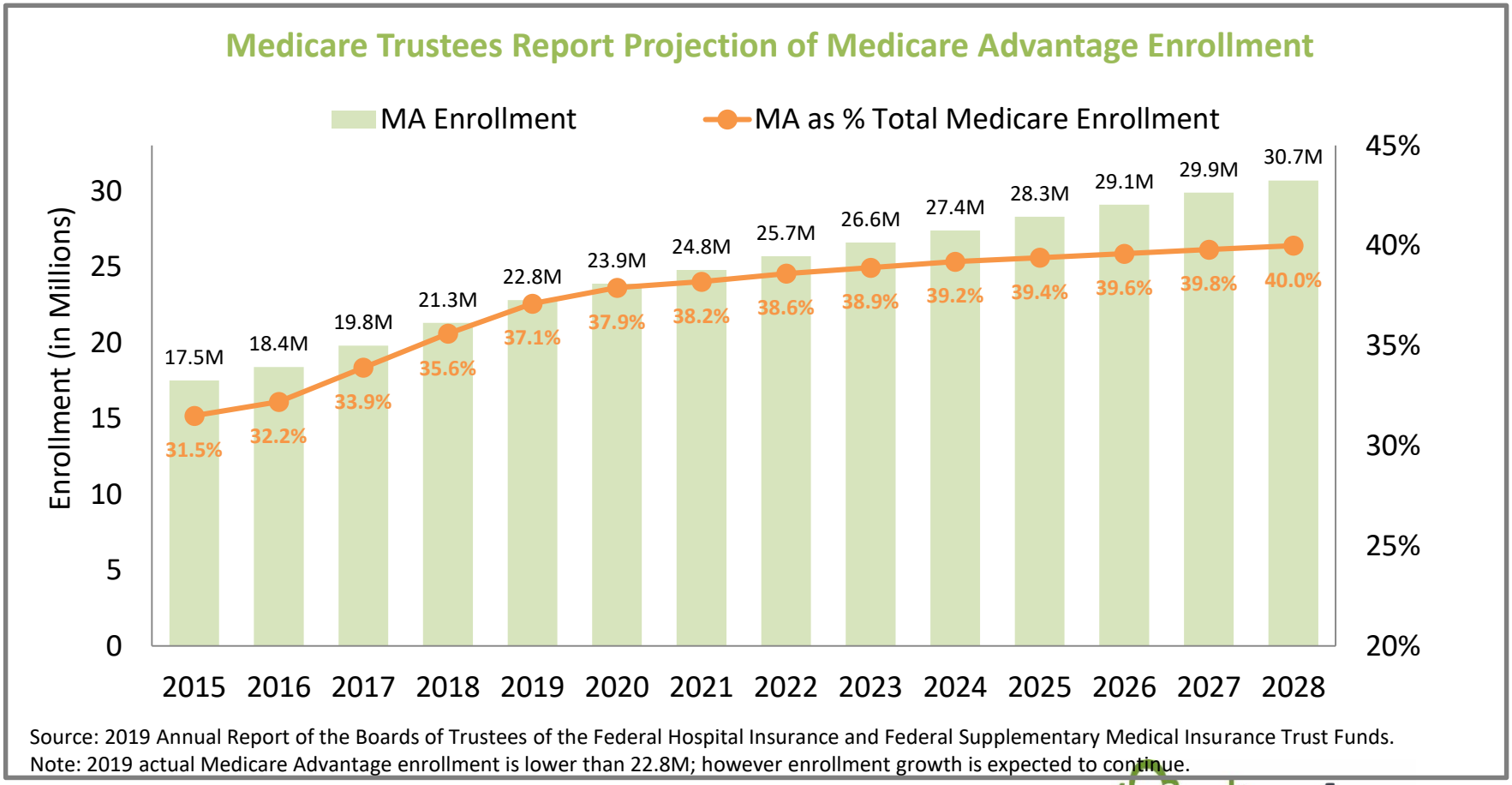
- Part A: Hospital
- Part B: Physicians

Individuals usually choose to enroll in plans that also offer:

- Part D: Prescription Drugs

What is Medicare Advantage Enrollment Compared to Medicare Fee-For-Service?

While actual Medicare Advantage (MA) enrollment has lagged slightly compared to projections, its annual enrollment growth is anticipated to continue.



Source: 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.
Note: 2019 actual Medicare Advantage enrollment is lower than 22.8M; however enrollment growth is expected to continue.

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Why Do Older Adults Select Medicare Advantage?

Medicare Advantage offers out-of-pocket cost protection. Medicare Advantage can often be less expensive than Original Medicare with extra (supplemental) benefits.

Medicare Fee-For-Service ("Original" Medicare)

- ❑ Part A deductible: **$1,364**
- ❑ Part B annual deductible: **$185**
- ❑ Part B coinsurance: **20%**
- ❑ Monthly Part B premium **(optional, varies by income)**
- ❑ Monthly insurance premium for Prescription Drugs (Part D) **(optional, varies by income and plan selection)**
- ❑ Medigap insurance premium **(optional, covers out of pocket costs, varies by plan selection)**

Medicare Advantage

- ❑ Monthly Part B premium
- ❑ Monthly health plan premium: **varies by plan**
- ❑ Deductibles and cost-sharing: **varies by plan**

Medicare Advantage limits beneficiaries' total out-of-pocket costs (e.g., in 2019 the maximum was $6,700, some plans are less)

Source: Medicare.gov, 2019 Costs at a Glance: https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance.

Why Do Older Adults Select Medicare Advantage?

Medicare Advantage plans can also supplemental benefits that are not covered under Original Medicare Fee-For-Service.

Statutory Authority to Cover		
	Medicare Fee-For-Service ("Original" Medicare)	**Medicare Advantage**
Dental		✓
Vision		✓
Podiatry	Medically necessary only	✓ May include routine foot care
Hearing exams and aides		✓
Non-medical services and supports*		✓ (Optional)

*New law now allows plans to cover some types of non-medical support and services and address social determinants of health.

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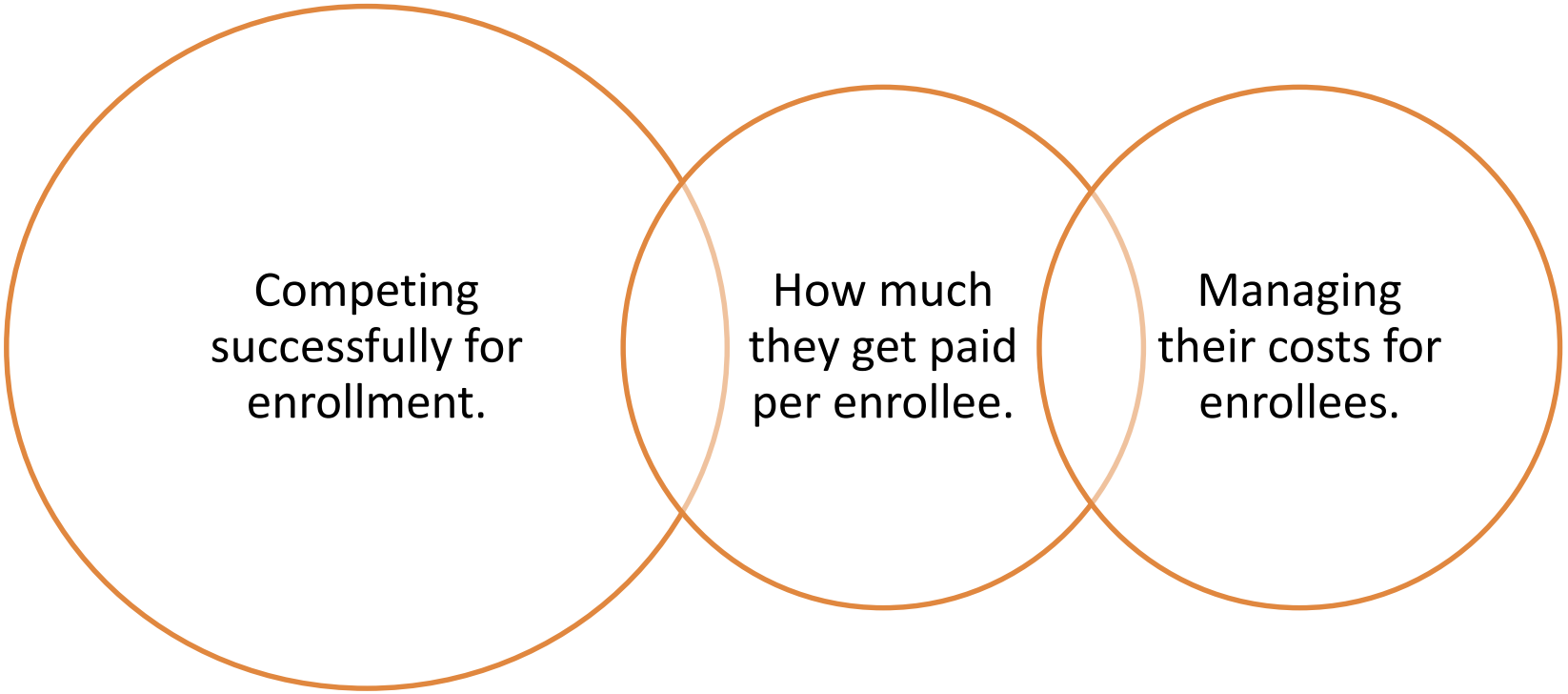
What Do Medicare Advantage Plans Care About?

Medicare Advantage plans care about three key things, but competition for enrollment drives decisions.



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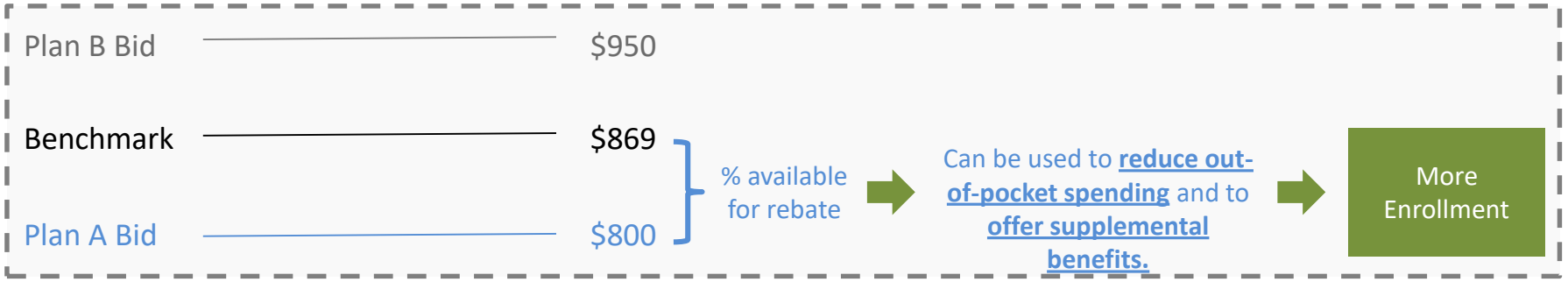
How Do Medicare Advantage Plans Compete for Enrollment?

Medicare Advantage plans compete on price and benefits to attract more enrollment by having lower premiums and cost sharing and by offering benefits attractive to Medicare beneficiaries.

- Every year, CMS sets a county-level benchmark based on average Medicare FFS spending in that county.
- Medicare Advantage plans submit bids for how much it will cost them to provide insurance coverage to enrollees.
- Plans that bid below the benchmark receive a rebate that allows them to reduce enrollee out-of-pocket spending and offer supplemental benefits.
- **Lower out-of-pocket spending and supplemental benefits help attract more enrollment. This is important in an extremely competitive Medicare Advantage environment.**



Tip: How are your services attractive to health plan enrollees?

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How Do Medicare Advantage Plans Compete for Enrollment?

Medicare Advantage plans also compete on quality. Plans that receive higher ratings can receive higher payments, which enables them to add supplemental benefits and lower cost sharing.

Clinical Quality	Member Satisfaction and Experience	Health Plan Operations
Annual Flu Vaccine	Getting Needed Care	Members Choosing to Leave Plan
Reducing the Risk of Falling	Customer Service	Health Plan Quality Improvement
Special Needs Plan Care Management	Care Coordination	Reviewing Appeals Decisions
Medicare Reconciliation Post-Discharge	Rating of Health Care Quality	
All-Cause Readmissions		

Tip: Providers' outcomes can influence a plan's performance on quality ratings. Explain how your organization's performance/outcomes and key programs or services can result in improved plan performance on these measures.

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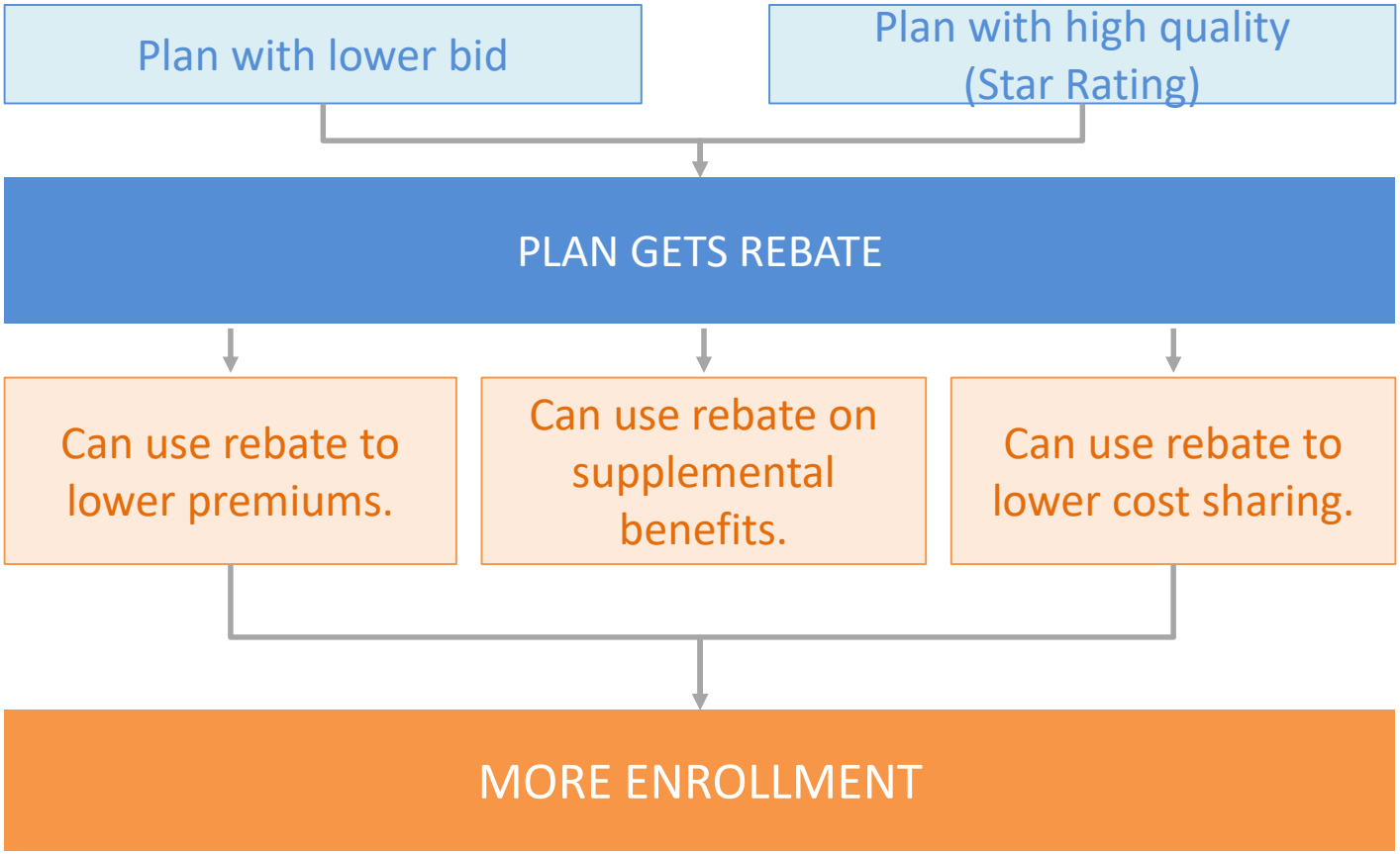
High Quality, Low Cost Plans Will Be More Competitive for Enrollment



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How Does Risk Adjustment Affect Payment?

Medicare Advantage plans get paid more for higher need/higher risk enrollees.

	Lower risk enrollee	Higher need enrollee
Age	65	89
ICD-10 Diagnoses	Healthy	Lung Cancer, Diabetes, Alzheimer's Disease
Other Characteristics	Not low income	Eligible for Medicaid
Risk Score	0.7	2.8
Risk Adjusted Monthly Payment*	$869 (Base Rate) x 0.7 (Risk Score) = **$608**	$869 (Base Rate) x 2.8 (Risk Score) = **$2,433**

*Note: Intended to be an illustrative example. The final adjusted monthly payment to plan includes reduction for coding intensity that will reduce risk score.

Tip: Providers can help plans by documenting conditions, needs, etc.

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New Opportunities in Medicare Advantage

Expanded Medicare Advantage Supplemental Benefits 2019 and Beyond

- CMS and Congress have expanded what Medicare Advantage (MA) plans can offer as supplemental or extra benefits to their enrollees:
  - CMS reinterpreted "primarily health-related" beginning in CY2019. This is a key term used in identifying what qualifies as a supplemental benefit. The new interpretation permits some home and community-based services to be included.
  - Congress, via the Bipartisan Budget Act, expanded supplemental benefit offerings further for CY2020 by establishing a special supplemental benefits for chronically ill option.
  - CMS reinterpreted the MA uniformity requirements to permit all MA plans beginning in 2020 to target their benefit designs to the needs of certain chronic condition enrollees.
  - MA plans are now permitted to offer more targeted and flexible benefit offerings (e.g., cost sharing, supplemental) by health status or disease.
  - Center for Medicare and Medicaid Innovation expanded the Value-Based Insurance Design (VBID) demonstrations to all 50 states and four interventions to test.

Options Through Which Medicare Advantage Plans Can Offer Supplemental Benefits

Updated Primarily Health-Related Definition (permits optional HCBS) (2019)

Special Supplemental Benefits for the Chronically Ill (2020)

Value-Based Insurance Design*

By Condition, Socioeconomic Status, or both (2020)
Wellness and Health Care Planning (2020)
Telehealth (2020)
Hospice (2021)

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Updated Primarily Health-Related Definition (2019)

Beginning in CY2019, CMS began interpreting supplemental benefits to be considered "primarily health-related" if they will:

- Diagnose, prevent, or treat an illness or injury.
- Compensate for physical impairments.
- Ameliorate the functional/psychological impact of injuries or health conditions.
- Reduce avoidable emergency or health care utilization.

Benefits MUST be:

- ✓ Medically appropriate.
- ✓ Ordered or directly provided by a licensed provider as part of a care plan.

Benefits MAY:

- ✓ Be targeted or time limited.
- ✓ Enhance quality of life.
- ✓ Improve health outcomes.

** Orange text reflects new additions to the definition.*

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Medicare Advantage Can Now Offer Expanded List of Supplemental Benefits

1

Congress Passes the *CHRONIC* Care Act in 2018

The *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act* expands MA supplemental benefits to meet the needs of chronically ill beneficiaries.

- The CHRONIC Care Act special supplemental benefits for the chronically ill (SSBCI) must have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee ***and may not be limited to being primarily health related.***
- Uniformity requirements are waived for SSBCI.

2

Additional Guidance from Centers for Medicare & Medicaid Services

CMS clarified what it means for enrollees to have one or more comorbid conditions but gives MA plans an unprecedented degree of flexibility to:

- Develop services they offer as SSBCI, so long as there is a reasonable expectation of improving and/or maintaining health.
- Target SSBCI as it relates to the individual enrollee's specific condition and needs.
- Address social determinants of health (SDOH).
- Consider SDOH as one (but not the sole) factor in targeting benefits.

Definition of Chronically Ill Enrollee under CHRONIC Care Act

A chronically ill enrollee is someone who:

1) Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee.
2) Has a high risk of hospitalization or other adverse health outcomes.
3) Requires intensive care coordination.

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What Is the Significance of This Shift in Policy?

The new SSBCI benefit reflects a major turning point in Medicare policy. For the first time, Medicare allows coverage for non-primarily health related benefits and flexibility around who is eligible for these benefits.

1

What Health Plans Could Cover Before New Law

1) Traditional Medicare benefits.
2) Care management.
3) Health-related "supplemental" benefits like dental and vision.

➢ **Everyone had to get the same thing.**

2

The New Law

Congress created a new category of benefits, called "special supplemental benefits," **just for the chronically ill**. These benefits do not have to be medical.

➢ **And they can be tailored according to individual need.**

What Does This Mean for LeadingAge Members?

While Medicare Advantage plans can now pay for non-medical benefits as part of the supplemental benefit offering to enrollees, not all will add these new supplemental benefits. This is the beginning of a new trend; however, LeadingAge members may have increased opportunities to provide services to Medicare Advantage enrollees and receive reimbursement ***when plans include non-medical benefits in their benefit package.***

The Centers for Medicare & Medicaid Services provided specific examples of allowable new benefits.

Examples of New Primarily Health-Related benefits plans could offer beginning in 2019

- Adult day care services
- Home-based palliative care
- In-home support services
- Support for caregivers of enrollees
- Medically-approved non-opioid pain management
- Stand-alone memory fitness benefit
- Home & bathroom safety devices & modifications
- Transportation
- Over-the-counter benefits

Examples of SSBCI benefits that plans could offer beginning in 2020

- Meals beyond limited basis
- Food and produce
- Non-medical transportation
- Pest control
- Indoor air quality improvement and services
- Social needs benefits
- Complementary therapies alongside traditional medical treatments
- Services supporting self-direction
- Structural home modifications
- General supports for living, such as housing

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Why Medicare Advantage Plans Care About Your Population

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Medicare Advantage Plans Care About Your Population

Why?

1. Medicare Advantage enrollees (who need non-medical services and supports) have multiple chronic conditions and functional impairment.
2. Data show that functional impairment and other markers of complexity, such as chronic conditions, are strongly associated with high healthcare spending.
3. Medicare Advantage plans are recognizing the need for better integration of non-medical supports and services into their enrollees' healthcare services to reduce costs and improve quality.

How Does Clinical Complexity in Medicare Advantage and Original Medicare Populations Compare?

The Medicare Advantage population with complex care needs now mirrors beneficiaries in Original Medicare.

Percentage of Population with Complex Needs (2015)

	Medicare Advantage	Original Medicare
75+ years[1]	38.2%	34.5%
Moderate – Severe Functional Impairment[2]	12%	12%
Cognitive Impairment	7%	7%
Diagnosed with 3+ Chronic Conditions	47%	45%

Functional Impairment refers to the need for non-medical supports and services that help with basic activities of daily living (ADLs), like bathing, dressing, and eating. It's highly associated with being over age 80 and having multiple chronic conditions.

Notes: Data exclude nursing home residents. Source: 1. America's Health Insurance Plans. Medicare Advantage Demographics Report, 2015. June 2018. Accessed at: https://www.ahip.org/wp-content/uploads/2018/06/MADemographics_IssueBrief.pdf. 2. Anne Tumlinson Innovations analysis of 2015 MCBS linked to claims.

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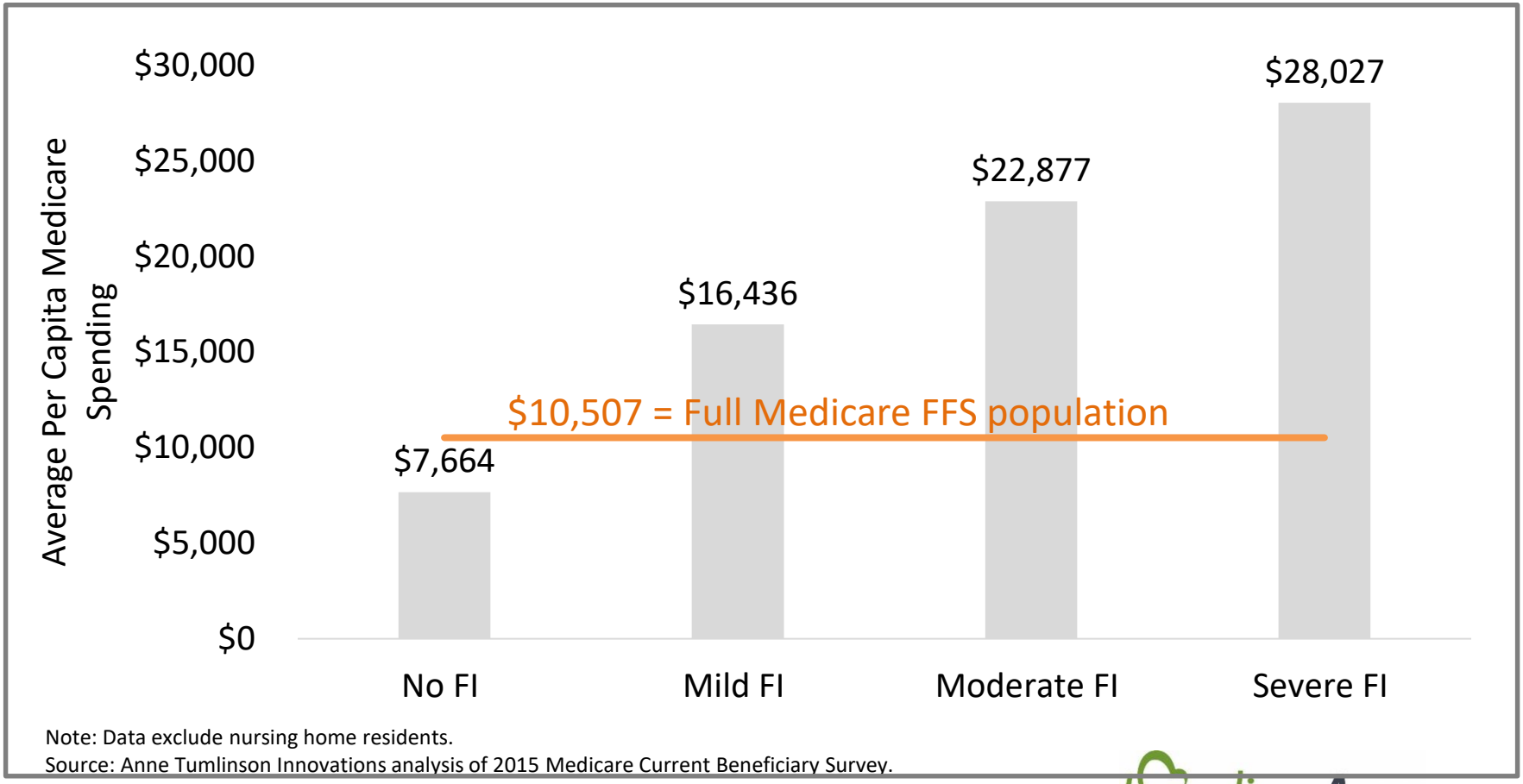
How Does Functional Impairment Affect Healthcare Costs?

Medicare beneficiaries with functional impairment are higher cost, compared to those without functional impairment.



Note: Data exclude nursing home residents.
Source: Anne Tumlinson Innovations analysis of 2015 Medicare Current Beneficiary Survey.

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How Does Complex Care Affect Healthcare Costs?

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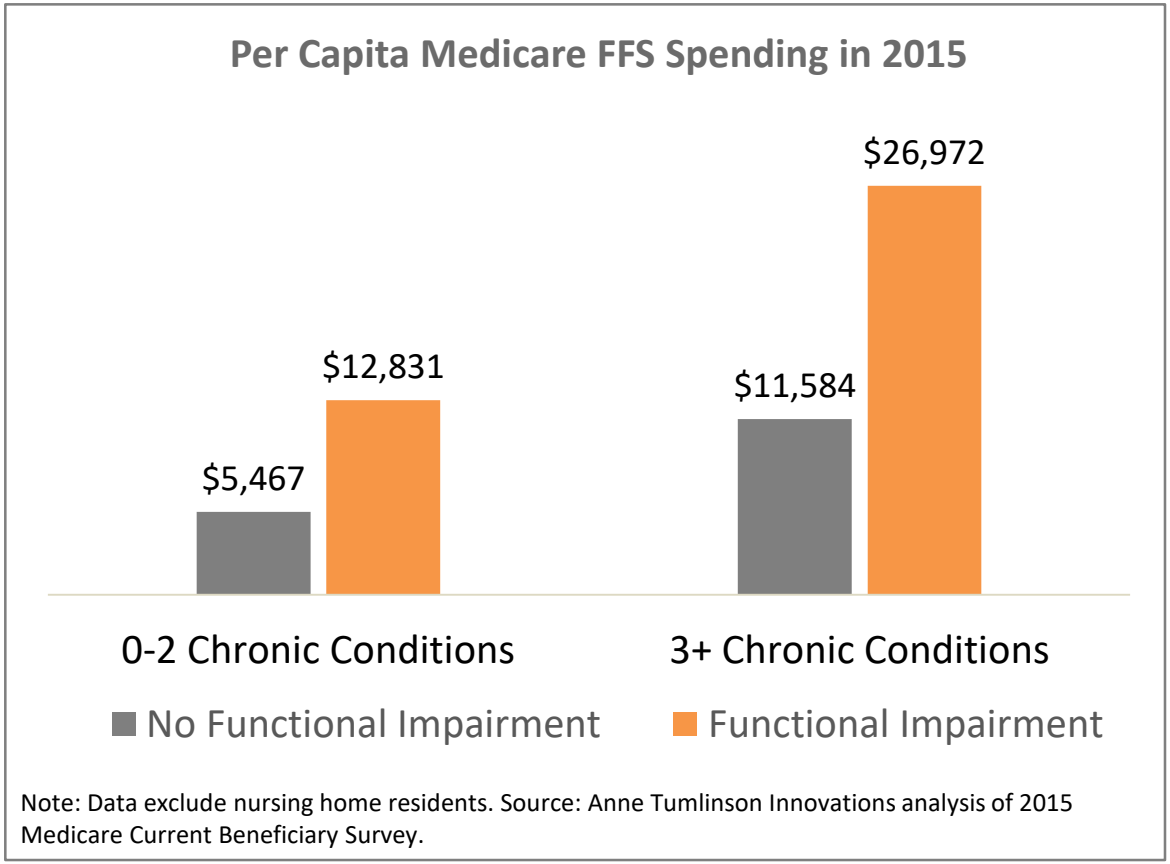

Note: Data exclude nursing home residents. Source: Anne Tumlinson Innovations analysis of 2015 Medicare Current Beneficiary Survey.

Key Takeaways

- When a person has moderate functional impairment, they are more than twice as expensive to Medicare than someone who does not have functional impairment, even when they have multiple chronic conditions.
- **Your population is health care's most expensive patients.**

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Medicare Advantage Plans Are Investing in Non-Medical Interventions

Plans and providers provide (medical and non-medical) transportation services to patients.
Example: CareMore Cal MediConnect Plan and Lyft

Medicare Advantage plan provides post-hospital meals for seniors.
Example: Aetna partnership with Meals on Wheels

Medicare Advantage plan moving care into the home.
Example: Humana buys Kindred at Home

State programs incorporating software and assessment tools to help family caregivers manage role.
Example: Tailored Caregiver Assessment and Referral (TCARE)

Technology solutions that combine human touch and technology to integrate and activate care team, family, and patient.
Example: Seniorlink technology: Caregiver Homes and Vela

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Are There Outcomes Data on In-Home and Non-Medical Interventions in the Medicare Population?

Yes, there is a growing evidence base of outcomes data on programs that offer non-medical interventions.

Program Service	Outcomes	Source
An adult day program	Reduction in 100-day rates of ER visits, hospital admissions, and days in the hospital; reduction in days of hospital stay; and days in a home care program.	The Gerontologist, The Effect of Adult Day Program Attendance on Emergency Room Registrations, Hospital Admissions, and Days in Hospital: A Propensity-Matching Study: https://academic.oup.com/gerontologist/article/57/3/552/2632072
An adult day center	Positive health-related, social, psychological, and behavioral outcomes for care recipients and caregivers.	The Gerontologist, Adult Day Care Center Programs and Their Associated Outcomes on Clients, Caregivers, and the Health System: A Scoping Review: https://www.ncbi.nlm.nih.gov/pubmed/28329856
A meal delivery program	Reduction in emergency department visits and lower use of high-cost health services for the dual-eligible population.	Health Affairs, Meal Delivery Programs Reduce The Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0999
A program offering 10 home visits by registered nurses, occupational therapists, and handymen	Reduction of Medicare expenditures by $2,765 per quarter, per patient.	Health Affairs, Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1305

How Will Medicare Advantage Plans Respond to New Flexibility in Supplemental Benefits?

Medicare Advantage plans are increasingly investing in non-medical interventions to better manage care. While this is the beginning of a trend, plans will need education from non-medical providers.

Plan Scenarios You May Encounter	How To Prepare for Engagement
Limited understanding of the impact of functional impairment on cost and on their enrollees' long term services and supports needs.	❑ Know the data on the population you serve (e.g., how many ADLs do they typically have). ❑ Consider how you collect data on outcomes in your organization (e.g., hospitalization rates).
Conservative view of benefit design as supplemental funding is limited.	❑ Take the long view. This is the beginning of a longer trend toward blending medical and non-medical as the healthcare system learns how to manage high cost, high need populations.
Limited understanding of how/why nonmedical services and supports are attractive to enrollees and families.	❑ Know how to describe your key operational capabilities and the value of your services. ❑ Assess your clients' satisfaction and collect data on satisfaction.
Preference to aggregate provider networks at regional or national level.	❑ Know the Medicare Advantage plans in your market. ❑ Know which plans are national, regional, local. ❑ Know which local and regional plans may be good targets for outreach.
Requirements around quality assurances, electronic visit verification, support for care management.	❑ Adopt electronic and digital platforms for verifying visits, capturing assessment and care plan information. ❑ Document process for hiring, training, qualifying workers.

Your Core Message To Medicare Advantage Plans

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Demonstrating Your Organization's Capabilities

Tips for Preparing to Engage Medicare Advantage Plans

Educate Plans on Your Services and Programs

- ✓ Clear descriptions of your service offerings.
- ✓ Detailed description of your assessment processes, including ability to identify interventions and follow-up on progress.
- ✓ Information on days/hours services available.
- ✓ Geographies covered.
- ✓ Evidence-based practices or programs used.
- ✓ Updated policies on hiring and training requirements and processes.

Collect Information on Your Population and Program Outcomes

- ✓ Understanding of your population (e.g., needs, challenges, cognition and functional limitations).
- ✓ Information on your client and family satisfaction.
- ✓ Feedback from your referral partners.
- ✓ Any key performance indicators of your programs (e.g., number of meals delivered, number of classes, attendance and participation, number of ancillary services offered).
- ✓ Number of plan's enrollees that you serve (if significant).

Enable Information Sharing

- ✓ Ability to communicate with medical providers and other care managers (e.g., Medicare Advantage care managers, Nurse Practitioners, Medical Directors).
- ✓ Ability to share assessments and care plans electronically.
- ✓ Ability to submit claims electronically.

Refine Your Pitch

- ✓ Program outcomes.
- ✓ Community partnerships.
- ✓ Repeat referral partners.
- ✓ Staff understanding of integrated care delivery and client satisfaction.

Educate Plans on Your Services and Programs

Preparation Tips	Educate Plans on Your Services and Programs
• Do not assume that plans know what you do or who you serve. • What services do you provide your clients? • Who do you serve? How many activities of daily living do they need help with? *(Your clients need assistance with daily activities and they have multiple chronic medical conditions. The combination of these needs (functional impairment + chronic conditions) is strongly associated with very high healthcare costs.)* • How soon can you make an initial visit? How do you document information on the visit (e.g., assessment)? • What does your assessment cover (e.g., home environment, fall risk, level and type of support needed, family needs)? • What do you include in care plans? • How do you share care plans with medical providers? • How do you recruit quality staff? How do you retain your staff? How do you build a positive culture?	✓ Clear descriptions of your service offerings. ✓ Detailed description of your assessment processes, including ability to identify interventions and follow-up on progress. ✓ Information on days/hours services available. ✓ Geographies covered. ✓ Evidence-based practices or programs used. ✓ Updated policies on hiring and training requirements and processes.

Collect Information on Your Population and Program Outcomes

Preparation Tips	Collect Information on Your Population and Program Outcomes
• Do you collect employee observations from visits regarding living environment, hazards (e.g., fall risk), changes in behavior, medication adherence, malfunctioning equipment (e.g., AirCon)? • Do you collect information on your populations' characteristics (e.g., chronic conditions, ADL supports needed, cognitive function, visual/hearing impairment)? • Do you track client needs or improvement throughout your service delivery program? • Do you track client satisfaction? • How do you communicate with clients' families or caregivers? • Do you offer additional support to family caregivers? • Do you have a secure platform for inputting client information? • Do you track hospitalizations or emergency room visits? • What is the average client retention time? Length of stay in service? • What is the average number of visits per month you deliver?	✓ Understanding of your population (e.g., needs, challenges, cognition and functional limitations). ✓ Information on your client and family satisfaction. ✓ Feedback from your referral partners. ✓ Any key performance indicators of your programs (e.g., number of meals delivered, number of classes, attendance and participation, number of ancillary services offered). ✓ Number of plan's enrollees that you serve (if significant).

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Enable Information Sharing

Preparation Tips	Enable Information Sharing
• Know the value of information you collect in assessments and in interactions with clients. *(Medicare Advantage health plans are motivated to reduce hospitalizations and ER visits. When you identify a problem or gap in a client's care, that information is important to communicate to the health plan's care management team and to the client's clinical care team. For example, is there an issue with the client's medication? Is there a fall risk?)* • How do you verify visits and services? • How do you capture information in assessments and care plans today? Can you share that information electronically?	✓ Ability to communicate with medical providers and other care managers (e.g., Medicare Advantage care managers, Nurse Practitioners, Medical Directors). ✓ Ability to share assessments and care plans electronically. ✓ Ability to submit claims electronically.

Refine Your Pitch

Preparation Tips	Refine Your Pitch
• What are your outcomes? • What community partnerships do you have in place? (For example, do you refer your clients to other service providers to help them access transportation to medical appointments? Do you refer your clients to food delivery services?) • Do you have any partnerships with medical providers? • Do you understand what plans most care about and how your services relate? • How can you help their care managers? Their Nurse Practitioners? Their Medical Directors? • How can you help them with client satisfaction?	✓ Program outcomes ✓ Community partnerships ✓ Repeat referral partners ✓ Staff understanding of integrated care delivery and client satisfaction.

Creating Your Organization's Targeting and Outreach Strategy

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Consider Targeting Certain Plans First

Local Plans:

Owned by local hospitals, skilled nursing facilities, and health systems; small regional plans: not United, Humana, BCBS, Aetna, or Anthem.

- ❑ It may be easier to secure meetings with local plans.
- ❑ Plans will work with providers to determine contract terms and to establish billing system.
- ❑ Local plans may be more flexible about how information is transmitted.

Dual-Eligible Special Needs Plans (D-SNPs):

A type of MA plan for special needs individuals that serves the population dually eligible for Medicare and Medicaid.

- ❑ D-SNPs may have more experience working with home and community-based service providers because they already serve the dual-eligible population.
- ❑ You may already have relationships or contracts with these health plans through Medicaid.

Steps for Approaching Plans in Your Market

Understand Your Market

- ❑ Educate yourself on what health plans care about most.
- ❑ Use the ***Step-by-Step Guide on Understanding Medicare Advantage Market Activity in Your Market*** document to educate yourself on the plans in your market. *(Who they are, enrollment)*
- ❑ Understand what Medicare Advantage plans your clients are enrolled. (Tip: October-December is open enrollment and a good time to update this information.)
- ❑ Consider partnering with other non-medical providers to expand your collective offerings and share information.

Select Plans to Target

- ❑ Approach health plans where you already have a Medicaid contract, if any (*it will make contracting easier).*
- ❑ Identify the "local" plans. The ones that are: 1) owned by local hospitals, providers, and health systems; 2) are not United, Humana, BCBS, Aetna, or Anthem. *(Local plans may be open to discussing your services in their market.)*
- ❑ Identify and target personnel in charge of care delivery (e.g., care management) who will more quickly understand your value.
- ❑ Talk with your existing referral partners (e.g., physicians, hospitals) who could advocate for plans to partner with your organization.

Prepare to Tell Your Story

- ❑ Use the ***Telling Your Story*** document to prepare information on your services, outcomes, and value in advance of meeting with plan(s).
- ❑ You will only have a short time (maybe 30 minutes) to make your pitch. Communicate that you can support their care managers and medical providers in taking care of the highest cost enrollees; and that you can do it in a high quality and reliable way.

Example of Health Plan Data

Plan Example: SCAN Plus Health Plan	
Los Angeles County Medicare Advantage Penetration (September 2019)	• 1,580,531 Total Medicare Eligible Beneficiaries • 759,142 Enrolled in Medicare Advantage • 48.03% Medicare Advantage Penetration
Health Plan Enrollment	• 202,987 total enrollees • 82,836 enrollees in Los Angeles County
Health Plan Quality Ratings	4.5 out of 5 stars

What Do These Data Mean?

- Los Angeles County has very high Medicare Advantage enrollment.
- SCAN Health Plan is a regional health plan with a small but high-quality footprint in LA County.

Tip: An additional web search on SCAN Health Plan yields a press release press release announcing in-home benefits in 2019.

Source: SCAN Health Plan Press Release. *SCAN Health Plan Announces 2019 Benefits, Offering Enhanced Choices for Seniors.* October 2018. https://www.prnewswire.com/news-releases/scan-health-plan-announces-2019-benefits-offering-enhanced-choices-for-seniors-300721889.html

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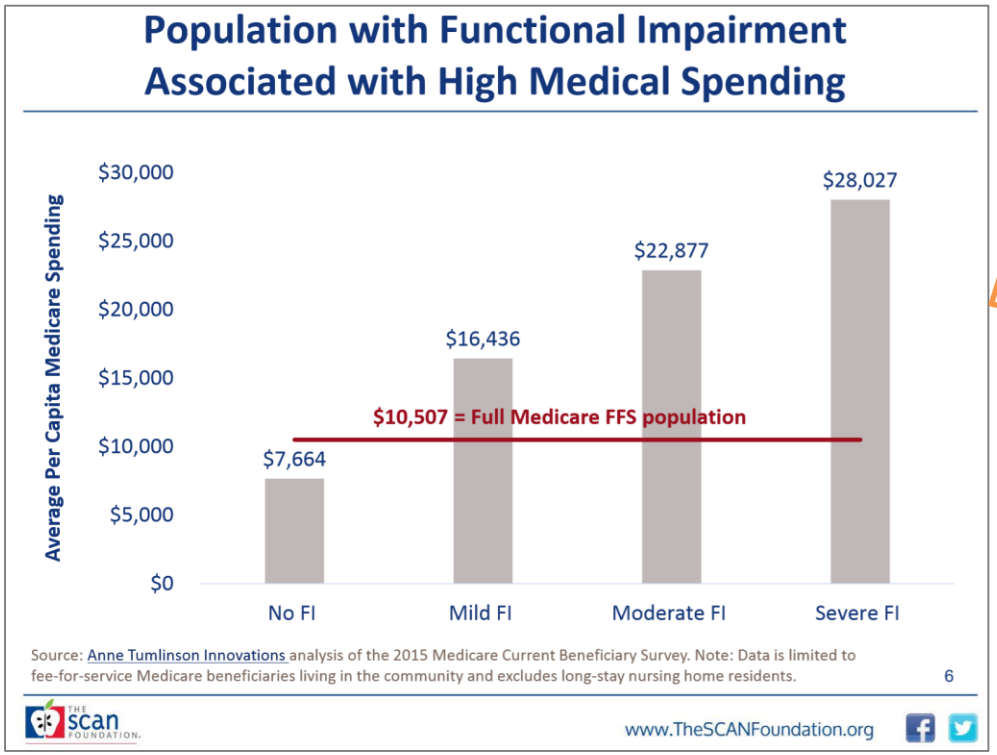
Data on Functional Impairment and Healthcare Costs: The SCAN Foundation

Online Resource: https://www.thescanfoundation.org/sites/default/files/2018-12-12_new_opportunities_for_serving_complex_care_populations_in_medicare_advantage_final_0.pdf



Talking Points:

- Average per capita healthcare spending increases as the degree of functional impairment increases.
- On average, people with moderate to severe functional impairment – that is, people who need help with at least one activity of daily living – spend more than twice as much on healthcare as the overall Medicare population and more than three times more than people with no functional impairments.

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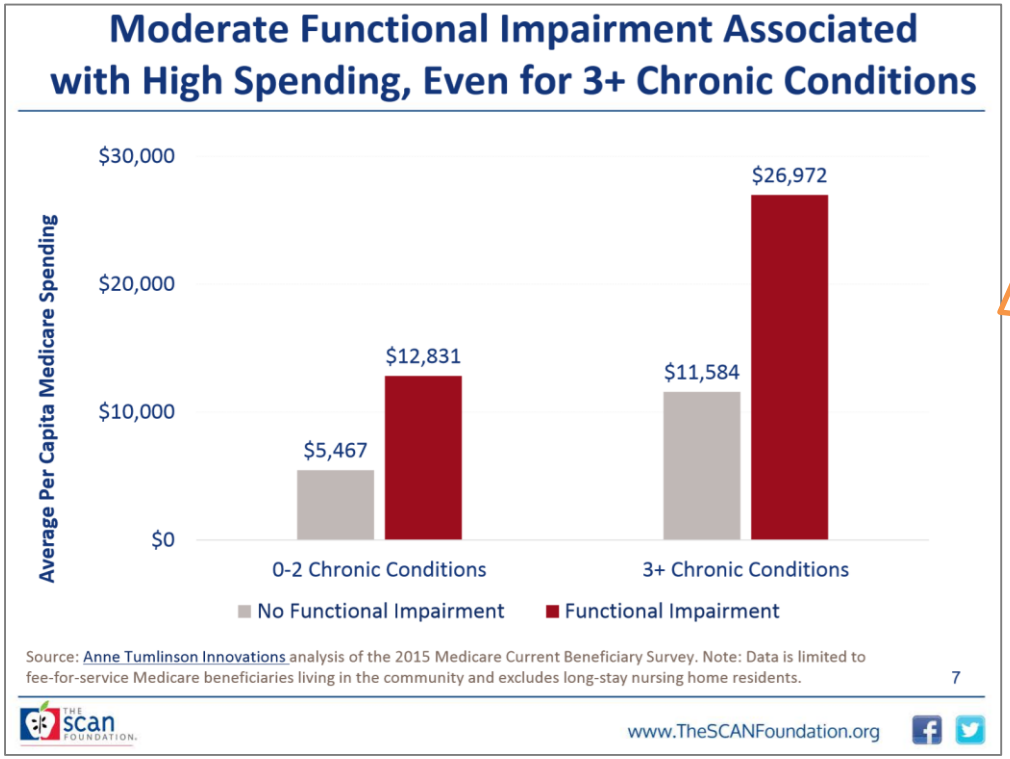

Talking Points:

- You might think that functional impairment is a proxy for chronic conditions.
- But actually, even among people who have three or more chronic conditions, having functional impairment, compared to not having it, doubles their healthcare spending.

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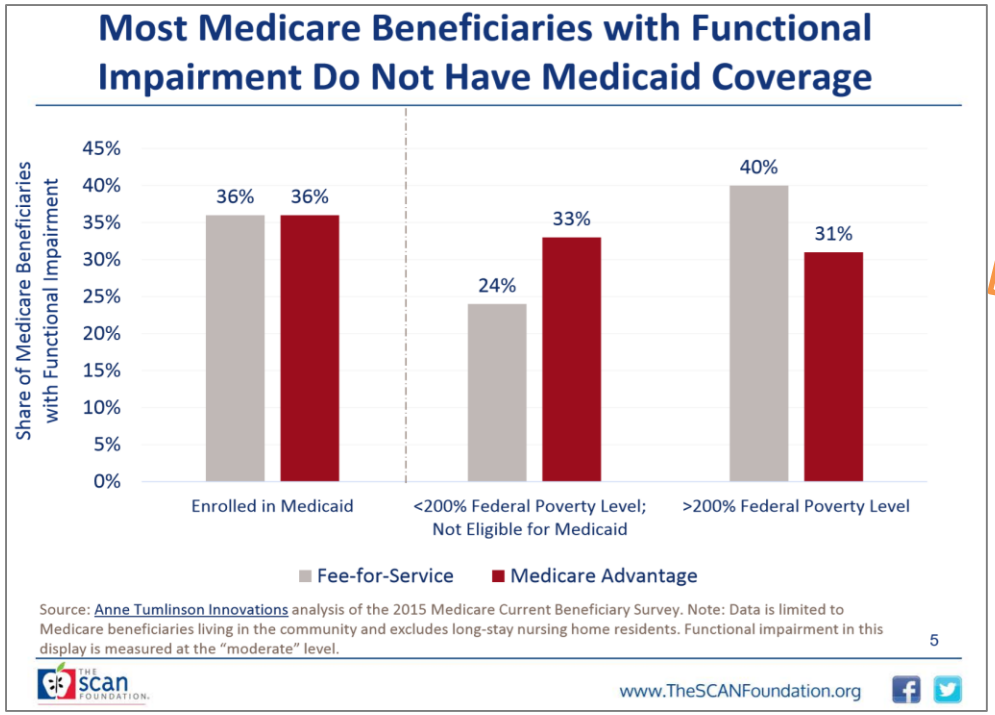

Talking Points:

- Not everyone who needs long-term services and supports can get them through Medicaid. In fact only about 36% of the health plan population with functional impairment is eligible for Medicaid.
- One-third of health plan enrollees with functional impairment who are not eligible for Medicaid live below 200% of poverty, making them much more likely to be relying on unpaid family members for most of their non-medical supports and services.

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