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Assisted Living Facilities: Considerations Regarding Medicare

June, 2024

Proposed regulations may open enrollment of assisted living facility residents to Medicare Advantage Institutional Special Needs Plans (SNPs) without the hassle of an institutional equivalent evaluation. This change may encourage more Assisted Living Facility (ALF) organizations to partner with Medicare Advantage (MA) plans. But, the history to date regarding ALFs and SNPs has been somewhat checkered. Despite the hoopla of 5 years ago around consortiums of ALF organizations seeking to form SNPs or partner with an existing one, enrollment in these programs and overall IE enrollment in SNPs is still quite small. Will this proposed change make a difference? There are many organization-specific factors to consider.

Why ISNP?

According to a 2019 article in Senior Housing News, roughly the same percentage of ALF residents are enrolled in Medicare Advantage Plans as the general community. As of June 2024 50.9% of Medicare eligibles are enrolled in an MA plan so it is likely about half of current ALF residents are members of a Medicare Advantage plan And the potion of residents that have Medicare fee for service percent coverage continues to shrink, even for dually eligible Medicare and Medicaid beneficiaries. This poses and opportunity and challenge for ALF owners.

Increasingly ALFs offer residents the convenience of on-site healthcare providers. To be paid for providing services to residents who have Medicare Advantage coverage providers must be 'in network' with the health plan. And for the sicker residents, ALFs who offer additional services like monitoring, telehealth or intervention, getting paid for those services by Medicare Advantage can be challenging. Forming or partnering with an ISNP can bring additional revenue to the clinical practice, increase resident retention and enhance both satisfaction and quality. Many ALF organizations are convinced that they coordinate care, reduce emergency room use and hospitalizations and save money. So, why not partner with a MA plan? In a word, enrollment.

Reducing a barrier to enrollment by dropping the hassle of demonstrating that the beneficiary qualifies as 'institutional equivalent' would seem to be a major positive change, at least from the enrollment perspective. But there remain headwinds. Residents may want greater choice of providers than an ISNP can offer. ALF residents are more mobile than SNF residents and may be more selective in which providers to see. And the ALFs themselves may not know as much about the health status of their residents as they assume. Even if they are currently providing clinical services to residents, they most

likely don't have line of sight on risk scores and the total cost of care – specialists, outpatient and inpatient stays, ancillary healthcare providers.

ALFs are not Medicare facility providers. As such, ALF contracts with health plans are creative, frequently involving providing non-Medicare services like transportation, food, etc. Contracts with Medicare Advantage organizations often involve an affiliated or partnering Medicare certified provider group, home health agency or hospice. If the trajectory of the ALF community continues towards providing more clinical care then ALFs need to be relevant to the current health plans and Medicare or risk getting left behind as simply a senior housing option.

Alternatives to Medicare Advantage and ISNP

CMS has been experimenting with Accountable Care Organizations since 2012 and even earlier with other types of at-risk provider organization demonstrations. Again, the track record has been checkered and in particular, ALFs have not found a niche. ALF resident populations aren't a good fit for traditional Medicare ACOs that are designed to serve community beneficiaries. A model that seemingly would be a good fit is the High Needs ACO REACH demonstration. But the criteria to participate in this model preclude many if not most of ALF residents. The High Needs ACO REACH program is designed for institutional beneficiaries with high risk scores or skilled stays. Now we're right back at the start.

What to Do?

1. Evaluate your options. MA, ISNP, ACO, concierge service
2. Determine if care coordination programs hosted by the ALF are robust enough to deliver savings and enhanced quality for a SNP or ACO
3. Project likely uptake by residents based on data (survey, focus groups, etc.) rather than anecdotal information.
4. Calculate the cost of entry for each type, the likely time and effort to get to the market, success factors, risk, reward and alternatives

For further information or to schedule a call to discuss further, contact Stephen Wood or Kirk Twiss at Clear View Solutions, LLC. Our experience with managed care, Medicare Advantage, SNPs and ACOs is comprehensive. We have assisted clients evaluate options, conduct feasibility studies and actuarial analysis that best fit their competencies and strategic goals for nearly 40 years.

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Future Prospects for Medicare Advantage

September, 2024

2025 is shaping up to be a seminal year for the Medicare Advantage market. Expense increases outpacing revenues, health system consolidation that translates into increased contract negotiation leverage and potential greater regulatory scrutiny all add up to headwinds. Pundits are calling it the 'Great Disruption" and comparing it to the last realignment in Medicare managed care in 2003 when overall enrollment dropped to 5.3 million from a previous high of nearly 7 million. But is the comparison relevant or valid? The Medicare market in 2024 is significantly different from 20 years ago.

For starters, at 34 million members, over half (54%) of all Medicare beneficiaries are enrolled in a Medicare Advantage plan compared to 13% in 2004. And it is highly unlikely that they will willingly return to traditional Medicare with outpatient and inpatient deductibles and 20% cost share for provider visits. Indeed, many beneficiaries don't even know what 'traditional' Medicare is – they never have been enrolled in fee-for-service.

Here are reasons why we think Medicare Advantage enrollment will remain strong. To remain competitive local providers will need to think through their strategy to deal with payors and potentially align with local health systems.

1. Providers and health systems cannot afford to walk away from Medicare Advantage despite their rhetoric. They may selectively drop Plans to make a point with selected carriers but they cannot afford to drop Medicare Advantage entirely.
2. National Medicare Advantage plans have all but eliminated local competition with benefits and low premiums but should they truly focus on margin over membership the local plans that have survived will willingly step up to fill the void. In fact this might just be the lifeline that they need to stem marginalization.
3. State Medicaid programs are not returning to fee-for-service and that also applies to dually eligible populations.
4. Accountable Care Organizations have little to offer Medicare beneficiaries. They don't provide extra benefits and the care coordination that they claim to provide does not make up for deductibles and copays in traditional Medicare.
5. Medicare Supplement premiums show no signs of lowering and reducing transfers from Medicare Advantage.
6. The principles of Medicare managed care – preventive visits, care coordination, transition care from one setting to another have repeatedly proven to be effective at reducing

unnecessary utilization and cost. Those savings have been applied to increased benefits – filling in cost sharing as well as enhanced extra benefits and healthy margins. When carriers trim the 'extra' benefits – gym memberships, over the counter drug cards, etc. some members may complain but there aren't genuine alternatives at the price point that they have enjoyed. As long as Medicare Advantage plans provide genuine economic value membership will stay.

7. The 'leveling off' of Medicare Advantage enrollment gains may have some truth but demographics are on the side of increased enrollment. Until the baby boom age-in population levels off significant enrollment increases are almost assured. Roughly 10,000 new Medicare beneficiaries are added daily and this will continue until 2029. At the current penetration rate this means that at least 5400 new members are added to Medicare Advantage each month. This market is too big to ignore.
   So, the question for providers and health plans isn't anticipating the demise of Medicare Advantage, it's how to develop and employ strategies to survive and thrive in a more competitive and economically challenging environment while continuing to focus on delivering quality care.

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ISNPs – poised for success or on life support?

October, 2024

ISNP formation and member growth has lagged behind other Medicare SNP programs. Over the last 10 years ISNPs have grown from 52 thousand members to nearly 126 thousand members for an average 14% annual growth rate. At the same time the nursing home resident population has dropped, from 1.4 million in 2014 to 1.2 million in 2024. But, compared to the rest of the Medicare market, ISNP formation and total enrollment gains have lagged. Since 2014 overall Medicare Advantage market penetration increased from 31% to 51%. During this time MA membership added 17.8 million net new members and now stands at over 34 million.

By far, the dominant plan in the ISNP market is United Healthcare. Currently the UHC Nursing Home Plan enrolls nearly 70,000 nursing home residents in its ISNPs. Revenue from this line of business exceeds $2 billion. Over the last 10 years UHC has doubled its enrollment in its ISNPs for an annualized average growth rate of 10%, not quite at the level of the overall growth of ISNPs but still significant. The rest of the market is largely made up of local plans with one or two locations and provider sponsored plans.

Given the complexity of the product, the challenge of caring for nursing home residents, the high turnover of members due to death and the challenge of gaining trust and cooperation from nursing homes and their staffs, is the low enrollment of ISNPs a show of weakness on the part of MA plans or an indication of the challenges of creating long term success?

<u>What is causing the lagging enrollment gains of ISNPs and will this change?</u>

Carriers are becoming increasingly conservative about maintaining existing organizations and forming new ISNPs with the number of ISNPs Plan options in 2025 falling by 16. While ISNP enrollment gains are a small fraction of the total Medicare Advantage market growth it is likely that many nursing home residents are already Medicare Advantage members, having enrolled prior to their nursing home stay. Converting current MA members with likely low premiums and extra benefits to an ISNP is challenging. And many residents are dually eligible Medicare/Medicaid where Medicaid enhanced benefits may already be offered. Indeed, DSNP enrollment is now nearly 6 million and by 2025 952 DSNP options will be available. Additionally, other Medicare Advantage options like Chronic Disease special needs plans may be increasingly interested in enrolling residents. Nursing home residents are not exclusively the domain of ISNPs.

The big perceived 'threat' to ISNPs may be High Needs Accountable Care Organization (ACO) REACH programs. While not fully 'tested' yet, ACO REACH programs are attractive to many nursing home operators because they don't require the same level of investment and enrollment is far easier and quicker. Residents are attributed to primary care providers and if the home has an affiliation with the provider it can participate in the shared savings. Particularly in rural markets, the high needs ACO REACH program is attractive. However, while it is likely to be renewed, this program is a demonstration and is only currently mandated through 2026.

The nursing home resident population has been dropping for the last several years even as the overall number of Medicare beneficiaries has grown. Partly due to technology advances, the availability of alternative settings like assisted living facilities and targeted managed long term care programs designed to keep beneficiaries at home, the nursing home industry is shrinking. Over the past decade nursing homes lost a net 200,000 residents.

Ideally ISNPs can mitigate this downward trend by rewarding nursing homes for reducing unnecessary emergency room visits and hospital admissions. But there can be a high level of mistrust between nursing home providers and health plans that operate the ISNPs. Overall success requires alignment between the ISNP and the nursing home. From marketing and enrollment to clinical care, a high degree of coordination is required.

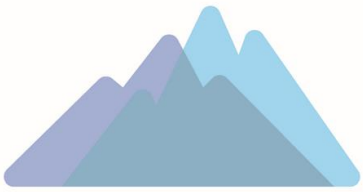
What's the future?

Selected provider sponsored ISNPs have gotten traction and are beginning to show success. The challenge is scalability. Starting a health plan is not for the faint of heart from a variety of perspectives – capital, regulatory requirements, state licensure, administration, actuarial risk. Membership potential is limited by the number of custodial nursing home residents in the provider network. The average size of an ISNP has changed little over the last 10 years, at only about 800 members. It's hard to cover your overhead, even an ISNP with high per member revenues, on such a small member base.

There are signs that the market is opening up. Humana has partnered with Longevity, an organization focused on ISNPs, to open up ISNPs in multiple states. This pairs the clout of Humana with the expertise of Longevity. If successful this may pave the way for other large commercial carriers to enter the market, reducing the overhead burden of the relatively small enrollment of an ISNP. But the total market size of ISNPs pales by comparison to the rest of the Medicare market and it is an open question whether additional large carriers will make the investment to capture more of this small segment.

As nursing homes become more familiar and comfortable with ISNPs they are joining selected plans. The larger nursing home network provides access to more potential members. Once the standalone plans can demonstrate success in increasing quality and reducing cost they become more attractive to increased nursing home participation. And ISNPs can help nursing home to address the concerns of CMS and state regulators that staffing levels in nursing homes are below minimum requirements by augmenting staff with ISNP practitioners.

Will ISNPs achieve the same success as other Medicare Advantage options? Doubtful. There are too many structural and competitive barriers, including a shrinking market size for institutionalized individuals. But that doesn't mean that ISNPs are a failed experiment. Those that succeed demonstrate that better quality and personalized care can even be delivered to a nursing home population at equal to or lower cost. The challenge is to balance small market size with the realities of health plan operations where administrative cost efficiencies are achieved with more members.



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