Medicare growth is exploding, with a projected 48 percent increase in the number of beneficiaries by 2030 and total Medicare spending up 85 percent over the next five years, while Medicare margins continue to shrink. In this environment, is it possible for providers to break even on Medicare? How can providers improve patient outcomes for this high-risk, high-utilization population while containing costs? The answer lies in recognizing the distinct requirements, preferences and trajectory of this unique population — and treating it differently.
The path to break even must include managing a growing number of lives in specific contracted programs, such as Medicare Advantage (MA), that focus on prevention and managing disease progression and are typically funded by a per member per month (PMPM) or other value-based reimbursement payment. Many health systems seem to recognize this, with more than a quarter of major US health systems planning to launch MA programs in the next four years, though less than 30 percent are confident they will be successful given the significantly different operating model required. Innovative for-profit companies, such as CareMore Health and Oak Street Health, are partnering with payors, employing new care models and finding ways to align care and costs with reimbursement by emphasizing preventive, out-of-hospital care and wraparound services, and reducing unnecessary inpatient admissions, readmissions and length of stay (LOS). To avoid risking a gradual demise under fee for service and increasing Medicare volumes, providers should consider entering into risk arrangements as they build capabilities to manage this population, to capture full value and promote better health and quality of life for seniors at lower costs and utilization.

How the Traditional Delivery System Fails Medicare Patients...and Increases Costs

The Medicare population is different — many people on Medicare live with serious health problems, including multiple chronic conditions, cognitive impairments and limitations in their activities of daily living. Many also live on modest incomes and are relatively isolated. As aging Americans face challenging life circumstances and the loss of social connections, they may become less able to independently manage their own health or activities of daily living. The graph below illustrates the unique characteristics of the US Medicare population:

### Characteristics of the Medicare Population

- **Long-Term Care Facility Resident**: 4%
- **Age 85+**: 13%
- **Under Age 65 with Permanent Disabilities**: 17%
- **Poor/Fair Health**: 27%
- **5+ Chronic Conditions**: 30%
- **Functional Impairment (1+ ADL Limitations)**: 34%
- **Cognitive/Mental Impairment**: 36%
- **Savings Below $74,450**: 50%
- **Income Below $26,200**: 50%
Our traditional care delivery system was built for the general patient population and is not well-designed or suited to a senior population with a very different set of requirements and long-term trajectory. While Medicare patients may require more frequent services or touches, such as quarterly chronic condition check-ins, the intensity of services should decline over time. Providing seniors with what they need — fulfilling activities of daily living and consistent touchpoints and support — requires less-intensive services than providing treatment and curative-oriented episodic care. However, most providers deal with this population by continuously increasing the number and intensity of services — more episodic care, more referrals to specialists, more procedures as “fixes,” more treatment and more clinical activity. In contrast, supportive care and wraparound services positively impact stabilization and management of chronic conditions, and result in lowered intensity of services and improved quality of life.

Four Pivots to Improved Medicare Outcomes and Break-Even

For most providers, effectively addressing the unique needs of the Medicare population will require pivoting away from a traditional mindset and approach, toward new models of care delivery and management, as described below:
Pivot 1 – Financial Position

Model Medicare patient utilization and develop care strategies and models that optimize Medicare economics.

Organizations must embrace a distinct Medicare business model, capable of margins that are sustainable without subsidies from commercial patient revenue. Per member per month funding or value-based payments from payors for specific Medicare population cohorts, such as Medicare Advantage patients, may bridge gaps in revenue previously closed by commercial subsidies.

Even in a Medicare fee-for-service environment, it is important to understand your organization’s Medicare profit and loss (P&L) and identify what is driving financial loss in the Medicare population. Those drivers provide insights into what is required to stem losses and create a more sustainable Medicare business model. By modeling the utilization of the Medicare population, organizations can see the requisite impacts on length of stay and readmissions, and the level of performance required to meet strategic goals and contract requirements.

- Methodical inpatient care management, discharge planning and purposeful transitions to vetted post-acute care partners;
- Management of conditions driving readmissions, especially sepsis and pneumonia;
- Increased referral to and use of community palliative care;
- Strong support of palliative care and hospice by primary care providers;
- Shift to the least restrictive site of service, i.e., from inpatient to the community or home;
- Management of post-acute length of stay;
- Active management of specialist-driven utilization, the use of lab tests and imaging; and
- Management of specialty pharmacy across the enterprise.
Pivot 2 – Organizational Structure
Create an autonomous organization that can bring Medicare patient management capabilities to the delivery system for outcomes and contract success.

Establishing a distinct functional unit, appropriately scaled and with dedicated resources and leadership, is critical to effectively managing care for this population. The Medicare population management unit must be understood as a distinct part of the organization, entirely focused on delivering the most effective, efficient care and achieving superior outcomes. A separate unit allows the organization to develop operational traction, with appropriate connections to the community and back into the delivery system. Separate governance and physician/administrator dyad leadership structures should be established to ensure accountability, manage the unit to expected performance, and sponsor the Medicare care model and delivery approach.

THE SEPARATE ENTITY AND FUNCTIONS ENABLE YOU TO MORE READILY:
- Leverage strong analytics to support detailed Medicare patient cohorting and target interventions;
- Actively manage the provider network to drive patient engagement, care planning, management and coordination for defined patient cohorts, based on health and medical expense risk;
- Proactively identify contractual opportunities and parameters for successful risk management; and
- Cultivate a culture of health by augmenting episodic care with ongoing health management.
Pivot 3 – Care Model

Focus on interventions and services delivered by non-traditional roles to delay progression to frailty.

 Organizations must be purposeful about selecting care models that can effectively delay progression to frailty, rather than leveraging a “one-size-fits-all,” provider-centric care model. The key is accurate, individualized patient evaluation around patient needs, preferences and socio-demographic factors to determine the day-to-day support structure and personal health management activities required to maintain the patient’s health status. Effective deployment of an innovative care team is essential. For the frail, complex patients, this may require pulling patients out of traditional primary care and into teams led by a discrete group of physicians who are expert in geriatric care. While physicians should provide care plan direction and care management oversight, they should not be the only consistent patient interface.

 THE FOLLOWING SERVICES CAN SUPPLEMENT AND SOMETIMES SUBSTITUTE FOR TRADITIONAL PROVIDER VISITS:

- Provide support services (i.e., social work, connections to community services) to augment and facilitate the decrease in overall intensity of care services;
- Organize patient-centric teams operating at top of license: advanced practice providers (APPs), registered nurses (RNs), Doctors of Pharmacy (PharmDs), licensed clinical social workers (LCSWs), community health workers (CHWs) and peer counselors;
  - Substitute physician visits with patient services that focus on social determinants, behavioral health, and chronic condition and medication management; and
  - Pilot interventions in the community and home to supplement clinic visits.
Pivot 4 – Time-Based Approach
Focus on cross-continuum, longitudinal care specifically for Medicare patients.

Providers and administrators must shift away from episodic, transactional, curative-focused care delivered within enterprise silos, toward a more supportive, holistic and clinically integrated approach across the enterprise and into the community and home.

THIS PIVOT REQUIRES MEDICARE PATIENT-FOCUSED CLINICAL INTEGRATION AND MANAGEMENT DISCIPLINE ACROSS THE DELIVERY NETWORK:

- Interventions that are prioritized to improve health disparities rather than manage a single disease;
- Seniors-specific, evidence-based care guidelines that span primary and specialty care including treatment goals focused on optimal management of disease progression and quality of life, rather than curative interventions;
- Episodic “bundles” that frame and standardize clinical protocols and care pathways for those conditions driving admissions and readmissions in the Medicare population;
- A performance-vetted, post-acute care network that serves as the foundation for care transitions, based on performance and unique patient requirements like dementia; and
- A knowledge base of community services and resources for patients to draw upon to establish and sustain health management at home.
The Path Forward

The four pivots described represent the path forward for health systems committed to delivering and managing care for their Medicare population. While some health systems will continue to manage in-house, others may consider partnerships with payors or other care delivery organizations to accelerate market position and gain experience with successful Medicare care models. Regardless, all providers will benefit from thoroughly evaluating their current Medicare organizational structure and financial and clinical performance.

The questions below provide a good starting point:

Are Medicare margins sustainable?

Create a test P&L of your Medicare patient population:

- What is the average length of stay for your Medicare patients?
- What percent of revenue is contributed by frail patients dying in the hospital instead of hospice?
- How is the organization performing on readmissions? Where are the financial opportunities and challenges?

Is there clear accountability for Medicare performance?

Assess the organizational structure and positioning of the Medicare-centric care model, and test if it is organized for success:

- How dispersed is accountability for Medicare performance in the organization?
- Are there clear and distinct performance expectations outlined for Medicare performance?

Do you have a unique care model in place for Medicare patients?

Assess the capability of your current care model, place of service and roles to decrease the intensity of service:

- How many “one-size-fits-all” clinic visits does the Medicare patient average per year?
- To what extent are less-intensive services, such as social support and community health workers, used to help manage chronic conditions and other factors that predispose the Medicare population to frailty and hospitalization?
- How often are pharmacist interactions substituted for a primary care visit?
- Are visits available in a community clinic or at home?

Is care holistic and clinically integrated?

Assess enterprise care delivery and integration for the Medicare population:

- How are health disparities addressed through interventions?
- Which specific Medicare patient guidelines and management practices have been developed and integrated across the enterprise and into the community?
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