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HOW HEALTH SYSTEMS CAN THRIVE WITH MEDICARE ADVANTAGE

The 2019 Medicare Advantage (MA) plan year began on January 1st and once again more Americans enrolled in MA plans than the year before. Fueled by an aging baby boomer population and attractive financial incentives to join, more than 22.3 million beneficiaries enrolled in a Medicare Advantage plan, an increase of 6.6 percent over last year.[1] With Medicare Advantage penetration currently at roughly 36 percent of the total Medicare-eligible population, the Congressional Budget Office is projecting that this number will reach 42 percent by 2028.[2] Some managed care plan leaders have even stated that there is a potential to reach 50 percent penetration.[3] Yet, despite the fact that 10,000 people age into Medicare per day, most health systems still draw their entire operating margin from commercial business, while the Medicare business at best breaks even. With this continuing demographic shift, health systems must find ways to profitably serve the Medicare population. Medicare Advantage creates the platform to do so.

Developing Your Medicare Advantage Strategy

While some organizations may be exploring whether there is a viable pathway to launch co-branded MA products with health plans or third-party administrators, given The Center for Medicare and Medicaid Services' (CMS) relatively strict network adequacy requirements, it will be difficult for many systems to successfully execute against this strategy. **Still, health systems can improve their financial and operational performance on MA payor products if they focus on four key strategies described below.**

2019 MA Plans Continue to Advance Member Financial Incentives

MA plan premiums decreased by 6% (compared to 2018) **to $28 per month**

46% **of MA enrollees will have a ZERO-PREMIUM PRODUCT**

Example **PRODUCT ADD-ONS** include:

- \+ $100+ Rx rebate cards
- \+ Dental and vision benefits
- \+ Free gym memberships
- \+ Two weeks of free delivered meals after a hospital visit

Source: CMS Newsroom, "Medicare Advantage Premiums Continue to Decline While Plan Choices and Benefits Increase in 2019," September 28, 2018

1

Optimize MA Reimbursement Processes

CMS ADJUSTS ITS MA REIMBURSEMENT PAYMENT – UP OR DOWN – FOR EACH MEMBER BASED ON ANTICIPATED CLINICAL COSTS THROUGH A RISK ADJUSTMENT FACTOR (RAF).

The implication for providers is that if they can focus on their Hierarchal Condition Coding (HCC) strategies and align MA plans with those efforts, there is an opportunity to receive reimbursement payments that most accurately reflect the clinical complexity of every patient (as well as positively influence the benchmark reimbursement rate that CMS uses to reimburse accountable care organizations (ACOs) participating in its Medicare Shared Savings Programs). CMS also provides additional revenue – up to 5 percent of total MA plan premium – based on annual Star rating attainment, which rewards MA plans for their performance on specific quality measures. The coupled effect of Star bonuses and effective risk adjustment can be the difference between a positive or negative margin if health systems are able to effectively negotiate aligned incentive sharing contractual terms with their MA health plan partners.

2

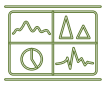
Unlock the Value of Population Health Management Investments

As described in our recent paper, "Managing Medicare to Break Even: Better Patient Outcomes at Lower Costs," realizing a positive operating margin in this segment requires pivoting the organization to more effectively manage the Medicare population in recognition of its unique needs and characteristics. The good news for improving performance is that the Medicare population is generally characterized by a higher incidence of chronic conditions than is the commercial population, which presents a greater opportunity within Medicare to drive improvement through clinical management, including the development and deployment of care models that integrate support services and other dimensions to delay progression to frailty. Within the Medicare segment, MA avails potential levers that can offer financial benefit from more effective health and utilization management, particularly relative to the Medicare fee-for-service (FFS) segment given CMS' broad network access requirements.

THROUGH A COLLABORATIVE STRATEGY WITH MA PLANS, HEALTH SYSTEMS CAN DEVELOP AND FUND FOUNDATIONAL POPULATION HEALTH AND CLINICAL MANAGEMENT COMPETENCIES WITH SENIOR POPULATIONS.

For example, in concert with clinical management improvements, health systems can work with MA plans to influence plan design, network design and pharmacy benefits to align and enable a financial return on their population health management efforts.

3



Build Claims-Based Data Analytics and Business Intelligence Competencies

With increased risk exposure – either through a value-based payor contracting strategy or a co-branded product – health systems must be able collect, manage and leverage new sources of data to drive better clinical and financial performance. In many cases, payor partners will offer health systems claims and socioeconomic data to enable better management of attributed MA lives, which is vitally important to understanding patient spend patterns across the care continuum, key clinical variation opportunities and referral patterns (which may be informative for other payor populations as well).

AS HEALTH SYSTEMS LOOK TO ADVANCE THEIR BUSINESS INTELLIGENCE CAPABILITIES, AN MA PRODUCT STRATEGY, WHEN NEGOTIATED PROPERLY, CAN PROVIDE ACCESS TO MUCH NEEDED DATA TO DEEPEN HEALTH SYSTEM BUSINESS INTELLIGENCE COMPETENCIES.

4

Develop Contracts Tied to the Premium Dollar

Neither of these models and their respective levels of risk-taking are advisable for health systems that are early in their value-based care journey.

YET, OVER TIME HEALTH SYSTEMS CAN DRIVE TOWARD NEW ECONOMIC ARRANGEMENTS TO CAPTURE THE VALUE THAT HEALTH SYSTEMS CREATE THROUGH AN MA STRATEGY.

There are many different approaches that health systems are taking. One is a co-branded model, where a system and plan create a joint-venture product that splits margins across both organizations. This approach, which is less common, creates economic alignment between the health system and plan. Another more common model is a contractual arrangement, where a health system negotiates reimbursement that pays a percent of premium collected for the members that the system manages. While neither of these models and their respective levels of risk-taking are advisable for health systems that are early in their value-based care journey, over time health systems can drive toward new economic arrangements to capture the value that health systems create through an MA strategy.

AS A HIGHER PERCENTAGE OF THE POPULATION AGES INTO MEDICARE IN MOST MARKETS AND COMMERCIAL REVENUE PRESSURES CONTINUE TO RISE, HEALTH SYSTEMS SHOULD CONSIDER A MORE AGGRESSIVE, INTENTIONAL AND THOUGHTFUL APPROACH TO THEIR MEDICARE ADVANTAGE STRATEGY.

The strategies described in this paper provide a starting point for systems to build a foundational platform around a growing Medicare Advantage population that will create direct strategic and financial advantage.

References

[1] CMS Medicare Advantage Monthly Summary Report, January 2019
[2] Congressional Budget Office's April 2018 baseline. Washington, DC: Congressional Budget Office, April 2018
[3] UnitedHealth Group Earnings Call, CEO David Wichmann, April 17, 2018

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