THE MEDICARE ADVANTAGE OPPORTUNITY

How payers and providers can capitalize on this growing segment

Enrollment in Medicare Advantage (MA) health plans is quickly growing, and providers and payers alike have an opportunity to capitalize on this growing segment. This white paper outlines the industry landscape and considerations for payers and providers around their MA strategies.

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Industry landscape

Never has the health care industry been under such intense pressure. With declining reimbursements, health care reform, provider shortages, an aging population and rising consumer expectations, how do organizations achieve success in this shifting market?

General sentiments from industry thought leaders seem to suggest that Medicare Advantage (MA) plans are a strong choice for organizations to consider as they develop value-based care strategies. Many suggest that industry trends point to MA as the first area of opportunity both payers and providers should explore.

MA plans are offered through private insurance companies that must follow the rules set forth by Centers for Medicare and Medicaid Services (CMS). They take the form of health maintenance organizations (HMO), preferred provider organizations (PPO), private fee-for-service plans, special needs plans and Medicare medical savings account plans.

Increasingly, MA plans pass risk to provider organizations via value-based contracts, which allow for more flexibility and customization relative to traditional Medicare programs. For example, under these arrangements payers and providers can negotiate risk thresholds, profit/loss sharing terms and bonus metrics that meet the provider organization where they are along the value-based spectrum (from upside-only models to fully-delegated risk and capitation).

Value-based payment spectrum

Health care is too important to stay the same:
Medicare Advantage trends

Let's examine a few of the underlying trends that support why payers should consider adding MA plans to their portfolio and providers might look at expanding their MA contracts with payers:

- Approximately 10,000 people are eligible to enroll in Medicare daily.¹
- 48 percent of new MA plan beneficiaries are newly eligible for Medicare, introducing a younger, healthier cohort.²
- Medicare enrollment has a projected 7.2 percent annual growth rate through 2025.³
- Between 2008 and February 2017, MA enrollment grew from 9.7 million, or 22 percent of all Medicare beneficiaries, to 19.6 million, or 34 percent of Medicare beneficiaries.⁴
- In 2020, the Medicare Access and CHIP Reauthorization Act (MACRA) will eliminate Medicare Supplemental C and F plans for new beneficiaries, or first-dollar coverage plans, which make up more than half of the market, and many of these consumers will turn to MA.⁵
- More than 41 percent of Medicare enrollees are projected to be in MA plans by 2026.⁶
- Once enrolled in MA, only 2 percent of enrollees revert to traditional Medicare, resulting in an increase in a population’s participation and utilization of services.⁷
- Seniors enrolled in MA are 94 percent satisfied.⁸
- MA presents significant revenue adjustment opportunities [Medicare Risk Adjustment (MRA) and Star Ratings].

Business challenges to maximize your value-based care initiatives

From a growth, regulatory and profitability standpoint, MA shows promise for taking advantage of the silver tsunami (baby boomers aging into Medicare) on the horizon. Let’s also consider a few known business challenges organizations face today that further support MA as an area of opportunity.

- Commercial plan members prove to be highly transient between carriers, and therefore, plans may not realize the returns on their preventive health investments.
- Medicaid presents a challenging population with which to engage, from both a state funding perspective and innovation/value-based models that are still largely unknown.
- Traditional Medicare offers less revenue opportunity [e.g. no Hierarchical Condition Categories (HCC) (a model to adjust capitation payments to private health care plans for the health expenditure risk of their enrollees), or Star Ratings (measurement of how well Medicare Advantage and Part D (prescription drug) plans perform)]. Further, many innovation models, like Accountable Care Organizations (ACO), have shown mixed results from a profitability perspective.
Medicare Advantage vs. traditional Medicare

There are a few rudimentary aspects to MA and distinctions from traditional Medicare.

MA plans cover the full range of traditional Medicare services, including Part A (hospital insurance) and Part B (medical insurance) coverage, and most also cover Part D plans (prescription drugs).

Payments from the government to MA plans are adjusted based on documented risk scores and quality results from their provider network (Star Rating system).

MA plans often pay their providers on a per member per month (PMPM), partial- or full-capitation, or percent-of-revenue basis, which enables providers to practice on a fee-for-value basis, without requiring them to participate in the Merit-based Incentive Payment System (MIPS) under Medicare Access and CHIP Reauthorization Act (MACRA).

Although MA plans have traditionally had a negative provider stigma associated with them, there has been recent changing of the tides. Once considered cumbersome, complex and a source of unwarranted claim denials, MA plans are now viewed as an attractive alternative for establishing clear financial risk terms than can generate sustainable and improved margins. These plans can also help to accelerate the transition to maximize quality and care coordination and align integrated provider networks.

Medicare Advantage penetration

<table>
<thead>
<tr>
<th>Top five states</th>
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<tbody>
<tr>
<td>State</td>
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<tr>
<td>Hawaii</td>
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<tr>
<td>Oregon</td>
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<tr>
<td>Florida</td>
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<td>Pennsylvania</td>
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<td>California</td>
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<table>
<thead>
<tr>
<th>Bottom five states</th>
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<tbody>
<tr>
<td>State</td>
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<tr>
<td>Alaska</td>
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<tr>
<td>North Dakota</td>
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<td>Wyoming</td>
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<tr>
<td>South Dakota</td>
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<td>Maryland</td>
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Considerations for providers and payers

MA presents attractive opportunities for both providers and payers and helps to facilitate enhanced engagement and collaboration between the two parties.

Namely, within MA, payers offer risk- or path-to-risk based contracts to meet providers where they are along the value-based spectrum. MA also presents an opportunity for increased data-sharing capabilities, customized network configurations, and product design and growth strategies that support both parties’ strategic objectives.

Providers

Specific to providers, the rationale to strategically align around an MA program includes hedging against the payment rate uncertainty of MIPS, helping to position organizations for success under alternative payment models (APM).

Providers can also drive growth under provider-sponsored health plans (PSHP), which account for roughly 19 percent of MA enrollment.¹⁰

Additionally, providers view MA as a means to hedge against Medicare fee-for-service (FFS) cuts, drive contract alignment, rationalize investments in value-based care initiatives and reduce network leakage, given enhanced patient loyalty within the MA population.

Payers

Payers have also taken notice of the opportunities an MA plan can afford, identifying MA as a sustainable and attractive line of business (near- and long-term). Humana, UnitedHealthcare and Kaiser Permanente, to name a few, have all experienced notable profitability in this segment, as well as many smaller players and PSHPs.¹¹

Payers entering this space can get direct return for Star Ratings, MRA performance and use their historical experience in managing costs, utilization and medical trends.

For payers, achieving a 4-, 4.5- or 5- Star Rating means an additional five percent bonus payment or roughly $500 per member annually. Plans below 4 stars receive no bonus payment. To put these numbers in perspective, an MA plan with 20,000 beneficiaries would receive an additional $10 million per year.

Plans that achieve a 5-Star Rating can also market to beneficiaries throughout the year, rather than being limited to the standard annual enrollment period (AEP) window of October 15 through December 7. This perk has demonstrated its benefits in terms of membership growth and engagement.
Star Ratings are a key catalyst in helping move quality improvement forward amongst health plans and their provider networks. Star Ratings measures evaluate quality performance based on outcomes, patient experience, access and process. They help drive the perception of high quality, which can translate into member growth, contracting opportunities and greater member retention.

Some payers also heavily invest in programs to maximize MRA scores and capture HCC activity, which can generate more than 100 percent additional revenue for a given patient or population.\(^{12}\)

A few best practices to achieve this type of growth, include: embedding certified coders in high-opportunity practices, automating the manual chart review process, stratifying populations and providers by risk adjustment factor (RAF) opportunity and ensuring documentation is CMS-audit ready. Accurate HCC coding helps providers deliver appropriate, high-quality care and enables both payers and providers to better know, engage and empower patients based on their unique needs.

### Risk Adjustment Factor (RAF) example

<table>
<thead>
<tr>
<th>Several HCCs</th>
<th>Some HCCs</th>
<th>No HCCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>82-year-old male</td>
<td>0.543</td>
<td>82-year-old male</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.177</td>
<td>Medicaid eligible</td>
</tr>
<tr>
<td>Diabetes with renal disease (HCC 18)</td>
<td>0.368</td>
<td>Diabetes (HCC 19)</td>
</tr>
<tr>
<td>Rheumatoid arthritis (HCC 40)</td>
<td>0.374</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Heart failure (HCC 85)</td>
<td>0.368</td>
<td>Heart failure (HCC 85)—not coded</td>
</tr>
<tr>
<td>CKD IV (HCC 137)</td>
<td>0.224</td>
<td>CKD IV—not coded</td>
</tr>
<tr>
<td>Disease interaction (HCC 18+ HCC 85; HCC 85 + HCC 137)</td>
<td>0.182; 0.317</td>
<td>No disease interaction</td>
</tr>
<tr>
<td>Risk Adjustment Factor</td>
<td>2.553</td>
<td>Risk Adjustment Factor</td>
</tr>
<tr>
<td>Anticipated expenditures</td>
<td>$23,682.29</td>
<td>Anticipated expenditures</td>
</tr>
</tbody>
</table>
Another consideration, and notable concern for payers offering MA plans is the accuracy of provider directories. CMS and state governments have started levying fines as steep as $25,000 per affected beneficiary for inaccurate MA directories, due to the public confusion and the potential financial harm to beneficiaries of unknowingly seeing an out-of-network provider.

For example, CMS recently released 31 notices of non-compliance and 18 warning letters including three with a “request for a business plan” to payers based on “failure to maintain accurate online provider directories.” For the plans, reviewed directories ranged from 19.66 percent to 70.75 percent inaccurate. Moreover, CMS advised that, if the plans failed to bring their directories into compliance in a timely manner (i.e., 30 days from receipt of the letter), “CMS may consider taking additional compliance actions, including a formal request for a corrective action plan (CAP), or taking enforcement actions in the form of the imposition of intermediate sanctions (e.g., the suspension of marketing and enrollment activities) or civil money penalties.”

To maintain an accurate provider directory and avoid penalties, organizations should consider:

- Creating a single source of truth that captures all necessary data elements, as well as takes into consideration the provider-network structure
- Reducing inefficiencies from the use of paper, such as costly communications and human errors, by using data reconciliation and automated systems
- Using a system that is scalable as the provider network grows and that can be easily maintained

Collaborating for success

To succeed in an MA strategy, payers and providers need to coalesce and meaningfully collaborate. Several key elements should be considered to accomplish their mutual profitability objectives under MA (and other lines of business):

Achieve clinical excellence across the health and care continuum

Clinical excellence, achieving the highest quality outcome for members, is an area of focus for many organizations that offer MA plans. To achieve clinical excellence across an MA plan, successful organizations need tools that enable them to:

- Proactively identify and manage patient risks and condition progressions
- View the key drivers of readmissions and implement strategies to keep patients from returning to the hospital
- Implement processes to help seniors understand their medications, schedules and improve adherence
- Launch a palliative care strategy to better serve beneficiaries in the end stage of their life

Boost revenue

Perhaps the most recognized and efficient strategies for a successful MA plan are centered around revenue maximization. A few key levers include:

- Using technology to ensure HCC capture is maximized to receive proper reimbursement for higher-risk patients
• Implementing a comprehensive Star Ratings strategy to improve performance, via point of care gap identification (prospectively) and using supplemental files and data mining (retrospectively)
• Optimizing the member onboarding and annual visit process to enable accurate and insightful risk profile capture
• Implementing product design strategies based on competitive positioning and market demand

**Improve member satisfaction and engagement**

Member satisfaction and engagement is a key focus across all areas of health care, but also crucial for MA beneficiaries since they have the option to switch to traditional Medicare or other MA plans each year. Member satisfaction and engagement can also affect the MA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which in turn has an impact on Star Ratings.

But, what approaches should you consider to better engage individuals?

Organizations should focus on identifying strategies to build customer loyalty. From there, you can assess the role of technology in your strategies and identify services that promote increased engagement and satisfaction. It will also be important for organizations to determine the tools needed to support individuals in staying well, managing risks and handling illness. An example where organizations have had success in this area includes developing programs and offering gym memberships where seniors feel like part of the community and want to stay active. This approach works best with a multichannel strategy, which enables you to stratify the population so you can be more effective in your engagement strategies.

**Drive operational and network efficiencies**

The current landscape requires constant improvements and seeking out opportunities to drive efficiencies – from referral management and new process implementations to contract negotiations. These opportunities require a methodical approach around process improvement, transparently measuring performance amongst providers and staff, and creating a collaborative culture to drive excellence.

A network management strategy plays a significant role in sustainability and healthy financial performance under value-based reimbursement. Inconsistent performance can lead to unnecessary costs, sub-optimal outcomes and varied beneficiary experiences.

Utilization management is also critical to achieve high quality clinical outcomes and reduced costs. Organizations should analyze referral patterns and practices and use algorithms and insights that steer members to the right venue of care that offers the highest care quality at the lowest price. Utilization rates by caregivers, as well as utilization of caregivers should be monitored. This analysis could include coordination between care settings, assessment of coverage by specialty and predictive modeling for staffing.

For these reasons, building a clinically-integrated network of payers and providers working from and aligning to a single longitudinal record is crucial. A well-thought strategy enables organizations to improve reliability with greater variance management, better manage in-network referrals to enhance performance and configure networks for market positioning.
Organizations must also factor integration of emerging trends, such as: transportation, social determinants, health coaching, concierge services and new-age mail order labs into their network design.

**Use analytic insights powered by data sharing**

To successfully manage an MA population, a robust data sharing strategy and contracting approach that enables it is essential. Payers have claims data and providers have clinical data. By bringing their data together, along with social determinants of health and third-party data, to form a longitudinal record – a 360-degree view of each beneficiary – both parties can greatly benefit. A complete electronic picture of an MA beneficiary and the entire population is necessary to fully understand the opportunities for care interventions, ensure quality measures are met and provide a deeper level of analytics to achieve clinical excellence, maximize revenue, engage members and manage the network.

Not only is data sharing essential, but organizations need the infrastructure, tools and people working in synergy to derive meaningful insights from the right data and the ability to push the insights to those individuals who can make a difference. The most important aspect of a data and analytics strategy is neither the data nor the insights; it’s the actions you put in place to make a positive impact.

To make a positive impact, you must start thinking about data and analytics at the organization level. The successful organizations of tomorrow will be those that implement a comprehensive data and analytics strategy, today.

In summary, the first step an organization should consider taking for its MA strategy is to assess its current capabilities from a value-based care perspective. For instance, what are its current IT capabilities, available resources, expertise in the area and dynamics in the market. Next, evaluate if and which partners will be needed to execute the strategy. Finally, organizations should determine the appropriate level of risk and engagement that will position it for long-term success.

**Conclusion**

For payers and providers looking to succeed in the shift to value-based care, MA can be a great opportunity to gain market share. Success in MA plans will require collaboration and sharing of data between both parties to help identify gaps in care, optimize revenue capture, engage beneficiaries in their health, and implement appropriate care interventions to improve outcomes and lower costs. For more information on population health management solutions to support your MA plan goals, contact us at populationhealth@cerner.com.
References/sources


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