Capitalizing on Comprehensive Care: Cultivating a Medicare Advantage Mindset

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This paper is Part 3 in our series on payment reform. After highlighting various efforts to reign in healthcare costs over the past 50 years in Part 1, Part 2 discusses the growing popularity of Medicare Advantage among consumers, as well as its alignment with the Triple Aim's goals of better care outcomes, lower costs and an improved patient experience. Part 3 examines the mechanics of launching provider-sponsored Medicare Advantage plans.

Cultivating a Medicare Advantage Mindset

Americans are growing older and sicker at an accelerating rate. Managing the ongoing care of distinct populations is the U.S. healthcare system's single biggest deficiency. It's also healthcare's biggest business opportunity. The future belongs to health companies that manage the health of large populations through more effective health assessments, predictions and interventions.

Medicare Advantage (MA) provides an avenue for health systems to acquire the capabilities required to manage the healthcare needs of select Medicare beneficiaries. Many health systems are launching their own MA plans to develop these capabilities. While this strategy has significant financial upside for plan sponsors, it also carries risk. Plans that cannot optimize their members' health expenditures lose money—sometimes a lot of money.

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MA success requires providers to engineer a managerial "mindset" that emphasizes prevention, early diagnosis, chronic disease management, behavioral health and health promotion. Rather than executing individual health "transactions," MA plans provide holistic and coordinated care services for their members.

Health systems often require significant platform redesign to develop and operate successful MA programs where they strive to accomplish the following:

- Manage a patient's care by addressing medical, psychosocial and home needs, and by providing seamless transitions between providers and care settings
- Engage physicians in proactive care management without increasing their administrative burden
- Teach patients how to manage and improve their health through self-care and by connecting them with community resources
- Align incentives to reward payer, provider and consumer behaviors that advance health and wellness
- Operationalize program data, monitoring and interventions to produce improved outcomes
- Navigate state and federal regulatory schemes for risk-based service offerings to optimize program performance

Healthcare organizations that deliver coordinated care with better clinical and financial outcomes will gain market share and become increasingly relevant in post-reform healthcare.

Winning at Value-Based Care with Medicare Advantage

As payment for healthcare services links more directly to care quality and outcomes, providers are expanding service provision beyond clinic and hospital walls. Medicare Advantage incentivizes health systems to emphasize value-based care delivery, manage premium revenues more efficiently, improve outcomes and build trust-based relationships with their members.

Payment follows value. Provider-sponsored plans can generate high returns on investment for plan sponsors as payment models reward value-based care provision.

In response to MA enrollment growth, the number of provider-sponsored MA plans is on the rise. In 2016, 11 out of 19 (58%) of new MA parent organizations were provider-sponsored.[1]

Developing insurance capabilities is not a core provider competency. Competing effectively against regional and national payers requires new infrastructure and a tolerance for risk-based contracting. Operating an MA plan incorporates operational, regulatory, financial and compliance risks, in addition to penalties for poor quality performance.

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The bottom line: offering an MA plan is not a slam-dunk for health systems. Success depends upon superior execution that engages stakeholders inside and outside the organization. Falling short in just one area can be devastating to a plan's success. Providers contemplating entry into Medicare Advantage must fully understand both its potential benefits and risks.

Eyes Wide Open: Key Challenges for Provider-Sponsored MA Plans

Aging demographics and seniors' market receptivity are fueling MA's growth. Operational and financial success requires plan sponsors to manage MA's unique program provisions, including risk-adjusted premiums, Star Ratings and benefit design. Starting an MA plan requires multi-faceted expertise in the following areas:

Operations: MA is a highly regulated market with high entry costs. Operationally, health systems must establish expertise in member acquisition, utilization management, regulatory requirements and compliance. Health systems can partner with specialized organizations to cover these functions. Without a solid operational infrastructure in place, it is almost impossible to manage MA products profitably.

Licensure and Network Requirements: CMS establishes network adequacy requirements for MA to ensure that beneficiaries can access care within specific time and distance requirements. These guidelines require that patients have sufficient access to in-network providers. To achieve network adequacy, a health system may have to include competitors in its network.

MA's emphasis on coordinated care means that health systems must emphasize superior primary care provision. Evaluating existing primary care physician (PCP) networks, as well as specialists to whom those PCPs refer, is essential. Analyzing physician practice patterns is the most effective method for determining which physicians should participate in the MA plan's network.

Physicians who are already achieving great outcomes through collaborative care should become the network's cornerstones.

Product Planning: Establishing plan benefits and bid design is much more than an actuarial exercise. It's imperative to gather input from marketing, clinical, sales, customer service, contracting, legal and compliance to structure effective MA insurance products to market to the public. Plan benefits influence Star Ratings. In turn, Star Ratings influence market receptivity (higher is better) and shape CMS' financial rewards and penalties to MA plans. Strong Star Ratings also correlate with high consumer and clinician satisfaction.

Risk Adjustment: MA plans must document its members' clinical diagnoses up-front to determine the premium payment. Complete and accurate documentation and coding through CMS's Hierarchical Condition Category (HCC) system guarantee that the plan will have adequate revenues to cover its members' healthcare needs. Understanding the intricacies of the HCC model, CMS's reimbursement cycle, coding mechanics, and documentation requirements are essential to optimize MA plan performance. HCC coding is based on diagnosis and not billing codes—quite a departure from current electronic medical record systems and historic programs.

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Medical and Quality Management: CMS has extensive delivery-of-care guidelines addressing quality, governance and medical management to ensure high-quality care for MA beneficiaries. Health systems should appreciate the expansive services required to manage care quality in a comprehensive fashion.

Though many health systems have made significant investments in data, systems and programs to manage care outside acute care settings, they still struggle to integrate these services into their acute operations. External care services are critical to driving better care outcomes and lower costs. MA plans with superior performance on CMS's 40+ metrics earn higher Star Ratings and bonus payments/rebates that enhance plan profitability.

Pharmacy Benefits: Given the widespread use of prescription drugs to manage beneficiary health, it's essential for MA plans to work with pharmacy benefit managers (PBMs) that understand CMS regulatory requirements. CMS scrutinizes drug services because they are among MA's most popular benefits. Sophisticated PBM capabilities enhance authorization processes, ensure that physicians have appropriate patient data and improve patient adherence to medication regimens.

Like MA plans, Medicare Part D plans also earn Star Ratings based on quality measures. These measures address medication adherence and patient safety, including prescribing of appropriate therapies. Having internal pharmacy benefit expertise within MA plans ensures that Part D pharmacy functions are fully integrated into patient medical management.

Compliance: Maintaining compliance with federal requirements related to MA is complex and all-encompassing. Regulatory compliance must become an organic component within all MA plan functions and operating procedures. This requires intensive staff training, compliant information technology systems, internal monitoring and mock audits. To emphasize its importance, CMS also requires MA plans to certify its downstream vendors (PBM, call center operations, etc.) are fully compliant with all pertinent regulations.

Provider Engagement: MA plans succeed when engaged physicians and aligned caregivers effectively manage the healthcare needs of plan beneficiaries. This requires many, perhaps most, physicians, to alter practice patterns to deliver outcomes-oriented care across a variety of care settings. To manage this transition, MA plans must enable strong clinical leadership and implement incentives that reward physicians for delivering efficient, high-quality care.

Successful physician engagement emanates from a managerial mindset that embraces value-based care delivery. It requires a culture of accountability, continuous education and training, and an integrated care team. Actionable and timely data that reinforces established care protocols turbo-charges the transformation process.

Advancing Value-Based Care

Health systems are increasingly becoming insurers – launching accountable care organizations, building payer partnerships and starting their own health plans. Redesigning care delivery positions integrated organizations for long-term success.

As the healthcare ecosystem shifts toward value-based care, new types of companies are emerging to deliver in whole or in part better, more efficient and more convenient healthcare services. Here are a few examples of organizations leading the shift to value-based care through Medicare Advantage:

Redesigning care delivery positions integrated organizations for long-term success.

Provider-Sponsored MA Plans: Providers operate many of the highest-quality MA plans in the marketplace, based on CMS' Star Ratings system. Many of the 15 MAPD plans with five-Star Ratings in 2018 are run by providers or integrated delivery systems, including Kaiser Permanente, Providence Health & Services in Oregon, and Gundersen Health System in Wisconsin.[2]

Social determinants of health—food, housing, employment, social relationships and education—can defeat the best care plans. In response, many integrated providers offer innovative programs that address patients' psycho-social needs. Geisinger Health System, for example, started a food pantry for patients with diabetes. Penn Medicine has a community health program through which health workers help patients reach their goals, sometimes even working out with them at local gyms.[3]

Enhanced Primary Care Companies: Innovative primary care companies are bringing personalized, high-touch care to those who need it most, including the frail elderly, those with multiple chronic conditions, and those dually eligible for Medicare and Medicaid.

Serving Medicare Advantage beneficiaries, ChenMed's high-touch delivery model allows it to better manage chronic disease and keep their members healthy. For example, ChenMed physicians have smaller member panels (500 versus the national average of 2,300 patients per doctor[4]), which allows them to spend significantly more time with individual patients.

Another primary care innovator, Iora Health, customizes its approach in each of its markets to serve a wide range of patients, from the relatively healthy to the chronically ill. Iora contracts with MA plans to provide care for beneficiaries, including many of whom are dually eligible for Medicare and Medicaid.[5]

Value-Based Care Managed Services Companies: Firms such as Lumeris partner with providers and payers to support their shift to value-based care delivery and payment. Through strategic advisory, value-based program operations, and next-generation actionable analytics, Lumeris works with healthcare organizations to create and capture value under risk-based contracts.

Engaging physicians, aligning incentives and implementing effective operational processes are essential to achieving better care outcomes. Lumeris "walks the walk" when it comes to delivering proven outcomes. The company's value-based care expertise stems from the long-term operation of its sister company, a high-performing Missouri-based MAPD plan. This positions Lumeris to innovate and share best practices with its provider and payer client partners.

Getting Started

Increasingly, health systems appreciate the financial benefits they can generate by managing care delivery more effectively under Medicare Advantage contracts. More importantly, they understand that improving care quality and efficiency enhances their communities' health and wellness and their own long-term sustainability.

The road to MA nirvana, however, has many twists and turns. Before launching an MA plan, health systems must undertake a comprehensive assessment of their care management capabilities to identify key knowledge, expertise and operations gaps. Once identified, health systems can build or buy the capabilities required to operate a high-performing MA plan.

For most health systems, working with an operating partner or health insurance company is more effective than building internal MA capabilities from scratch. MA-savvy partners have experienced professionals, proven processes and purpose-built technologies. They can help health systems achieve the right managerial mindset, avoid predictable pitfalls and build brand strength.

With the right partner, Medicare Advantage plans offer health systems accelerated growth, competitive advantage, and real care management expertise. That is the Medicare Advantage "advantage."

Endnotes

1 *Avalere analysis of 2016 MA Landscape file.*

2 *CMS. Fact Sheet - 2018 Part C and D Star Ratings. Retrieved from: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. Oct. 23, 2017.*

3 *Modern Healthcare. Special Report: The Transformation Imperative: Why the Social and Economic Forces Disrupting Healthcare are Here to Stay. Retrieved from: http://www.modernhealthcare.com/reports/transformationimperative/#!/. Oct. 5, 2017.*

4 *ChenMed, May 31, 2017. Retrieved from: https://www.chenmed.com/news/chenmed-joins-health-care-transformation-task-force.*

5 *The Commonwealth Fund. Transforming Care: Reporting on Health System Improvement. March 24, 2016. Retrieved from: http://www.commonwealthfund.org/publications/newsletters/transforming-care/2016/march/in-focus. Oct. 19, 2017.*

About the Authors

Dave Johnson

David Johnson is the CEO of 4sight Health, a boutique healthcare advisory and investment firm. Dave wakes up every morning trying to fix America's broken healthcare system. He is a frequent writer and speaker on market-driven healthcare reform. His expertise encompasses health policy, academic medicine, economics, statistics, behavioral finance, disruptive innovation, organizational change and complexity theory. Dave's newly published book, Market vs. Medicine: America's Epic Fight for Better, Affordable Healthcare, is available on www.4sighthealth.com.

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Richard Jones is the president and CEO of Essence Healthcare, one of the nation's first accountable delivery systems and a consistently high-rated Medicare Advantage Prescription Drug (MAPD) health plan. In addition, he leads Lumeris Healthcare Outcomes, which offers full turnkey business process outsourcing and management services to support MA and commercial health plans.

Richard is an experienced healthcare business executive, a certified public accountant and Founding President of Lumeris. He previously served as Chief Financial Officer of Essence Group Holdings Corporation (including Essence Healthcare), National President of UnitedHealthcare Medicare and Medicaid lines of business, President and Chief Executive Officer of Coventry Healthcare of the Midwest and Chief Financial Officer of Coventry Corporation.

About 4sighthealth

4sight Health operates at the intersection of healthcare economics, strategy and capital formation. The company's four-stage analytic (Assess. Align. Adapt. Advance.) reflects the bottom-up, evolutionary character of disruptive, market-driven change and guides 4sight Health's professional services, which include the following: regular commentary on market-driven reform; public speaking; board education; strategic advice; capital formation design and execution; advancing organizational change; venture investing: strategic partnerships, capital funding, product/service design.

About Lumeris

We provide strategic advising and technology to help providers and payers get back to the way healthcare should be—and share in the rewards. We guide health systems and providers through seamless transitions from volume to value, enabling them to deliver improved and more affordable care across populations—with better outcomes. And, we work collaboratively with payers to align contracts and engage physicians in programs that drive high-quality, cost-effective care with satisfied consumers—and engaged physicians.

An industry recognized leader, Lumeris was awarded 2017 Best in KLAS for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the second year we received this distinguished award. For the past six years, Essence Healthcare, Lumeris' premier client with more than 63,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. We enjoy working with all of our clients, delivering these same results, and aligning our proven multi-payer, multi-population model with their value-based care vision.

For more information contact us at 1.888.586.3747 or go to Lumeris.com

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