Medicare Advantage 2.0: Next Generation Growth Strategies

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Today’s Speaker

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Past Experience:
• Vice President for the Sg2 Consulting team
• Leadership roles in surgical services at Loyola University Health System and the University of Chicago Medical Center
• Senior consultant in the health care provider strategy and operations practice at Deloitte Consulting LLP
• Completed an administrative fellowship program under the COO at Advocate Health Care
Medicare Overview

Medicare funded benefits are referred to as “Original Medicare” and are the basis for all other forms of coverage such as Medicare Advantage, Prescription Drug Plans and Medicare Supplements.
Fundamentals of Medicare

**Part A**
Part A covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care. Part A benefits are subject to a deductible ($1,340 per benefit period in 2018). Beneficiaries are subject to coinsurance amounts for extended inpatient stays in a hospital or skilled nursing facility.

**Part B**
Part B covers physician visits, outpatient services, preventive services, and some home health visits. Part B benefits are subject to a deductible ($183 in 2018), and most Part B benefits are subject to coinsurance of 20 percent. No coinsurance or deductible is charged for an annual “wellness visit” or for preventive services generally.

**Part C (Medicare Advantage)**
Part C refers to the Medicare Advantage program through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A / Part B benefits and typically Part D benefits. Enrollment in Medicare Advantage plans has grown over time, with 19 million beneficiaries enrolled in Medicare Advantage plans in 2017, or 33 percent of all Medicare beneficiaries.

**Part D**
Part D covers outpatient prescription drugs through private plans that contract with Medicare, including both stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PD plans). Enrollment in Part D plans is voluntary. Additional financial assistance is available for beneficiaries with low incomes and modest assets. Those who do not receive low-income subsidies pay 5 percent of total drug costs after reaching the catastrophic coverage threshold. In 2017, more than 42 million people were enrolled in Part D.
## Medicare Coverage Options

<table>
<thead>
<tr>
<th>Medicare Advantage</th>
<th>Current State</th>
<th>Future Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts for 33% of the total Senior market or ~19M members</td>
<td>• Grew 5%+ since 2015</td>
<td>• Expected to grow at a rate of 3-4% each year</td>
</tr>
<tr>
<td>• The top 10 carriers account for ~60% of enrollment</td>
<td></td>
<td>• Estimated to make up 43% of Medicare enrollees (or ~30M enrollees) by 2025 and become the market share leader for senior health solutions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Supplement</th>
<th>Current State</th>
<th>Future Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwritten product that accounts for 21% of the total population or ~12M members</td>
<td>• Senior market grew ~6% since 2015</td>
<td>• Two plans (C&amp;F) cover 63% of beneficiaries, and will be phased out starting 1/1/2020</td>
</tr>
<tr>
<td>• The top 10 carriers account for ~70% of enrollment</td>
<td></td>
<td>• Shift in consumer purchasing patterns creates unique opportunity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traditional Medicare</th>
<th>Current State</th>
<th>Future Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal health insurance program that covers nearly 38M individuals</td>
<td></td>
<td>• Expected to grow at a rate of 5-6% each year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• By 2025, Medicare enrollment is projected to nearly ~45M eligible individuals</td>
</tr>
</tbody>
</table>
Basics of Medicare Funding & Coverage

Medicare was signed into law in 1965, and since then, has expanded eligibility requirements and introduced more types of benefits (including the prescription drug benefit, Part D) to improve access to healthcare for millions of Americans.

The Basics

- Federal health insurance program that covers nearly **54M individuals** both over and under the age of 65
- Program is financed primarily through general revenues (~41%), payroll tax deductions (~38%), and beneficiary premiums (~13%)

Structure of Medicare

- Benefits, totaling over $583B in 2014, are organized and paid for in different ways:
  - Part A: Hospital Insurance
  - Part B: Medical Insurance
  - Part C: Medicare Advantage
  - Part D: Prescription Drug

Supplemental Sources of Coverage

- Medicare
- Medicare Advantage
- Medigap
- No Supp. Coverage
- Medicaid

Figure shown as a % of total Medicare Population

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>16.9M</td>
</tr>
<tr>
<td>Employer Sponsored</td>
<td>14M</td>
</tr>
<tr>
<td>Medigap</td>
<td>11.3M</td>
</tr>
<tr>
<td>No Supp. Coverage</td>
<td>4.3M</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7.5M</td>
</tr>
</tbody>
</table>
Historical Approaches to Medicare Advantage

Many health systems avoided MA contracts because of administrative complexities, such as collections challenges, denied claims, and difficulties negotiating payment rates that were equivalent or favorably comparable to traditional Medicare rates. Today, those that do address MA deploy one of two strategies—but these are no longer adequate.

**Scenario 1:** Health system contracts with a mix of carriers, maintains a list of health plans in which it participates, and sends an annual letter to patients turning 65 with basic information about MA.

**Scenario 2:** Health system launches its own MA provider-sponsored plan with conventional sales/marketing tactics such as mass mailings, broker commissions, and educational fairs to expand membership during AEP.
MA is Becoming an Attractive Market

In general, health systems have several important goals that are causing them to find this market increasingly attractive.

### Health System Priorities

1. The need to hedge against declining payment rates of Medicare fee-for-service and financial uncertainty created by MACRA

2. The drive for greater scale and contract alignment to rationalize population health investments and shift care models

3. The desire for enhanced patient loyalty and protection against health system leakage supported by enrolled membership models and narrow networks

### Medicare Advantage Growth

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>14.4</td>
</tr>
<tr>
<td>2014</td>
<td>15.7</td>
</tr>
<tr>
<td>2015</td>
<td>16.8</td>
</tr>
<tr>
<td>2016</td>
<td>17.6</td>
</tr>
<tr>
<td>2017</td>
<td>19</td>
</tr>
</tbody>
</table>

*Medicare Advantage is a rapidly growing market that providers must have strategies to address.*

### Benefits of Medicare Advantage

- Positive regulatory outlook
- Attractive source of value-based payment
- Clear financial risk terms
- Accelerate transition to population health management
- More patients enrolled and tightly aligned networks

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The New Integrated Revenue Cycle

In delegated risk arrangements, coordination between payers and providers is critical to ensuring accurate revenue capture.

Key Elements of Provider Revenue Cycle
- Scheduling
- Registration
- Insurance Verification
- Coding & Charge Capture
- Medical Records
- Claim Submission & Billing
- Patients Pay Collection
- Payment Posting

Key Elements of Payer Revenue Cycle
- Enrollment / Eligibility
- Member Premium Collection
- MSP Validation
- ESRD Validation & Reporting
- Risk Adjustment
- Quality Reporting
- Encounter Reporting

Risk Coding & Documentation
Complete / accurate risk documentation to the appropriate level of specificity.

Encounter Reporting
Complete data transmitted through many systems to submission / acceptance by CMS

MSP Designation & COB
Correct ESRD entitlement and MSP status determinations.

HEDIS/Stars
Accurate capture and submission of CPT, HCPS, ICD-10s, and revenue codes.

Addressing Compliance Threats
Preventing over-coding in encounter documentation and overpayments in MSP.
Margin Improvement Through Strategic Contracting

Using a more strategic approach to managing value-based payments can yield significant financial impact on a provider’s revenue.

**Impact of Star Rating Bonuses**

*MA plans can earn bonuses by way of performance on Stars Quality metrics*

**Financial Rewards Tied to Risk Scores**

*Accurate coding can have a significant impact on a health plan’s profitability*

**Financial Impact of Accurate Coding & Star Performance Bonus**

<table>
<thead>
<tr>
<th>Description</th>
<th>Starting PMPM*</th>
<th>Risk Score</th>
<th>Star Rating</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1: Partially Coded, No Star Bonus</td>
<td>$800</td>
<td>0.573</td>
<td>+ $0</td>
<td>$458</td>
</tr>
<tr>
<td>Scenario 2: Fully Coded, Star Bonus (4 Star)</td>
<td>$800</td>
<td>1.682</td>
<td>+ $50</td>
<td>$1,396</td>
</tr>
</tbody>
</table>

* Same Patient $938 PMPM Revenue Differential

* Sample per-member per-month value; actual PMPM’s vary by county

**Investments in quality and documentation for MA can cascade to all risk-adjusted lines of business**
MA 2.0: Building a Next Generation Growth Strategy

As healthcare organizations develop growth strategies for Medicare Advantage, they should take a data-driven approach across the following steps.

**Develop a Medicare strategic planning process to approach the senior markets**

- Conduct a self-assessment
- Devise a strategic roadmap
- Build consensus with key stakeholders

**Engage in data-driven segmentation to profile consumer segments**

- Segment the MA market
- Align segments with outreach tactics
- Identify populations you’re best positioned to manage

**Assess the organization’s mix of products / contracts to ensure alignment with segments**

- Determine the right degree of integration
- Select the right mix of operating models
- Strategically participate in the contracting process

**Deploy consumer outreach & navigation strategies to execute the plan**

- Align sales and marketing campaigns to consumer segments
- Focus on building relationships with consumers
Key Questions to Ask in Preparation

One of the primary challenges for a health system in pursuing an MA growth strategy is to define its desired stakes in the market. To help do that, ask yourself some key questions.

Focus on a line-of-business approach, rather than clinical service lines or site-of-care (e.g., post acute, ambulatory) strategies

- How will you commit resources across your portfolio: traditional Medicare, performance-based Medicare (i.e., MIPS), APMs under MACRA, and MA?
- Will you be more aggressive in MA at the expense of traditional Medicare?
- How can you make MACRA investments work in MA care model strategies?
- How can your ACO strategies and provider-sponsored MA products work together?
Building Stakeholder Consensus

Health systems that have been successful in building senior market strategies begin by bringing together a diverse set of organizational leaders to focus on the Medicare population.

- Finance
- Managed Care
- Strategic Planning
- Post-acute care areas
- Delivery system
- Marketing
- Medicare Advantage Planning Committee
- Legal/Compliance
- Operations
- ACO leadership

Health plan leadership
Devising a Strategic Roadmap

Before determining the operating model, our experience consistently finds that a best-in-class approach for developing a MA strategy must start earlier with a health system conducting a self assessment and clearly developing a senior market strategy.

Conduct Provider Self-Assessment

Assess market opportunity and high-level market entry diagnostics (i.e., market opportunity, competitive landscape, financial, operational, compliance)

Build Your Senior Market Strategy

Set strategic objectives, vision, value proposition and guideposts which inform strategic alternative analysis to select operational construct

Assess Operational Alternatives

Conduct diligence on strategic alternatives (i.e., contractual arrangements, joint venture, launch health plan) to achieve the objectives

Select and Plan for Operational Model

Select operational construct and key partners/vendors based on strategic alternative analyses

Deploy Implementation of Strategy

Delineate and stage rollout of major work streams, as necessary
Organizational Self-Assessment

A self-assessment is designed to provide a preliminary indication of a health system’s starting capabilities and organizational readiness to address the MA market.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Evaluation Criteria</th>
<th>Areas of Exploration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise Governance</td>
<td>• What is the progressive culture of the organization?</td>
<td>• Leadership &amp; Culture</td>
</tr>
<tr>
<td></td>
<td>• Where is the organization heading?</td>
<td>• Previous Experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strategic Alignment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Market Strength</td>
</tr>
<tr>
<td>Care Delivery</td>
<td>• How does the care delivery model work?</td>
<td>• Access &amp; Engagement</td>
</tr>
<tr>
<td></td>
<td>• Are there current capabilities that are applicable?</td>
<td>• Care Coordination</td>
</tr>
<tr>
<td>Health Technology &amp; Infrastructure</td>
<td>• What tools and processes are currently used to support care delivery and might be applicable?</td>
<td>• Care Delivery Model</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Workforce Model</td>
</tr>
<tr>
<td>Operational Performance</td>
<td>• Is the organization financially stable enough to implement new processes and risks?</td>
<td>• Financial Readiness</td>
</tr>
<tr>
<td></td>
<td>• How is current quality performance and what functions need to improve to potentially integrated an MA strategy?</td>
<td>• Quality Performance</td>
</tr>
</tbody>
</table>
Engaging in Data-Driven Segmentation

Once the planning infrastructure is in place, a health system can begin to focus on specific consumer segments within Medicare Advantage.

Current Approach

64+

Age-based targeting when individuals age closer to Medicare eligibility

New Approach

Lifestyle Information

Patient Economics

Competitive Market Intelligence

Health Status

Demographics

Purchasing Behavior (e.g., switchers)

Expanded age segments, such as pre-seniors (56-64), age-ins (65-67), new Medicare (65-75), mature Medicare (75+)
Sample Medicare Market Analysis

Health systems should determine their target demographic by employing more granular segmentation to ensure maximum return on investment.

301,652 Medicare Eligible*

*Eligibility is limited to those that are 65 or older, younger than 65 with disabilities, and those with End-Stage Renal Disease

108,622 MA Enrollees

UnitedHealth Group: ~40k / 36%
Group Health Cooperative: ~30k / 28%
Blue Plans: ~16k / 15%

*Eligibility is limited to Medicare eligibles without ESRD

Potential MA Patients

Provider Opportunity:
Convert Medicare eligible / original Medicare enrollees to Medicare Advantage

Provider Opportunity:
Contract with leading health plans to obtain MA membership

Key Factors Driving Capture Rates:

- Exclusivity with payors
- Business model
  - E.g., innovative payment arrangements
- Plan benefit design
- Group practice dynamics
  - E.g., quality ratings, number of providers
Value of Patient Level Economics

When evaluating a market, the economic value of senior market segments should be conducted at the patient level, allowing for segmentation of patients into cohorts to understand drivers of profitability.
Approach to Patient Level Economics

Analyzing data to understand drivers of profitability, cost and revenue can be used to determine which patient populations, and in turn, which physicians, are effectively managing their patients under a post-risk adjusted economic model.

Step 1: Collect & Analyze Data

- Claims & Clinical Data (medical, pharmacy, ADT, HIE, lab results, C-CDAs)
- Enrollment Data (product, age, rating area, premium)
- Product Design (Standard benefit features)
- 3rd Party Data (competitive positioning, utilization, cost, quality, risk scores)
- SocioEconomic Data (i.e., income, purchasing habits)

Step 2: Understand Drivers of Profitability, Cost & Revenue

**Profitability**
- 2016 & 2017 patient level profitability
- Forecast 2018 & 2019 patient level profitability

**Cost**
- Evaluate care efficiency and network performance
- Episodic level cost evaluation

**Revenue**
- Undocumented risk identification
- Opportunity quantification and segmentation

Step 3: Generate Insights to Guide Performance Improvement Strategies

- Profitability segmentation:
  - Geography
  - Patient
  - Physician
  - Condition

- Physician level economic performance evaluation

- Year-over-year performance trending (cost management, utilization, documentation capture)

- Identification of effectively managed population segments to focus acquisition strategies
Evaluating Regional Differences

Geographic segmentation provides detailed insights into the unique market factors that are driving positive and negative financial performance.

<table>
<thead>
<tr>
<th></th>
<th>Your Data</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016 P&amp;L Performance</strong></td>
<td>($92 PMPM)</td>
<td></td>
</tr>
<tr>
<td><strong>2017 Projected P&amp;L Performance</strong></td>
<td>($108 PMPM)</td>
<td></td>
</tr>
<tr>
<td><strong>Average Age</strong></td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td><strong>Average Risk Score</strong></td>
<td>0.89</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Enrollment</strong></td>
<td>12,000</td>
<td>200,000</td>
</tr>
<tr>
<td><strong>PMPM Cost</strong></td>
<td>$905</td>
<td>$778</td>
</tr>
<tr>
<td>Inpatient/hospital</td>
<td>$208</td>
<td>$237</td>
</tr>
<tr>
<td>Post Acute Care</td>
<td>$226</td>
<td>$140</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$163</td>
<td>$159</td>
</tr>
<tr>
<td>Professional</td>
<td>$181</td>
<td>$117</td>
</tr>
<tr>
<td>Rx</td>
<td>$127</td>
<td>$125</td>
</tr>
<tr>
<td><strong>County Stars</strong></td>
<td>3.5</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Lower RAF scores compared to the market may present an opportunity for financial improvement.

Higher cost driven by Post Acute Care and Professional service categories.

Improving to 4+ Stars presents significant financial opportunity.

Note: Illustrative in Nature
Assess Product Mix & Contracts

There is a variety of health plan and provider operating models along a degree-of-integration spectrum that would allow a health system to participate in the MA market.

Low

Traditional, arms-length contracts *(may have a value-based component, such as stars or risk coding incentives)*

Degree of Integration

Virtual integration models, typically involving some degree of shared financial risk and joint governance, as well as collaborative initiatives around clinical programs or comarketing efforts

High

Shared ownership (e.g., joint venture) or full ownership models, including profit-and-loss accountability for the owners
Determining the Level of Integration

To determine the most appropriate position along the integration spectrum, health systems should evaluate the following key functional areas.

**Local market dynamics**—What is the growth potential, and what level of financial relationship and number of partners are needed for a competitive offering?

**Capabilities**—What are the health system’s baseline people, process, and technology capabilities to execute on the model?

**Cultural alignment**—Are there potential partners that would approach governance and product offerings with similar objectives?

**Partner experience**—Are there previous partnerships and risk arrangements that would bias model preference?
### Medicare Advantage Operating Models

#### Medicare Advantage Market Entry Example

The preferred mix of operating models often will relate to build, buy, and partner decisions. Health systems should weigh how much control they want over the member life against the cost and risk of delivering a product to the degree that it corresponds with their capabilities.

<table>
<thead>
<tr>
<th></th>
<th>Shorter-term</th>
<th>Longer-term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FINANCIAL RISK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BUILD</strong></td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Long-term financial opportunity with significant upfront risk</td>
<td></td>
</tr>
<tr>
<td><strong>BUY</strong></td>
<td>$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Upfront costs amortized over time</td>
<td></td>
</tr>
<tr>
<td><strong>PARTNER</strong></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Resources and investment shared across partners</td>
<td></td>
</tr>
<tr>
<td><strong>GENERAL RISK &amp; COMPLIANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BUILD</strong></td>
<td></td>
<td>+ All risk internalized (e.g., compliance, execution, implementation, integration)</td>
</tr>
<tr>
<td><strong>BUY</strong></td>
<td></td>
<td>+ Purchase the necessary competencies from vendor(s)</td>
</tr>
<tr>
<td><strong>PARTNER</strong></td>
<td></td>
<td>+ Shared risk across partners</td>
</tr>
<tr>
<td><strong>OWNERSHIP RISK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BUILD</strong></td>
<td></td>
<td>+ License and contract directly with CMS</td>
</tr>
<tr>
<td><strong>BUY</strong></td>
<td></td>
<td>+ Own member lives</td>
</tr>
<tr>
<td><strong>PARTNER</strong></td>
<td></td>
<td>+ Becomes a long-term strategic asset</td>
</tr>
<tr>
<td><strong>BUILD</strong></td>
<td></td>
<td>+ License and contract directly with CMS</td>
</tr>
<tr>
<td><strong>BUY</strong></td>
<td></td>
<td>+ Own member lives</td>
</tr>
<tr>
<td><strong>PARTNER</strong></td>
<td></td>
<td>+ Allows for choice to carve-in operations in longer term</td>
</tr>
</tbody>
</table>
Deploy Consumer Outreach & Navigation

The challenge for health systems is to design a sales and marketing campaign that appeals to the right segments. Building consumer relationships in a competitive MA market requires infrastructure to educate consumers on their options when they seek advice and clearly communicate the value of MA.

Stimulus

- Affiliation Letter
- Awareness from promotion and advertising
- Questions to clinicians or front desk
- Clinic website

Designated Medicare Advisors

One-on-One Consultation (Upon Request)

Informational Brochures in Facilities

- CMS approved brochures on key features of MA products

Field Sales Representatives

- Ability to connect to trained and certified insurance agents
- Custom appointments at patient preference (Home, Starbucks, etc)

Enrollment Call Center

- Transfer to sales staff
- Access to listings of dates and locations (prescheduled)

Educational Seminars in Adjoining Facilities

One-on-One Consultation

Informational Brochures in Facilities

Field Sales Representatives

Enrollment Call Center

Educational Seminars in Adjoining Facilities
Key Takeaways

MA is not simply a volume and market-share play; it is a laboratory of innovation for value-based care and population health management, and many health systems use this segment as the entryway into managing financial risk.

+ Medicare Advantage is a growing and increasingly attractive market
+ Look to data-driven growth strategies to succeed in Medicare Advantage

1. Develop a Medicare strategic planning process to approach the senior markets
   - Devise a strategic roadmap
   - Conduct a self-assessment
   - Build stakeholder consensus

2. Engage in data-driven segmentation to profile consumer segments
   - Expand analyses to include new datasets
   - Evaluate patient-level economics

3. Assess the organization’s mix of products and contracts to ensure alignment with segments
   - Choose the appropriate level of integration and the right mix of operating models

4. Deploy consumer outreach and navigation strategies to execute on the plan