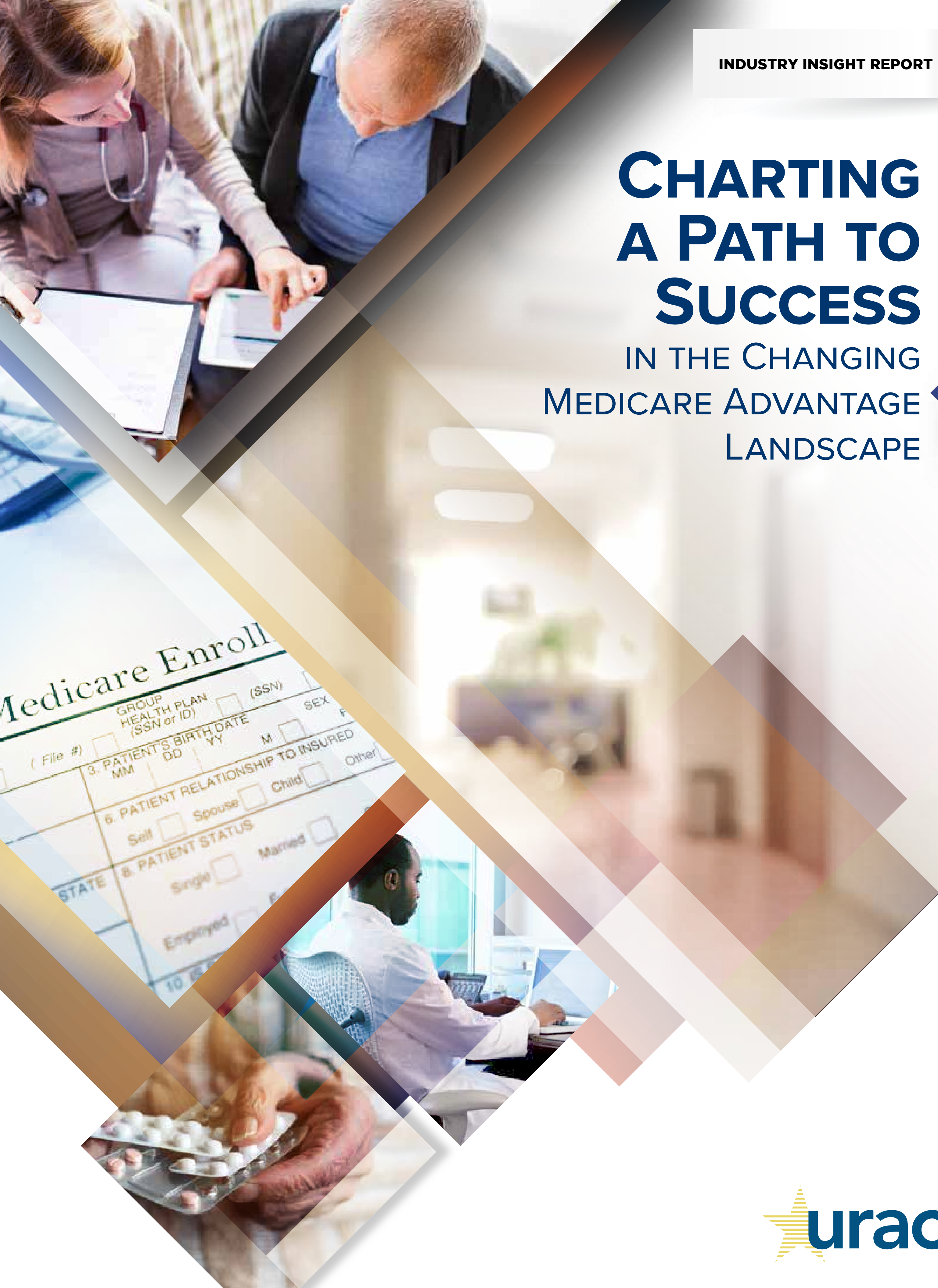
INDUSTRY INSIGHT REPORT

CHARTING A PATH TO SUCCESS

IN THE CHANGING MEDICARE ADVANTAGE LANDSCAPE



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The stars are aligning for Medicare Advantage.

First introduced in 1997, the private managed care option for Medicare beneficiaries has slowly been gaining popularity among payers, patients, and even providers. More than one third of Medicare beneficiaries are now enrolled in Medicare Advantage plans, and with patient satisfaction scores in the mid-nineties, they seem happy with their choice. By some estimates, Medicare Advantage plans will capture 42 percent of the Medicare market by 2028.

But just because the stars are aligning doesn't mean the path ahead is clear, or even well lit. Entering this market takes careful planning, persistence and vigilance. The Medicare Advantage (MA) market offers great opportunity, but also multiple challenges that call for innovation and creativity.

SUPPORT FROM THE TOP, INTEREST FROM ALL SIDES

The past two White House administrations (current and Obama) have been supportive of the MA market, which some call the "private option" for Medicare, says Billy Wynne, CEO and founder of a private sector health policy and government relations consulting firm.

Although the Affordable Care Act cut overall per member payments (to bring them more in line with traditional Medicare), it added bonus payments for highly rated plans. More recently, changes introduced through the **Chronic Care Act** add flexibility and reimbursement options that increase attractiveness to insurers. Payments to MA plans increased 3.4 percent in 2019—a bigger increase than in 2018, signaling support from the current administration. Medicare Advantage in 2019 offers insurers more flexibility in benefits, more ways to engage members, and more ways to improve care and increase profits through technology, population health strategies, and cost-sharing designs.

For their part, providers are becoming more amenable to participating in these plans. As more providers embrace technology, data analysis and alternative payment plans, they're seeing more ways that they can improve outcomes for their patients while contributing to the efficiency of care and achieving a better bottom line.

Meanwhile, demographic and perceptual shifts have increased interest in Medicare Advantage plans among beneficiaries. As the "trailing edge" of the baby boomer generation comes of Medicare age, they have lower retirement savings to devote to healthcare and more comfort with technology than their predecessors. They are on the lookout for lower-cost healthcare options, and they're open to technological innovations that reduce healthcare costs while increasing accessibility. For growing numbers, Medicare Advantage plans may fit the bill.

Wynne has worked with a number of health plans and health systems with products on the MA market and believes, "The overall picture seems to be positive. The reimbursement pie is growing. Seniors are getting more educated about the product, enrollment has been growing."

Andrew Kadar, managing director of healthcare services with LEK consulting, concurs. He sees "a lot of new opportunity" to "align healthcare providers around right care and right time to bend the cost curve and give better value for seniors."

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Health plans are responding with new offerings for this market. In 2019, there will be more plans than any other year since 2009—nearly 2,800 in all. Many established Medicare Advantage insurers have expanded with new plans and new regions. UnitedHealth Group, Humana and Aetna still dominate, accounting together for half of the national enrollment. Five companies left the market, but fourteen new ones launched, including several startups backed by venture capital investors.

According to the Centers for Medicare and Medicaid Services (CMS), 99 percent of the country has at least one MA plan to choose from and the average beneficiary can choose from 24 plans. However, according to an analysis by the Kaiser Family Foundation, the distribution is quite uneven across the country. In some counties, beneficiaries can choose from up to 60 plans, while in 57 counties only one plan is offered, and Puerto Rico is the only U.S. Territory where insurers offer an MA plan.

IDENTIFYING MARKETS AND PROVIDERS

Launching a Medicare Advantage plan involves lots of moving parts. Insurers must look at the number of eligible beneficiaries in the area, as well as demographics and the healthcare needs of that population. They must also look at the areas resources to meet those needs: providers, services and potential barriers. And, of course, they must look at what other plans are offered and whether they can design something better or at least as good.

Insurers have more tools and information than ever to make these decisions, and, Wynne says, they are becoming sophisticated in how they use population data to devise strategies for mitigating risk and developing a package of benefits that can compete in that marketplace. He points out that CMS goes to great lengths to make rural areas attractive with higher reimbursement rates. Still, he says, the volume of potential members in urban areas is a draw, and accounts for the uneven distribution of plans.

Attracting the right providers can make or break a plan. "One of the hardest things about MA plans is contracting with an adequate network," Wynne says. CMS has strict requirements on specialties, facility types within a certain distance of most members.

Getting a "marquee provider" on board can help attract members and ensure quality care, but name recognition is just part of the picture of a successful provider network. To be competitive, plans want to work with doctors who will manage care and avoid unnecessary procedures, Kadar says, but also establish strong relationships with

members. The provider-member relationship is key to quality care and loyalty to a plan, and "a great relationship will reflect in star ratings and retention rates," Kadar explains. To get the right providers, plans will sometimes pay reimbursement rates higher than the traditional Medicare fee schedule.

Providers have historically been skeptical about Medicare managed care plans, but proactive providers are attracted to MA plans that offer pay for performance or global capitation arrangements. They have become more open to taking risk because they've learned that if they can produce good outcomes and satisfied patients, they can do well financially. Given that Medicare Advantage is poised for growth, Kadar believes more providers will be interested in partnering with plans.

SPOTLIGHT ON INNOVATION HEALTH

The Northern Virginia patient population just outside Washington, D.C. would appear to be an ideal market for Medicare Advantage (MA). And **Innovation Health** is poised to play a leading role.

As a relatively new entrant, Innovation Health, a joint venture of provider Inova Health System and insurer Aetna, has amassed nearly 4,000 MA members since launching its program at the beginning of last year (2018).

"Our [Northern Virginia] market is full of wealthy and highly educated individuals," says Nannette Henderson, Innovation Health's chief financial officer. However, MA isn't as well-known as other Medicare programs, and that presents a challenge for the new market entrant. "We need to work on ways to better educate the market," Henderson explains.

"We knew this was going to be a disruptive new way of rolling out a Medicare solution for the market," says Dr. Sunil Budhrani, medical director at Innovation Health. "We really had no intention of being the 'traditional MA' plan," he adds. Innovation Health's strategy is to leverage its partner assets to be "something different and lead as a provider-centric type of health plan," Budhrani says. Innovation Health kept its initial sales targets on the conservative side, he says, in part because of its "novel experiment bringing together a payer and provider" in an MA offering.

Innovation Health has some unique advantages, Budhrani says. For example, he estimates somewhere between 30 and 50 percent of its patient population is within its provider network. "It gives us a bit more control over the care management than a traditional MA plan," Budhrani notes.

From a care management perspective Innovation Health can offer more "levels" of service and care planning, Budhrani says. "We have teams made up of doctors, social workers, behavioral health workers, nutritionists, dieticians and multi-disciplinary teams," he says.

Innovation Health's MA teams can directly correspond with providers and generate "more payer provider collaboration than you would normally see in a MA product," Budhrani says.

They've also differentiated themselves with some of their product offerings. Innovation Health was the first in the market to offer a zero premium plan along with a PPO plan that costs around $70 per month. "There are pros and cons to going with a zero-premium plan," she notes. Potential customers sometimes think it's an option "that's too good to be true," Henderson says.

Ultimately, flexibility is the foundation for future success, Henderson says. "Everything's up for grabs in terms of strategy and tactics," she explains, "and you can't take it for granted that what worked last year is going to work again."

ATTRACTING BENEFICIARIES

Medicare Advantage plans draw beneficiaries away from traditional Medicare by offering more generous benefits and the chance for one-stop shopping, offering medical, dental and vision benefits-- and sometimes even gym membership--all in one plan. Successful plans tailor their offerings at the community level based on member surveys, actuarial data, and demographic information.

But the best plan can't attract members if they don't understand the offerings—or even what Medicare Advantage is. (Surveys show that only about one in four people aged 50 to 64 don't know what the term means.) Beneficiaries often complain about either having too much information or not enough. Understanding their true costs is difficult to determine from a list of co-pays and out-of-pocket costs. Assisting beneficiaries in choosing the right plan helps everyone, since plans only reap the benefits of preventive care if they retain their members for the long haul.

Patient satisfaction ratings and star ratings are also key to attracting beneficiaries—and for the bottom line for the plan. Plans that rate four or five stars earn bonuses of up to $500 per members annually, which adds up to a sizeable chunck of additional revenue. In addition to bonuses, highly rated plans also get additional flexibility on how and when they can market to beneficiaries.

This poses an extra challenge to newer plans. It takes about two to three years before CMS has enough data to rate a plan on the star system. "Penetrating the market can be difficult when you are competing with four- and five-star plans," says Wynne.

Newer plans depend on low premiums and rich benefits to stand out on **Plan Finder**. Easy-to-use websites and responsive call centers should make it easy for prospective members to get information, sign up or convert to the plan.

Making the promise and attracting members is the first step. The plans then must deliver and earn those high star ratings. "The best plans are very proactive with their care model, so as soon as the data comes through, it's positive," says Kadar.

SPOTLIGHT ON BRIGHT HEALTH

A relative newcomer to the Medicare Advantage market is Minneapolis-based Bright Health. They introduced their Medicare plans in three markets in 2018 and expanded to three more in 2019.

The Bright Health difference has a lot to do with its selection of new markets, says Kathleen Elli, vice president, Medicare Marketing. Starting with Medicare plan offerings in Phoenix, Arizona, the greater Denver, Colorado area, and Birmingham, Alabama in 2018, they expanded in 2019 to Nashville, Tennessee, 4 counties in Ohio and 3 counties in New York City.

According to Elli, Bright Health looks beyond the number of eligible Medicare beneficiaries in any given market and instead focuses on identifying a health system, or as they refer to them "Care Partner" who is willing to share Bright Health's vision for delivering "a different kind of healthcare" that's committed to building a strong provider-patient relationship to best coordinate and personalize member's care.

And, Elli says, the Bright Health Care Partner health plan model is resonating with both health systems and consumers across the country. By working with only one system per market, Elli says, Bright Health has removed the friction that has traditionally existed between payers and providers. Instead they become collaborative partners on everything from pricing to technology to innovative programs. Teaming with the Care Partner leads to the consumer having a simpler, more streamlined healthcare experience, increased satisfaction and a closer connection with care providers to achieve improved health outcomes.

As a new MA plan, Bright Health has not yet earned a CMS STAR rating so instead they attract Medicare beneficiaries through competitive plan offerings (HMO, HMO-POS and PPO plans with a $0 or low monthly premium) and competitive benefits designed to meet and exceed the needs of the senior market (dental, vision, hearing, and prescription drug coverage). For example, in health-conscious Colorado, plans include a free gym membership and acupuncture benefits and all markets offer plans with Over-the-Counter debit cards.

Elli says Bright Health is building programs and systems that support a very personalized approach to healthcare at a local level. It's the strength of the member and Care Partner relationship that makes it easier to ensure members get the care they need, when they need it, at a price they can afford. And building a strong data infrastructure makes on-demand care coordination possible. Such personalized care may include re-directing a member's care to an in-network facility to save its members hundreds on their out-of-pocket healthcare expenses.

DELIVERING THE RIGHT CARE AT THE RIGHT TIME AND PLACE

Although a marquee healthcare system can help plans attract members and deliver state-of-the-art care, not all patients are best served by a large academic medical center—and some would have trouble getting there at all for regular care. The best care is often the most accessible care—close to home and personalized to the member. Telehealth, in-home visits by nurses or paramedics, community-based facilities are among the ways MA plans bring quality care to patients in a way that is accessible and acceptable.

Other approaches include stratifying member populations to identify the right intervention for the right member at the right time and place. For example, for members with polychronic conditions (three or more chronic diseases), a plan may deliver

proactive care through in-home visits from a nurse practitioner. Other plans use more frequent primary care visits to avoid higher cost emergency visits. Many plans purchase software packages or develop their own propriety systems that combine electronic health records data with actuarial data to identify members at high risk for expensive procedures or hospital re-admission.

HANDLING CHRONIC CONDITIONS

Delivering the right care at the right time and place is especially important in chronic care management. Most Medicare beneficiaries have at least one chronic condition, more than half have four or more. The Chronic Care Act that passed in 2018 allows plans more flexibility in serving the needs of these patients, with increased frequency and variation of preventive screenings based on health conditions. For example, members with diabetes might be eligible for more foot exams than someone without diabetes.

MA plans have a good track record on chronic care management, in terms of outcomes, cost savings, and complication rates. Some of the solutions used by plans to earn that record include delivering diabetes education, coaching and health monitoring via computer and ensuring accurate coding that connects members with the care they need.

Caring for members with multiple complex chronic diseases is time consuming and expensive, but some providers and plans have developed models that are especially successful. Companies like Landmark Health partner with health plans to deliver quality care to members with five or more chronic care conditions. Their home-based, personalized and focused care model has resulted in lower hospital admissions, fewer emergency visits and high ratings from members.

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Sometimes what stands between a member and better health isn't something traditionally delivered by the healthcare system. Nutritious food, safe housing, and reliable transportation all play a role in successful prevention, treatment and recovery from illness. Increased attention to the social determinants of health means that more plans are looking at ways to help members meet these needs as well. Kaiser Permanente has made investments in housing options. Bright Health offers meal delivery for just-released surgical patients who may have trouble making their own meals. Some payers have partnered with ride sharing programs and businesses to offer free or low-cost transportation to medical appointments.

SPOTLIGHT ON ARKANSAS BLUE CROSS AND BLUE SHIELD

Arkansas Blue Cross and Blue Shield serves about 15,000 residents of Arkansas in its Medicare Advantage plans (Medi-Pak). The plans rely on personalized, proactive care coordination to help members get the care they need. This includes not only filling gaps in services, but also addressing social determinants of health.

Carolyn (Kris) Gipson, BSN, RN, CCM, and her team of three RN Certified Case Managers and one LPN Nurse Facilitator, provide that personalized service. Located remotely, throughout the state and equipped with an experienced knowledgebase of the services and challenges of their regions, these case managers are problem solvers, connectors, and overseers who work directly with members. "We have a one-on-one conversation [with patients] about their barriers and possible resources in that location," Gipson says. "Nothing is standard across the state," in terms of available resources and services. And, of course, no two patients have the same situation either. "We creatively try to overcome barriers one at a time."

Gipson says her department receives referral opportunities through a variety of sources. Members themselves can call any time. Hospitals also refer members when they are admitted to the hospital or during the discharge process for assistance with transitions of care and follow up case management. Gipson and her staff also receive referrals based on claims, prior authorizations and pharmacy data, to proactively identify members with complex chronic conditions, gaps in care, high risk of hospitalization or medication education and assistance needs. They work not only with the member, but also with their health care team of providers, family members and available local resource providers.

"Our MA Case Management Team works diligently with our members to identify the specific barriers to care they face, and then assists to overcome those barriers in an effort to obtain quality healthcare outcomes" says Gipson.

ENSURING COMPLIANCE WITH CMS RULES AND REGULATIONS

Changes to Medicare Advantage regulations are fast and frequent, both positive and negative. “It is a challenge for [plans] to deal with the rapid pace of change,” says Wynne. “Just about every year you have some new rule making. For some companies this can be a barrier to entry to respond on an annual basis to an ever-evolving regulatory landscape.”

Every aspect of offering a Medicare Advantage plan has a compliance element. “Compliance has to be a priority across all business aspects,” says Kadar, including marketing, coding, and handling appeals and grievances. To be successful, he says, plans “have to hire the right people, have clear policies and procedures and audit, audit, audit.” To keep up with changes, bigger plans have in-house staff, consultants, and publications that track changes in the regulatory sphere.

Penalties for non-compliance can be steep. In January 2019 CMS announced that 21 Medicare Advantage plans with errors in their online provider directories would face penalties or stop enrollment if the problems were not fixed.

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REDUCING THE COMPLIANCE BURDEN WITH ACCREDITATION

MA organizations can reduce their compliance burden, including punitive audits by CMS, by becoming accredited by a CMS-approved accrediting organization. When the MA organization is accredited, they can get “deemed” status for CMS requirements for the deemable areas.

URAC was approved by CMS as an accreditation organization, receiving deeming authority for a period of six years, through June 2, 2025. URAC's Medicare Advantage Accreditation standards are mapped directly to CMS requirements, and recognized by CMS as complying with federal regulatory requirements related to their Part C coverage for:

- Quality improvement
- Antidiscrimination
- Confidentiality and accuracy of enrollee records
- Information on advance directives
- Provider participation rules

Accreditation as a Medicare Advantage plan is a complicated, multifaceted process that involves standards and measures, review of documentation, and submission of documents that must pass muster with a high score. Working with an independent third-party accreditor like URAC can help streamline that process, turning into an opportunity for learning and improvement, and adding another layer of assurance for both the plan and for CMS.

URAC's Medicare Advantage Accreditation program is a stand-alone accreditation program -- health plan accreditation is not required. The program features a simplified accreditation process, focused standards, reduced compliance burden, and affordable pricing. Plus, the accreditation process has been streamlined to shorten the timeline and effort needed for MA organizations to achieve URAC accreditation while easing CMS oversight.

Learn more about Medicare Advantage Accreditation **here**.

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Founded in 1990, URAC is the independent leader in advancing healthcare quality through leadership, accreditation, measurement and innovation. URAC offers a wide range of quality benchmarking programs that reflect the latest changes in healthcare and provide a symbol of excellence for organizations to showcase their validated commitment to quality and accountability. URAC uses evidence-based measures and develops standards through inclusive engagement with a broad range of stakeholders committed to improving the quality of healthcare.