FEATURE STORY

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Medicare Advantage 2.0
next generation growth strategies

Healthcare organizations are looking to data-driven growth strategies in order to succeed in Medicare Advantage.

AT A GLANCE

As healthcare organizations develop growth strategies for Medicare Advantage, they should take the following steps:

- Develop a Medicare strategic planning process to approach the senior markets
- Engage in data-driven segmentation to profile consumer segments
- Assess the organization's mix of products and contracts to ensure alignment with segments
- Deploy consumer outreach and navigation strategies to execute on the plan

Health systems generally recognize Medicare Advantage (MA) as being an important market segment, but many lack effective growth strategies and tactics for engaging and retaining consumers in this dynamic growth market. Health systems would be well-advised, however, to be active participants in the MA market, adopting next-generation growth strategies to achieve their strategic objectives. Such strategies are predicated on the use of data-driven, consumer segmentation methods to tailor offerings and approaches to specific consumer profiles and, in turn, to create a more sustainable path to growing market share in MA.

MA Versus Traditional Medicare

There are distinct differences between MA plans and traditional Medicare. MA plans, sometimes called "Part C" plans, are offered by private insurance companies that must follow the rules set by Medicare, and take the form of products such as HMOs or PPOs.[a] Part C 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 (prescription drugs). Hospice care remains covered under traditional Medicare for MA enrollees, and MA coverage often includes supplemental benefits such as vision, dental, and wellness programs. Payments from the government to MA plans are adjusted based on documented risk scores and quality results from their provider network. In turn, many MA plans pay their providers on

a. Centers for Medicare & Medicaid Services, "Medicare & You 2017."

a per-member-per-month (PMPM) partial or full capitation basis, which allows the physicians to practice on a fee-for-value basis without requiring them to participate in the Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act (MACRA). Historically, 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 same health systems view MA contracts as an attractive source of value-based payment based on clear financial risk terms, and subsequently, participation in MA can accelerate their transition to population health management and raise the percentage of their patients in enrolled and tightly aligned networks.

Common MA Strategies

The approaches to MA most commonly used by health systems today harness only a fraction of the consumer intelligence and strategic options available to most such organizations. Two scenarios are most prevalent. Under the first scenario, a 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. Under the second scenario, the health system launches its own MA provider-sponsored plan and employs conventional sales and marketing tactics such as mass mailings, broker commissions, and educational fairs to expand membership during the annual enrollment period.

Neither of these approaches is adequate for positioning a health system to take advantage of a market that is poised for continued expansion and relief from regulatory uncertainty. By reconsidering their MA growth goals and overall marketing strategy for their senior population, health systems can implement tactics that will best position them for promising new opportunities in the evolving MA market.

A Growth Market

In recent years, health systems have demonstrated a strong interest in MA based on positive market fundamentals and as part of their MACRA implementation strategy. As a portion of the Medicare market, between 2008 and February 2017, MA grew from 9.7 million, or 22 percent of all Medicare beneficiaries, to 19.6 million, or 34 percent of Medicare beneficiaries.[b] Meanwhile, provider-sponsored plans have established a significant presence in MA, representing 54 percent of plans that entered and remained in the program and accounting for nearly 20 percent of MA enrollees between 2012 and 2015.[c]

In the post-MACRA environment, MA presents alternative to the payment rate instability of MIPS, which affects only Part B payment and does not apply to Part D payment. Alternatively, it can provide a forum for contracting for advanced alternative payment models (APMs), which potentially can count as MACRA-qualifying models starting under the All-Payer Combination Option in 2019, or it can be the start of a movement toward value-based care delivery models.

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

- The need to hedge against declining payment rates of Medicare fee-for-service and financial uncertainty created by MACRA
- The drive for greater scale and contract alignment to rationalize population health investments and shift care models
- The desire for enhanced patient loyalty and protection against health system leakage supported by enrolled membership models and narrow networks

b. Jacobson, G., Casillas, G., Damico, A., Neuman, T., and Gold, M., "Medicare Advantage 2016 Spotlight: Enrollment Market Update," Issue Brief, Kaiser Family Foundation, May 11, 2016; Mark Farrah Associates, "Medicare Advantage Membership Up Nearly 1.4 Million Year-Over-Year," March 15, 2017.
c. Carpenter, E., "Nearly 60 Percent of New Medicare Advantage Plans Are Sponsored by Healthcare Providers," Avalere, Jan. 26, 2016.

Positive Regulatory Outlook

A positive regulatory outlook bolsters the business case for MA. Republicans support the program, and future legislative proposals are likely to favor MA as a private market reform aimed at extending the life of the Medicare Trust Fund. Less-recognized regulatory tailwinds include changes that are taking place in the Medicare supplemental market under MACRA. In 2020, 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.[d] Given these growth dynamics, health systems need to be active participants in the MA market; it is no longer enough for them to launch a product or execute a contract and passively sit by waiting for the volume to materialize.

Growth Strategies

Health systems should take the following steps to transform their growth strategies.

Develop a Medicare strategic-planning process to approach the senior markets. One of the primary challenges for a health system in pursuing an MA growth strategy is to define its desired stakes in the market. In a post-MACRA environment, a health system confronts significant strategic questions about where and to what extent it should commit resources across its portfolio of traditional Medicare, performance-based Medicare (i.e., MIPS), APMs under MACRA, and MA. Health systems need to determine whether they want to become more aggressive in MA at the expense of traditional Medicare, how to make MACRA investments work in their MA care model strategies, and how their Centers for Medicare & Medicaid Services (CMS) accountable care organization (ACO) strategies and provider-sponsored MA products can work together. Answering these questions can help a healthcare organization create a coordinated approach to the Medicare population that integrates business units and planning functions to plot the course for financial and clinical operations for the entire senior age demographic.

The concept of integrated Medicare planning is not foreign to health plans, which for years have organized their line-of-business approach around government market strategy. For health systems, however, this concept is a departure from traditional planning models, which have focused on clinical service lines or site-of-care (e.g., post-acute, ambulatory) strategies.

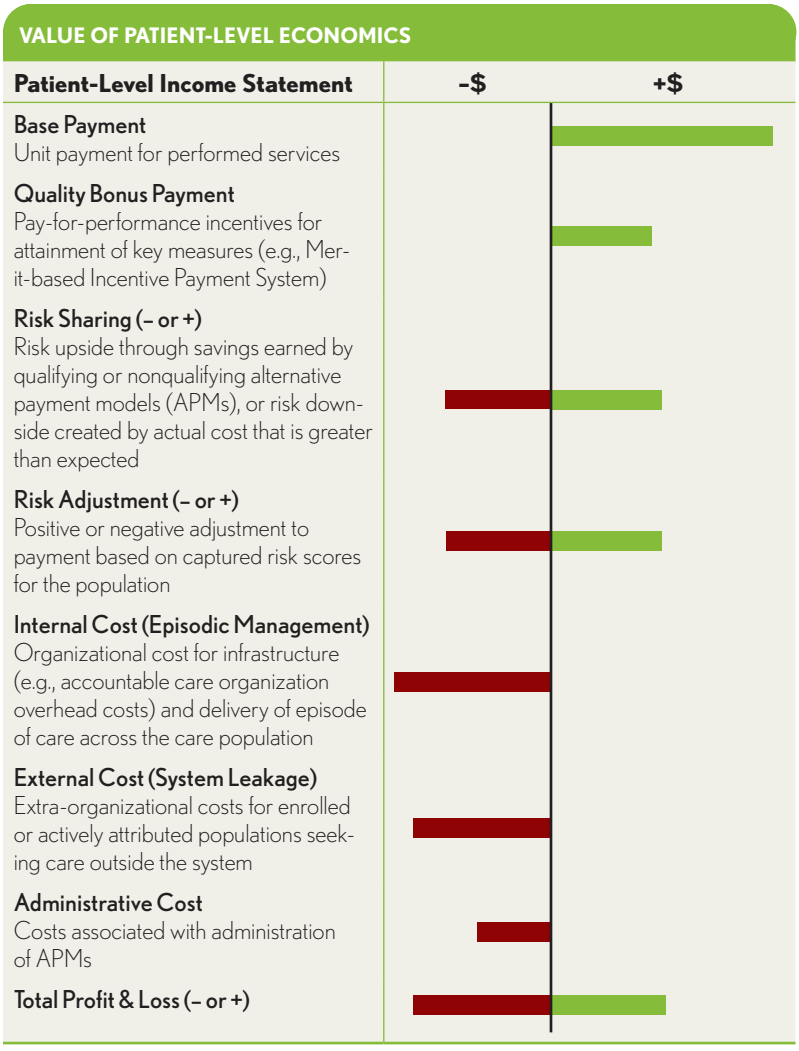
Health systems that have been successful in building senior market strategies begin by bringing together a diverse set of organizational leaders to focus on the Medicare population. These planning committees typically include representatives from finance, managed care, strategic planning, operations, marketing, and legal/compliance areas. These organizations also bring together leaders of enterprise units such as the ACO, health plan, post-acute care areas, and delivery system. A senior market strategy can clarify the organization's desired stakes in MA versus other areas of Medicare and can ensure those targets are reachable through planned investments across a range of financial, clinical, and operational strategies.

Engage in data-driven segmentation to profile consumer segments. Once the planning infrastructure is in place, a health system can begin to focus on specific consumer segments within MA. Frequently, health systems use age-based targeting to determine prospective MA enrollees. Most health systems start sending letters about MA plans or products, or invitations to educational seminars, to individuals when they reach age 64. Patient economics, health status, competitive market intelligence, and demographic and lifestyle information can offer a more nuanced picture of a prospective MA member.

There are multiple ways to segment the MA market, and effective approaches use a combination of criteria to calibrate outreach tactics.

d. Herman, B., "Changes Loom as Most-Popular Medigap Plans Face Extinction," *Modern Healthcare*, June 25, 2016; AHIP Center for Policy and Research, "Trends in Medigap Enrollment and Coverage Options, 2014," October 2015.

VALUE OF PATIENT-LEVEL ECONOMICS



The product can be an important lens when deciding whether to pursue standard MA populations or the subset populations of MA enrollees who are eligible for special needs plans because they have chronic conditions, are dual eligible, or are institutionalized.

Health systems also should determine their target demographic. Healthcare organizations have an opportunity to think about the population as different demographic stages including pre-seniors (age 55-64), age-ins (age 65-67), new Medicare (age 65-75), and mature Medicare (age 75-end-of-life). Each of these cohorts has unique needs and considerations around joining MA plans. Organizations that take a myopic focus on 64-year-olds on the cusp of eligibility miss the opportunity to progressively educate pre-seniors or discuss the unique benefits of MA-supported care models, such as high-intensity care management programs, with "mature Medicare."

Purchase behavior is another key area for segmentation. MA beneficiaries can be divided into different classes of age-ins and "switchers" (e.g., those coming to MA from another Medicare program or switching carriers within MA) associated with their legacy coverage. If the consumer has been covered by a commercial plan, he or she may have purchasing habits that differ from those of a consumer with individual or exchange coverage. Switchers can be grouped into several subcategories of consumers as well, depending on what types of plans they had previously.

Some MA beneficiaries present financial opportunities, while others pose financial challenges. MA is a risk-adjusted market, so patients with chronic conditions generate higher levels of revenue. A health system may have very different economics on traditional Medicare and MA based on its risk coding and accuracy as well as the cost effectiveness of its chronic and poly-chronic care management programs. This level of economic segmentation also should look at the full patient profit-and-loss equation: both direct revenue and expenses as well as indirect funds such as those generated from quality bonuses (e.g., stars), APM risk sharing, and risk adjustment payments.

As shown in the exhibit above left, determining which segments the organization is best positioned to serve helps bring product and contracting strategies into focus. To the extent possible, the economic value of senior market segments should be addressed at the patient level, allowing for segmentation of patients into cohorts to understand drivers of profitability. Under the traditional site-of-care transactional perspective—an approach that looks at inpatient, outpatient, and clinic profits and losses separately—the organization's total cost will miss costs of care outside the health system, and its total

revenue will not account for risk adjustment or risk sharing. By contrast, under the new patient economics perspective, where profits and losses are viewed at the patient level (with additional segmentation criteria by carrier contract, clinical practice, and clinical condition), it is possible to obtain a view across all providers, inside and outside the system accounting for all forms of revenues and costs.

Assess the organization's mix of products and contracts to ensure alignment with segments. 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. Traditional arm's-length contracts entail the lowest level of integration but may have a value-based component, such as stars or risk coding incentives. Virtual integration models, in the middle of the spectrum, typically involve some degree of shared financial risk and joint governance as well as collaborative initiatives around clinical programs or comarketing efforts. And at the highest degree of integration, shared ownership (e.g., joint venture) or full ownership models include profit-and-loss accountability for the owners.

To determine its most appropriate position along this spectrum, a health system should assess the following:

> 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?

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.

Deploy consumer outreach and navigation strategies to execute on the plan. 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 compared with that of traditional Medicare or Medicare supplemental plans for certain patient conditions. This infrastructure for provider-sponsored plans that are offering products in the market will be different from that for health systems that are participating in contractual networks.

The challenge for provider-sponsored MA plans is to build a sales and marketing campaign to appeal to the right segments. These plans need to model the direct sales effort split between field sales (e.g., home visits, sales seminars) and other direct sales (e.g., telephone, online, fax, Medicare website, brokers). There should be a plan around the number of impressions, the costs of those impressions, and the resulting yield in enrollment. Many plans struggle with targeting the right geographic locations for sales and marketing investment, but effective segmentation can help.

Health systems present different challenges. Across the industry, concerns around compliance issues have had a chilling effect on the level of Medicare education provided to pre-seniors and seniors. Under Medicare guidelines, a health system may provide information about the various plans and products, but it is prohibited from promoting any specifically.[e] Health systems wishing to ramp up their education efforts can consider adopting the role of designated Medicare advisor—a specific form of navigator trained on the financial and benefit aspects of Medicare coverage. Physicians and clinical staff also may be trained on how to engage patients in educational conversations around Medicare coverage options

e. CMS, "Medicare Marketing Guidelines," Section 70.11.1—Provider Based Activities, CMS.gov.

that are directly relevant to the patients' clinical histories and healthcare needs when patients asks for such counsel.

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 government payer segment as the entryway into managing financial risk. Each point of market share provides a learning opportunity around high-intensity care management models, telehealth, group visits, and expanded care teams. However, the MA market is not easily won. Unlike CMS innovation models, the market share does not stem from filing an application and being accepted into a program. A well-organized, highly planned approach is necessary to attract the desired patient segments and align each segment with participating contracts or products. Health systems have a tremendous opportunity to consider their MA growth goals and to begin employing next-generation tactics to pursue this highly diversified consumer base. ■

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