

POINT OF VIEW

Taking a Fresh Look at Medicare Strategy

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Why Focus on Medicare Now?

Public attention on health care recently has been largely focused on the Supreme Court, the fate of the Patient Protection and Affordable Care Act (PPACA), and the individual mandate which will be decided this June.

Regardless of what the Supreme Court decides, the government is already the largest payer for health care. Even without the new eligibility made possible by the PPACA, government already pays approximately half of all U.S. health care costs. Given the millions of baby boomers who will roll into Medicare each year during the next decade, and growth in the higher utilizing elderly patient segments, the government share of the market is projected to grow to well over 50% of the total cost of care provided by 2020. Furthermore, the recently released Medicare Trustees report shows that the Hospital Insurance Trust Fund (HI) is expected to remain solvent until 2024, the same as last year's estimate. "While Medicare is stable for now, we have a lot of work ahead to guarantee its future," said the Acting CMS Administrator Marylyn Tavenner. Pressure will only grow to contain Medicare costs.

To date, most public attention has been focused on the Medicare Shared Savings Program, the innovative effort to replace fee-for-service with value-based payments. By July, CMS will have announced approximately 175 accountable care program awards, although a relatively modest number of total Medicare beneficiaries will be involved and only a small portion of all hospitals and medical groups. In contrast, CMS' Medicare Advantage program, the federally funded managed care program, covers far more people already. In fact, approximately one-quarter of all Medicare beneficiaries are now enrolled in private Medicare Advantage plans. Since 2004, this number has more than doubled from 5.3 million to 11.9 million in 2011.¹ While Medicare utilization will continue

¹ Kaiser Family Foundation, Medicare Policy Fact Sheet, November 2011

to grow as a percent of the total, per capita Medicare expenditures are not projected to keep pace with costs and will grow at only 1% to 2% a year, less than health care cost inflation. Over the past decade, hospitals have become increasingly reliant on commercial reimbursement to make up the shortfall in Medicare, but the advent of the PPACA and pressure from payers and business makes cost shifting a less reliable strategy for the future. Wringing higher margins from Medicare has thus become an imperative for any provider to maintain long term financial viability. Some observers have characterized this as a “growing elephant in the room for health systems.”

All of these factors argue for a review of Medicare strategy now.

What are Your Medicare Strategy Options?

Improving margins on Medicare patients requires a strategy that balances changing business models to increase clinical efficiency, while expanding market share to achieve economies of scale (*as well as maintaining good commercial rates for as long as possible*). Providers have four main strategic options for addressing this problem:

- **Option #1: Reduce Costs Enough to Break Even on Medicare FFS.** CMS has a stated goal of changing the volume based fee-for-service (FFS) Medicare Program to a value-based payment model reimbursement linked to quality and outcomes, but for the foreseeable future, most providers will continue to be paid FFS for physicians and case-based rates for hospitals. Succeeding in this FFS environment will require relentless emphasis on the reduction of unit costs through improved clinical efficiency, increased throughput and reduction of length of stay, and improved care management for episodes of care, chronic disease and end-of-life care. A significant degree of clinical integration will be required to achieve these efficiencies with hospitals and physicians aligned to manage care and eventually share risk and having the organization and IT capability to successfully participate in more sophisticated pay-for-performance (P4P) contracts. Having a plan for a high performance organization that can bridge the gap from a FFS and volume-based culture to a fee-for-value one will be critical for profit improvement from all payers, particularly Medicare.
- **Option #2: Participate in the ACO / Shared Savings Program.** About 30 health systems have been accepted into CMS' Pioneer ACO demonstration program. CMS also recently announced the first 27 awards to participate in their standard ACO Shared Savings Program and in July will announce 150 more. CMS reports there has been strong interest in participation among all types of organizations in both high and low cost markets. There are structural challenges to participating in the program since a significant infrastructure investment is required; there is a 2-3.0% threshold to share any savings and probably a short

half-life for shared savings opportunities, since the bar will be continually reset in terms of performance.

The ACO revenue opportunity is based on delivering savings under the county level FFS cost rate plus an adjustment for the risk profile of the ACO population. CMS will then calculate a Minimum Savings Rate as the threshold requirement to participate in shared saving. CMS will then share 50% of the savings above the Minimum Saving Rate. This may prove challenging, and the large investment required to get started may prove a barrier to market entry.

Nevertheless, for many health systems, this will be a better alternative than riding down the curve on Medicare FFS reimbursement. Moreover, a Medicare ACO strategy will likely be an increasingly useful adjunct for the commercial insurance markets since United, Aetna, WellPoint and the Blue Cross affiliates are all adopting ACO principles into their business models, and depending on providers' readiness to accept risk, will be moving increasing parts of their business into shared risk arrangements in the future.

**Summary Assessment of Medicare ACO
Shared Savings Program Participation**

Pros / Advantages	Risks
<ul style="list-style-type: none"> • Opportunity to offset declining Medicare FFS reimbursement rates 	<ul style="list-style-type: none"> • If the ACO does not meet the Medicare Shared Savings Rate threshold; ACO receives no additional upside
<ul style="list-style-type: none"> • Ability to leverage ACO infrastructure for other populations 	<ul style="list-style-type: none"> • Significant Infrastructure Investment required; sophisticated DP requirements
<ul style="list-style-type: none"> • Build branded patient experience driving patient loyalty 	<ul style="list-style-type: none"> • CMS patient attribution model requires communication of ACO members to opt out
<ul style="list-style-type: none"> • Receive 50% of shared savings on top of Medicare FFS rates 	<ul style="list-style-type: none"> • CMS shares in savings; 50% split with ACO
<ul style="list-style-type: none"> • Improve quality of care through clinical integration 	<ul style="list-style-type: none"> • Requires meeting quality measures and ability to share risk
<ul style="list-style-type: none"> • Opportunities for increasing share to achieve scale economies 	<ul style="list-style-type: none"> • Performance bar will continually be reset

- **Option #3: Develop a Plan for Bundled Payments.** In addition to the Shared Savings Program, the Affordable Care Act has authorized a program of Bundled Payments for Care Improvement Initiatives. CMS is currently reviewing applications submitted for the first round of bundled payment initiatives--a three

year program--which will link payments for multiple services patients receive during an episode of care. Participating hospitals in these models would be paid for their services under the standard Medicare FFS system, but at discounted rates. An earlier pilot program, the ACE Demonstration, funded three years ago covering both Part A and Part B Physicians services, was focused on cardiovascular and orthopedic procedures.

Two of the ACE participants, the Hillcrest Medical Center in Tulsa and the Lovelace Medical Center in Albuquerque, have reported significant savings because of improved care coordination and improved use of quality metrics. Four different bundled payment mechanisms were offered under the first year bundled payment program with varying degrees of gain sharing and risk. Model #4 *Prospective Payment Bundling*, in which CMS will make a single, prospectively determined bundled payment to a hospital that would encompass all service furnished during the inpatient services for selected diagnoses for hospitals, physicians and other practitioners is the most comprehensive model and has the most risk since a single payment for all services is involved.

The Bundled Payment program has not received the same attention as the Medicare ACO Shared Savings initiative since the ACE demonstration focused on a limited number of surgical DRGs and was concentrated in areas where there are clearly defined procedures; it is less certain how bundling will work in more complex medical cases with more variation, such as diabetes or congestive heart failure. Nevertheless, early participants foresee substantial opportunity for clinical improvement as well as gain sharing.²

- **Option #4: Develop a Plan for Medicare Advantage.** Ever since the 1970s, Medicare beneficiaries have had the option of receiving their benefits through private health plans, mainly HMOs, as an alternative to the federally administered Medicare fee-for-service program. In 2003, Medicare's managed care program was renamed Medicare Advantage and by 2012 it constituted a \$115 billion market and approximately 21% of total Medicare spending. Despite the size of Medicare Advantage, it has been under the radar screen for many provider organizations and clearly deserves a second look. There are three major myths surrounding MA plans that must be dispelled, however, before moving forward with any type of Medicare Advantage strategy.

Myth #1: Medicare Advantage is Going Away

Fact: Policy analysts focused criticism over the past several years on one particular type of Medicare Advantage Plan – Private Fee-for-Service (PFFS) plans. PFFS plans received high premium payments above expected Medicare








² Beckers Hospital Review, 2 Major lessons From CMS' Bundled Payment ACE Demonstration, April, 2012

fee-for-service reimbursement and lacked meaningful care management. The Affordable Care Act reduced payments significantly for PFFS. The act also initiated a policy designed over the long term to bring Medicare Advantage payments more in line with the Medicare Fee-For-Service Program.

The reality is that Medicare Advantage HMOs have proven popular and cost effective and will in all likelihood continue to grow, albeit with slower PMPM growth than in the past. Planned reductions in MA reimbursement premiums can be offset through intelligent plan design and management. The outcome of the Supreme Court’s decision of the Affordable Care Act in June is not likely to have a significant impact on Medicare Advantage.

Myth #2: A Large MA Population is Required to Spread Risk

Fact: Because of their higher utilization than commercial plans, MA plans can be viable at 5,000 to 10,000 members; 20,000 to 30,000 member plans can be very profitable. The following chart provides an outline of the favorable market characteristics to have a successful MA plan:

Favorable Market Dynamics	
<i>Medicare Eligible Population in Market >100,000 65+</i>	
<i>Above FFS County Reimbursement Rates</i>	
<i>Existing Medicare Advantage Penetration Between 20 – 40%</i>	
<i>Steadily Increasing 65+ Population</i>	
<i>Physician Alignment; Patients will Move with Physician</i>	
<i>High Medicare Share in Physician Panels</i>	
<i>Physicians Open to Value Payments and Clinical Coordination</i>	

Myth #3: Owning a Medicare Advantage Plan is Highly Risky

Fact: Approximately 80% of all MA plans with greater than 10,000 beneficiaries are profitable; well managed plans with a 4 STAR rating should conservatively earn a 5-10% profit margin, with some well managed plans earning considerably more.³ In fact, retrospective risk adjustment makes Medicare Advantage plans much less risky than a typical commercial plan. Industry experience indicates it is

³Based on reports filed to state insurance commissioners. California Medicare Advantage plans that do not report financial details are excluded from the sample.

possible to have a profitable MA plan in almost any county depending on the price appetite of the customer.

Succeeding in Medicare Advantage

There are four primary ways providers can participate in Medicare Advantage:

- Contract as a provider network with an existing Medicare Advantage plan with a performance based plan
- Contract as a network with an existing MA plan with a risk-based capitation or shared savings contract
- Develop a narrow network / private label Medicare Advantage product with an established health plan as a partner
- Own a Medicare Advantage plan directly

Selecting the right approach will depend on the characteristics of the market and skills and risk appetite of the provider system. Plans compete in every market at the county level by offering Medicare beneficiaries a package of benefits that are generally superior to those available in traditional Medicare at a competitive price, generally significantly lower than a Medicare supplement plan.

Premiums are established through a complicated bid process based on a formula driven by county level FFS benchmark costs. Revenue is adjusted based on the risk profile of individual members and adjusted retrospectively on a 12 month basis. CMS also offers revenue bonuses for plans who qualify for a STAR quality bonus, and starting in 2014, a plan will need to receive at least 4 out of a possible 5 rating to achieve the bonus.

Many of the key functions for a successful Medicare Advantage Plan, in fact, are similar to those required of an Accountable Care Organization, including: (i) physician alignment and care / population management; (ii) network contracting and management; (iii) CMS reporting & compliance; and (iv) member communication. Other functions such as plan management, marketing, member operations and actuarial pricing & bid capabilities are services which could be purchased from a health plan partner or a Third Party Administrator.

Succeeding in Medicare Advantage requires mastery of four essential capabilities:

- *Product Design* to ensure balance between competitive attractiveness and adverse risk selection
- *Revenue Management* to optimize risk, ensure coding is accurate, and capture, as well as achieve, 4 or 5 STAR ratings for quality. Without a top STAR quality rating, an MA provider will not have a competitive product

- *Care Management* with particular focus on management of chronic disease in the frail, elderly and end-of-life care
- *Regulatory Compliance* with focus on management of all aspects of the value chain based on CMS rules

Provider owned plans have traditionally out-performed national and regional plans and all of the 4 or 5 STAR MA plan nationals are provider owned.⁴ Currently, industry experience indicates a Medicare Advantage plan with 10,000 lives, with a medium level of medical management cost and a 4 STAR rating, has far more upside than an ACO with 10,000 lives. The profit differential between Medicare Advantage and an ACO will likely diminish as CMS squeezes MA premiums down to FFS cost levels, but in the near to mid-term, MA offers a significant business opportunity.

Key Questions

We would suggest addressing the following key questions in reconsidering Medicare strategy.

1. What is your Medicare market size? How does it fit together with your key commercial payers?
2. Which of the four major strategic options— Break Even FFS, Bundled Payment, ACO Shared Savings or Medicare Advantage—is the best fit for your organization and its capabilities?
3. Do you understand the Medicare trend in the market and what your competition is up to?
4. Do you have a clinically integrated network capable of participating in performance based contracting?
5. Is your network adequate to meet Medicare coverage requirements and will the MA rates provide you the resources needed to break even?
6. Can your ACO or MA product membership grow to satisfy scale requirements?
7. Given local market conditions and your capabilities, which Medicare strategy – ACO or Medicare Advantage, offers the best risk / reward tradeoff?
8. Recognizing that Medicare will account for a growing share of your market, how much of your organization’s resources is it reasonable to invest to succeed with this business segment?

⁴ Examples of 4 or 5 STAR plans: Kaiser, UPMS For Life, Geisinger Gold, Baystate Health, Group Health Cooperative, AdvoCare, Gunderson Lutheran. Most national and regional players such as United, Aetna, WellPoint, Humana or the Blues affiliates are 3 to 4 STAR.

9. Will your organization be willing to make the investment required in the highly regulated revenue headwind to be successful?

Regardless of the answers to these questions, one point appears clear – not having a Medicare strategy in place during the next decade is the least tenable option of all.

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Bill Eggbeer leads BDC Advisors' Payer-Provider Practice, and with Dudley Morris, Senior Advisor with BDC Advisors, has published articles recently on the growth of Total Cost of Care Contracting and the resurgence of narrow, tailored and tiered networks as part of new lost-cost benefit plans. Krista Bowers, also a Senior Advisor with BDC Advisors, was most recently Senior Vice President and President of Senior Business at WellPoint, Inc. where she was responsible for the corporation's \$8 billion Revenue Medicare business line including Medicare Advantage.