The Academy
The Health Management Academy

The Academy Lumeris Strategic Tracking Survey

Strategic Survey Q4 2018: Medicare Advantage

December 2018

Lumeris

Medicare Advantage Plans

Introduction

As the healthcare industry continues to transition toward value-based care, health systems are prioritizing the implementation of risk-bearing models that control costs while improving the quality and coordination of care delivered. The Medicare population is a particular area of focus for provider organizations, as the country's population ages and requires a higher volume of more complex services. Reflective of these trends, Medicare spending is projected to grow to 18% of total federal spending by 2028.[1] Due to these pressures, many providers are looking toward Medicare Advantage (MA) to better manage this complex population. Leveraging MA's expanded benefits and capitated payments allows providers to deliver coordinated care to their Medicare population while having greater control over the total cost.

In Q4 2018, The Health Management Academy (The Academy) conducted a qualitative assessment of health system executives around the current landscape and strategies for providers' MA plans.

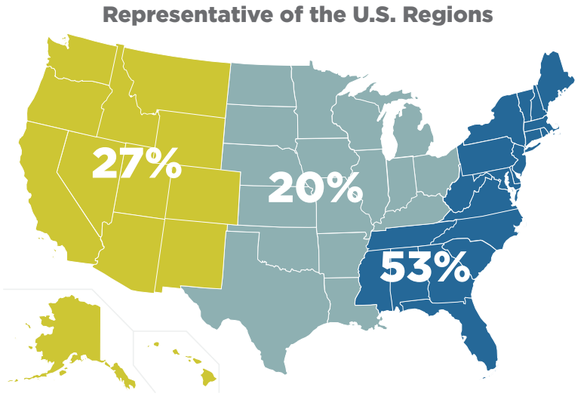
Methodology

In November 2018, The Academy conducted the seventeenth round of phone interviews for its quarterly strategic survey among Leading Health System executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue.

Profile of Participating Health Systems



MEDIAN REVENUE
$3.8 BILLION

OWN OR OPERATE
172 HOSPITALS
WITH 34,250 BEDS

SINGLE-STATE SYSTEMS: 67%
MULTI-STATE SYSTEMS: 33%

[1] Cubanski J, Neuman T. The Facts on Medicare Spending and Financing. Kaiser Family Foundation. Jun 2018.

Key Findings

1. Primary factors underlying increased provider participation in MA are the ability to provide improved benefits for patients at a reduced cost and consumer demand.

2. Health systems include a variety of supplemental benefits in their MA plans, aimed at improving the satisfaction and overall health status of MA beneficiaries, which will ultimately lower the cost of care.

3. Health systems are focused on improving consumer and physician engagement with in MA, offering additional resources and benefits for consumers and leveraging data analytics to assist providers in identifying gaps in care.

Market Factors Influencing MA Uptake

Health system executives reported a variety of factors driving increased provider focus and participation in MA, primarily centered around reducing costs and consumer demand. Overall financial pressure and stagnant Medicare reimbursement have incentivized providers to participate in programs that allow them to better control the cost of care. Additionally, changing population demographics and the aging population have resulted in the conversion of many commercial patients into Medicare beneficiaries. Due to the flexibility in benefit design and capitated payment structure, health systems see MA as a way to offer additional benefits, better manage the total cost, and improve care coordination for this complex patient population.

Health systems report that having a significant patient base in order to accommodate the risk associated with MA plans is a primary barrier. Despite this barrier, MA plans are seen as a growth opportunity towards value-based care and increased risk assumption.

All responding health systems report contracting with multiple payers, ranging from 3-6 payer arrangements. Health systems report that they typically contract with all the payers in their market.

> "The recent changes afforded to MA plans through the Chronic Care Act, which makes MA more appealing to consumers, may even accelerate these enrollment trends away from FFS Medicare. This growth trajectory has also led to a number of new payer entrants in our market and they are typically looking for more non-traditional payer-provider partnerships to manage MLR and generate new membership." (COO)

> "We see MA as a growth opportunity. MA helps us in terms of pushing toward pre-payment and taking on risk. It's in alignment with where we're trying to go with our organization, which is taking on full risk." (CSO)

Leveraging Supplemental Benefits & SDOH Data

Responding health systems report significant variation in supplemental benefits offered through MA plans, most commonly including benefits such as dental care or transportation. Additionally, there is variation in benefits across each of the different MA plans a health system participates in.

Health Systems report an anticipated increase in overall health in MA population, with modest to significant improvements in outcomes, cost, and consumer satisfaction as a result of MA supplemental benefits.

While many organizations do not yet comprehensively leverage social determinant of health (SDOH) data to better target interventions for the MA beneficiaries, most organizations see this as an opportunity and are beginning to collect this data and implement programs around SDOH. Most organizations utilize external partners (e.g., Evolent) or partner with existing community organizations to access and leverage SDOH data. Common SDOH data points health systems utilize include housing conditions, transportation availability, access to food, access to a pharmacy, employment status, and loneliness, as well as clinical data such as fall risk, medications, lab results, biometric data, and other clinical metrics.

Supplemental MA Benefits

- Dental Care
- Eye Care
- Gym Membership
- Transportation
- Telemedicine
- Lower PCP Co-pay
- No Inpatient Co-pay

> “As MA plans expand services we expect that patients’ consumer experience and outcomes will improve as patients receive services tailored to their specific needs. MA plans show that they manage total cost of care better than the traditional Medicare FFS and we expect that to continue.” (COO)

Improving Physician & Consumer Engagement

Physician Engagement

Health system executives report that physicians participating in MA typically are not engaged differently than physicians in traditional FFS contracts. Physicians practice and treat patients consistently across contracts, however health systems commonly offer additional resources for patients in MA programs. Commonly, health systems leverage clinicians including nurse practitioners and case managers to help manage their panel of MA beneficiaries and conduct follow-up or pre-visit services.

The most significant workflow changes for physicians reported includes additional documentation requirements and providing additional services such as risk assessments. To help manage this process change, health systems are highly focused on provider education and leveraging analytics around cost and quality data to help drive engagement.

> "Data analytics of a PCP's attributed lives helps in the identification of high risk patients that can be supported through care management, navigation, and education. Analytics and pop health management infrastructure also help PCP's address gaps in care." (COO)

Consumer Engagement

Health systems have implemented a variety of additional resources and programs to help improve consumer engagement for MA beneficiaries. Health systems leverage in-house population health teams and care managers to identify and target at-risk patients for additional interventions, conduct risk-assessments and preventative screenings for MA patients, and perform outreach for scheduling appointments and annual visits.

Health systems have focused on improving engagement for their MA beneficiaries and measure the effect of these programs through patient satisfaction surveys (e.g., HCAHPs, Press Ganey).

> "Primary strategies around patient engagement include outreach to schedule annual visits, complete preventative screenings, as well as support for MA members deemed high risk through care management programs." (COO)

Lumeris Commentary

This recent survey from the Academy highlights the continued strategic importance of Medicare Advantage (MA) for health systems across the country. MA has demonstrated success as a value-based model, and if done right, allows providers to manage three critical levers for improving clinical and financial outcomes: quality (as measured through Star Ratings), medical cost management, and a rational risk adjustment methodology.

At Lumeris, we see MA as a critical part of health systems' strategies for moving to risk-based arrangements. Changing market and regulatory factors mean that health systems must have a strategic and operational plan to meet the heightened demand for MA. However, success in managing a complex population such as MA can also help drive initiatives across other populations.

As seen in the survey, use of advanced analytics to drive decision making and interventions will continue to improve patient care. However, to truly succeed in MA and all value-based arrangements, providers need more than technology. They must be supported with the right tools, information, incentives, education, and operational resources to drive the required changes for delivering high quality, cost-effective care and enhancing the consumer experience.

About the Academy

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com

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About Lumeris

Lumeris serves as a long-term operating partner for organizations that are committed to the transition from volume-to value-based care and delivering extraordinary clinical and financial outcomes. 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 won the 2018 Best in KLAS award for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the third year it received this distinguished award. For the past seven years, Essence Healthcare, Lumeris' inaugural client with more than 65,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. Lumeris is committed to delivering these same results with its multi-payer/ multi-population clients to meet their goals and missions.

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