

GETTING READY FOR THE NEW CHALLENGES OF MEDICARE ADVANTAGE

Medicare Advantage plans have been leaders in moving healthcare toward value and retail. But the bar is going up. Here are six areas where you must excel.

AUTHORS

Jim Fields
Partner

Martin Graf
Partner

This spring, when the Centers for Medicare and Medicaid Services (CMS) issued its final rates for 2014, it reversed itself after proposing a controversial set of rate cuts. By doing that, it arguably saved Medicare Advantage (MA)—and sent a clear message that the government intends MA to play a major, growing role in Medicare for years to come. The Congressional Budget Office, long a pessimist on MA, now projects that by 2023 the program will grow to 22 million members, or about 30 percent of total Medicare membership (See Exhibit 1 on following page).

MA plans should be pleased but not complacent. MA plans have long been the front runners in moving toward value-based care and developing a retail approach to healthcare. But CMS has made it clear that yesterday's successes won't guarantee tomorrow's survival. To keep succeeding, MA plans need to keep advancing—building consumer value, deeply engaging providers, and optimizing capabilities to ensure they are “purpose built” to serve seniors. If they haven't already, they need to spend less effort trying to satisfy CMS and more on producing better outcomes and healthier members.

Prioritization is not easy, but it is perhaps the single most powerful tool for improving MA.

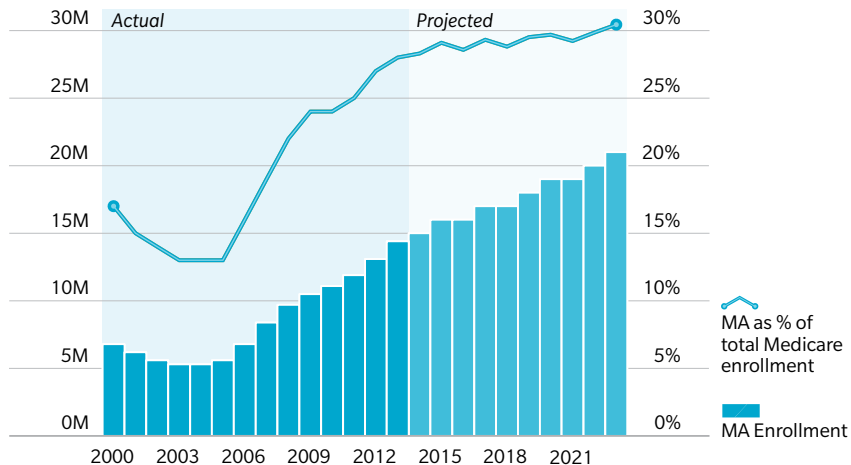
What will the new state of the art look like? In our work with MA plans, we have learned that market leaders consistently excel in six key areas:

1. Market prioritization: Go county by county. Medicare Advantage, with its retail consumer orientation and county-level reimbursement, demands a very local approach. Plans that pursue a “border-to-border” strategy, targeting every doctor, hospital, and patient, will wind up with counties where they make money and counties where they lose. (Many MA plans currently lose money in a significant portion of the counties they serve.) As the market increasingly moves to value-based care, which emphasizes the quality and preparedness of individual providers, MA will inevitably become even more local.

How to respond? Start by understanding your market county by county. Dig deep into demographics, MA market penetration, provider infrastructure and readiness, quality of care, disease prevalence, reimbursement history and projections, costs, and competitive offerings, to name just the most obvious factors. Then comes the step that many insurers find difficult: Decide where to put your effort, where to adapt products to local conditions, where to use your buying power to push the market in the right direction, where to hurry, and where to take some time. Prioritization is not easy, but it is perhaps the single most powerful tool for improving MA financial performance. Ultimately, if a plan picks its spots well and avoids structurally weak geographies (where providers are of low quality, for example, or reimbursements are weak and declining, or MA has historically languished), it will be much more likely to succeed.

EXHIBIT 1: MEDICARE ADVANTAGE IS AN ATTRACTIVE GROWTH OPPORTUNITY FOR HEALTH PLANS WITH THE CAPABILITIES AND CLINICAL EXPERTISE TO MANAGE SENIORS

MEDICARE ADVANTAGE IS EXPECTED TO EVENTUALLY SERVE ALMOST ONE-THIRD OF MEDICARE BENEFICIARIES



MEDICARE ADVANTAGE (MA) MARKET OVERVIEW

The Dynamics

- Demographics (i.e. Boomers) and consumer preferences driving rapid growth and competitiveness of the MA market

The Challenge

- The bar on what it takes to play in MA continues to rise
- CMS issuing tighter rates, higher quality standards, tougher restrictions on coding
- The days of “me-too” MA plans are over... successful players have a culture of member engagement, quality, provider buy-in, and execution excellence that pervade the entire organization

The Opportunity

- MA enrollment projected to increase 50% over the next decade

Sources: Kaiser Family Foundation “Medicare Advantage 2013 Spotlight: Enrollment Market Update” for actuals; CBO “May 2013 Medicare Baseline” Group Plan Enrollment projections for 2014-2023; Census Bureau Population Projections, Oliver Wyman analysis; CBO projects CMS payments of \$250 billion to Medicare Advantage plans in 2023

In true value-based care, payers and providers need to be business partners and allies; what's good for one needs to be good for the other as well.

2. Provider partnerships: Incentives aren't enough. On one level, an MA plan needs providers to do three things: (1) completely and accurately code member risk, (2) document and treat gaps in care to ensure high quality scores and great patient outcomes, and (3) focus on the high-cost, complex patients who generate the largest share of costs.

But on another level, MA plans need much more from providers. The most successful value-based healthcare organizations—the CareMores and Geisingers and their peers—have generated remarkable value for members, providers, and themselves through innovation, creativity, and deep physician commitment. Their doctors don't just tick off boxes; they pursue patient wellbeing with energy and imagination. How does a health plan bring its providers to that level of engagement? Certainly the structure of the contract matters. So do goals and incentives. But in the long run, they're just a start. Health plans need to fine tune incentive programs so they're meaningful and tied directly to the factors that drive revenue, quality of care, and members' cost of care. They need to enable providers. In some cases that will be mostly a matter of providing analytics and integrated clinical data: gaps in care, records of out-of-network care, prescription data that will help identify compliance problems, and so forth. In other cases, it may be useful to provide patient education, staff training, or even in-office care coordinators. This is not the old world of fee-for-service (FFS) or even pay for performance. In true value-based care, payers and providers need to be business partners and allies; what's good for one needs to be good for the other as well.

3. Stars ratings: Don't overreach. MA plans are already well aware of the importance of CMS's Star quality program, but some of the early movers in Stars have shown a tendency toward a shotgun approach—they go to providers with a laundry list of initiatives covering all CMS MA and PDP Star metrics and imagine that financial incentives will prevail. Unfortunately, given the fragmented nature of care delivery, with 80 percent of providers serving an average of just 10 percent of a given payer's member panel, that isn't likely to happen.

Incentives alone won't win the Stars game. It takes resources, planning, and support to change behavior. And CMS's Star bonuses aren't for general improvement in quality—they're for achieving a specific score on a set of weighted metrics, some easier for particular physician practices and some harder, some relatively straightforward to document and some not. Your providers can't make a hundred significant changes in a year. Instead, work with them to identify a handful that (1) are achievable and financially material, (2) make sense for the provider and member, (3) will actually be detected by CMS's evaluation system, and (4) will win the reimbursement increase.

Sometimes, when providers are either unable or unwilling to perform, the best strategy might be to eliminate them by using narrow and tiered networks. Stars can provide either a healthy revenue boost or be a sinkhole of efforts, initiatives, and costs. It is crucial to develop an optimal strategy up front.

Stars can provide either a healthy revenue boost or be a sinkhole of efforts, initiatives, and costs. It is crucial to develop an optimal strategy up front.

4. Risk adjustment: Put your risk insight to work. Most MA plans have learned to identify potential gaps in patient revenue (and records) and modify their risk scores after the fact (known as retrospective risk adjustment). This is a core competency for most plans, but it will become much less important over the next few years as CMS moves closer to its goal of eliminating rewards for behaviors that create revenue for payers and providers without enhancing patient welfare.

Until then, as MA plans ratchet up their risk assessment and optimize code capture efforts, they should not work in a vacuum. The data collected as part of risk adjustment needs to feed into the care model for the patient and population health model. All major MA plans now use predictive modeling to stratify patients. That data needs to be better translated into action—identifying patients who need to be visited and documented in more detail, launching a process of keeping them well and reducing their total cost of care. The health plan cannot do this without deeply engaging physicians and other practitioners, and as the process of incentivizing providers and writing value-based contracts evolves, a key concern will be to ensure that risk assessment and adjustment is not just a filing with CMS, but a key element in improving care.

5. Retail positioning and execution. Medicare Advantage was the first retail individual health insurance market of any consequence and has grown to more than 13 million members. But to date the majority of plans have developed relatively little retail sophistication. Compared to retail chains or consumer packaged goods companies, MA plans know little about their customers outside of claims information and related data. That needs to change. The shift to value-based care makes it especially important to understand what motivates your customers, what will engage them in caring for their own health, what costs they are likely to incur, and how to align them with the specific product that is best for patient and health plan alike.

This means that leading MA plans need to invest in understanding consumers, for example: How does the population distribute across the acuity scale from healthy to end-of-life? What ethnic groups or other segments must you effectively serve? What messages will they respond to, and what channels can you use to deliver those messages? What are their satisfactions—and more important their dissatisfactions—with their healthcare? What consumer hassles can you solve, and how can you provide the kind of customer experience that drives positive word-of-mouth? What other non-healthcare data can be leveraged to gain a deeper understanding of their life stage and priorities?

This may sound like classic market research, but we believe that the most successful MA plans will use research and analytics to go much further. They will understand not just what seniors would be willing to buy, but what problems and hassles they face in their lives as healthcare consumers, hassles so entrenched that they have become almost invisible. As the great tech giants of the past few decades have learned, there is no more powerful way to transform a market than to solve a problem no one was actively thinking about.

As the great tech giants of the past few decades have learned, there is no more powerful way to transform a market than to solve a problem no one was actively thinking about.

As you better understand your customers, it is also crucial to understand your own changing role. All health plans have long been in the insurance business, but like it or not, they are now being pulled into the healthcare business, and nowhere is this truer than in MA. More than ever, MA plans are putting dollars to work at the point of care and staking their success on a variety of partnerships with providers (with many different models and structures). Increasingly customers will no longer judge you on how well you pay claims but rather what you're doing to provide health assistance and lifestyle support at a cost they can afford—and make them feel good about it.

6. Resource alignment and commitment. For most of its history, Medicare Advantage has been a line of business added onto a health insurance organization built around selling to employers and paying claims. In the past decade that has changed as the success of “purpose built” MA plans—like CareMore and HealthSpring—have shown that there is an exciting, valid, and profitable business in MA that deserves its own organization, leadership, and strategy. It is now clear that health plans that have specific MA divisions with their own networks, member engagement programs, care management, and compliance programs outperform those that don't. In the near future, when additional cuts to Medicare arrive, as they inevitably must, these players will be the ones that prosper.

A STEP TO THE FUTURE

Medicare Advantage will continue to be an important and viable market, but one that demands greater focus and competency. Players that want to succeed must accept the good (a rapidly expanding base of government-backed customers) and deal with the bad (political risks and the inevitability that reimbursements will fall). Is this a good tradeoff? We think so. More important, we believe that the only future for health insurance in the United States is to move decisively toward greater retailization, toward value, and toward providing not just coverage but care. These are all attributes that leading MA plans have embraced. As a result, they are ahead of the market. A well-conceived, deliberate effort in MA can bring your organization's future, and its future success, that much closer.

The success of “purpose built” Medicare Advantage plans have shown that there is an exciting, valid, and profitable business in MA that deserves its own organization, leadership, and strategy.

ABOUT THE AUTHORS

Jim Fields is a partner in Oliver Wyman’s Health & Life Sciences practice group, the head of the Chicago office, and leads the practice’s work in government programs. Jim has guided several companies in the development and implementation of Exchange strategies, Seniors strategies, and Medicaid expansion plans. He has deep experience in strategic planning and has worked with health plans of all sizes, as well as healthcare technology companies and health delivery systems. He can be reached at jim.fields@oliverwyman.com.

Martin Graf is a partner in Oliver Wyman’s Health & Life Sciences practice group. He has extensive experience advising managed care, provider organizations, private equity firms, and a wide range of companies that enable healthcare services. His areas of expertise include growth strategy development, business planning, assessing and managing operations, establishing/leveraging partnerships, and maximizing on M&A opportunities. He can be reached at martin.b.graf@oliverwyman.com.

ABOUT OLIVER WYMAN

Oliver Wyman is a global leader in management consulting. With offices in 50+ cities across 25 countries, Oliver Wyman combines deep industry knowledge with specialized expertise in strategy, operations, risk management, and organization transformation. The firm's 3,000 professionals help clients optimize their business, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is a wholly owned subsidiary of Marsh & McLennan Companies [NYSE : MMC], a global team of professional services companies offering clients advice and solutions in the areas of risk, strategy and human capital. With 53,000 employees worldwide and annual revenue exceeding \$10 billion, Marsh & McLennan Companies is also the parent company of Marsh, a global leader in insurance broking and risk management; Guy Carpenter, a global leader in risk and reinsurance intermediary services; and Mercer, a global leader in human resource consulting and related services.

Oliver Wyman's Health & Life Sciences practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions.

For more information, visit www.oliverwyman.com. Follow Oliver Wyman on Twitter @OliverWyman.

www.oliverwyman.com

Copyright © 2013 Oliver Wyman

All rights reserved. This report may not be reproduced or redistributed, in whole or in part, without the written permission of Oliver Wyman and Oliver Wyman accepts no liability whatsoever for the actions of third parties in this respect.

The information and opinions in this report were prepared by Oliver Wyman. This report is not investment advice and should not be relied on for such advice or as a substitute for consultation with professional accountants, tax, legal or financial advisors. Oliver Wyman has made every effort to use reliable, up-to-date and comprehensive information and analysis, but all information is provided without warranty of any kind, express or implied. Oliver Wyman disclaims any responsibility to update the information or conclusions in this report. Oliver Wyman accepts no liability for any loss arising from any action taken or refrained from as a result of information contained in this report or any reports or sources of information referred to herein, or for any consequential, special or similar damages even if advised of the possibility of such damages. The report is not an offer to buy or sell securities or a solicitation of an offer to buy or sell securities. This report may not be sold without the written consent of Oliver Wyman.