

Can provider organizations succeed in Medicare Advantage?

Opportunities and Challenges

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As of December 2020, nearly 25 of the 63 million people (approximately 40%) currently covered by Medicare are enrolled in Medicare Advantage (MA) plans.¹ The Congressional Budget Office (CBO) projects that MA enrollment will grow to nearly 50% of total Medicare enrollment by 2029.² Traditionally, MA plans have been offered exclusively by private health plans, but the growing market size has attracted provider organizations to establish partnerships with private health plans to participate in the market in new ways.³

To succeed in the MA space, provider-based MA plans face the challenge of providing affordable, efficient health care to Medicare beneficiaries without cutting into their own revenue flow.

Many provider organizations that have succeeded in the MA space have balanced providing affordable and efficient care with financially sound revenue management by utilizing one or more of the following levers:

1. Limiting reimbursement concessions
2. Constructing a narrow provider network
3. Focusing on effective diagnosis coding
4. Ensuring providers are still working at capacity levels

Using these levers while establishing a successful MA product is a delicate balancing act for many provider organizations, but the long-term rewards of a stable MA product can provide a valuable additional income source.

Background

MA is a government-sponsored program which offers an alternative to traditional fee-for-service (FFS) Medicare, in which Medicare beneficiaries receive health coverage through private health plans, known as Medicare Advantage organizations. The MA market has become an increasingly popular option for Medicare beneficiaries versus FFS Medicare by offering enhanced medical benefits and integrating with pharmacy coverage.⁴

A main avenue for provider organizations to actively participate in the MA market is to partner with an existing private health plan on a product offering. This kind of arrangement best lends itself to entities that are interested in taking on more risk for a Medicare population but lack the administration and infrastructure required to fully operate an MA plan.

Commonly in these arrangements, the private health plan administers benefits as well as processes and adjudicates claims in exchange for a share of the profits/losses. The provider organization provides the health plan access to new members already using the provider's network and the opportunity for improved care coordination. Additionally, the private health plan partner may be able to leverage their current MA product offerings to allow the provider-based MA product to be under a contract that has already attained an elevated star rating, increasing the benchmark revenue.

¹ CMS (January 2021). Monthly Enrollment by State. Retrieved January 2021. from <https://www.cms.gov/files/zip/monthly-enrollment-state-december-2020.zip-0>

² Congressional Budget Office (March 2020). Medicare-CBO's Baseline as of March 6, 2020. Retrieved December 16, 2020, from <https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf>

³ Angeloni, M. (December 2020). Opportunities, challenges, and considerations for new entrants. Milliman. Retrieved January 4, 2021 from https://us.milliman.com/-/media/milliman/pdfs/2020-articles/articles/12-21-20-opportunities_challenges_and_considerations-v1.ashx

⁴ Murphy-Barron, C. (October 2020). Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare. Milliman Retrieved January 4, 2021 from <https://us.milliman.com/en/insight/comparing-the-demographics-of-enrollees-in-medicare-advantage-and-fee-for-service-medicare>

By providing the product with access to established administrative services, efficient claims processing, and perhaps elevated star ratings and associated additional revenue, the private health plan allows the provider-based MA product to get a head start towards profitability for both the provider organization and the private health plan. Typically, new MA plans do not generate a profit in the first few years,⁵ often due to the upfront costs involved with administering MA benefits, risk score coding lag for new MA members, and the lack of a competitive star rating, among other challenges.

Aligning common goals and incentives through the MA plan's shared profits lays the foundation for a successful long-term relationship between the provider organization and the private health plan. Once formed, leveraging the existing infrastructure from the MA arrangement may also facilitate expansion into other lines of business, such as commercial or Medicaid.

Alternatively, some provider-led entities willing to seek the full benefits and risks of the MA marketplace have launched their own provider-sponsored health plans (PSHPs). The popularity of this strategy has waned and waxed over the past decade but has found a recent resurgence due to the growing size of the Medicare population and success of leading PSHPs, including Kaiser, Meridian, and Geisinger.⁶ Over a quarter of executives in leading health systems that responded in a 2018 survey as anticipating to launch an MA plan in the next few years.⁷

Opportunities are compelling

There are numerous opportunities that the introduction of an MA-product offers to provider organizations including the ability to increase market share, improve care coordinate and management, and the opportunity to gain diversified revenue streams.

INCREASED MARKET SHARE

One major benefit to a provider organization participating in the MA market is the ability to steer patients toward services within owned or affiliated networks. Medicare Advantage provides an excellent vehicle for increasing market share through provider networks beyond FFS Medicare. The MA plan is able to attract new members by offering enhanced benefits (additional services covered and/or reduced cost sharing) when utilizing the network of the partnering health care system.

CARE COORDINATION AND MANAGEMENT

An MA plan provides the opportunity for better continuity in delivering patient care since the majority of a patient's medical services will be performed within the same MA plan's provider network. The same benefit enhancements that act to increase the provider organization's market share (discussed above) also incentivize existing patients to receive more of their care within the MA plan's network. Provider organizations typically do not have the expertise or infrastructure to effectively manage drug spending and should consider only taking risk for medical services (typical for provider organizations partnering with health plans on MAPD products).

The benefits of care coordination can be furthered by implementing a narrow-network product (while satisfying MA network adequacy requirements) where members are required to receive services within the MA plan's network. While a narrow network will likely increase the steerage to the provider organization's network and increase the effectiveness of care management activities, it may also decrease market appeal and hinder enrollment.

Additional touchpoints in the patient care experience enhance the ability of an MA plan to manage patient care and costs. The effectiveness of a care management program for the MA plan's enrollees can be improved through data sharing between the provider organization and the health plan as well as increased access to the healthcare delivery system for the health plan's care management resources.

REVENUE DIVERSIFICATION

Operating an MA plan can provide revenue diversification for a provider organization. During the COVID-19 pandemic, many states implemented rules that restricted elective services, which had a devastating impact on provider revenue. The revenue diversification from operating a MA plan can help reduce the provider's reliance on revenue from care delivery. An MA plan provides a safety net to a provider organization experiencing lower network utilization by creating a new revenue stream. The financial gains a private health plan may receive from lower healthcare spending would now be shared with the provider organization through the MA plan's profitability.

Increasing market share, care coordination, and care management are essential to the long-term success of a provider organization and leveraging an MA product can be an effective means in furthering each goal as well as facilitating potential expansion and diversification into other lines of business.

⁵ Killian, R. (March 2016). Medicare Advantage: Market entry variables to success. Milliman Retrieved January 4, 2021 from https://us.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2016/2200hdp_20160314.ashx

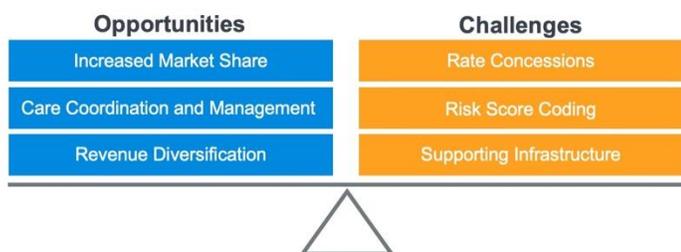
⁶ Lumeris (June 2018). Survey of Major Health Systems Reveals that 27 Percent Intend Launch of Medicare Advantage, Though Most Lack Confidence in Ability to Succeed. Retrieved on January 25, 2021, <https://www.lumeris.com/survey-of-major-health-systems-reveals-that-27-percent-intend-launch-of-medicare-advantage-though-most-lack-confidence-in-ability-to-succeed/>

⁷ Daly, R. (February 2019). Provider Interest in MA Plans Surges. Healthcare Financial Management Association. Retrieved December 16, 2020, from <https://www.hfma.org/topics/news/2019/02/provider-interest-in-ma-plans-surges.html>

Challenges must be managed

Provider organizations considering whether to enter the MA market have a tendency to focus on the potential opportunities without fully considering the significant challenges associated with participation.

FIGURE 1: OPPORTUNITIES AND CHALLENGES



RATE CONCESSIONS

Some provider organizations view an MA plan as an opportunity to increase their reimbursement. To the contrary, these arrangements sometimes require the provider to offer rate concessions from FFS rates (e.g., discounts) to make the plan profitable. The extent to which the provider organization's lost revenue through rate concessions is replaced by plan revenue and profits (often shared between the provider organization and the health plan) is an important consideration and risk factor.

RISK SCORE CODING

A key opportunity for provider organizations to succeed in the MA market without sacrificing revenue is improved medical risk coding. MA plans receive capitated payments from the Centers for Medicare and Medicaid Services (CMS), which scale up or down based on the risk score of the enrolled members. Risk scores are calculated based on the number and type of medical diagnoses coded for each plan member.

Traditionally, CMS has not provided financial incentives to providers for maintaining up-to-date medical diagnoses across all points of service for their patients. On the other hand, an MA partnership directly incentivizes (through increased revenue from CMS) the provider organization to maintain comprehensive diagnosis capture within their Medicare population. Additionally, risk-based contracts have become more common across commercial and Medicaid markets, so improvements in the provider organization's risk capturing activities will likely yield benefits beyond the MA line of business.

While coding diagnoses more aggressively is an avenue for a provider organization to increase their chances for success in MA, failing to do so will almost certainly lead to losses for the product. Further exacerbating financial stress for newer

MA plans is the lag between medical coding efforts and their impact on plan payments. Medical coding activity taken in a given year will not affect the plan's revenue until the following year, delaying the realization of any risk score gains. Supporting Infrastructure

Health systems/provider organizations have traditionally operated in a mostly FFS environment. Medicare Advantage plans drive profitability through effectively managing utilization and reimbursement down, aimed to lower overall costs within the healthcare system. Striking the appropriate balance of achieving health care savings necessary for a profitable MA plan while adequately funding the health system can be far more difficult than it appears on the surface.

MA plans need sufficient enough enrollment to generate economies of scale necessary to offer competitively priced plans. Opportunity generated by the growing Medicare-eligible population has brought with it a plethora of new MA plan offerings, all hoping to share in the market's overall success. The dynamics of building sufficient market size while facing increased competition burden a new MA plan's chances for early profitability.

State regulators generally require health plans to hold a minimum level of Risk Based Capital (RBC) to protect members against potential insolvency of the plan. Provider organizations accepting risk from a health plan should consider holding some level of financial buffer to support risks arising from the MA plan.

SUPPORTING INFRASTRUCTURE

In addition to solvency considerations, starting an MA plan requires a significant investment in technology, business processes, and talent. Expertise in healthcare analytics is paramount to appropriately identifying and managing risks, such as high cost utilizers and inefficient uses of care. Many health systems have neglected the potential value-add of healthcare analytics in the past. While a formal relationship between a provider organization and an existing MA plan may allow for the health system to leverage the plan's existing capabilities, structuring an arrangement that equitably aligns interests between payers and providers is a significant challenge. Each partner, the provider organization and the Medicare Advantage organizations, should have its own independent advisors (to align with their distinct goals for the product), and for a PSHP, the provider organizations may need assistance developing completely new functions.

Conclusion

Health systems have options when deciding how to participate in the MA market. Partnerships allow for risk sharing and the ability to leverage the expertise of existing health plans. Launching a stand-alone PSHP offers greater potential benefits such as not having to share the profits with another entity but requires a considerably larger investment and greater downside risk.

Even the decision to not participate in the MA marketplace may create challenges for provider organizations. If a competing health system launches its own MA plan, it may be able to steer patients toward its own plan and away from other health systems.



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