Medicare Advantage – Planning Considerations

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Medicare Advantage Planning Considerations

I. Highlights of MA Landscape Webinar - Glenn Tolchin
II. Value-Based MA Plan Considerations - Jordan Holland
III. Orienting Your Organization - Beau Sorensen
IV. Regional MA Plan Relationships - David Holmes

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MA Landscape: Highlights

- Three broad learnings:
  1. Prepare for Medicare Advantage enrollment growth in your market.
  2. Understand the health plan's perspective in provider contracting.
  3. Home health is valued by health plans.

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MA Landscape: Enrollment Growth

- Medicare Eligible Trends – Significant Growth
  - Medicare Eligibles are a growing demographic, currently 6% annual growth.
  - Nationally in 2022 almost half, 48%, were enrolled in MA plans.
  - Regional MA growth has varied, but >50% states have 50-60% MA enrollment.

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MA Landscape: Plan Growth

- Medicare Advantage Plans – Market Penetration
  - Doubled to 4,000 nationally, with about 40 or more available in half the country.
  - Can be national or local, but national plans control over 80% all MA enrollees.
  - Likely with be D-SNP (focused on Medicare & Medicaid Eligibles), C-SNP (focused on those with Chronic illnesses) Special Needs Plans.

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MA Landscape: Plan Perspective

- MA plans seek to balance quality, outcomes and cost.
- Offer benefit package beyond traditional Medicare.
- Laser focus on Stars ratings, which drive premium dollars and enables broader benefits.

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MA Landscape: Value-based Focus

- MA plans see value-based care/contracting as a driver of outcomes, quality and cost efficiency.
- Pairs the value-based payment model with the population health management model.
- Requires provider readiness to assume risk, care manage based on risk stratification.

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MA Landscape: Provider Relationship

- MA plans seek providers who place the member/patient as central focus, not a transactional relationship.
- Engage with providers who offer solutions to pain points.
- Value providers who achieve favorable care management outcomes, deliver quality care, serve specialized populations, with regional coverage.

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MA Landscape: Opportunities

- Home Health is well positioned as a vehicle for cost reduction, quality care and outcomes.
- Attractive especially to D-SNPs or C-SNPs, serving high need, complex dually eligible or chronically ill members.

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MA Planning Considerations

Where to focus our planning efforts?

1) Value proposition, align with Health Plan pain-points.
2) Care management, data-driven risk management.
3) Payer relationship management, ongoing engagement.
4) Payer-level costing, drive rate negotiations.
5) Referral – Collection meet payer requirements.

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Value-Based MA Plan Considerations

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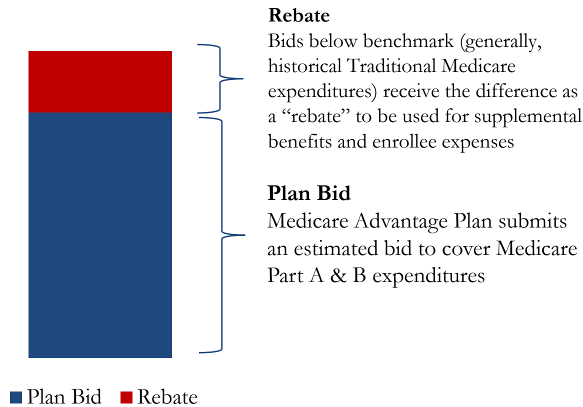
MA Perspective: Staying competitive in the MA marketplace

Medicare Advantage Bid



Rebate
Bids below benchmark (generally, historical Traditional Medicare expenditures) receive the difference as a "rebate" to be used for supplemental benefits and enrollee expenses

Plan Bid
Medicare Advantage Plan submits an estimated bid to cover Medicare Part A & B expenditures

If the benchmark is 100% of Medicare, how do Medicare Advantage Plans sustain Bids below Medicare reimbursement while providing supplemental benefits?

- Manage unit cost
- Manage utilization
- Reduce Total Cost of Care through value-based care, innovation, and supplemental benefits

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Cost Management Strategy Implications

	Manage Unit Cost	Manage Utilization	Reduce Total Cost of Care through Value-Based Initiatives
MA Plan Impact	• Reduce total cost	• Reduce cost within spend category • Reduce total cost if utilization reductions unnecessary/avoidable	• Reduce total cost if initiatives drive anticipated total cost reductions
Provider Impact	• Lower funding to deliver services	• Increased cost to delivery services (admin costs)	• Increased accountability for outcome performance • Payment risk (+/-) associated with performance

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MA Perspective: Spend by category

Category (% of Total Spend[1])

- Other (e.g., DME) (5%)
- Home Health (5%)
- Skilled Nursing Facilities (7%)
- Professional Services (33%)
- IP & OP Services (50%)

- There are ~6,000 hospitals in the US accounting for 50% of total medical spend[2]
- There are ~33,000 home health agencies accounting for 5% of total medical spend[3]
- High provider counts across low relative spending the potential for oversized administrative burden for MA plans

1) *Estimates based on Performance Year Financial and Quality Results Public Use Data (2020)*
2) *AHA Fast Facts 2022*
3) *NAHC Industry Overview*

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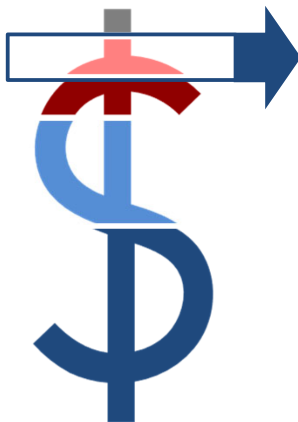
Expansion of delegated Home Health models



MA Plan delegates Home Health premium to Managed Services Organization/Convener

Typical Responsibilities
- Provider contracting
- Credentialing and network management
- Utilization management and authorizations
- Referral management
- Claims adjudication and payment

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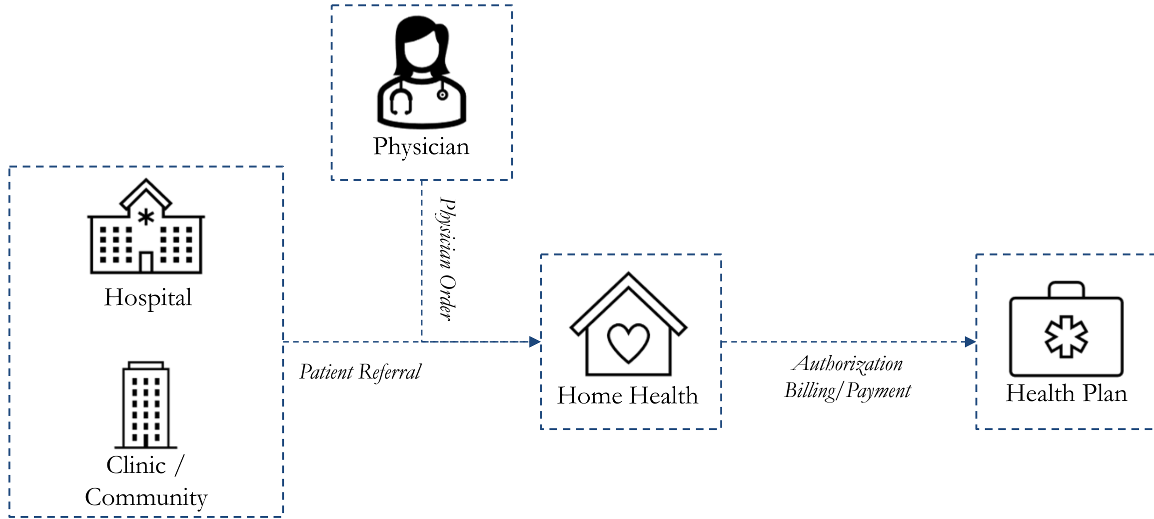

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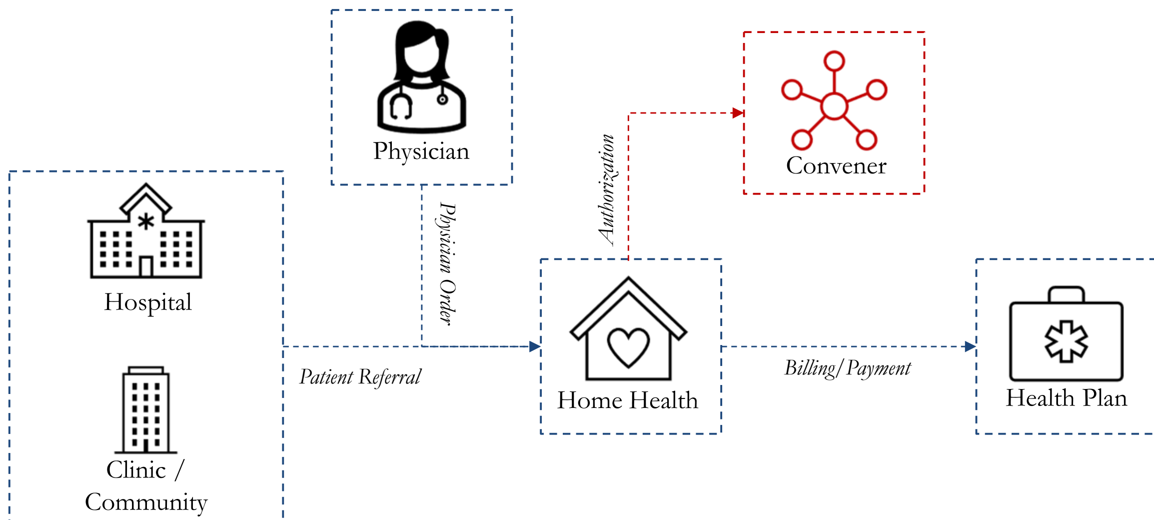

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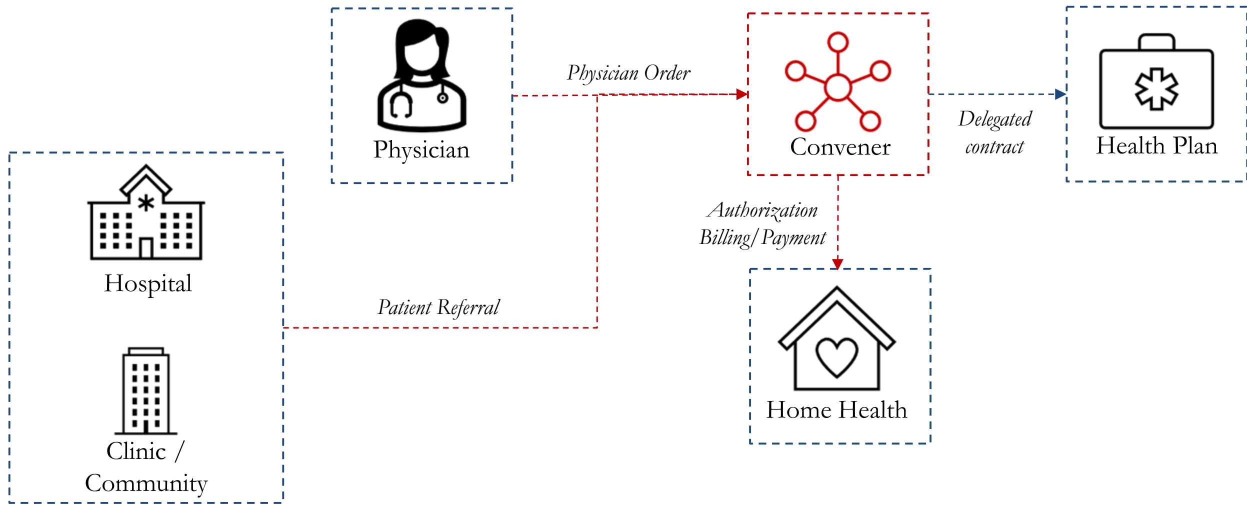
Referral management scenario implications

Scenario 3: MA Plan fully delegates home health services



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Convener organizations vary in value contribution

Responsibility	Low Value Contribution	High Value Contribution
Provider Contracting	• Depress rates creating short-term gains with long-term access issues in labor-constrained environment	• Appropriately value provider contribution and cost • Drive outcomes and total cost of care reductions through value-based models
Network Management and Credentialing	• "Shotgun" approach to market attracting low-quality providers	• Attract and maintain high quality providers to improve clinical quality
Utilization Management and Authorizations	• Restrictive U/M processes focused on reducing utilization that creates short-term cost reductions at the risk of long-term quality issues	• Collaborative approach with co-developed standards of care to improve quality and reduce administrative burden
Referral Management	• "Jump ball" approach with challenging system integration	• Increased collaboration between referrer and home-care provider
Claims Adjudication and Payment	• High denial rate with significant administrative costs for provider and convener	• Clinical standards collaboration to improve clinical quality • Reduction in administrative burdens across all parties

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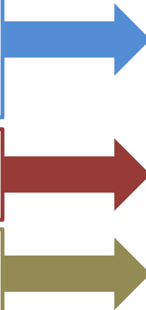
Value proposition considerations

Goal: Shift from unit cost/utilization discussions → total cost of care discussions
Shift from "low value contribution" → "high value contribution"



Potential Value Proposition Metrics	Messaging to MA Plan/Convener
• Star ratings • Rehospitalization rates • Differentiation in clinical quality • Innovation programs	We can help keep patients out of the hospital
• Referral response times • Patient satisfaction	Referral sources and patients want to work with us
• Clinical capacity • Geographic coverage	We can guarantee to serve your population

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How are you currently oriented?

- What insurances do you currently accept?
- What insurances do you have experience with in the past?
- What insurances do you **want** to accept?

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Step 1: Research the Landscape

- What plans are the most popular in your area?
- What plans have the most providers in your area?
- What plans have the fewest providers in your area?

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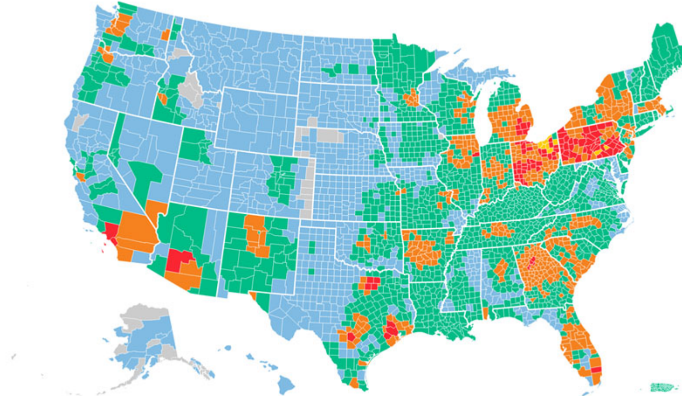

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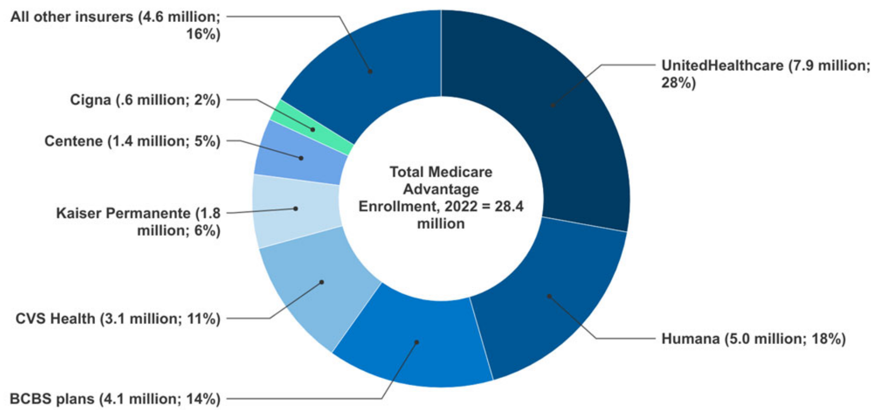

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Step 1: Research the Landscape

- What plans have gaps – you may not be approved for all plans.
- Do they sublease their network to other payors?
- Does the MA contract come with a commercial insurance contract?

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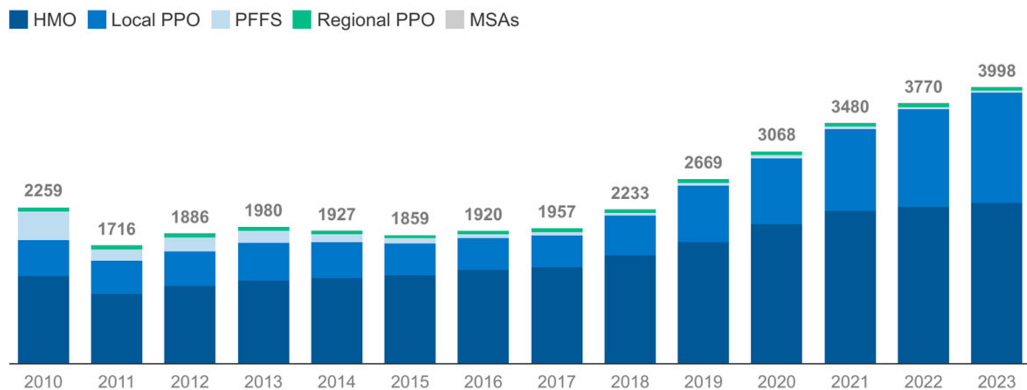
Figure 2

More Medicare Advantage plans are available in 2023 than in any other year going back to 2010

Number of Medicare Advantage plans generally available by plan type, 2010-2023



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans and MMPs. Numbers may differ from previous publications in cases where the Landscape File for the year was updated after initial publication.
SOURCE: KFF analysis of CMS Landscape files for 2010-2023.

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Step 1: Research the Landscape

- https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County
- This is a great resource to see growth in your area by plan

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Step 2: Research the Plans

- What are the authorization requirements for these plans?
- What is the authorization process?
- Do authorizations and/or the authorization process change depending on the plan?

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Step 2: Research the Plans

- What are their medical record review practices?
- What kind of collaboration do they want from you?
- What are their timely filing deadlines?

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Step 3: Research the Payment Structure

- How do they pay?
  - Per visit
  - Per hour
  - Per 15 minutes
  - Per period
  - Per episode
  - Other payment considerations – visit caps may apply

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Step 4: Research their Billing and Payment Practices

- What will the claims you submit look like?
  - CMS-1500 or UB-04?
  - Visits per code
  - Do they pay differently for LPN/RN, PT/PTA, OT/COTA?
  - Max services per day or different codes for second visits

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Step 5: Planning Your New Processes

- What differences will there be between your current processes and your new processes?
- What new job responsibilities will be needed?
- What staff will be needed?
- Where does it make the most sense to put these new responsibilities?

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Step 6: Changing Your Orientation

- Every aspect of your intake/care/billing/ collections process needs to be oriented around individual payer requirements.
- Communicating changes when they occur. Who is responsible, how does it happen?

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The thing that keeps a business ahead of the competition is excellence in execution.
-Tom Peters

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Step 7: Communication and Administrative Execution

- Staying on top of network verification processes
- Maintaining relationship with network manager – they can be your best friend with a payor.
- Are you over-promising and under-delivering?

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Step 8: Process Execution

- Dealing with payor sprawl in your EMR
- Ringing the alarm bells when needed

"Once you're clear on what your bottom line is, you have to be willing to walk away." – Chris Voss

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Step 9: Payment Execution

- Are you being paid for the work that you do?
  - If not, where is the breakdown?
    - Contracting
    - Billing
    - Authorizations
    - Payor-side

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Know your costs per payor

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Know your costs per ~~payor~~ plan

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Factors to take into consideration

- Standard per-visit costs
- Standard overhead
- Lost reimbursement from missing/late authorizations

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Your costs will be a mix of fixed and variable

- Per-visit costs, supplies, etc. are variable
- Your overhead per plan changes depending on authorization, collection, and denials and doesn't track on a per-visit basis.

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Cost Factors to take into consideration

- Lost reimbursement from denials
- Patient copays/coinsurances/deductibles
- Added collection costs
- Card processing fees
- Authorization collection costs

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Cost Factors to take into consideration

- Insurance verification costs
- New system costs
- Additional administrative overhead

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Develop and explain your care management capabilities

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Payors are moving from "dumb care" to "smart care"

- They don't want to just be giving you money to do what you want
- UnitedHealthCare (especially via their Optum unit) is at the forefront of this
- You need to show your value to the payor

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Why should they work with you?

- What is it that you do that is unique? Everyone out there "gives great care" and "keeps people out of the hospital."
- Have metrics available to back up your claims

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Your Metrics

- First and foremost – your hospitalization percentage at Medicare Compare
  - This is the highest cost item for health plans
- HHCAHPS
- Medicare Compare

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Your Internal Metrics

- 30-day rehospitalizations
- Satisfaction surveys
- Length of stay
- Visits per period
- Any data that supplements Medicare Compare (i.e. for non-covered payors)

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Regional MA Plan Relationships

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Medicare Advantage Regional Plan

1. Engaging in Payer Relationship Management
   - What Level do you need to engage with the Payor?
     1. Chief Executive Officer
     2. Senior Management
     3. Regional Network Development Team

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MA Regional Plans Negotiations

- Regional Medicare Advantage Plans have to meet Time and Distance requirements for Home Health Agencies. To meet Network Adequacy
  - Use this to your advantage when negotiating.
  - Find Out as Much as you can about the plan

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MA Regional Plan Negotiations

- Ask Probing Questions to the Health Plan
  - Health Plans want Contracts negotiated by June of Each Year. Start these conversations so start early in the Year.
  - Ask the Health Plan What There Targeted Membership Goal.
  - Geographic Coverage Area
  - If these goals overlap then you can proceed to the further negotiations.

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MA Regional Plans

- Who are the Health Plan's Partners?
  - Determine what the Plan is Marketing through
    - Physicians
    - Pharmacies
    - Health Systems
    - Outside Insurance Agents

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MA Regional Negotiating Best Practices

- Know your Audience
- Be Prepared to Define the Value Proposition.
    - Value to Medicare Advantage equals Data
- Don't be afraid to put the Cards on the Table
- Advocate for your Agency when all else fails be prepared to Walk Away.

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MA Regional Plans

- Determine the answer to these questions will help you negotiate a fair rate for the services that you provide.
- If at the end of the day the two parties are unable to reach an agreement don't be afraid to Walk Away.

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Questions

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Upcoming Events

2023 Financial Management Conference (FMC)
July 16-18, 2023 | New Orleans, LA

2023 NAHC Home Care and Hospice Conference & Expo
October 15-17, 2023 | National Harbor, Maryland

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