Point of View:
Medicare Profitability in a Reform Market

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Introduction

Overall, Medicare accounts for approximately 20% of the total domestic healthcare spending, but is often 50% or more of a hospital’s total reimbursement. The average annual total Medicare budget will grow by 6% annually between 2013 to 2020 according to the most recent National Health Expenditure Projections. This annual increase reflects increasing costs per member and the increased enrollment expected due to baby boomers – approximately 12 million new enrollees will become eligible for coverage during this time. Medicare will continue to increase in importance as a payer for hospitals and physicians.

While Medicare grows in importance, commercial revenues will be growing more slowly, or shrinking, as small group and individually insured patients move into Health Insurance Exchanges, with lower reimbursement rates, and as employers put pressure on payers to drive down large group insurance costs. Hospitals ability to cover Medicare losses with commercial profits is diminishing, forcing a rethinking of Medicare as a business segment, with new focus on profitability.

Shifting Landscape

As illustrated in Figure 1, below, Medicare is an increasingly complex market segment, with ongoing margin pressure...

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1 National Health Insurance Projections 2011-2021, Centers for Medicare & Medicaid Services
changes to the traditional fee-for-service business model, widespread participation in the Medicare Shared Savings Program (ACO) pilot, bundled pricing initiatives, and rapid growth in private Medicare Advantage and Dual Eligible plans.

In traditional Medicare, a host of CMS initiatives, with both carrots and sticks, are aimed at reducing the rate of growth in medical costs, with particular focus on the hospital. The Hospital Value-Based Purchasing Program, makes incentive payments to hospitals based on their performance against certain quality metrics and punishes hospitals for utilization attributed to hospital acquired infections. The Hospital Readmissions Reduction Program forces hospitals to absorb the costs of excessive readmissions. The net effect, for most hospitals, will be reduced, or more slowly growing, revenue per Medicare admission.

The Medicare Shared Savings Programs (ACO and “Pioneer” ACO) and the state Medicare-Medicaid Dual Eligible pilots will likely have an increasing impact on the marketplace and favor organizations with care and risk management capabilities: approximately 4 million beneficiaries will be covered in these demonstration programs in 2014, but the impact will be broader, with a positive spillover of clinical efficiencies to other insured populations. The Bundled Payment for Care Initiatives Program announced January 31, 2013, will involve some 450 different hospitals across the nation in a 3 year program who will set payments for 48 different episodes of care.

Medicare Advantage is rapidly increasing in importance as a sub segment of the Medicare market. Enrollment in Medicare Advantage is up 30% since 2010 and 10% between 2012 and 2013. In 2013, enrollment will be over 14 million beneficiaries, which is 28 percent of the Medicare population, up from 24% just 4 years ago. In some markets, Medicare Advantage penetration is reaching 45-50%.

**Medicare Strategic Options**

Improving Medicare profitability requires a strategy that balances operational improvements to optimize reimbursement under the traditional fee-for-service program, moving to risk to capture the value inherent in more effective medical management, and expanding market share to achieve economies of scale.

Four strategies have emerged as key plays for leading health systems:

- **Option #1: Reduce Costs and Move towards Break Even on Medicare FFS.** Traditional fee-for-service reimbursement is not going away, but is definitely in the cross-hairs of policy makers. Most
providers will continue to be paid FFS/DRG rates for major portions of their business. Succeeding in this pressurized reimbursement 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 and effective care management capabilities will be required to achieve these efficiencies, with hospitals and physicians aligned to manage care and eventually share risk.

- **Option #2: Participate in the Medicare ACO / Shared Savings Program.** Provider organizations and health systems participating in Medicare ACOs have the prospect of earning a portion of the savings they generate in addition to their normal Medicare and FFS reimbursement. The Shared Savings model is potentially superior to Medicare FFS as it provides an opportunity to gain valuable population management skills, with some upside revenue opportunity to offset revenue declines resulting from reduced utilization. ACOs are a good option for large medical groups who are accustomed to risk arrangements and who have a strong primary care base. Approximately 250 organizations have now been approved for the Medicare Shared Savings program serving an estimated 4 million Medicare beneficiaries. However, there are risks to participating in the program since a significant infrastructure investment is required; there is a 2-3.0% threshold to share any savings and a short half-life for shared savings opportunities, since the bar is likely to be continually reset in terms of performance. (Any savings between 0 and 2%, of course, is kept by CMS.)

In addition, scale is important, and at least 5,000 enrollees may be needed to meet Minimum Saving Rate thresholds. In addition, ACOs require significant clinical informatics and care management infrastructure. Moreover, the Shared Savings program provides little or no control of the major managed care levers such as product design, member incentives, pre-authorization, or utilization control. For physician groups and health systems with effective care management capabilities, however, ACO shared savings participation is clearly preferable to riding the deteriorating traditional fee-for-service model with sub-inflation rate reimbursement increases.

- **Option #3: Develop a Plan for Bundled Payments.** Under the
Bundled Payment Care Initiative Program announced in January, 450 different provider organizations have entered into payment arrangements that will include financial and performance accountability for 48 different episodes of care. The BPCI program is comprised of (i) one model covering retrospective bundled payment for Acute Care Hospital Stay only; (ii) one model combining retrospective payment for Acute Care Hospital Stay and Post-Acute Care; (iii) a model providing retrospective payment for Post-Acute Care only; and (iv) a model providing prospective bundled payment for Acute Care Hospital Stay only. This is an ongoing program, however, and CMS has largely closed out the application process given the strong response.

- **Option #4: Start to Accept Risk for Medicare Advantage.** Developing a strategy to accept risk for Medicare Advantage may be the most attractive option for improving Medicare profitability. A wide range of risk options are available, ranging from fee-for-service contracts with performance incentives, to ownership of Medicare Advantage plans, as illustrated in Figure #2, below.

**FIGURE #2 - MEDICARE ADVANTAGE RISK CONSIDERATION CONTINUUM**

Selecting an option should be influenced by capabilities and risk appetite, but rewards increase substantially as providers move upstream.
Focus on Medicare Advantage - Debunking Myths:
Despite the fact that MA accounts for almost 30% of the Medicare market, it has been, until recently, under the radar for most healthcare systems. Most hospitals contract with Medicare Advantage plans on a straight fee-for-service basis at rates that largely mirror those of traditional Medicare. We believe participation on a risk-basis in Medicare Advantage has been viewed unfavorably by many health system leaders as a result of three myths:

Myth #1: Medicare Advantage is Unstable & Going Away
Fact: PPACA killed a sub segment of the Medicare Advantage program, Private Fee-for-Service Plans, that has long been a target of policy makers. The heart of the Medicare Advantage program, HMO, PPO, and Special Needs Plans, has strong support among many policy makers and, as discussed above, a rapidly growing consumer constituency. Earlier this year, there was a great deal of attention and focus on the 2014 Medicare Advantage rates, with the legitimate concern that CMS actuarial calculations for the national annual per capita growth rate for Medicare would result in a (22%) reduction in Medicare Advantage rates, which would seriously destabilize the program. These proposed rates generated a massive industry lobbying effort and, coupled with Congressional concern, resulted in CMS correcting what is informally known as the “the Doc Fix,” the SGR issue that had been lingering since the 1997 BBA, which averted the severe year-over-year reduction, but did not specifically address the annual per capita growth rate issue. Most important, however, is the fact that both industry associations and Congress were able to affect a positive reimbursement change that will support the ongoing viability of the Medicare Advantage program.

FIGURE #3 – MEDICARE ADVANTAGE PLAN PROFITABILITY

<table>
<thead>
<tr>
<th>Medicare Advantage Plan Profitability by Year</th>
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<tr>
<td>Year</td>
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<td>2008</td>
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<td>2009</td>
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Source: Mark Farrah Associates; NAIC Data-File Operation by Lines of Business Information; BDC Advisors Analysis
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. Figure #3 shows the total number of Medicare Advantage plans that were profitable by a membership breakdown at above and below 5,000 members for 2008 through 2010, for which data is available. In 2010, just under 75% of plans over 5,000 lives were profitable.

Myth #3: Participation in a Medicare Advantage Plan is Highly Risky
Fact: Retrospective risk adjustment makes Medicare Advantage plans much less risky than a typical commercial plan. Medicare Advantage plans conduct health risk assessments on members and submit risk scores to CMS. Premium levels are adjusted based on health risk, so plans have little underwriting risk related to adverse selection.

Key Success Factors
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-Sponsored Medicare Advantage Plans Outperform Traditional Plans
Provider owned plans have traditionally out-performed national and regional plans in key areas of success including revenue management and STAR ratings; currently, all of the 4 or 5

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2 Examples of 4 or 5 STAR plans: Kaiser, UPMS For Life, Giesinger 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.
STAR MA plans nationally are provider owned. Provider-Sponsored MA plans have been able to better manage total cost of care, and their Medical Loss Ratios normally run below commercial, open access Medicare Advantage Health Plans. Finally, health plan members are first and foremost patients whose most important relationship with the healthcare system is their physician. Provider-Sponsored health plans have an opportunity to leverage the unique relationship between network physicians and patients/members.

Evaluating the Medicare Advantage Opportunity
CMS contracts with Medicare Advantage plans on a county-specific basis, and premiums vary widely by county based on a complex set of factors. The first step in the analysis of a Medicare Advantage opportunity is a basic financial feasibility assessment for the counties of interest, testing a set of underlying market conditions, including these factors:

- Medicare Market Size
- Projected Medicare Population Growth
- Medicare Advantage Enrollment and Penetration Rates

ANALYSIS APPROACH

Market Size
Market Growth
Product Mix
Market Share
Group vs Individual
MA Attractiveness
County Pro Formas
Partnership RFI
Impact ACA
Network Strength
Competitive Reaction

Medicare Advantage Plan

Analysis-Potential Opportunities to Move Along Value-Based Corridor

Value-Based Contracting
The output from the feasibility assessment will show how financially attractive Medicare Advantage is in targeted markets.

The next step is a more detailed pro forma development process, taking into account product design and an actuarially based analysis of revenues and costs. The result is a three to five year pro forma that, coupled with a detailed market analysis and internal capabilities assessment, can inform a decision to enter a risk arrangement with an existing plan, or start a new provider-sponsored plan. This process will include an assessment of partnerships with an existing health plan, either informally, or through a formal Request for Information (RFI) or Request for Proposal (RFP) process. The process concludes with a definition of market entry options and evaluation of start-up costs.

**Conclusion**

Medicare Advantage can be a key strategy for achieving Medicare profitability in the new world of Health Care Reform and the growth likely to come from the Baby Boomers. Deciding how best to consider taking on risk is the key strategic decision for all provider organizations and health systems. Starting with a basic financial feasibility assessment is the first step in the process and can help guide organizations toward defining how best to leverage the population management skills and value-based contracting efforts that are going to be required for long-term financial success.

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