M. Orry Jacobs

Should MA Plans Try to Attract the Sick?
should MA plans try to attract the sick?

The Medicare Advantage (MA) program offers the potential for substantial savings for health systems that are able to attract sicker patients.

Improved care coordination, new risk-adjustment methodologies, and predictive modeling create new opportunities for provider-sponsored MA plans or health systems partnering with MA plans to earn substantial savings from the treatment of sicker patients, while improving the quality of care and of life for those patients. These developments make it advantageous for these organizations to target sicker populations for enrollment in their MA plans.

The increasing attractiveness of MA plans has prompted a growing number of health systems to pursue MA licenses or to partner with established plans on private-label MA products. Provider-sponsored plans traditionally have done well in the MA space. The majority of the best-performing plans earning five-star ratings are sponsored by provider organizations, and year-end case mix adjustment for MA payments shelter plans from the impact of unexpected acuity spikes among the beneficiaries they serve.

Historically, MA health plans, like all managed care organizations, have been careful to attract a population of enrollees composed of a high percentage of healthy people. Product design to ensure balance between competitive attractiveness and adverse risk selection is seen as a core business competency for all plans. But under some circumstances, it makes sense for an accountable care organization (ACO) to assume significant risk by enrolling individuals who are sick, including those who have multiple chronic conditions or even mental illness. Organizations like Indiana University’s GRACE Team Care (see sidebar on page 3) have found that they can improve outcomes and lower costs for this population.

---

a. Bonuses tied to Medicare’s Star system—up to five of the total revenues—are used to reward plans for high performance and weed out poor performers. A plan that earns less than a three-star rating for three consecutive years may be terminated from the program. MA plans are rated on their performance in terms of keeping patients healthy and managing chronic long-term conditions, and on plan responsiveness and care, member complaints and turnover, and customer service.
The MA program is one of the nation’s most popular government healthcare programs, with roughly 30 percent of all Medicare beneficiaries enrolled in an MA plan. An additional 12 million beneficiaries will become eligible for Medicare by 2020, with total Medicare expenditures estimated to rise from $597 billion in 2014 to $849 billion in 2020.\(^b\) MA enrollment is expected to grow along with the participation of provider-sponsored health plans. Since 2008, there have been 30 new provider-sponsored health plans—a 30 percent expansion of existing plans and a 70 percent increase in new market entrants.\(^c\) These trends likely will continue to grow given that the Centers for Medicare & Medicaid Services (CMS) aims to have 75 percent of Medicare enrollees in value-based contracts by 2020. There may be significant untapped opportunities for plans that are able to align their care models to focus on beneficiaries with multiple chronic conditions or disease diagnoses.

**New Business Skills and Technology Create Market Opportunity**

A great deal has changed since the wave of provider organizations assumed capitated risk in the early 1990s. Data systems and the related analytics have improved significantly; knowledge of how to manage the health of populations has increased; and risk-adjustment payment methodologies have been adopted by Medicare and some commercial insurers. Retrospective risk adjustment has certainly reduced the risk of enrolling those with multiple chronic conditions. Taken together, the changes create a situation where, under the right conditions, MA plans can potentially benefit from a strategic focus on attracting enrollees from high-risk and high-cost population—i.e., individuals who can most benefit from effective care coordination programs. As Medicare Advantage participants know, high-risk patients such as diabetics who have their disease under control may be lower-cost patients even though they have high ICD-10 scores. An untreated diabetic is high-risk and likely to be high-cost. A similar differentiation could be for patients with osteoarthritis who might be kept comfortably ambulatory for several years with the proper diet and preventive exercise and physical therapy—or if untreated would be likely to become expensive total joint replacement candidates more immediately.

**Sizing the Opportunity**

In its June 2014 report on healthcare spending and the Medicare program, the Medicare Payment Advisory Commission (MedPAC) finds that 5 percent of Medicare beneficiaries accounted for 39 percent of total Medicare fee-for-service expenditures in 2010, and it can be expected that spending for this population has remained similarly high.\(^d\) This high-cost population tends to have multiple chronic conditions and to be

---

\(^b\) Congressional Budget Office, Updated Budget Projections, Fiscal Years 2013-2023.
\(^c\) CMS.gov enrollment data, 2013.

---

**Case Example: GRACE Team Care**

The Indiana University School of Medicine’s Center for Aging Research developed the GRACE Team Care approach more than 10 years ago. It is offered to providers and is being utilized in several communities across the United States.

In this model, enrollees are assigned a team consisting of a nurse practitioner and social worker, who work closely with the patient, caregiver, and the enrollee’s primary care physician. The team performs an in-home assessment, develops an individualized care plan with input from a larger interdisciplinary team (geriatrician, pharmacist, mental health professional, and community resource expert), implements the care plan in coordination with the primary care physician, and provides ongoing care coordination, including during care transitions.

An evaluation performed by Avalere Health LLC found that the GRACE Team Care approach reduced the cost of care by $4,291 per enrollee per year, while costing $2,201 per enrollee to operate, for a net savings of $2,090 per enrollee per year. It should be noted that this evaluation was conducted on enrollees constituting the top 20 percent in cost, not the 5 percent representing the highest-cost group, as referenced in this article.

**Sources:** GRACE Team Care website, www.graceteamcare.indiana.edu/home.html; and Rodríguez, S., Munear, D., Delaney, C., Yang, L., and Tuminson, A., “Effective Management of High-Risk Medicare Populations,” Avalere Health LLC, September 2014.
FEATURE STORY

HYPOTHETICAL CASE ANALYSIS:
MEDICARE ADVANTAGE PLAN NET OPERATING INCOME ($ IN MILLIONS)

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Cost Enrollees</td>
<td>$0.87</td>
<td>$14.79</td>
<td>$26.36</td>
</tr>
<tr>
<td>Other Enrollees</td>
<td>$1.36</td>
<td>$5.45</td>
<td>$2.74</td>
</tr>
<tr>
<td>Total</td>
<td>$2.23</td>
<td>$20.24</td>
<td>$29.1</td>
</tr>
<tr>
<td>Net Income as a Percentage of Revenue</td>
<td>2%</td>
<td>9%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Doing the Math
Let’s say that a provider has 10,000 enrollees in an MA health plan. Let’s also assume that the plan revenue per enrollee matches the average Medicare expenditure per enrollee identified by MedPAC for 2010—that is, $11,157. Let’s also assume, based on MedPAC’s 2010 findings, the average expenditure for the high-cost enrollee is $87,024 and the average expenditure for the balance of enrollees is $7,164. Thus, the total annual revenue for these 10,000 enrollees would be $111,570,000 per year. Suppose one wanted to double the MA revenue. One option would be to target getting another 10,000 enrollees, assuming a split of 500 high-cost enrollees and 9,500 other enrollees.

A second option for doubling the revenue would be to work to attract high-risk patients (high-risk will be used rather than high-cost, because one would need to make a prospective determination). As shown in the exhibit above left, one would need to enroll an additional 1,282 high-risk enrollees, for a total MA patient population of 11,282.

Given the potential to improve care for the high-risk population and reduce the associated costs, there also is an opportunity to improve profitability for the MA plan. Assume the following for purposes of discussion:
> The current operating margin is 2 percent.
> The plan develops an aggressive, effective care management program in concert with the providers in its panel (the challenge of accomplishing this step should not be underestimated).
> The care management program can reduce costs of the high-cost enrollees by 20 percent, with a net of 15 percent after deducting the cost of the program.
> The care management program can reduce the cost of care for the balance of the enrollees by a net of 2 percent.

Using the same two options as shown above, the results are shown in the exhibit on page 5.

The first observation is the significant increase in net income that is derived from better
treated by multiple providers, frequently with care that is not coordinated. Studies have shown that a well-developed care management program can improve the quality of life and reduce the cost of care for this population by up to 20 percent.e

So-called “dual eligibles”—beneficiaries who receive full benefits under both Medicare and Medicaid—account for about $320 billion in healthcare costs annually and are another potential target market. It has been estimated that up to $20 billion could be saved annually while improving quality of care and outcomes.f Such evidence suggests there is strong potential to improve care and save significant dollars by focusing on these populations.


Elements of Enhanced Care Management

> Care managers who will see patients at home
> Advanced practice nurses who can make some clinical decisions and prescribe medications
> Pharmacists who can reconcile medications and provide medication advice
> Social workers who can deal with socioeconomic issues and refer to appropriate agencies/organizations
> Access to mental and behavioral health expertise to deal with issues such as depression and substance abuse
> Enhanced communication and access to information among the care management team and with the enrollees
coordinating and improving the care of the high-cost population. Even without focusing on marketing to the high-cost population, net income increases over four-fold. The second observation is that when focusing on attracting the high-cost population, net income increases more than six-fold.

**Critical Success Factors**
This analysis depends on a number of assumptions, described below.

*An excellent risk-adjustment model exists that accurately reflects the increased cost of the high-cost population in calculating the revenue the plan receives.* Medicare’s risk-adjustment model, developed by actuaries, has been in operation for several years and is constantly being refined. The author is unaware of any definitive outside evaluation of the effectiveness of the current Medicare risk-adjustment methodology for the high-cost population, but it has been accepted by most MA plans.

*The documentation and coding for the population of enrollees (which drives the risk-adjustment methodology) by the participating providers are accurate and complete.* Full and accurate documentation of patient conditions has a direct impact on the additional retroactive risk-adjustment payments MA plans receive after the year-end books close if the patients treated by the organization are sicker than the average for the Medicare population as a whole. The risk-adjustment payments are a permanent part of the ACA, and can be coupled with the 5 percent bonus MA plans can earn by achieving a five-star rating.

The care management/coordination program for the high-cost population is highly effective. Two assumptions here are that the program is focused on management of chronic disease in the frail elderly and coordination of post-acute care, and that it can generate the care improvement and cost reduction described above. Gaining the effective participation of primary care physicians in this effort is essential (and can be difficult).

*The plan exhibits excellent regulatory compliance, with a focus on management of all aspects of the value chain based on CMS rules.* The plan must be able to capture a four- or five-star rating to have a competitive product in the market.

*It is possible to identify the high-cost population in advance, so that it can be targeted for care management intervention.* This is challenging, because a high-cost enrollee in one year may not necessarily be a high-cost enrollee in subsequent years, or vice-versa. A recent study by Avalere Health LLC found that taking into account nonmedical factors, such as activities of daily living, through health-risk assessments and other techniques can improve a plan’s ability to predict high-cost enrollees in advance.\(^*\)

Provider-owned MA plans that have all these skills and infrastructure systems together often have outperformed commercial plans in key metrics of success, including revenue management and star rating; currently most five-star plans are provider-sponsored.

---

There are challenges with each of these assumptions that make it likely that only some of the cost savings identified above may be achievable. In particular, developing and operating an effective care management model for the high-risk population is challenging. However, with a concerted effort, it should be possible to obtain at least a portion of these results.

**Having the Right Product Design**
Several strategies can be effective in helping MA plans successfully identify and attract high-risk enrollees.

**Offer an enhanced drug benefit.** Doing so will draw enrollees who use a number of drugs and are likely to have multiple chronic conditions.

**Participate as a sub-contractor in one of CMS’s state demonstration programs to integrate care for dual eligibles.** Such programs now operate in 23 states. Approximately 9.5 million dual-eligible beneficiaries are estimated to be eligible to participate nationally, and actual participation could reach 2 million.

**Participate as a Medicare special needs plan.** This program is for enrollees with specific severe or disabling conditions and requires an application to CMS. There are three different special needs plans addressing chronic conditions, dual eligibles, and institutional concerns.

**Use primary care physicians and specialists in the provider network to identify patients who could benefit from effective care management and encourage these patients (legally) to consider the MA program.** This strategy provides an effective means of marketing directly to Medicare beneficiaries and their families, with a focus on the benefits of the care management program and its success in improving the quality of life for enrollees with multiple chronic conditions.

Health systems that offer their own MA plans or partner with such plans are well-positioned to play a role in marketing to this population. Most already have a strong brand associated with providing health services to those who are sick or injured.

Attracting older, sicker Medicare beneficiaries can be a key strategy for improving Medicare profitability, as fee-for-service Medicare is gradually replaced by new CMS initiatives. The critical prerequisite, however, is having an effective care management/care coordination program for this population.

Amid today’s evolving circumstances in health care, with increased emphasis on managing population health, ACOs that assume significant risk, particularly for the Medicare population, should consider whether they are well-positioned to benefit from attracting the high-risk population. All providers should be able to answer the following three questions in the affirmative before starting:

> Are our physicians accurately and completely documenting their patients’ conditions?
> Do our information system have the capabilities necessary to support population health, including an electric health record, patient portals, disease registries, and predictive modeling?
> Do we have an effective care management program that identifies and coordinates the care of high-risk patients?

One should not automatically assume that increasing the high-risk population that an ACO serves is a bad strategy. If the organization has an effective program to manage and coordinate that population’s care, this may be a good time may to deliver valuable services profitably.

**About the author**

M. Orry Jacobs, MBA, is senior advisor at BDC Advisors, LLC, Beachwood, Ohio, and a member of HFMA’s Northeast Ohio Chapter (orry.jacobs@bdcadvisors.com).