ECG MANAGEMENT CONSULTANTS

New Jersey Hospital Association

Medicare Advantage: A Provider-Sponsored Insurance Opportunity

May 18, 2018

Agenda

I. Introduction to ECG
II. Medicare Advantage (MA): an Overview
III. The US and New Jersey MA Markets
IV. Why Consider an MA Plan?
V. Obtaining a CMS MA Contract
VI. The MA Funding Process
VII. Key Factors in Success
VIII. Summary

I. Introduction to ECG

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The Presenter and Representative Clients

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I. Introduction to ECG

Representative Insurance Services

Strategy

- Enterprise Strategy
- Service Line Strategy
- Physician Strategy and Alignment
- Health Reform and ACO Strategy
- Transactions and Affiliations
- Organizational Design and Development

Finance

- Business and Financial Advisory Services
- Payor Contracting and Reimbursement
- Provider Compensation Planning
- Valuation Services
- Industry Benchmarking

Operations

- Performance Improvement
- Care Model Transformation
- Patient Access
- Revenue Cycle Optimization

Technology

- IT System Strategy
- IT System Implementation and Optimization
- System Integration
- Patient Engagement
- System Reporting Enhancement

II. MA: An Overview

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Program History and Milestones

CMS has more than a 35-year history of managing private health plan coverage of Medicare beneficiaries as an alternative to original Medicare.

Program	Year	Description
Medicare Coordinated Care Plans	1982	TEFRA enabled HMOs to contract with CMS to offer Medicare coverage.
Medicare+Choice (M+C)	1997	BBA expanded the organizations that could contract with CMS to offer Medicare coverage.
M+C: Risk Adjustment	2000	Risk adjustment phase-in started for M+C plans, with a phase-in schedule for dual demonstrations.
Medicare Part D	2003	MMA introduced the stand-alone prescription drug benefit (or integrated with Medicare Part C).
Medicare Part C and Employer Group Waiver Plans (EGWPs)	2003	M+C was renamed MA (Part C) and EGWPs were introduced to enable employers to transition retirees to this form of plan.
Medicare Part C	2010	ACA introduced the MLR (85%) and instituted programs to narrow the cost difference between Part C and Parts A and B benefits.

II. MA: An Overview

Plan Designs

CMS recognizes a number of plan designs, each of which is subject to a separate contract and may have a different payment methodology.

Plan Types	Description
CCP: HMO/HMO POS Plan[1]	A plan with covered services, other than ED services, available only from a closed network of providers
CCP: PPO and RPPO Plan[1]	A plan where a member can obtain services (1) in network, or (2) out of network at a higher cost ("R" is multistate)
CCP: Special Needs Plan (SNP)[1]	A plan that serves: (1) institutionalized members, (2) dual-eligible members, or (3) members with designated chronic conditions (HIV, diabetes, CHF, ESRD, dementia)
EGWP	A plan offered by an employer to its Medicare-eligible retirees
Private Fee-for-Service (FFS) Plan	A plan that sets FFS payment rates and establishes a provider network that agrees to accept the rates (nonparticipating providers can elect to treat members)
Section 1876 Cost Plan (no longer available as a new plan)	A plan where a member can obtain services from an in-network provider, which is paid at reasonable cost, or any Medicare participating provider (paid Medicare FFS)

[1] A CCP must offer at least one plan with an integrated Part D drug benefit throughout its service area in the state.

III. The US and New Jersey MA Markets

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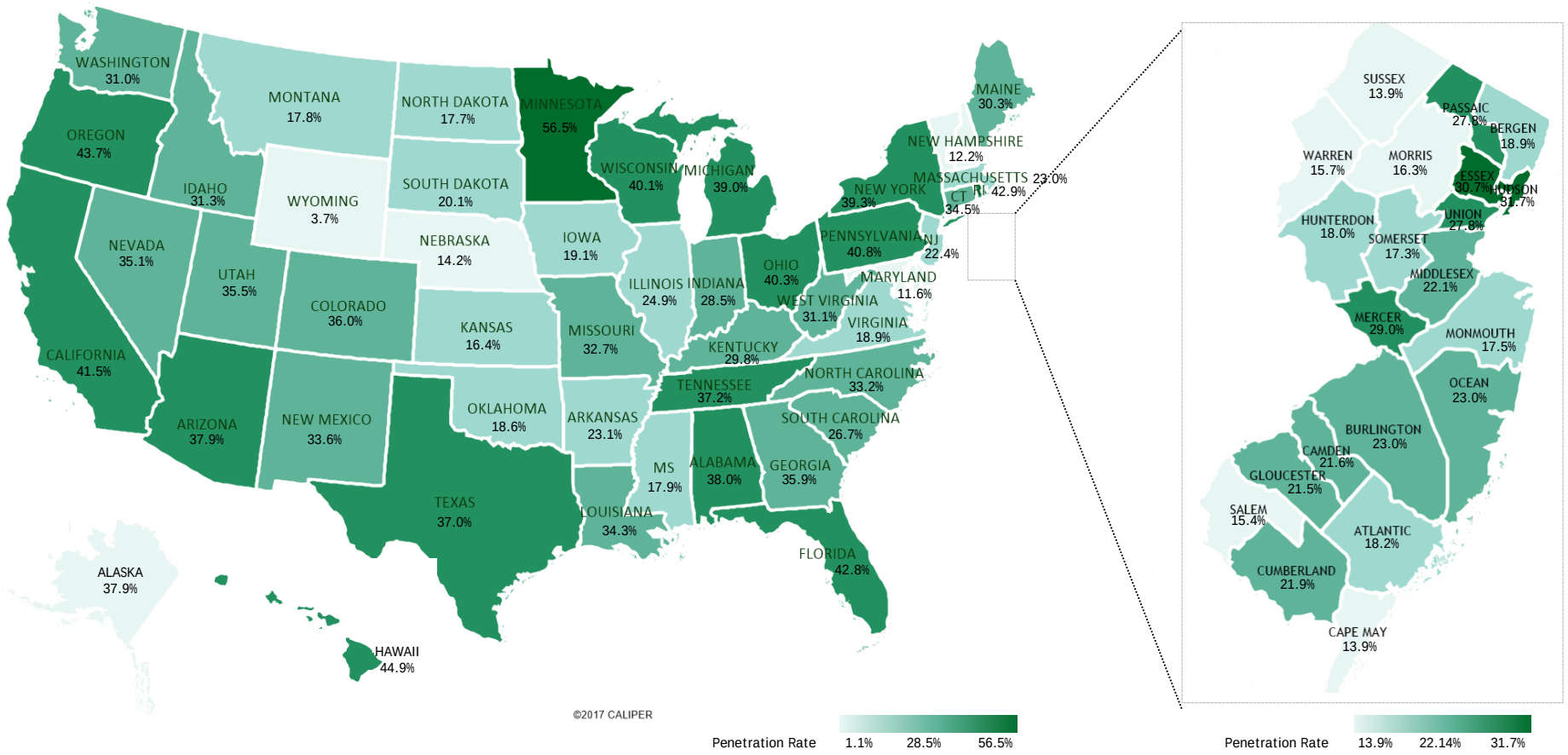
MA-Penetrated Markets

The US MA penetration rate is 34.2%, while the New Jersey penetration rate is 22.4% for April 2018.



Source: http://cms.gov.

There are opportunities to expand the MA market across New Jersey.

III. The US and New Jersey MA Markets

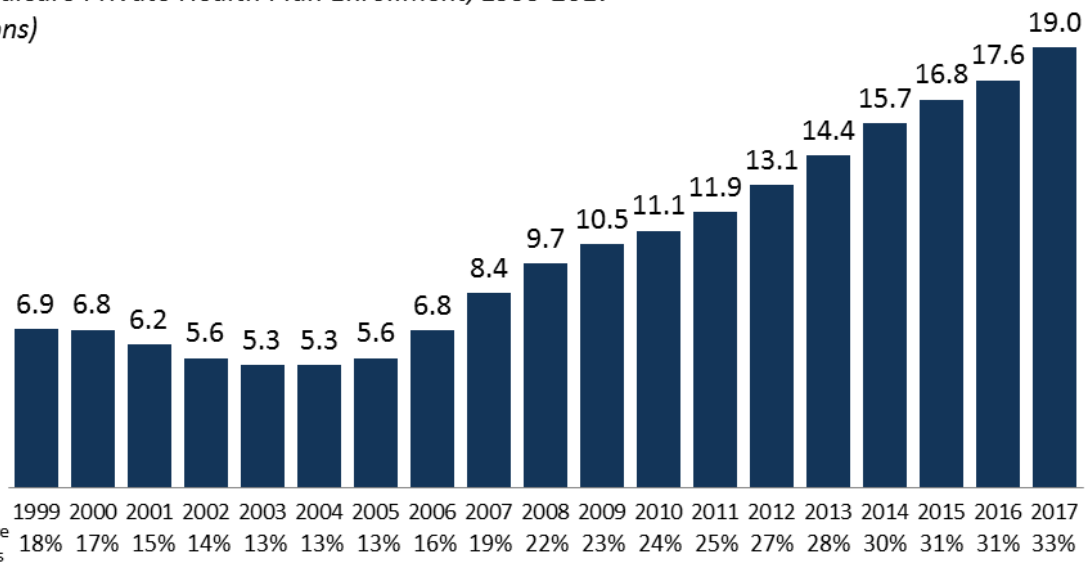
The Penetrated Market Trend

MA continues to capture an increasing share of the available Medicare-eligible market.

Figure 1

Enrollment in Medicare Advantage plans has steadily increased since 2004

Total Medicare Private Health Plan Enrollment, 1999-2017
(in millions)



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS Medicare Advantage enrollment files, 2008-2017, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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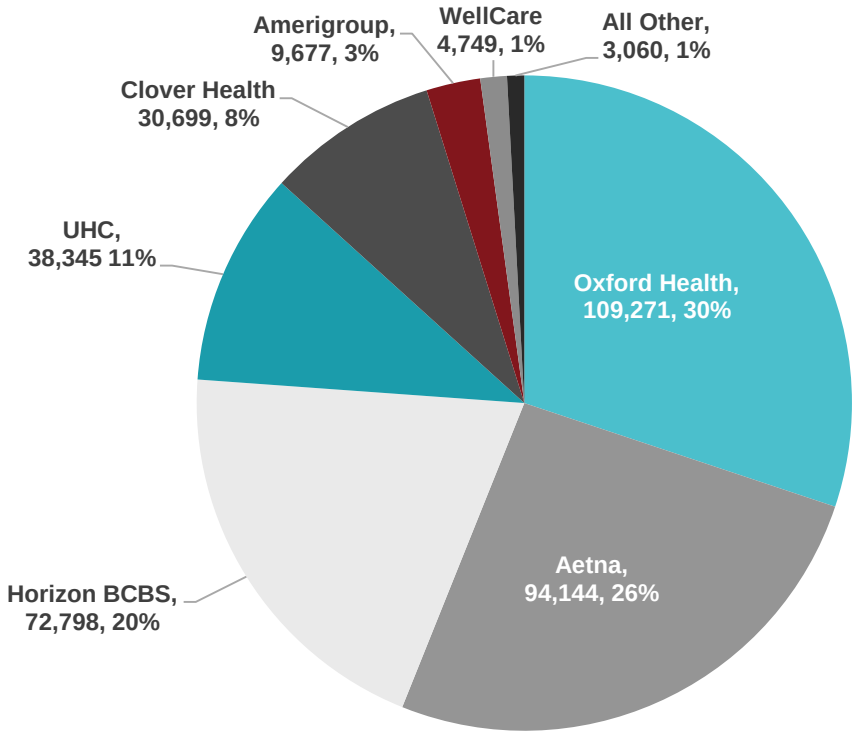
Many project MA growing to 40%–45% of Medicare eligibles by 2027.

III. The US and New Jersey MA Markets

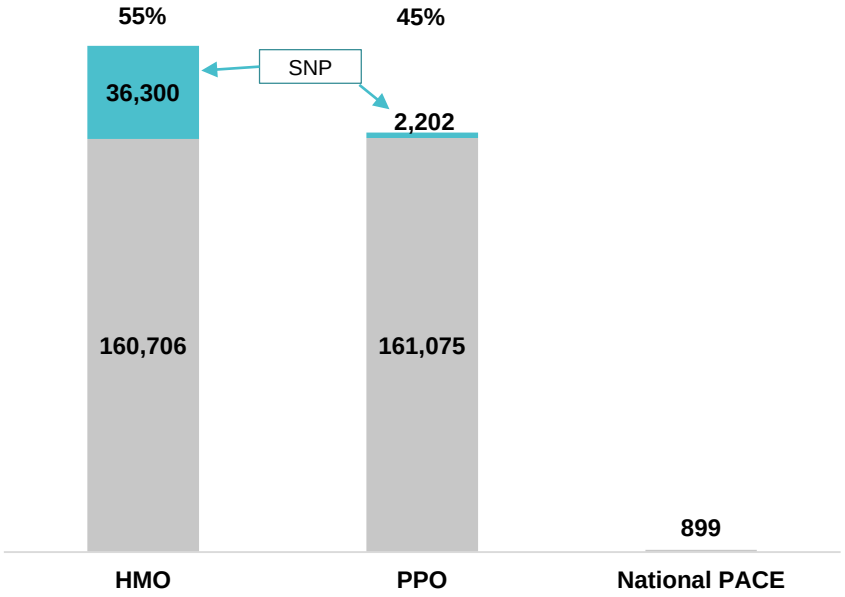
Hospital and Medical Enrollment

Across New Jersey, 361,182 members are enrolled in MA hospital and medical plans, with UHC (Oxford Health–HMO, Sierra Health–PPO, and UHC–PPO), Aetna, and BCBS representing 87% of the market share.

*Enrollment and Distribution by Plan**



Enrollment and Distribution by Plan Type



*Note: UHC includes Sierra Health enrollment.

Provider-sponsored plans, while prevalent nationwide, are largely absent from New Jersey.

IV. Why Consider an MA Plan?

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The Strategic Vision

MA may present a unique market opportunity with care delivery synergies.

Market Size

- Medicare Available Market: The 65+ population is growing.
- MA Available Market: The MA share of the available market is growing and estimated to reach 40%–45% of the available Medicare-eligible market by 2027.

Market Stability

- Medicare demographic trends are very stable and predictable, enabling longer-term business investment.
- Market changes will favor organizations that can manage medical risk.

Secure Funding

- The MA rate-setting model, risk adjustment system, and Star Rating system are well established.
- MA funding, supported by a powerful political bloc, is difficult to change.

Business Model

- There is a well-defined business model to achieve success, including effective referral, care, quality (Star Rating), and pharmacy management and accurate documentation of performance (risk adjustment).

Market Risk

- Providers are best positioned to manage medical risk, which drives cost, but must address capital competition and the pressure to increase volume.
- Providers frequently interact with enrollees to affect purchasing decisions.

IV. Why Consider an MA Plan?

The Strategic Vision *(continued)*

Health systems must face the growing demands of the senior population, either as MA health plan sponsors or as contractors under value-based arrangements.

Health Plan

- Benefits
  - Derive greater control of synergistic effects of health system and insurance operations.
  - Obtain potentially greater return on investment.
- Risks
  - Competing for capital: large health system capital needs
  - Acquiring management expertise
  - Achieving scale
  - Managing the pressure of volume

Value-Based Contractor

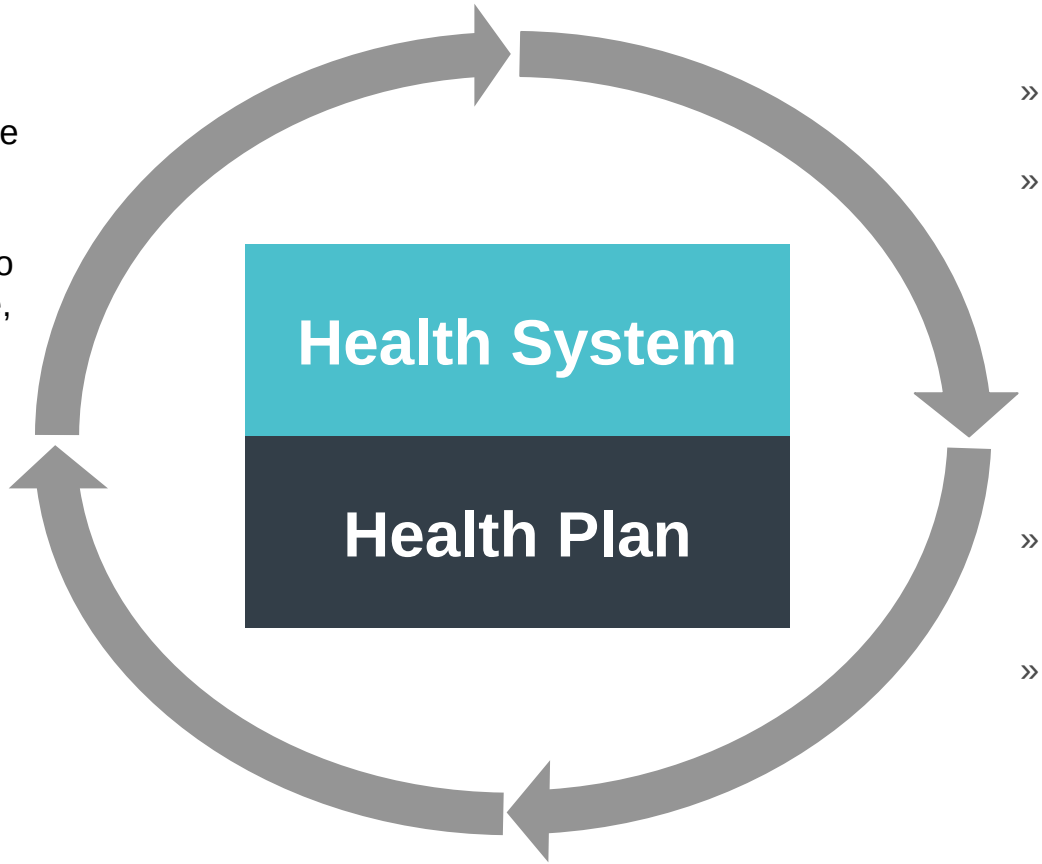
- Benefits
  - Limit capital investment.
  - Avoid complex management.
  - Retain responsibility for risks within management competencies.
- Risks
  - Loss of flexibility to manage
  - Experiencing revenue pressure through unit price reductions, volume controls, or contract loss
  - Achieving scale
  - Managing the pressure of volume

IV. Why Consider an MA Plan?

The Strategic Vision *(continued)*

Successful health system–health plan sponsors must continually challenge performance in care delivery and health insurance businesses, especially concerning reduction of low-value volume.

- Develop systems to manage units of service ***and*** members.
- Use actionable information and tools to manage referrals, care, and quality day to day.



- Gain unit price efficiencies.
- Eliminate low-value volume.

- Market and sell to increase members.
- Convert data to actionable information.
- Provide scalable processes and tools to support provider care management (CM).

- Issue competitive premium, high-value plans.
- Develop market-valued plans with member engagement features.

Successful plans continually build on the synergies of achieving efficiencies in care delivery, which reduce premiums and attract more members (i.e., volume).

V. Obtaining a CMS MA Contract

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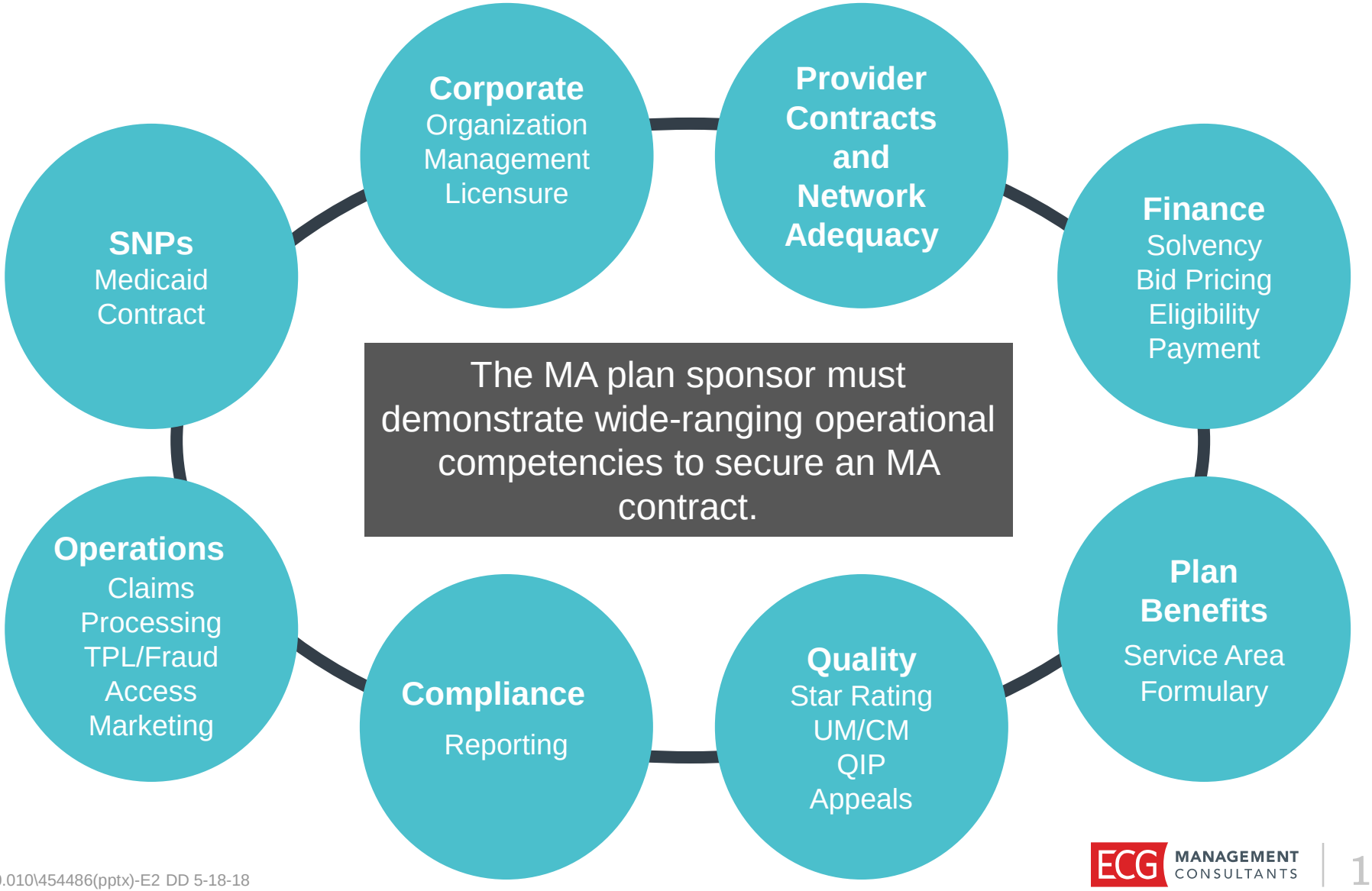
Key Approximate Dates and Milestones for the 2020 MA Application

Medicare has a well-defined process and milestones to obtain a CMS MA contract.

Date	Activity
November 15, 2018 (approximate)	Submit Notice of Intent to Apply to CMS to ensure access to Health Plan Management System (HPMS) by the date applications are released.
First Friday in December 2019	CMS User ID form is due to CMS.
January 10, 2019	Final applications are posted by CMS.
January 26, 2019	NOIA form must be submitted to CMS.
February 14, 2019	Completed applications are due to CMS (including service area and partial county).
April 2019	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) are available on HPMS.
May 3, 2019 (approximate)	PBP/BPT Upload Module is available on HPMS.
May 13, 2019	CY 2019 Formulary Submission Module is released.
June 3, 2019 (approximate)	Bids are due to CMS.
Late August 2019	CMS completes review and approval of bid data.
September 2019	CMS executes MA and MA-PD contracts with organizations whose bids are approved and that otherwise meet CMS requirements.
Mid-October 2019	Annual Coordinated Election Period begins for CY 2019 plans.

V. Obtaining a CMS MA Contract

Key Elements of the MA Application



VI. The MA Funding Process

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MA Plan Development Will Require $35 Million–$60 Million of Start-Up Capital

Successful plans have sufficient capital to support launch, demonstrate ability to manage medical risk before seeking growth, and have a clear growth plan.

Capital	Medical Risk	Scale
» A new plan requires $35 million–$60 million in capital, depending on the size of the service area and number of products launched. » Minimize capital requirements by taking advantage of the synergies of the health insurance and care delivery businesses.	» With 85%–87% of premium devoted to medical cost, there is no substitute for effective medical cost management. » A comprehensive program requires: › Risk stratification. › Referral management. › Utilization management (UM). › CM. › Value-based incentives.	» An MA plan achieves actuarial credibility as to its medical budget with 15,000 members. » Fast member growth can reduce working capital requirements. » One option to achieve fast scale is to develop partnerships with other providers to quickly gain market share.
Launch	**Perform**	**Grow**

VI. The MA Funding Process

Substantial Funding Is Entering the Market, but There Is Considerable Risk

DevotedHealth

Founded by the Bush family (athenahealth), Devoted Health recently closed a $62 million round of funding. The focus is on a caring approach, technological simplification, and high-performing providers. Plans launch in 2019.

Clover

Clover integrates technology into all aspects of care and targets a low price point, with $0-premium plans, $0-copay PCP visits, and $0 generic drugs. Clover has approximately 30,000 members in New Jersey and is expanding to Georgia, Pennsylvania, and Texas. It has raised $425 million.

VI. The MA Funding Process

Multiple Revenue Sources Fund MA Benefits

Members

- Must participate in Parts A and B and pay a Part B premium.
- Depending on plan benefits, may pay a supplemental premium.
- Pay cost sharing when incurred.

CMS Premium Contribution

- MA plan submits a bid that is subject to a county FFS cap.
- The cap is computed based on two-year-old Medicare FFS costs trended to the current year and normalized.

CMS Rebate

- The rebate is an amount equal to (Cap – Bid) × 50%.
- The rebate funds additional benefits or profit, or it reduces member cost sharing.

Risk Adjustment

- Pays for differences in member medical risk based on the HCC algorithm.
- MA plan members have an estimated 6%–8% lower acuity than original Medicare members (-5.90% adjustment).

Star Bonus

- The bonus is an amount equal to a 5% premium bonus for MA plans achieving a four or five Star Rating.
- New MA plans receive a 3.5% bonus for three years.

VII. Key Factors in Success

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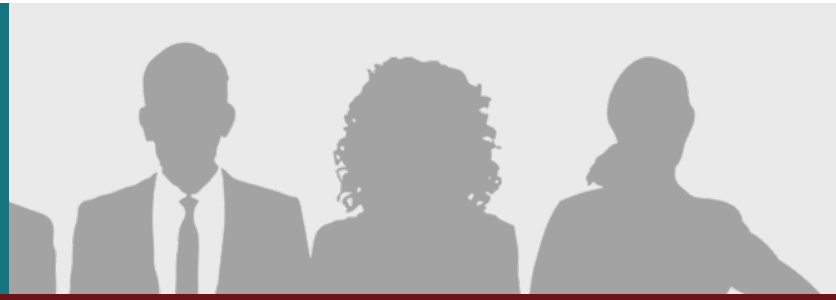
Recruit an Experienced Management Team

"We're in healthcare . . . How hard can it be?"

Medicare is very complex and subject to constant tinkering. The team must be adept at staying abreast of changes and adjusting strategy.



A seasoned board that challenges leadership to excel is invaluable. Recruit board members with insurance experience.

Be prepared to respond quickly to challenges. There will be many choices and decisions; time is not an ally.

VII. Key Factors in Success

Design Products That Are Consumer Responsive

In your market, understand consumer needs and the most attractive plan features.

"If dogs don't like your dog food, the packaging doesn't matter."[1]

$0-Premium Plans

- Half of all MA members, and 60% of all MA HMO members, first enroll in $0-premium plans.
- $0-premium plans attract healthier aging-in members.
- Only 6%–7% of members voluntarily terminate from a plan annually.

Lifetime Profitability

- Given the low member turnover, it is often more valuable to attract members and derive profitability in varying degrees over their lifetimes than seek to realize a profit on all products at all times.
- Consider effective end-of-life management.

Additional Benefits

- Strive to add benefits highly valued by members:
  - Fitness programs
  - Hearing aids
  - Telehealth
  - HMO plan out-of-area network coverage to attract "snowbirds"

[1] Stephen Denny, "Killing Giants: 10 Strategies to Topple the Goliath in Your Industry" (2013).

VII. Key Factors in Success

Achieve a Four- or Five-Star Rating to Increase Premiums and Demonstrate Quality

New plans have a 3.5 Star Rating and receive a 3.5% bonus for three years. Thereafter, plans are rated on quality experience, and the Star Rating comes with benefits and penalties.

3.5 Stars or Less

- After the first three years, a plan rated at 3.5 stars or less receives no bonus.
- If a plan remains at 2.5 stars or less for three years, it can be terminated from MA as a "low performer."
- In 2018, there were no low-performer plans.

Four Stars

- A plan rated at four stars receives a 5% bonus.
- A four-star plan is eligible for a double bonus in select counties.
- Out of 384 MA plans, 44% —or 169 plans—with a Part D drug plan scored four or more stars.
- These plans account for 73% of enrollees, up from 69% in 2017.

Five Stars

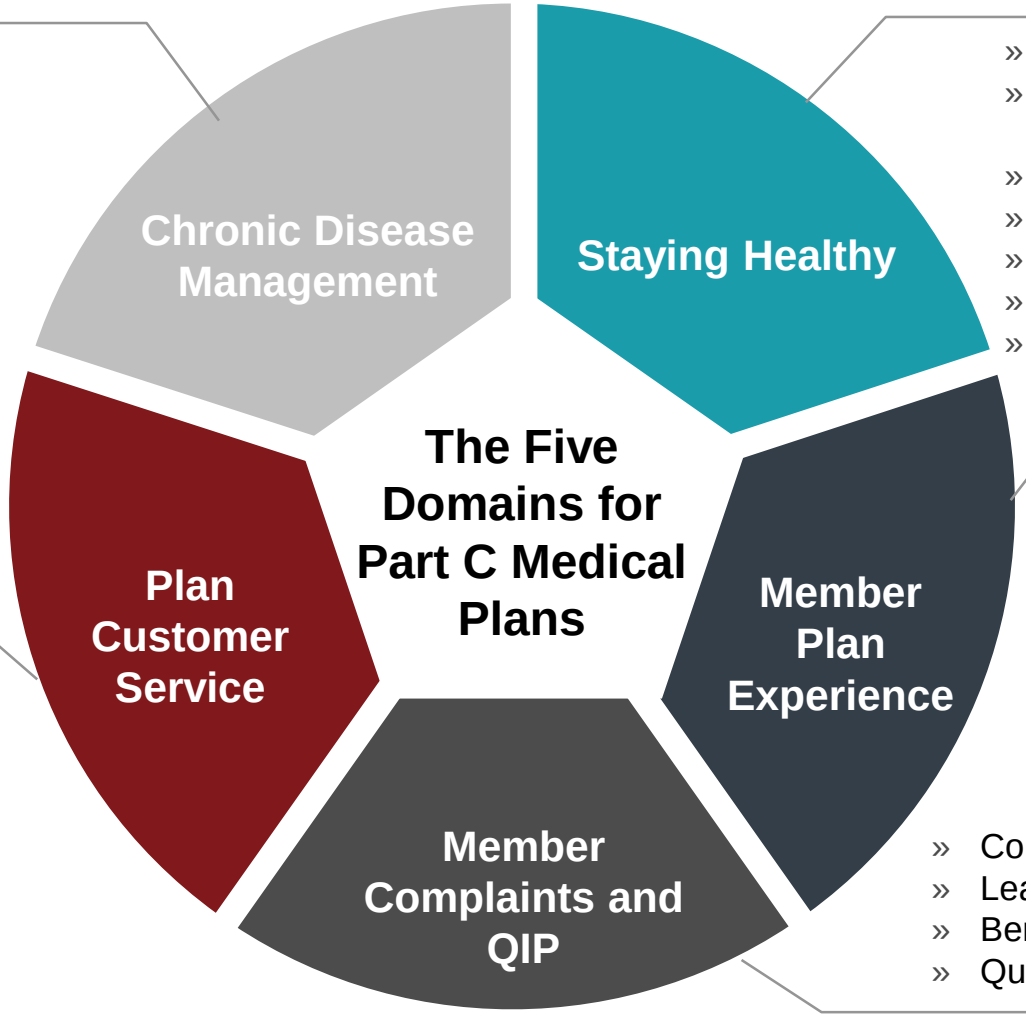
- A plan rated at five stars receives a 5% bonus.
- A five-star plan is eligible for a double bonus in select counties.
- Members may switch to a five-star plan at any time (this can account for 2%–4% of new members).
- Of all MA plans, 23 earned a five Star Rating.
- Provider-owned plans have a larger share of five-star plans.

After three years, new plans underperform the average plan by 9%.

VII. Key Factors in Success

There Are Separate Star Ratings for Medical and Drug Plans

Part C medical services are evaluated across five domains.



- Medication review
- Pain review
- Functional review
- Osteoporosis
- Diabetes–eye exam
- Diabetes–kidney
- Diabetes–A1c
- Arthritis
- Bladder control
- Risk of falling
- Plan all-cause readmission

- Breast cancer screening
- Colorectal cancer screening
- Flu vaccine
- Improved physical health
- Improved mental health
- Monitoring activity
- Adult BMI

- Time to appeal decisions
- Reviewing appeal decisions
- Call center–interpreter and TTY

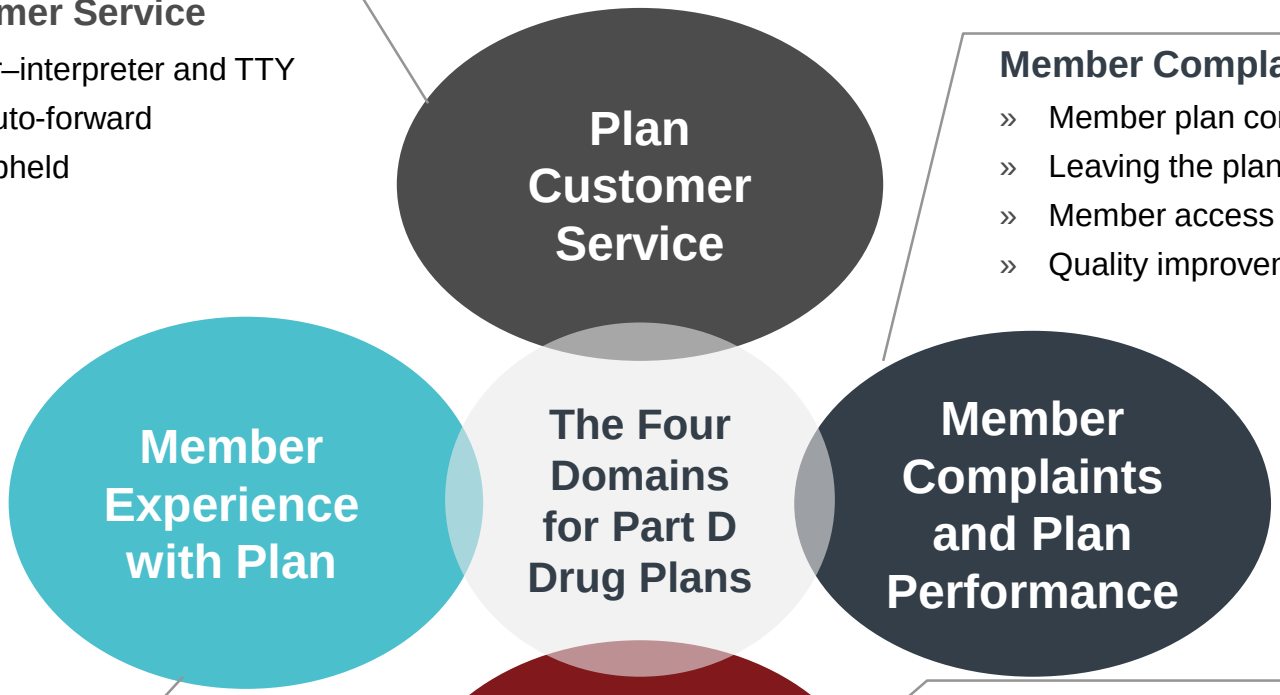
- Getting care
- Fast appointments
- Customer service
- Health plan quality
- Health plan care coordination

- Complaints
- Leaving the plan
- Beneficiary access
- Quality improvement plan

VII. Key Factors in Success

There Are Separate Star Ratings For Medical and Drug Plans (*continued*)

Part D drug services are evaluated across four domains.



Plan Customer Service

- Call center–interpreter and TTY
- Appeals auto-forward
- Appeals upheld

Member Complaints

- Member plan complaints
- Leaving the plan
- Member access
- Quality improvement plan

Member Experience

- Drug plan rating
- Getting needed drugs

Title

- MPF pricing accuracy
- Medication adherence–diabetes
- Medication adherence–hypertension
- Medication adherence–cholesterol
- MTM completion rate

VII. Key Factors in Success

Risk Adjustment: Understand the RAPS to EDS Transition

CMS is in the middle of a risk adjustment methodology transition, shifting to a system that reprices claims under Medicare FFS rules and eliminates multiple HCC counts.

EDS-RAPS Risk Score Difference: PY 2016–December 2016

Plan type	20th	40th	50th	60th	80th
All plans	-7.2%	-4.8%	-4.0%	-3.4%	-2.6%
SNPs	-8.4%	-6.6%	-5.1%	-4.7%	-3.1%
General enrollment	-6.8%	-4.2%	-3.8%	-3.2%	-2.5%

12% of members have higher RAPS risk scores.

EDS-RAPS Risk Score Difference: PY 2017–December 2017

Plan type	20th	40th	50th	60th	80th
All plans	-6.2%	-3.3%	-2.5%	-2.0%	-0.8%
SNPs	-5.6%	-2.5%	-2.2%	-1.8%	-0.6%
General enrollment	-6.6%	-5.6%	-5.2%	-3.2%	-1.7%

Source: Milliman.com.

9% of members have higher RAPS risk scores.

Plans must be prepared to track the performance of every member to understand the differences in risk scores resulting from RAPS and EDS.

VII. Key Factors in Success

Risk Adjustment: More Factors Affecting Patient Care

CMS analysis indicated that dual-eligible plans require finer segmentation to allow a more accurate calculation of predicted costs and improve payment accuracy.

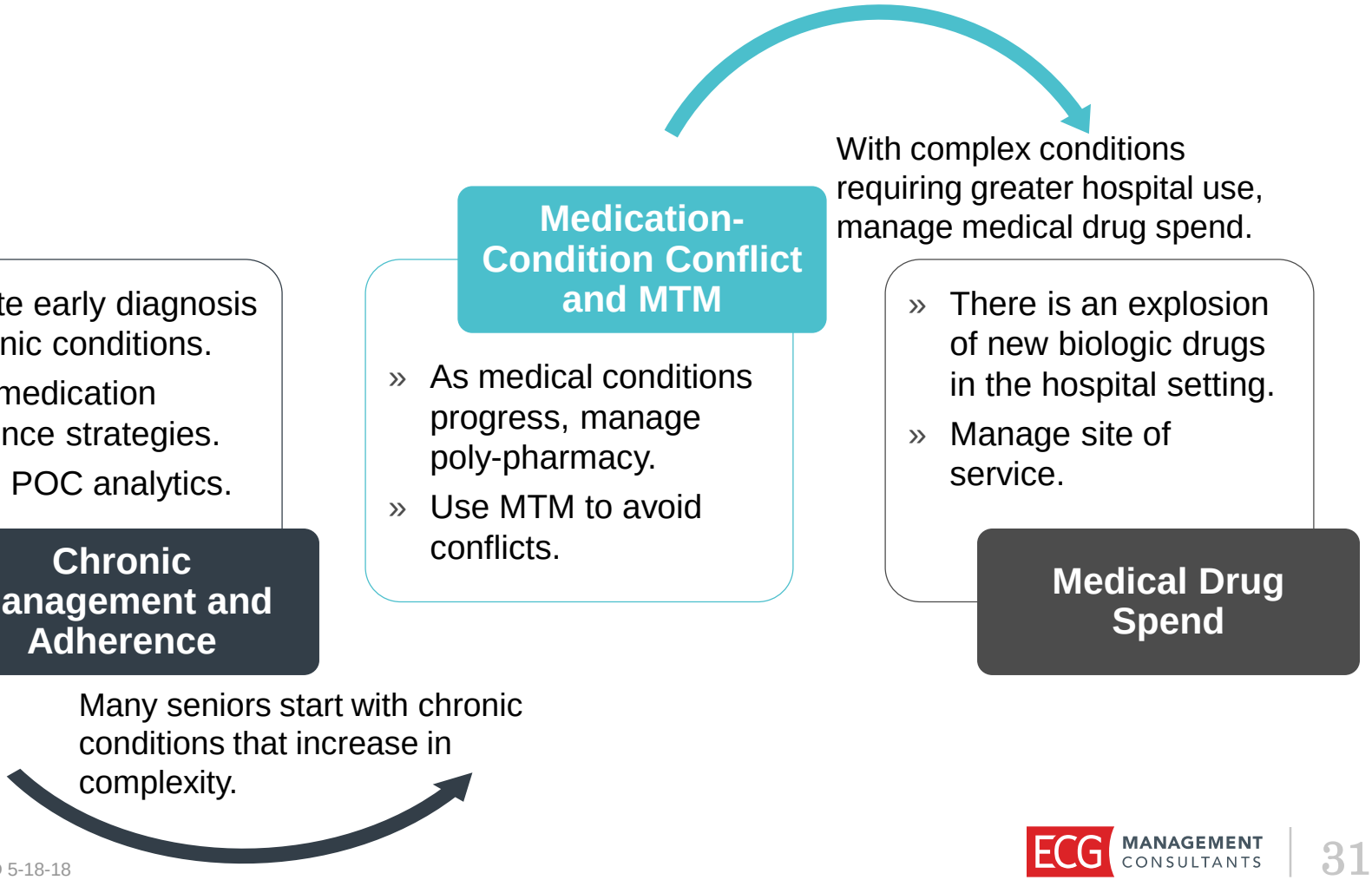
2014 Model	2017 Revised Model
Two full-risk segments: » Institutional » Community	Seven full-risk segments: » Institutional » Community: Full benefit dual aged » Community: Full benefit dual disabled » Community: Partial benefit dual aged » Community: Partial benefit dual disabled » Community: Non-dual aged » Community: Non-dual disabled
Dual status for full-risk beneficiaries identified in base year	Dual status for full-risk beneficiaries identified in payment year
79 HCCs	Same HCCs as 2014 model

The adjustments shift more funding into the D-SNP population, with funding amounts better aligned to member cost.

VII. Key Factors in Success

Pharmacy Manages Chronic Conditions but Can Lead to Conflicts

Pharmacy helps reduce cost through effective management of chronic conditions and medical cost avoidance due to medication-condition conflicts. As complex patients transition to poly-pharmacy, it is essential to manage medical drug spend.



VII. Key Factors in Success

Adopt Provider Contracts That Align Clinical and Financial Interests

Payors

- Pay the majority of health coverage costs.
- Establish business rules that affect insurers, providers, and members.

Insurers

- Embrace value-based payment principles in provider contracts: quality and surplus bonuses.
- Design products to encourage member care participation, adherence, and in-network services use.
- Provide PHM support but limited day-to-day CM.

Providers

- Develop CINs of high-performing providers; shared savings ➔ full risk.
- Align provider incentive distribution to encourage performance.

Members

- Must be engaged in order to manage care and wisely use services.
- Are motivated by financial incentives or physician relationships to change behaviors.

Clinical

Payors | Insurers | Providers | Members

Financial

Payor Policy

- Payors adopt funding policies that reward value-based care.
- Payor-insurer contracts incorporate value-based principles.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Insurance Services

- Insurers support data collection and conversion of data to actionable information in near real time (BI/analytics).
- Insurers provide UM and CM planning and oversight.

Care Delivery

- Providers depend on payors/insurers for actionable information and to orchestrate CM.
- Providers execute day-to-day CM and clinical coordination through referral management.
- Providers are rewarded for quality and value-based care.

VII. Key Factors in Success

Effective UM Promotes a High-Value Culture

Value-based care is provided by the least-expensive qualified caregiver in the lowest-cost setting appropriate to the patient's medical condition. Day to day, the lowest-cost qualified caregiver is the patient.

Prior Authorization

- Identify services with high risk of low value:
  - High-cost imaging
  - Inpatient services where outpatient alternatives are available
  - Repeat diagnostics
- Reward high performers through waivers.

Referral Management

- Define the network of high-performing providers by medical condition or procedure.
- Manage referrals to the least-expensive qualified caregiver in an appropriate setting.
- Continuously assess and reward performance (financial incentives, gold carding).

Concurrent Review

- Drive care efficiency in every setting:
  - Weekend/evening discharges
  - Complete discharge plan
  - Engaged family members
- Postdischarge care has high cost variability: know your network and create clear expectations.

VII. Key Factors in Success

CM Delivers Superior Outcomes with an Exceptional Member Experience

For young plans, CM should focus on high-cost and impactable cases and effective transitions of care.

Risk Stratification	» Use historical data and HRAs to identify the highest risks and most impactable cases. » Engage members and PCPs to commence CM.
High-Cost Case Management	» Have dedicated staff manage high-cost cases. » Develop a limited set of diagnosis-specific care models. » Understand provider readiness for VBAs and CM. » Consider CM stipends to support provider CM.
Transitions of Care	» Identify impactable cases. » Manage transitions effectively. » Expand transition to home, and engage family members where possible (low-cost qualified caregivers).
Provide Actionable Information	» Develop the plan for data collection: what data is important? » Convert data into actionable information, and inject it into the physician workflow to manage care in real time: prescriptions, gaps in care, missing diagnoses (risk adjustment). » Measure and report performance with peer comparisons to change patterns.

Summary

"Insurance is an easy business. You collect a premium, pay claims, and have a profit . . . There a just a million ways to screw it up."

Secure experienced leadership that will foster collaboration across the insurance and care delivery businesses.

Develop a high-value culture that constructively challenges everything you do and rewards performance.

Use capital wisely.

Measure, assess, and learn every day. Don't be afraid to admit that something isn't working, and nimbly pivot to new solutions.

Questions & Discussion

Contact ECG

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