Establishing a MA Managed Care Strategy

Presentation: Southeastern Association of Orthopaedic Executives
Date: Sept. 9, 2023

Strategic Healthcare Partners, LLC – Who We Are and Who We Serve

- Founded by Principals John Crew and Mike Scribner in 2009.
- Over 30 years experience in the field.
- Broad spectrum of healthcare clients including:
  - 35+ hospitals
  - Over 1,000 physicians/extenders
  - IPAs/CINs, ASCs,
  - All 22 of the community mental health centers in Georgia.
- Specializing in rural healthcare providers; experience in working in HPSA designated areas.

Agenda

- Overall Managed Care Strategy
- Medicare Advantage & Your Practice
- Monitoring Payer Performance
- Vetting New Carriers / Payers
- Contract Negotiation / Renegotiation Best Practices
- Wrap Up

Overall Managed Care Strategy

MA Issues vs. Overall Managed Care Strategy

- Typically, the carriers offering MA products also offer commercial (small group/large group), Health Exchange, and Medicaid products in the market.
- Understanding carrier goals around other product lines and your issues with those products plays in to practice/ASC response.
- Real Examples:
  - ASC with exceptional % of charge Anthem commercial agreement (35% of payer mix vs. 2% Anthem MA product. Little motivation to fight MA issues.
  - Practice/ASC with many Humana/UHC MA issues receives Medicaid managed care proposal. Response- No consideration of Medicaid until MA record requests/claim issues are resolved.

Georgia Market Example

No Such Thing as a Commercial Only Carrier

	Product Type					
	Commercial	Health Exchange	Medicare	Medicaid	SHBP-Actives	SHBP-Retirees
Carrier:						
Anthem	Market Leader		Small	Via Amerigroup	Statewide	Statewide
United Healthcare			Market Leader	Prospect	Statewide	Statewide
Aetna/CVS				Prospect		
Humana	Leaving by 2025		Fastest Growing	Prospect		
Cigna			Expanding			
Kaiser	Expanding-2024	Expanding-2024		Prospect	Atlanta Market Only	Atlanta Market Only
Ambetter/Peach State		Market Leader	Via Wellcare	Via Peach State		
CareSource			Expanding			

- All major carriers offer multiple product lines and, for the most part want to expand their presence in each/grow to others.

Summary 2023 Managed Care Action Plan Review

Orthopedic ASC

FFS/Value Based Programs

Network	Product	Accessed	Current Discount %	Current % of Medicare	Claim Filing Limit	Appeal Filing Limit	Payer Retro Audit	Anniversary Date	Term Renewal	Term Notice	Suggested 2020 Fee for Service Action Plan
Medicaid CMO Plans											
Amerigroup	Medicaid	Direct	64.3%	80.5%	12 Months	12 Months	12 Months	9/2/2017	1 Year	120 Days	No action necessary.
Caresource	Medicaid	SGPA	62.8%	83.9%	12 Months	12 Months	12 Months	n/a	n/a	90 Days	No action necessary.
PeachState	Medicaid	SGPA	60.5%	88.8%	180 Days	13 Months	12 Months	n/a	n/a	90 Days	Participate in incentive program when/if available.
Wellcare	Medicaid	SGPA	60.3%	89.4%	180 Days	180 Days	Not Specified	n/a	n/a	90 Days	No action necessary.
Health Exchange Plans											
Caresource	Exchange	SGPA	Go Live 1/1/20		12 Months	12 Months	12 Months	n/a	n/a	90 Days	No action necessary.
Ambetter	Exchange	SGPA	Not Listed		180 Days	90 Days	12 Months	n/a	n/a	90 Days	Participate in incentive program when/if available.
BCBS Pathways	Exchange	Direct	Not Listed		90Days	90 Days	Not Specified	3/23/2018	1 Year	180 Days	Consider termination if BCBS movement not obtained.
Commercial Plans											
Aetna/Coventry	Commercial	SGPA	45.7%	122.3%	120 Days	180 Days	Not Specified	n/a	n/a	90 Days	Participate in incentive program when/if available.
BCBS	Commercial	Direct	49.8%	113.0%	90 Days	90 Days	Not Specified	3/23/2018	1 Year	180 Days	No action necessary.
Cigna	Commercial	Direct	43.6%	127.0%	180 Days	180 Days	24 Months	n/a	n/a	6 Months	No action necessary.
Humana	Commercial	SGPA	43.0%	128.4%	90 Days	12 Months	18 Months	n/a	n/a	90 Days	No action necessary.
UHC	Commercial	Direct	42.3%	129.9%	90 Days	12 Months	12 Months	1/7/2010	3 Years	120 Days	No action necessary.
Local Network	Commercial	Direct	47.3%	180.3%	180 Days	180 Days	12 Months	Evergreen	1 Year	90 Days	No action necessary.
Medicare Advantage Plans											
Aetna/Coventry	Medicare	SGPA	49.0%	114.7%	120 Days	180 Days	12 Months	n/a	n/a	90 Days	No action necessary.
Clover	Medicare	SGPA	Immaterial until 2020.		180 Days	90 Days	12 Months	n/a	n/a	90 Days	No action necessary.
Humana	Medicare	SGPA	49.9%	113.0%	90 Days	12 Months	18 Months	n/a	n/a	90 Days	No action necessary.
UHC	Medicare	Direct	50.5%	111.0%	90 Days	12 Months	12 Months	1/7/2010	3 Years	120 Days	No action necessary.
Wellcare	Medicare	SGPA	51.5%	109.7%	180 Days	180 Days	Not Specified	n/a	n/a	90 Days	No action necessary.

Medicare Advantage- The Big Picture

Medicare Advantage- National Perspective

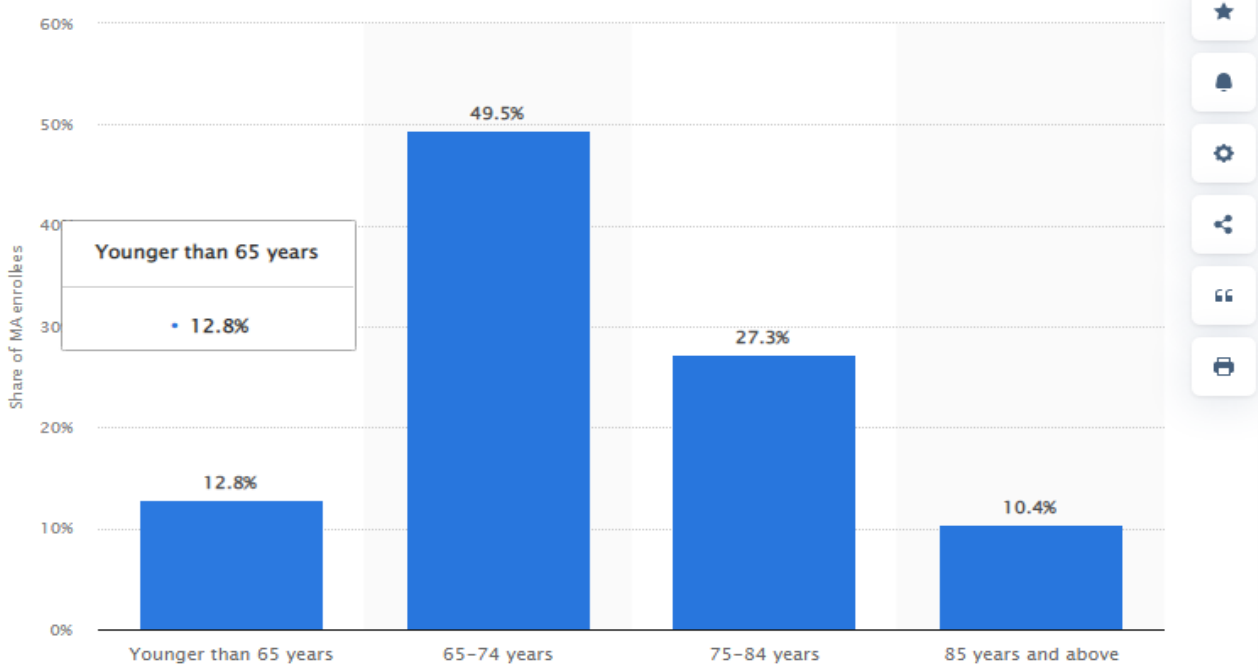
- Fastest growing healthcare population
  - Medicare provides health insurance coverage for 65 million beneficiaries
    - By 2060, projections estimate that this number will increase to 93 million and will account for 23% of the total US population
    - In 2023, the Medicare population became evenly split between traditional Medicare and Medicare Advantage enrollment.
    - By 2033, projected that 62% of eligible Medicare beneficiaries will be enrolled in a Medicare Advantage plan.
- CBO estimates MA plans pay 3% LESS than traditional Medicare to providers.
- Scarcity of rural providers and low patient volume in rural areas is less appealing for MA plans.
- Network adequacy standards hinder MA competition in rural markets (both good and bad for providers).

Medicare Advantage National Trends

	FY2023 MA Membership	Percentage Growth (FY 2010 vs FY 2023)
Aetna	3.3 million	532%
Anthem	4.3 million	264%
Humana	5.5 million	316%
Cigna	573 thousand	178%
United Healthcare	8.9 million	415%
Kaiser Permanente	1.8 million	199%
Centene	1.2 million	188%

What is Driving the Trend?

Distribution of Medicare Advantage enrollment in the U.S. in 2020, by age



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Release date
February 2023

Region
United States

Survey time period
2023

Supplementary notes

Citation formats
- View options

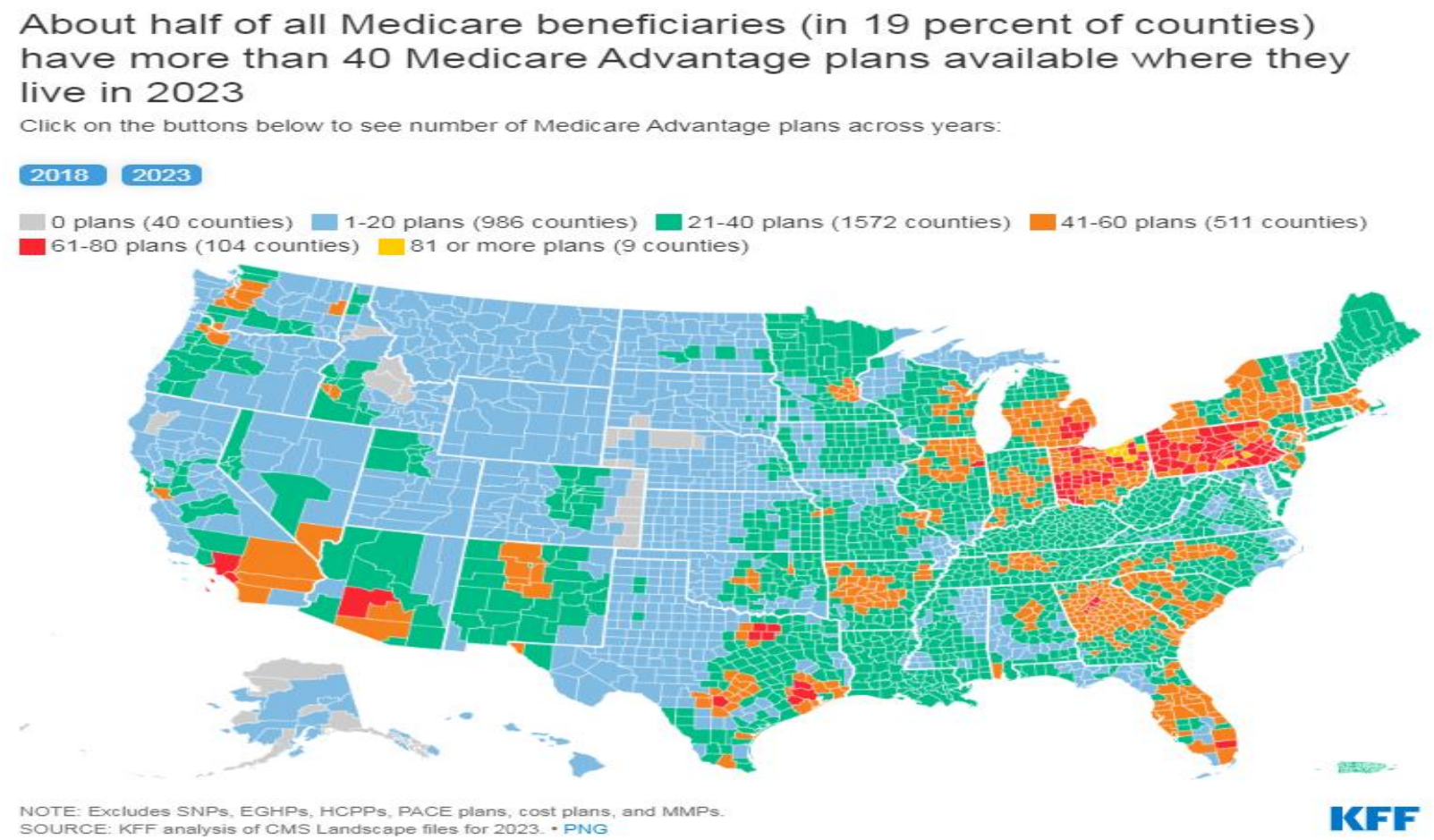
What is Driving the Trend?

- Health Plans:
  - In 2023, 8 new payors entered the market for the first time.
    - Two of the new firm entrants are offering plans in California, and the remainder are offering plans in Arizona, Connecticut, Iowa, Idaho, Massachusetts, and Missouri.
    - Attractive growth market for health plans - Medicare spending for Medicare Advantage enrollees was $321 higher per person in 2019 than if enrollees had instead been covered by traditional Medicare.
- Medicare Beneficiaries:
  - Rapidly growing population is a key indicator driving growth.
  - Incoming Medicare eligible beneficiaries are more familiar with managed care plans and look for options that mirror their traditional health coverage.
    - Definitely attractive to the younger Medicare eligible block.
  - ***MA plans exploded when $0 premium plan options became prevalent. Enrollment via signature w/o payment.***

Medicare Trends

- Rapid proliferation of health plan options via Medicare Advantage
  - In 2023, the average Medicare beneficiary can choose from **43 different Medicare Advantage plans**, double the number available 5 years ago.
  - What Types of Plans are Offered:
    - HMOs: 58% of all offerings
    - Local PPOs: 40%
    - Regional PPOs/PFFS plans: declined to 1% by 2023

Medicare Trends



Summary of Trends

- This stuff ain't going away; it's going to grow, both in plan membership and in number of different carriers/plans involved.
- Inevitably, there will be carrier consolidation (ala commercial market) but a zillion players right now.
- Regulatory support has been garbage; we have to defend ourselves.
- Value based $'s might even out the game for primary care but not for specialists/ASCs (well, any time soon….).

Medicare Advantage & Your Practice

MA Plan Administrative Burden- Impact on Provider

- As plans continue to proliferate with little to no regulatory oversight, so does the overwhelming bureaucracy:
  - Same population of patients = endless variation of provider manuals & policies
    - Prior Authorizations
    - Appeals
    - Claims Payment Methodology
    - Carve-Out Vendors
    - Record Requests
    - Commercial policies applied to Medicare beneficiaries
- Death by Medical Record Request- Lead by UHC and Humana
  - UHC MA plus Humana MA, typically 15-20% of ASC payer mix; Likely 75% of chart requests.
  - Gambling for lack of ASC response leading to technical denial.
  - Provider examples of 100% approval rate post record submission…still not leading to fewer requests.

MA Plan Burden- Impact on Member

- Patient Confusion
  - How do I purchase the right plan?
  - How do I navigate my plan design?
  - Overzealous marketing efforts – health plans & brokers
- Patient Liability
  - 5-7 years ago, Medicare Advantage patient liability was roughly half of traditional Medicare – today, it equals or exceeds traditional Medicare. See ASC example below:

Example ASC		
Patient Liability as % of Allowable		
	2019	2023
Traditional Medicare	20.0%	20.0%
Medicare Advantage	14.5%	32.4%

Understanding MA Reimbursement Differentials

- If contracted/in network, MA plans have no obligation to match Medicare methodologies in terms of payment structure, CPT/APC weights, multiple procedure rules, etc.
- Be careful to include language that nails down Medicare rate structure, underlying weights, and payment policies.
  - ***Saying the payment methodology needs to match Medicare is not enough.***
- Payers may not be able to administrate straight Medicare payment methods and request to move to different, more simplistic structures.
  - ***Not opposed to this strategy but must be clear and understood to allow you to model accurately.***
- Recent trend to attempt to reduce reimbursement below Medicare in some areas. Currently, MD rates, lab, rad, etc. vs. ASC facility but likely coming for all provider types.
- Policy Changes Correlating to Compensation Reductions- Changes to payer bundling, MPR, etc. leads to sub-Medicare reimbursement, even if contracted rates are at/above Medicare.
  - ***Must be able to track correct payment accurately.***

Is your ASC in network? (Seems like a simple question, right?)

- Given the poor networks offered by MA plans originally, their reaction was one of several moves:
  - Offer mostly PPO plan designs with no out of net penalties for major services.
  - Deem in physicians via commercial agreements at unilaterally set rates.
  - Use physician agreements to deem in ASCs at unilateral rates.
  - If all else fails, actually engage the provider in discussions……
- Determining whether in net or not (If you're not sure…..)
  - Start with the payer online directory. Be sure to look for various product lines, both commercial and MA to determine whether included in everything.
  - If ASC included in payer online directory, contact payer for agreement or deeming mechanism. Determine terms/rates outlined in contracting mechanism.
- ***Being in network not always better….by a long shot.***

In vs OON Strategy - Pros and Cons

- In-Network Pros
  - Contract governs relationship.
  - In theory, negotiable.
  - Avoids out of net penalties, typically for HMO plans (as PPOs tend to be full out of net benefit plan designs).
  - Steers patients based on network directory listing.

- Out of Network Pros
  - Payer must use Medicare rates, payment structure, and payment policies.
  - Allows for full appeal rights generally not given in a contract (i.e. the ability to appeal all the way to Fed ALJ mechanism vs. being stuck inside payer mechanisms/some arbitration rights typically).
  - Retains ability to take issue to CMS for regulatory oversight. CMS will **NOT** engage in disputes between payers and providers **IF** there is a contract/in network situation. Will only engage if non contracted/out of net.

In vs OON Strategy- How to Decide?

- Understand market plans (licensed & sold by county) PPO vs. HMO, carrier by carrier.
- Understand plan design of your local offerings –
  - Is there a patient cost differential for out of network services?
- Loss of appeal rights- How far do we typically fight claim issues? Past the payer? To arbitration? To Administrative Law Judge? To Maximus?
- Historical administrative burden of each payor
  - Low: Anthem
  - Medium: Aetna
  - High: UHC & Humana
  - Obvious that plan growth = tighter control of the dollar and less authorized care
- ***One caution- No network adequacy play that will impact overall Medicare Advantage growth unless you have unique influence in your market. Make the assumption that MA as a whole and most plans individually will continue to grow….at least for a while.***

In vs OON Strategy- Rural Market Case Study

Payer	Total Enrollees	HMO %
Aetna Medicare	665	***22%***
Aetna HMO	147	
Anthem Blue Cross and Blue Shield	495	***30%***
Anthem HMO	147	
Clover Health	348	***0%***
Clover HMO	0	
Georgia Health Advantage	44	***0%***
GHA HMO	0	
Humana	5,702	***0%***
Humana HMO	0	
PruittHealth Premier	37	***100%***
PruittHealth HMO	37	
UnitedHealthcare	10,851	***17%***
UHC HMO	1,866	
Wellcare	774	***66%***
Wellcare HMO	514	
Totals	18,916	***14%***

In vs OON Strategy- Rural Market Case Study

Benefit Plan Comparison				
Plan Overview	**Aetna Medicare Eagle Plan (PPO)**		**Aetna Medicare Freedom Plan (PPO)**	
Monthly Premium	$0		$0	
Health Plan Premium	$0		$0	
Drug Premium	$0		$0	
Standard Part B Premium	$164.90		$164.90	
Part B Premium Reduction	No		No	
Health Deductible	$0		$0	
Drug Plan Deductible	$0		$150	
Plan ID	**H3288-034-0**		**H3288-031-0**	
Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Primary doctor visit	$0	$25 copay per visit	$5 copay per visit	$25 copay per visit
Specialist visit	$35 copay per visit	$50 copay per visit	$40 copay per visit	$50 copay per visit
Diagnostic tests & Surgical procedures	***$0-95 copay***	***35% coinsurance***	***$0-95 copay***	***35% coinsurance***
Lab services	$0 copay	35% coinsurance	$0 copay	35% coinsurance
Diagnostic radiology services	$0-195 copay	35% coinsurance	$0-225 copay	
Outpatient x-rays	$0-75 copay	35% coinsurance	$5-45 copay	
Occupational therapy visit	$25 copay	$50 copay	$30 copay	35% coinsurance
Physical therapy	$25 copay	$50 copay	$45 copay	35% coinsurance
Durable medical equipment	20% coinsurance per item	35% coinsurance per item	20% coinsurance per item	30% coinsurance per item
Prosthetics	20% coinsurance per item	35% coinsurance per item	20% coinsurance per item	35% coinsurance per item

In vs OON Strategy- Urban Market Case Study

Payer	Total Enrollees	HMO %
Aetna Medicare	4,321	***10%***
Aetna HMO	427	
Anthem Blue Cross and Blue Shield	1,773	***54%***
Anthem HMO	958	
Clover Health	32	***53%***
Clover HMO	17	
Georgia Health Advantage	559	***0%***
GHA HMO	0	
Humana	9,547	***28%***
Humana HMO	2,704	
PruittHealth Premier	50	***100%***
PruittHealth HMO	50	
UnitedHealthcare	9,099	***19%***
UHC HMO	1,746	
Wellcare	3,409	***83%***
Wellcare HMO	2,825	
Totals	37,517	***23%***

In vs OON Strategy- Urban Market Case Study

Benefit Plan Comparison				
Plan Overview	**Wellcare Patriot No Premium (HMO-POS)**		**Wellcare No Premium Focus (HMO)**	
Monthly Premium	$0		$0	
Health Plan Premium	$0		$0	
Drug Premium	N/A		$0	
Standard Part B Premium	$170		$170	
Part B Premium Reduction	No		No	
Health Deductible	$0		$0	
Drug Plan Deductible	N/A		$0	
Maximum Cost Share	$3400 In and Out-of Network; $3,400 In-Network		$3,450	
Benefits	**Wellcare Patriot No Premium (HMO-POS)**		**Wellcare No Premium Focus (HMO)**	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Primary doctor visit	$0 copay	20% coinsurance per visit	$0 copay	***N/A***
Specialist visit	$0 copay	20% coinsurance per visit	$30 copay per visit	***N/A***
Diagnostic tests & procedures	$0-20 copay	20% coinsurance per visit	$0-75 copay	***N/A***
Lab services	$0 copay	20% coinsurance	$0 copay	***N/A***
Diagnostic radiology services (like MRI)	$0-150 copay	20% coinsurance	$0-275 copay	***N/A***
Outpatient x-rays	$0 copay	20% coinsurance	$10 copay	***N/A***
Urgent care	$35 copay per visit (always covered)	$35 copay per visit (always covered)	$25 copay per visit (always covered)	***N/A***
Occupational therapy visit	$35 copay	20% coinsurance	$40 copay	***N/A***
Physical therapy & speech & language therapy visit	$35 copay	20% coinsurance	$40 copay	***N/A***
Durable medical equipment (like wheelchairs & oxygen)	20% coinsurance per item	20% coinsurance per item	20% coinsurance per item	***N/A***
Prosthetics (like braces, artificial limbs)	20% coinsurance per item	20% coinsurance per item	20% coinsurance per item	***N/A***

Value Based Care & Referral Patterns

- CMS continues to push towards value-based care – models developed around primary care providers
- ACOs/Risk-Sharing Models/Capitated Models are all dependent on controlling overall cost & quality of care **ESPECIALLY** care that is directed towards specialist providers.
- How does this happen?
  - Scorecarding cost and quality for specialist referral network
    - How are surgeries handled – ASC setting or hospital setting?
    - What is the quality of care – readmissions/infection rates/PT, etc?
    - Overall cost of similar cases depending on delivery site
- What happens next?
  - Redirection of care – do you know what your referring PCPs are looking at and how you potentially partner with them in these efforts to ensure retention of referral stream.

Monitoring Payer Performance/ Resolving Problems

Monitoring Payer Performance

- Clean Claim Pass Rate by Payer
- Denial Rates / Zero Pay by Payer by Code
- Days in AR by Payer
- Underpayment by Payer
- Assessing Administrative Burden by Payer
  - MA Plans vs Traditional Medicare
  - Pre-auth Burden
  - Appeal Overturn Rate

Payer / Carrier Relationship Management

- Understanding carrier goals – across all product offerings.
- Building relationships beyond conflict resolution.
- Participating in payer initiatives where possible.
- Utilizing your patients as your advocates.

Issue Resolution

- The Art of Escalation
  - Baseline Payer Relationship
  - When to pull escalation levers
  - When to pull in regulatory overseers
    - CMS
    - HHS
    - State Insurance Regulators
    - State Community Health Departments (i.e. Medicaid/other State run health plans)

Fragmented Oversight: Who's Here to Help?

- **Department of Insurance (DOI)**
  - In theory, fully insured commercial carrier issues only but they avoid health exchange issues like the plague.
  - New commissioner testing waters to engage beyond fully insured. Medicare Advantage issues discussed with DOI General Counsel.
- **Department of Community Health (DCH)**
  - Traditional Medicaid and CMO issues.
  - Support level has vacillated over time.
- **Department of Labor (DOL)**
  - In theory, oversees commercial self funded claim issues/disputes but support is non-existent.
- **Centers for Medicare and Medicaid (CMS)**
  - Oversees traditional Medicare and Medicare Advantage issues.
  - In theory, applies standards for network adequacy for MA plans. Minimal oversight; overall belief that providers have a methodology for resolving MA issues by suing the health plans.
- **Federal Department of Health and Human Services (HHS)**
  - Oversees Medicare/Medicaid plus more directly responsible for Health Exchange carriers/network adequacy. ***Terrible support.***
- **Department of Defense (DOD)**
  - Oversees Tri-Care issues….sort of…..
  - All issues appear delegated to intermediary (Humana); seemingly disengaged support.
- **State/Federal Legislators- When all else fails……**

Vetting New Carriers/Payers

Vetting New Carriers / Payers

- Pre-Contract Payer Questionnaire
- Evaluation of Financial Strength
- Cautionary Tale – Friday Health Plans
  - Payer insolvency / continuation of care
- Vetting Administrative Burden – Medicare Advantage
  - Excessive medical record requests
  - Excessing low cost pre-auth policies
  - Use of nationally available enrollment data by MA plan by product
  - Knowing **when** to contract – OON vs. INN Benefit Structure
  - Understanding lost appeal rights when in network

What To Do Next?

- Pull your numbers- Know the relative reimbursement, denial rate, underpayment rate, and general hassle factor for each material payer.
- Pull your contracts- Lay out key terms in one spot (Contract matrix).
- Develop your annual plan:
  - Remember- Old agreement does not equal bad agreement; but old fixed rates (even with a small escalator) usually means below market rates.
  - Know who is trying to put something new in the market. Determine whether they need you and impact on any leverage you might have.
  - Managed care strategy needs to jive with overall growth/physician recruitment/local employer outreach strategy. Consider all when laying out strategy.

Wrap Up & Questions