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## Preparing for the future

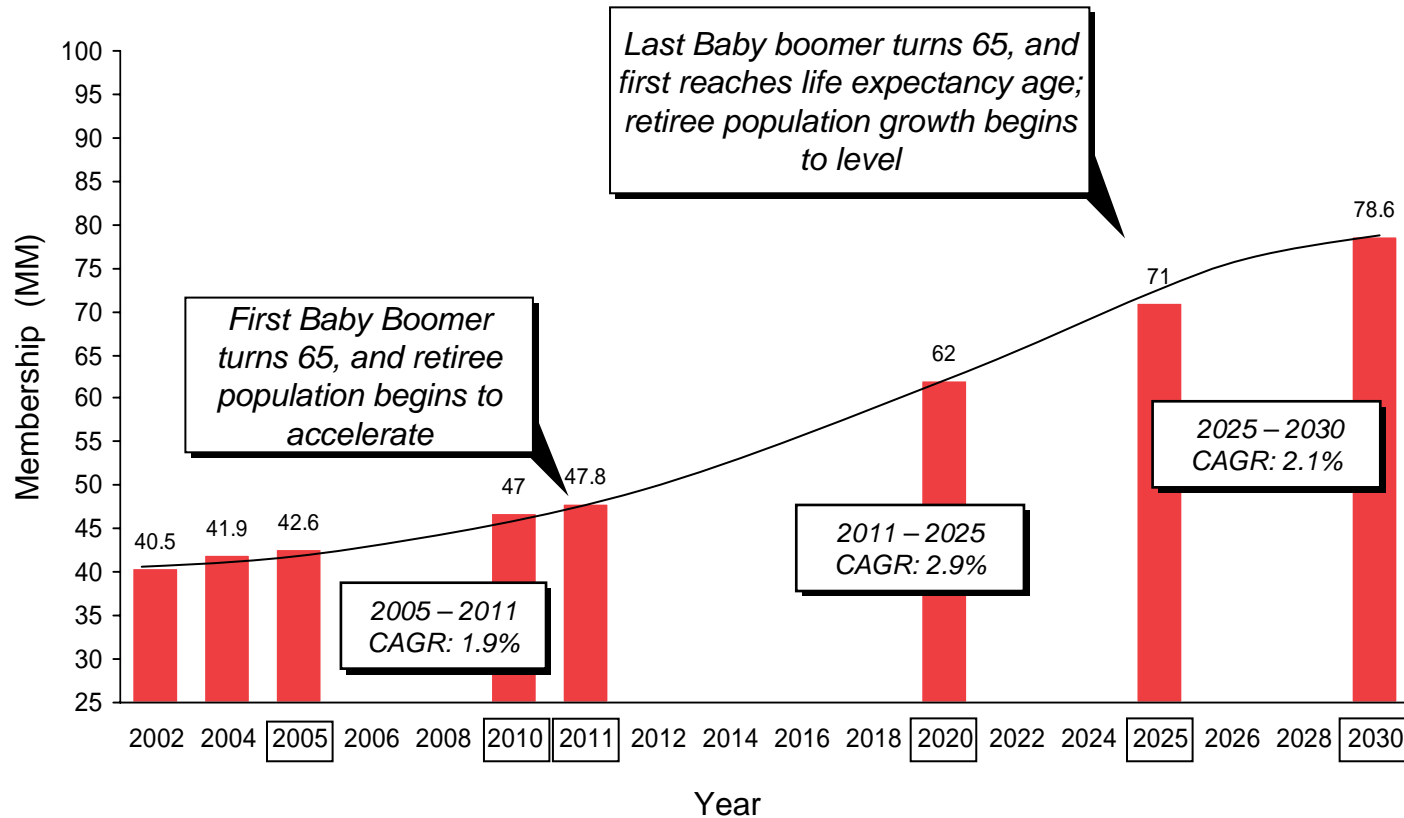
***Medicare Advantage: Strategies for Successful Retention and Management of High Cost/High Revenue Members***

October 21, 2008

Presented by:  
Rick Bowles, Principal

# The Medicare population grows dramatically

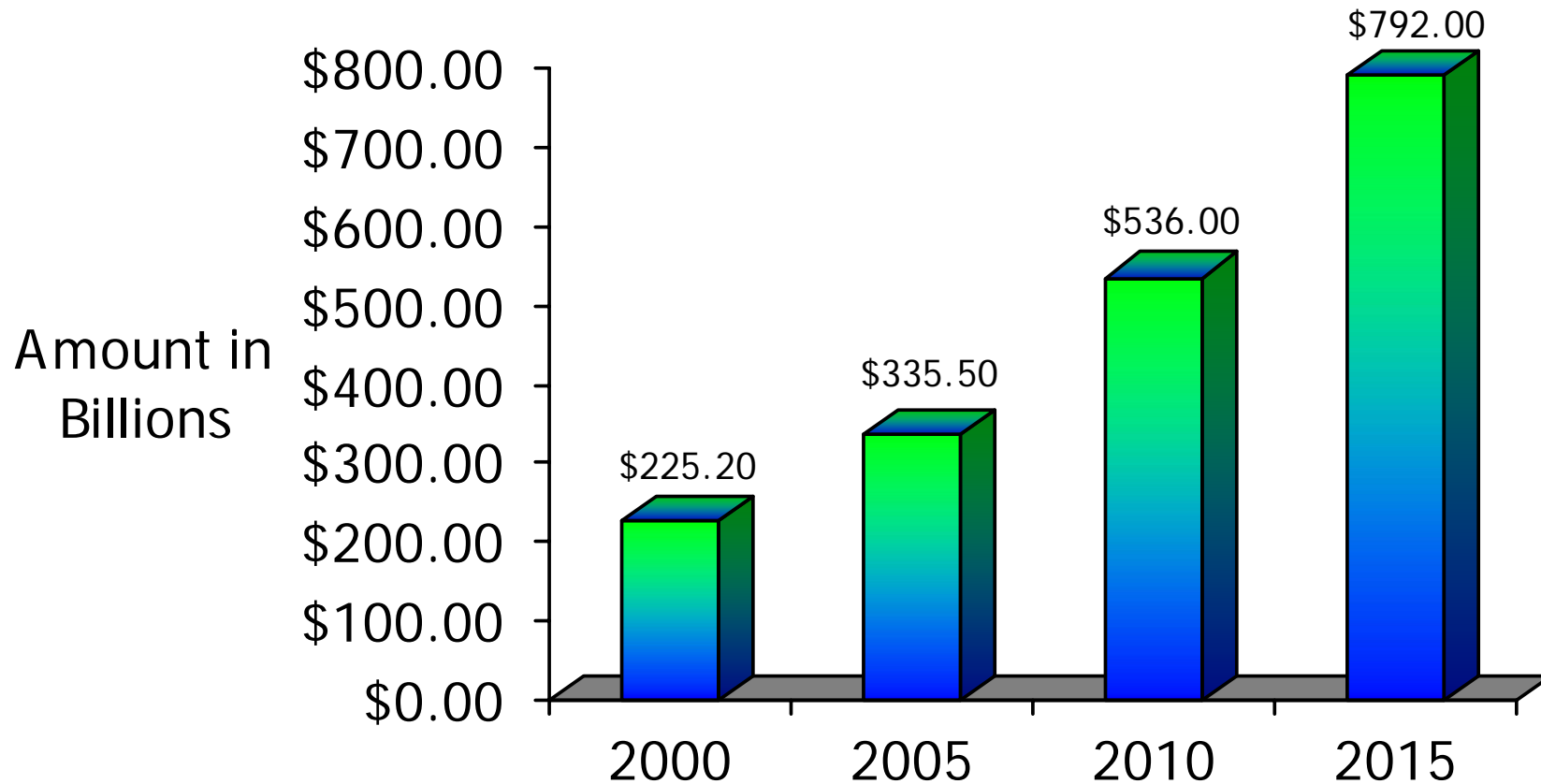
**Medicare Beneficiaries  
(2008 – 2030 projection)**



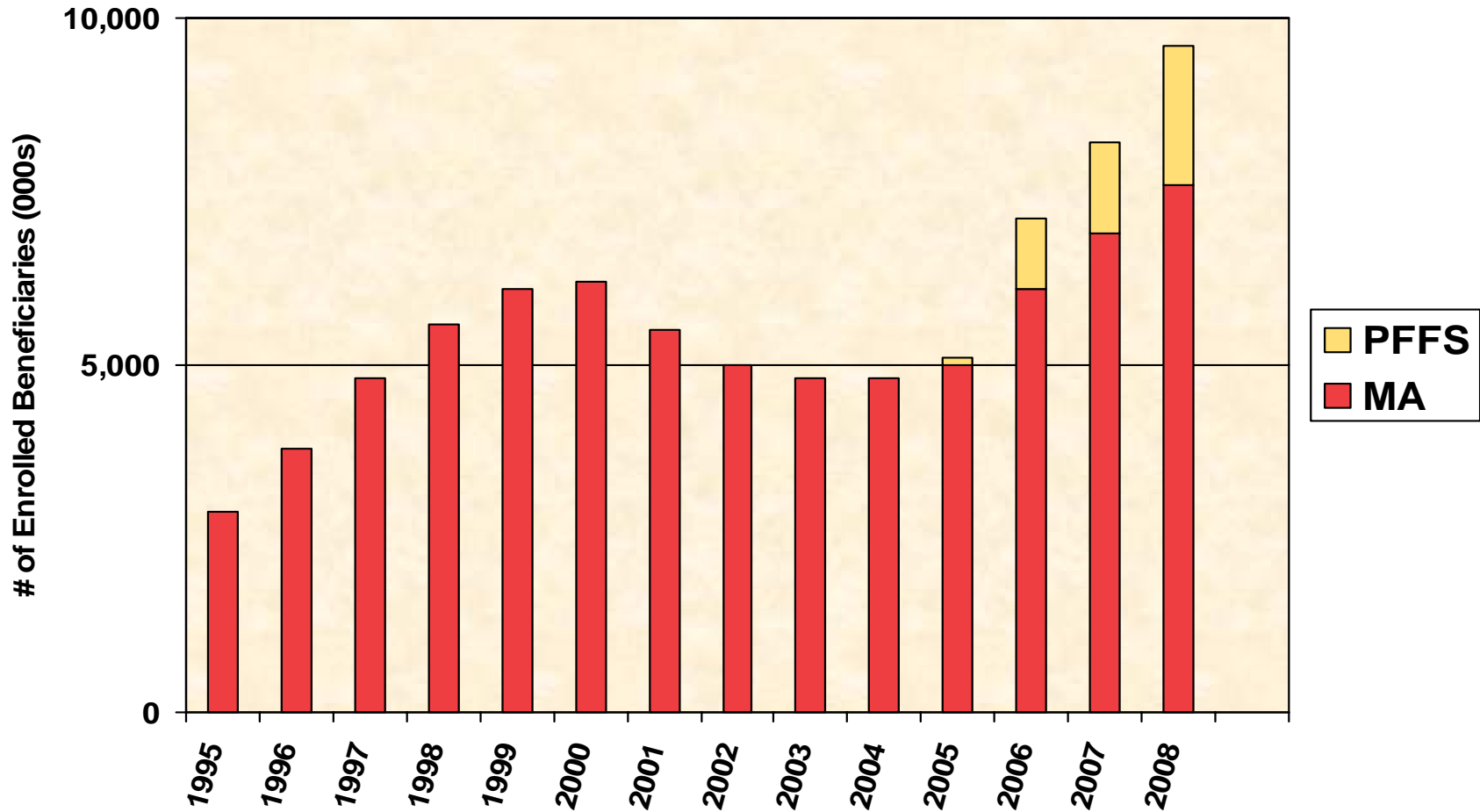
Source: CMS – 2008 Medicare Trustee Report

## ... as have Medicare costs

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# MA-PD growth due in large measure to PFFS growth



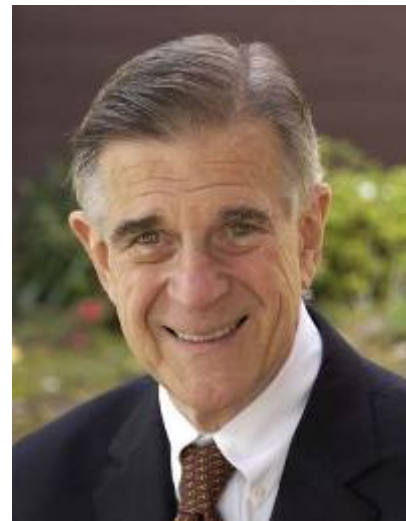
# 2008 Enrollment Results

<b>Enrollment Growth in Medicare Advantage Plans and PDP Plans between Feb. 2007 and Feb. 2008</b>					
	<b>No. of Contracts 2/1/07</b>	<b>No. of Contracts 2/1/08</b>	<b>Total Enrollment as of 2/1/07</b>	<b>Total Enrollment as of 2/1/08</b>	<b>Enrollment Growth Feb. '07-Feb '08</b>
<b>Total Prepaid Contracts</b>	<b>604</b>	<b>723</b>	<b>8,282,806</b>	<b>9,609,452</b>	<b>16%</b>
Local Coordinated Care Plans (CCPs)	410	509	6,064,666	6,829,803	12.6%
<b>Private-Fee-for-Service (PFFS)</b>	<b>47</b>	<b>77</b>	<b>1,327,826</b>	<b>2,057,472</b>	<b>54.9%</b>
Demonstrations	38	17	210,675	4,088	-98.1%
1876 Cost	27	25	305,753	271,386	-11.2%
1833 Cost (HCCPs)	13	13	78,486	75,719	-3.5%
Program of All-Inclusive Care for the Elderly (PACE)	37	44	12,535	13,952	11.3%
Medical Savings Account (MSAs)	2	9	2,238	3,358	50%
Employer Direct PFFS	1	2	10,200	12,755	25%
Pilot*	15	13	149,657	83,815	-43.9%
<b>Regional PPOs</b>	<b>14</b>	<b>14</b>	<b>120,770</b>	<b>257,104</b>	<b>112.8%</b>
<b>Total PDPs</b>	<b>101</b>	<b>102</b>	<b>16,929,499</b>	<b>17,409,977</b>	<b>2.8%</b>
Employer/Union Only Direct Contract PDP	10	9	122,863	123,526	0.5%
All other PDPs**	91	93	16,806,636	17,286,451	2.8%
<b>Total</b>	<b>705</b>	<b>825</b>	<b>25,212,305</b>	<b>27,019,429</b>	<b>7.1%</b>
* Pilot refers to contracts to provide care management services to FFS beneficiaries with chronic conditions.					
** Totals include beneficiaries enrolled in employer/union-only group plans.					
Sources: Medicare Advantage News, Feb. 21, 2008. CMS MA Monthly Summary Reports Feb 2007, Feb 2008					

# Congress taking a close look at MA and PDP

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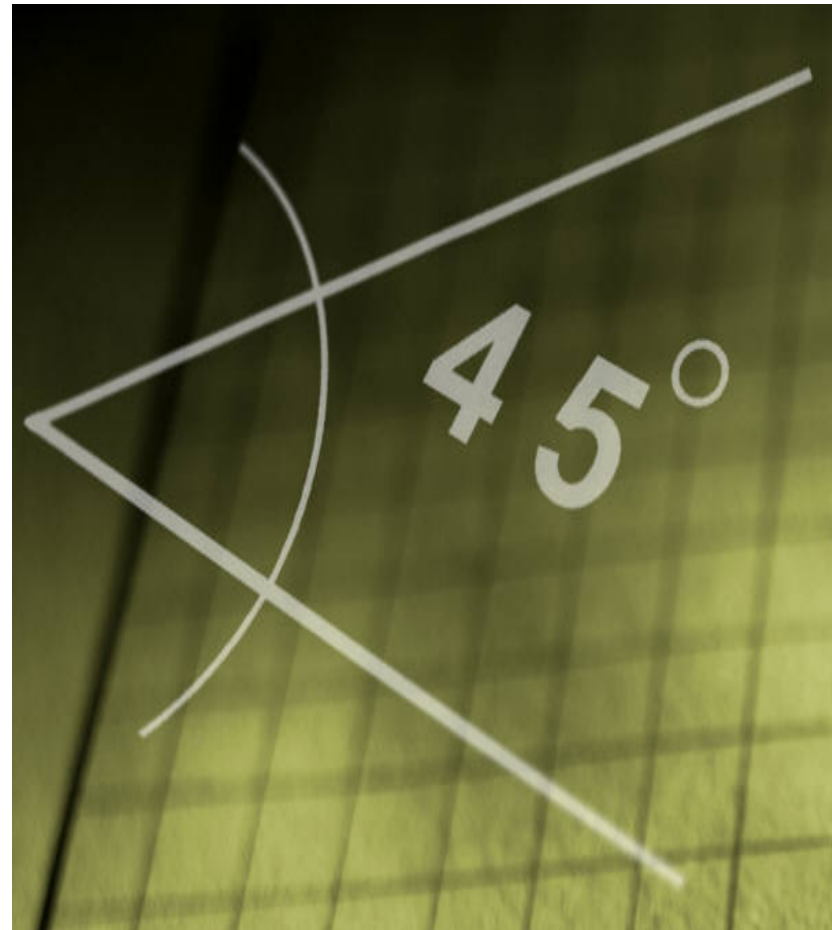
- MA overpaid
  - Reduce to 100% of FFS
  - Use savings for other programs
- PFFS and SNPs bad policy
- Options
  - Cap enrollment
  - Cap the number of plans
  - Eliminate option
  - Phase out option
- Industry suggestions (6331)
  - Allow care management
  - Eliminate deeming
  - Require QI participation



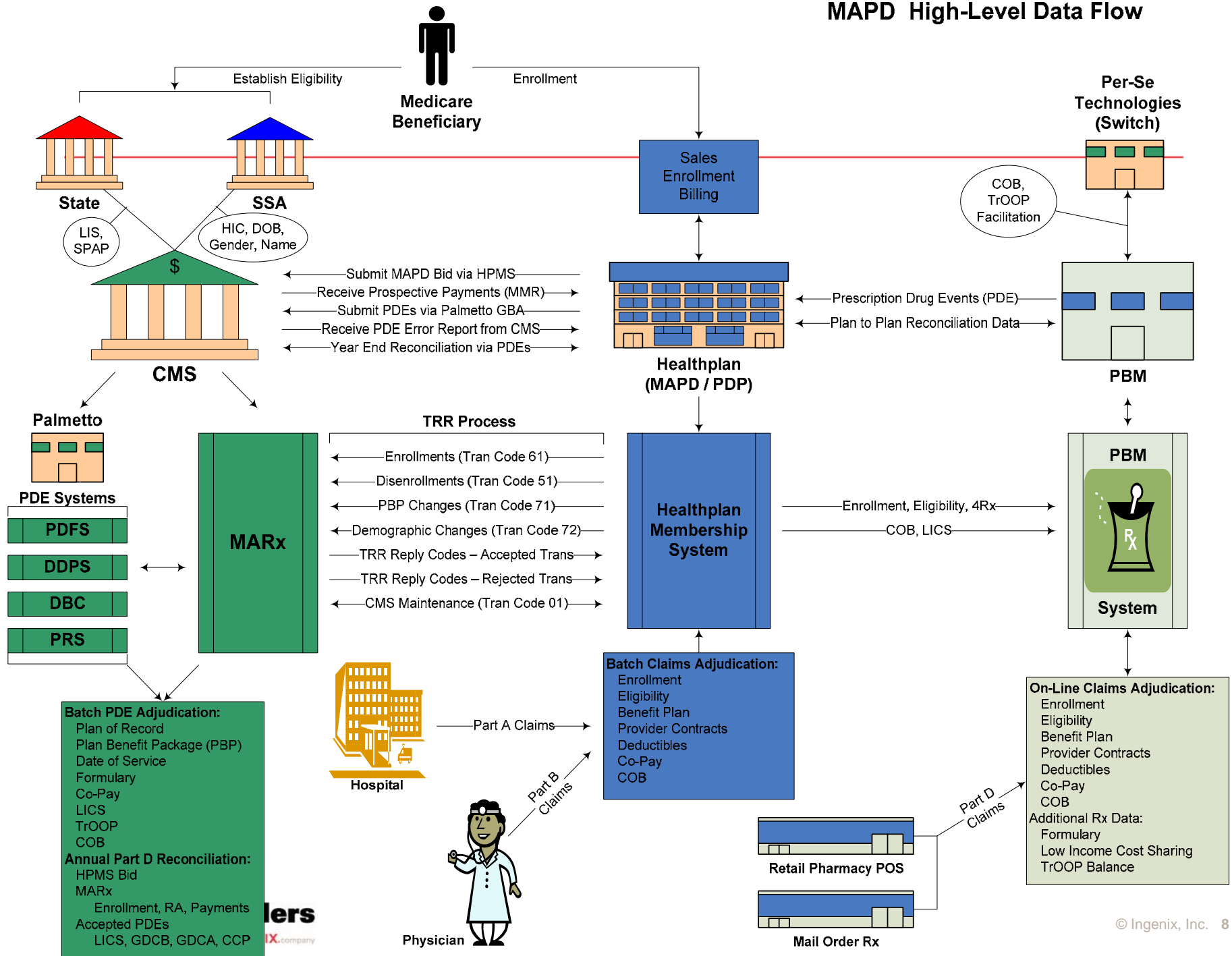
# Information is the lifeblood of a Health Plan

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For a successful  
Medicare product,  
Health Plans must have  
A view of all the angles.



# MAPD High-Level Data Flow



# Paradigm Shift

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- Diversified portfolio
  - HMO
  - PPO
  - PFFS
  - Chronic SNP
  - LTC SNP
  - DE SNP
- Sicker the beneficiary, higher the premium
- As we get to year 4 + of Risk Adjustment, non SNP MAPD plans will look like PFFS or have a premium

# Secret Sauce for Most Needy Members

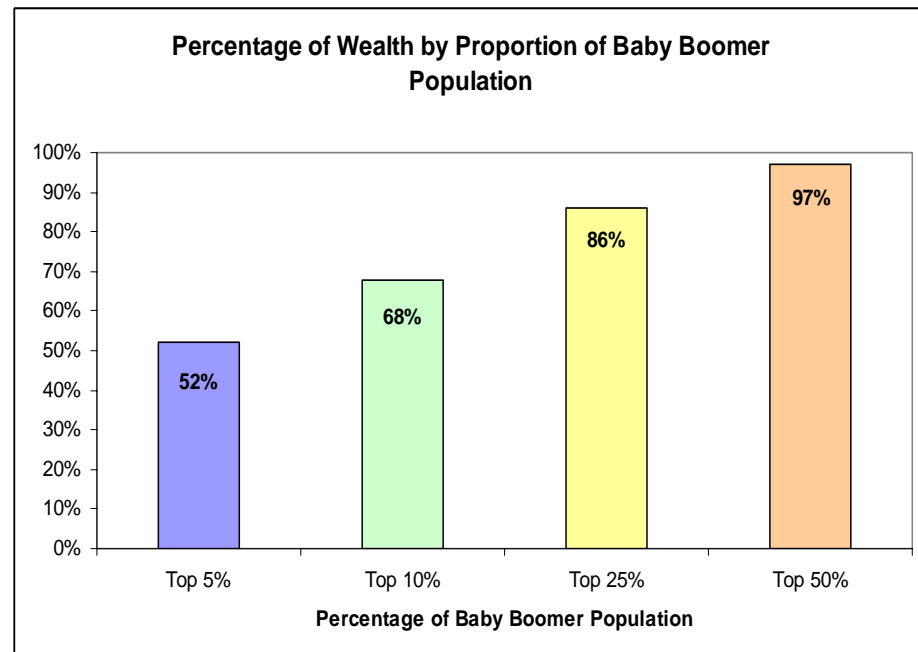
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You are managing a lifestyle assistance program,

**Not a benefit plan.**

# The Next Generation of Medicare Supplemental Insurance/MA Buyers will be Financially Challenged

- A small percentage of baby boomers own much of the group's wealth
- One third of baby boomers do not own assets in stocks, bonds, mutual funds, or retirement accounts
- Boomers retirement funds inadequate
  - Only 78% of workers covered by a Direct Contribution plan participate
  - Over one-half of 52 to 61 year-olds have \$0 in DC pensions or IRAs
  - The projected monthly annuity at retirement for those with DC pension and IRA funds is less than \$450



Source: US Government Accountability Office Report, July 2006

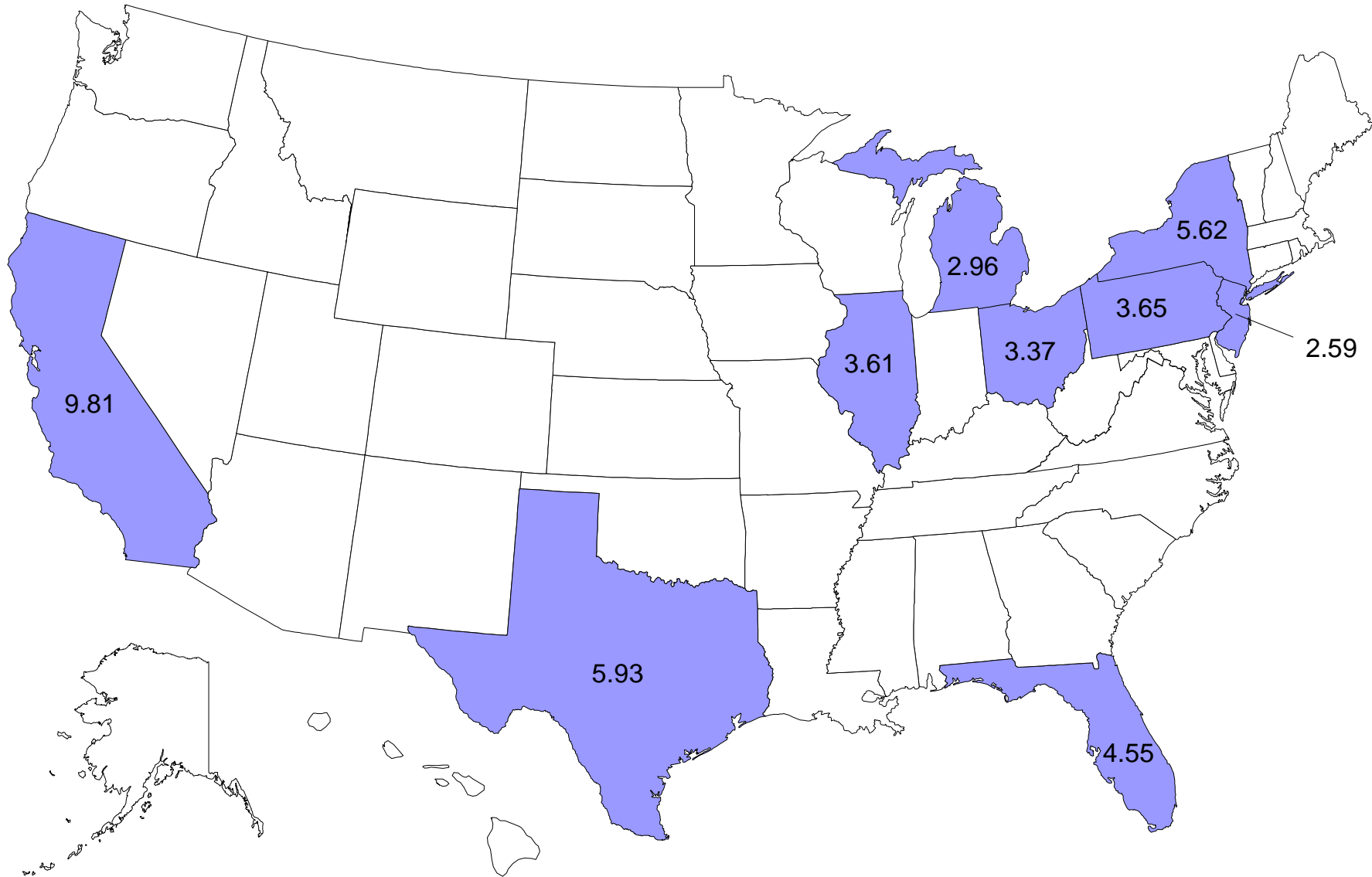
# Baby Boomer Lifestyle and Health

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- Baby boomers are not as healthy approaching retirement as previous generations
  - Boomers report having difficulty with routine activities and are less likely to report health as “excellent” or “very good” as predecessors
  - More likely to report having pain, chronic health conditions, drinking and psychiatric problems than people who were the same age 12 years earlier
  - Possible decline in life expectancy

Sources: April, 2007 Washington Post, March, 2007 National Institute on Aging Press Release

## States with Largest Baby Boomer Population (in Millions)



Source: 2003 MetLife Mature Market Institute Demographic Profile

# Projected Eligibles and MA Enrollment Compared to Baby Boomers by State

**Top Nine States by 2003 Baby Boomers**

State	(In Millions)
California	9.8
Texas	5.9
New York	5.6
Florida	4.6
Pennsylvania	3.7
Illinois	3.6
Ohio	3.4
Michigan	3.0
New Jersey	2.6

**Top Ten States by Projected 2007 Medicare Eligibles**

State	Projected Eligibles (Millions)
California	4.3
Florida	3.1
New York	2.8
Texas	2.7
Pennsylvania	2.1
Ohio	1.8
Illinois	1.7
Michigan	1.5
North Carolina	1.3
New Jersey	1.2

**Top Ten States by 2007 MA Enrollment**

State	Total MA Enrollment (Millions)
California	1.5
Florida	0.8
Pennsylvania	0.7
New York	0.7
Texas	0.4
Puerto Rico	0.4
Ohio	0.3
Arizona	0.3
Michigan	0.2
Oregon	0.2

Note: IL and NJ were numbers 19 and 20, respectively

*The largest Baby Boomer populations are also in states with the highest MA plan enrollment in 2007*

*The largest Baby Boomer populations are in the states with the most projected Medicare eligibles for 2007*

## Big Picture: Factors Affecting MA Revenue (or, CMS can make huge changes without legislative intervention)

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- A/B Revenue
  - Growth Rate
  - Rebasing FFS amounts
  - Recalibration of CMS risk scores
  - FFS Normalization Factor (FFS Coding Intensity Trend)
  - Difference in FFS versus Managed Care Coding
  - Budget Neutrality Adjustment
  - How well to risk adjusters work?
  
- Part D Revenue
  - RxHCCs – How well do they work?
  - National average bid and federal reinsurance amounts
  - Regional LIS premium benchmarks (impact of MA PD buy-downs)
  - Competitors, premiums and benefits
  - Risk Corridors

# Part C Risk Adjustment vs. Part D

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- Do you have a large gap between your Part C and Part D RAF scores?
  - Different categories (e.g. Alzheimer's)
  - Under reporting
  - Specialist Rx prescribing
  
- Are your RAF improvement projects CMS compliant?
  - Must be coded appropriately
  - No HCC inflating
  - Documentation must be air tight

# What is Risk Adjustment?

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- Method used to adjust payment based on the **health status and demographic characteristics** of an enrollee
- Allows for **comparison** of beneficiary to the average Medicare beneficiary
- Risk adjustment for Medicare is built on **FFS data sets**
- **Prospective model** – diagnoses from year prior to payment used
- Payment neutral to inpatient/ambulatory diagnosis source
- System neutral to treatment type – medical/surgical

# Risk Adjustment Overview

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- Clinical medical record documentation
- Face to face encounter
- Coding per ICD-9 CM guidelines
- DOS within the data collection period
- Appropriate provider type
- Appropriate physician data source

# CMS-HCC Model -- Demographics

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- Age
  - Payment for year based on enrollee age as of February 1st
- Sex
- Medicaid Status
  - Under CMS-HCC model, applies only to community residents (including short term institutional)
  - Defined as one month of Medicaid eligibility during data collection period
  - New enrollees use concurrent Medicaid
- Original Reason for Entitlement
  - Applied to community residents only
  - Applies only if originally entitled to Medicare due to disability

# Potential Compliance Risk Areas

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- **Provider Submission**
  - Diagnosis codes submitted on claims or encounters may not be supported with clinical medical record documentation that meets CMS risk adjustment guidelines
- **Plan Programs**
  - Programs the plan may do to facilitate diagnosis code capture (ex: chart review) may not be supported with clinical medical record documentation that meets CMS risk adjustment guidelines
- **Data Edits/Filtering**
  - Process for extracting and submitting diagnosis codes in RAPS files to CMS may not accurately identify appropriate provider types and/or physician sources

# Impact of Unsupported HCCs

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- CMS will perform data validation and cites the medical record (not the health plan's data trail) as the source of proof
- Discrepant records (records that do not support the HCCs submitted to CMS) are subject to financial take-backs
- CMS has advised of plans to extrapolate discrepancies and related financial impact to the MA organization's broader population

# Administrative Concerns

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- Submitting Claims
  - Filtering claims for submission
  - Navigating the system
    - How?
    - When?
  - Correcting claim submissions
- Risk Score Reconciliation
  - Reports provided by CMS
  - Which diagnoses are being used?
  - Timeframe
  - Tools available from CMS
  - In depth reconciliation

# MA Status Reconciliation

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Are you reconciling your membership monthly?

- ESRD
- Medicaid
- Working Aged
- Out of Area

# Care Management

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Maximizing Revenue and Reducing Costs through a comprehensive care management strategy.

# Care Management Program as an Integral Component of the Plan Model of care

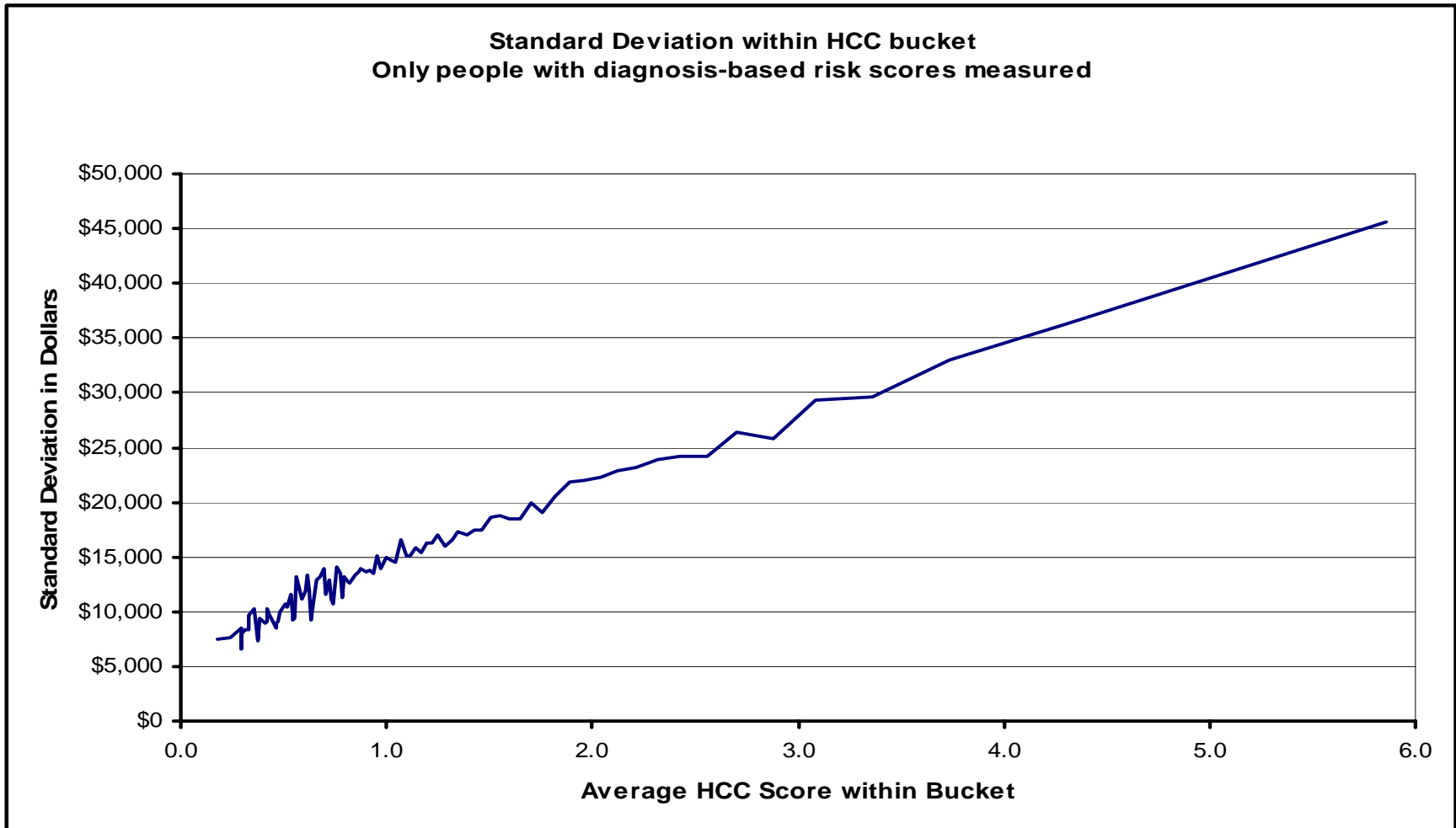
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## Key Components of a Comprehensive Case Management Program

- Member identification and risk stratification
- Proactive Case Management
- Provider engagement and communication
- Member education and self care management
- Technology
- Outcomes measurement and monitoring

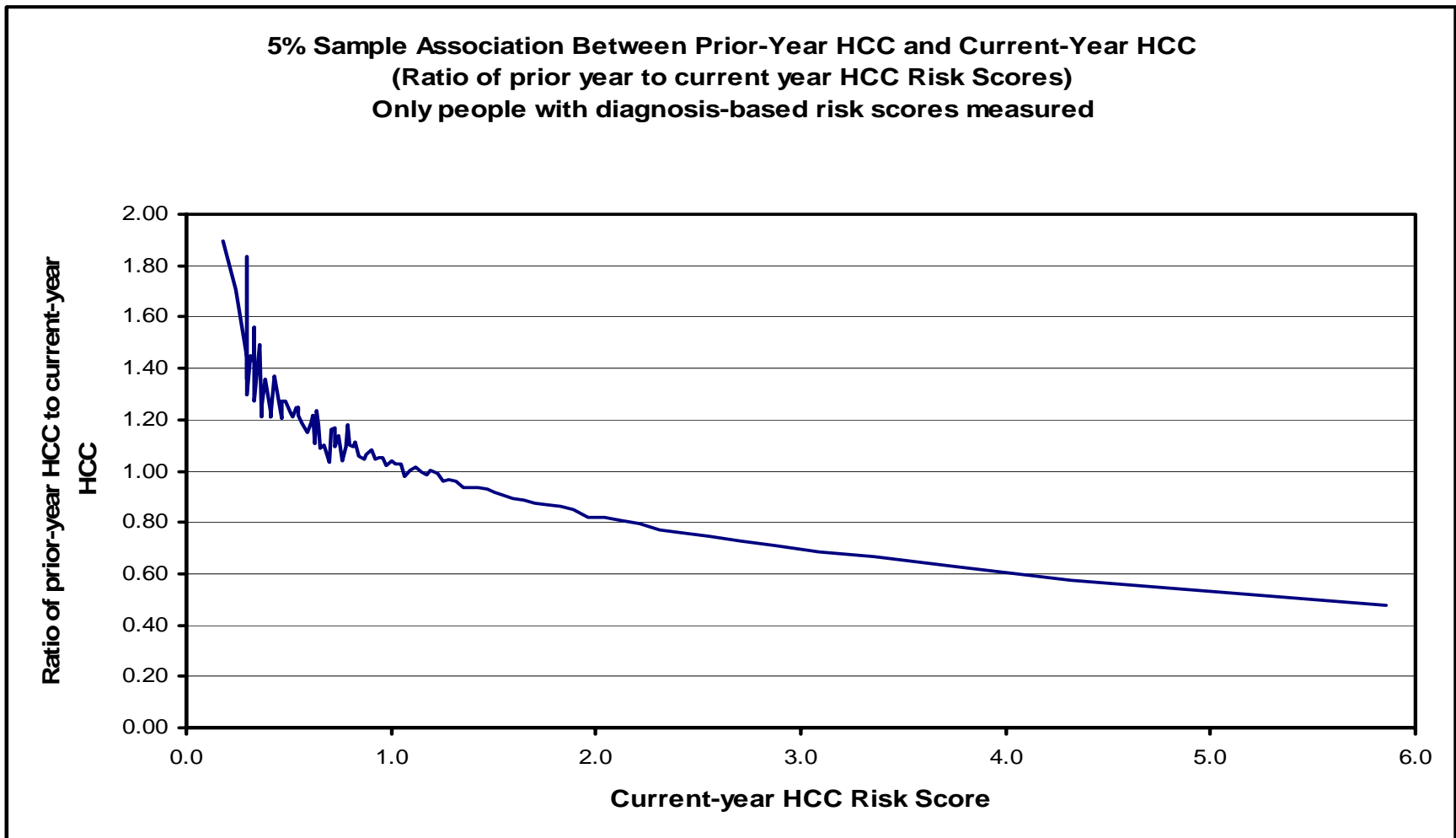
**Comprehensive  
Case Management**

# The Higher the Illness Burden, The Higher The Variability in Annual Claims Cost



# The Higher the Illness Burden The Less Likely You Have Appropriate Revenue

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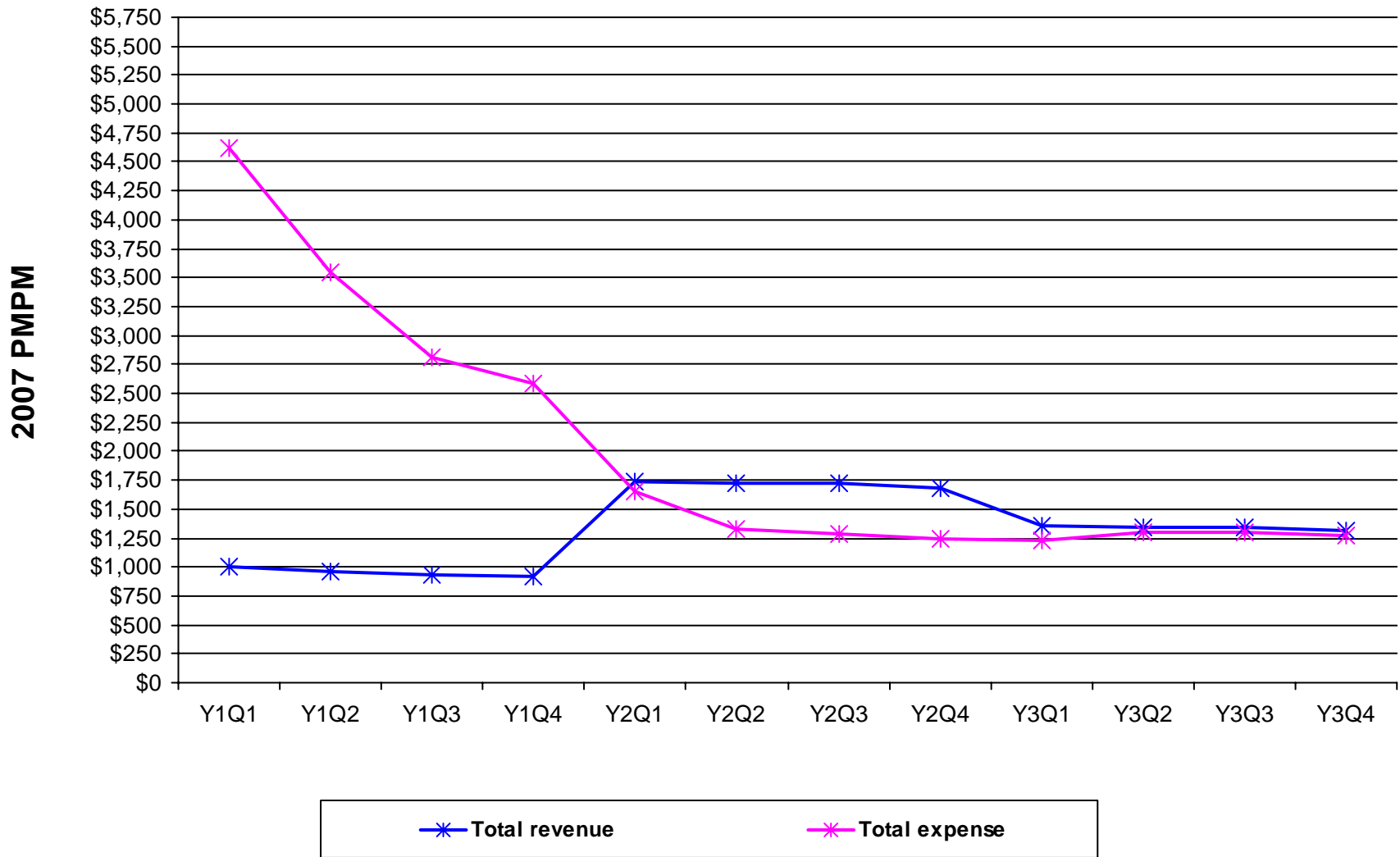


# Summary of High Rev Member Risks

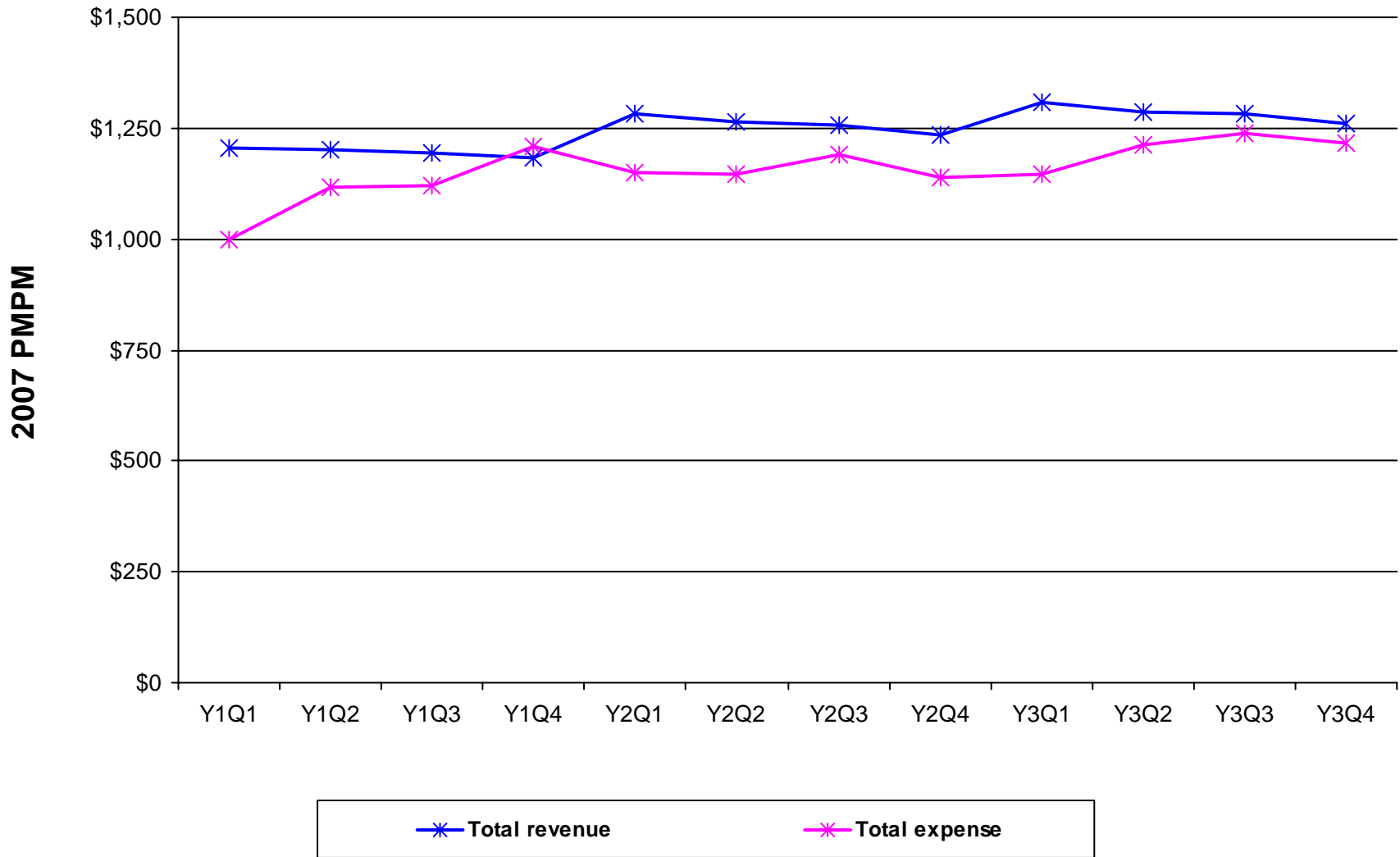
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- Not Having Diagnosis-Based Revenue
- Diagnosis-Based Revenue Inconsistent with Condition
- Recoding/Maintaining Chronic Revenue Not Automatic
- High Variability in Annual Claims Costs
- Probability of Death High
- Membership Years in Plan Low
- Margin in Year of Death Catastrophic
- CMS Continues to Maintain an Appropriate Level of Risk-Based Reimbursement

**First Diagnose in Year Enrolled by Chronic SNP (Year 1)**  
**Medicare PMPM Margin Components - 2007 Dollars**  
**CHF (HCC Definition; one or more hits on HCC 80) - Total**



**First Diagnose in Year Prior to Year Enrolled by Chronic SNP (Year 1)  
 Medicare PMPM Margin Components - 2007 Dollars  
 CHF (HCC Definition; one or more hits on HCC 80) - Total**



# Probability of Re-diagnosing

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By chronic condition, assuming diagnosis in Y0, the year before Chronic SNP enrollment, in addition to diagnosing in Y1 ...

Diagnose	Y0	Y1	Y2 & Y3	Y2 Only	Y3 Only	Never Again
CAD	100%	100%	33%	21%	11%	35%
CHF	100%	100%	43%	21%	7%	30%
COPD	100%	100%	51%	18%	7%	24%
CVD	100%	100%	34%	21%	8%	38%
Diabetes	100%	100%	75%	10%	3%	12%

# 2009 Medicare Hot Topics

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- Competitive Bid Process
  - Market competitive and manageable Part C and Part D benefit design
  - Competitive market analysis
- Revenue Reconciliations
  - Managing your Risk Scores
  - Enrollment Reconciliations
  - PDE (Prescription Drug Event) reconciliations
  - Other CMS reconciliations
- Organic Growth
  - Managing acquisition cost
  - Real, workable marketing and Sales plans
- Compliance
  - Marketing and Sales
  - Part C and Part D operations

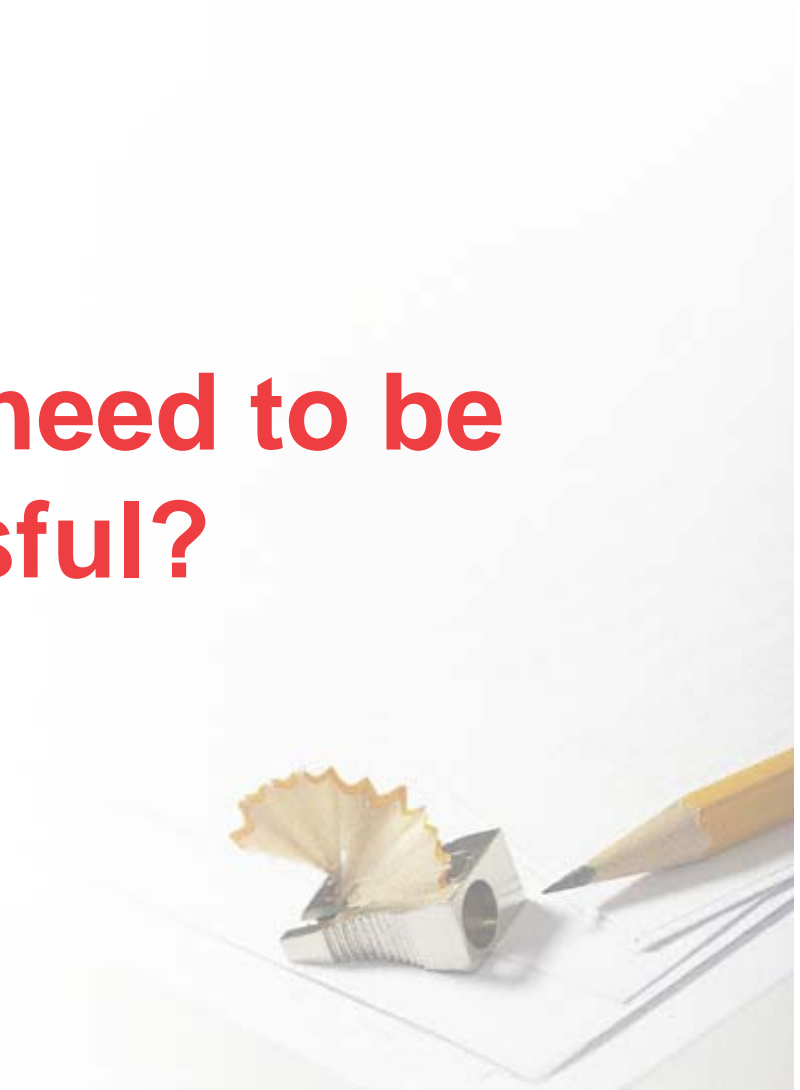
# 2009 Medicare Hot Topics, continued

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- Controlling Medical Cost Trend
  - Designed Care Management programs
  - Integrated DM, CM and Customer Service
  - Specific Health Risk Assessments and Interventions
- Retention
  - Lowering Rapid Disenrollments
  - 6 – 7 times cheaper to keep a member then to replace them
- Special Needs Plans (SNP)
  - Dual Eligible SNP
    - In a “For Profit” Plan
    - In a “Not for Profit” Plan
  - Long Term Care SNP
  - Chronic Disease SNP

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# What do you need to be successful?



# Management and Strategy Planning

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- Product Portfolio Strategy
  - With all the existing MA products available (HMO, POS, PPO, PFFS, SNP, MSA, Demos, PDP, MAPD, Employer 800 plans), what is the right product for the right population and service area?
  - Also must remember that Medicare Supplement products are not dead and still a viable product for some
  - Evaluation of market expansions, product development, benefit design, medical management, pricing, etc.
- Sales and Marketing
  - Development of a sales and distribution channel strategy to support your strategic plans
  - Developed Tools
    - Sales Training
    - Compliance Training
    - Project planning/business planning for independent distribution
    - Reporting templates/matrixes
    - Templates
      - Broker contracts

## Management and Strategy (continued)

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- HR 6331 (2009)
  - Updated policies and procedures
    - Part C
    - Part D
  - Updated sales and marketing procedures
    - Business planning
    - Broker due diligence
  - Developed compliance programs/tools
    - Review tools
    - Audits
  - Audits
    - Rules are being revised by CMS
    - No audit template
    - CMS Site Visit Preparation

# Management and Strategy Plans

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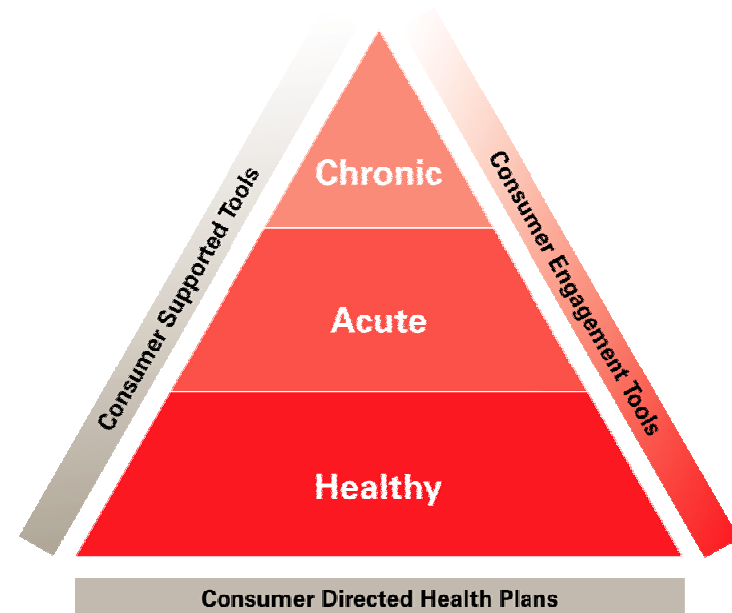
- Systematizing our senior market strategy facilitation and business development processes
- Design the next generation of Medicare products and benefits
- Expand benefit packages and products in service areas
- Explore other MA strategies and products
  - MSA
  - SNP
  - Group Retiree

## About the Solution

# Consumerism Trends: Driven by Employers Need to Reduce Costs

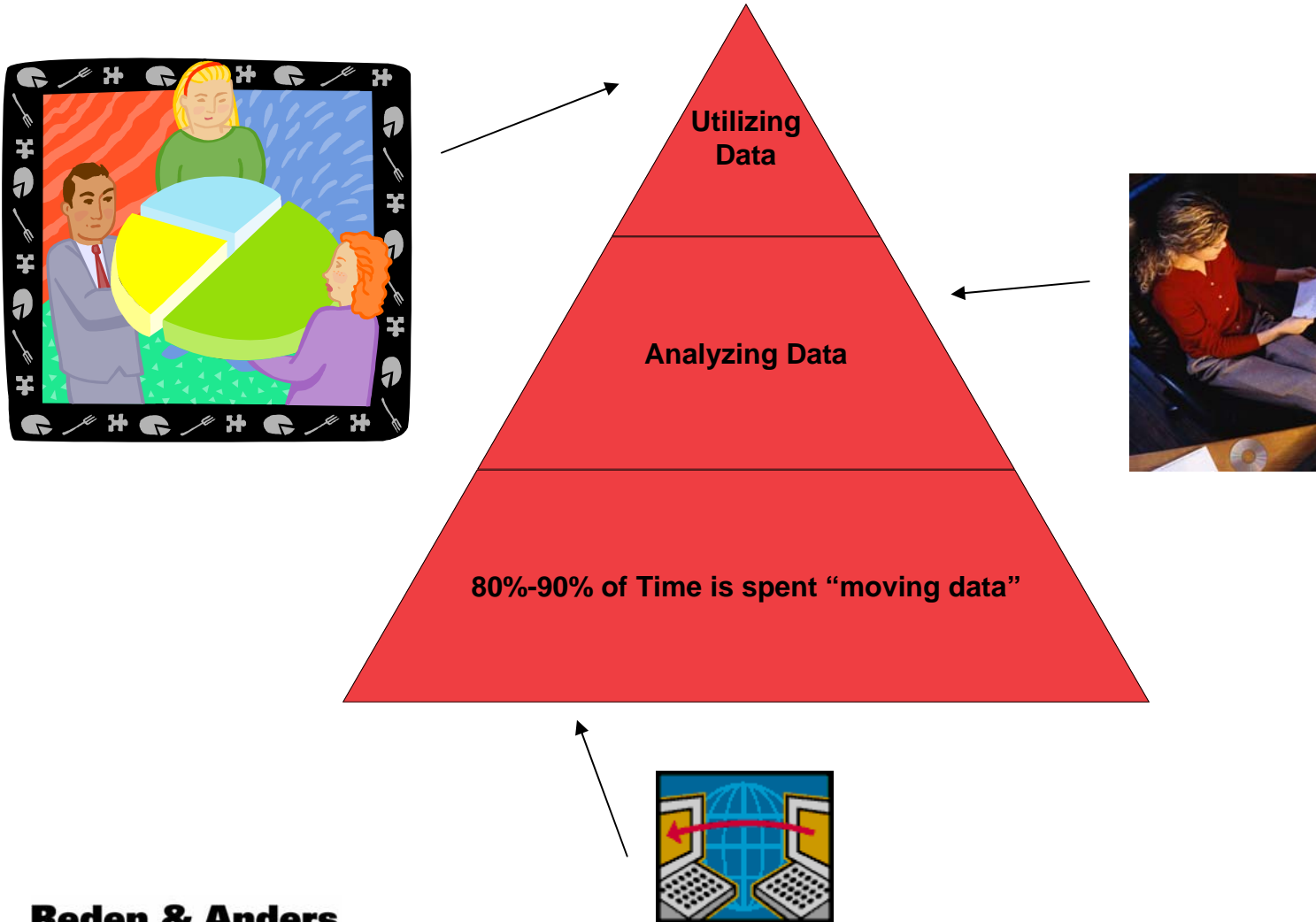
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- Determinants of Health Status
  - Behavior - 50%
  - Genetics - 20%
  - Environment - 20%
  - Access to care - 10%
- **Behavior accounts for 50% of health status!**
- **59% of next years medical cost comes from this years low & medium risk populations**



# “Data is the lifeblood of a health plan”

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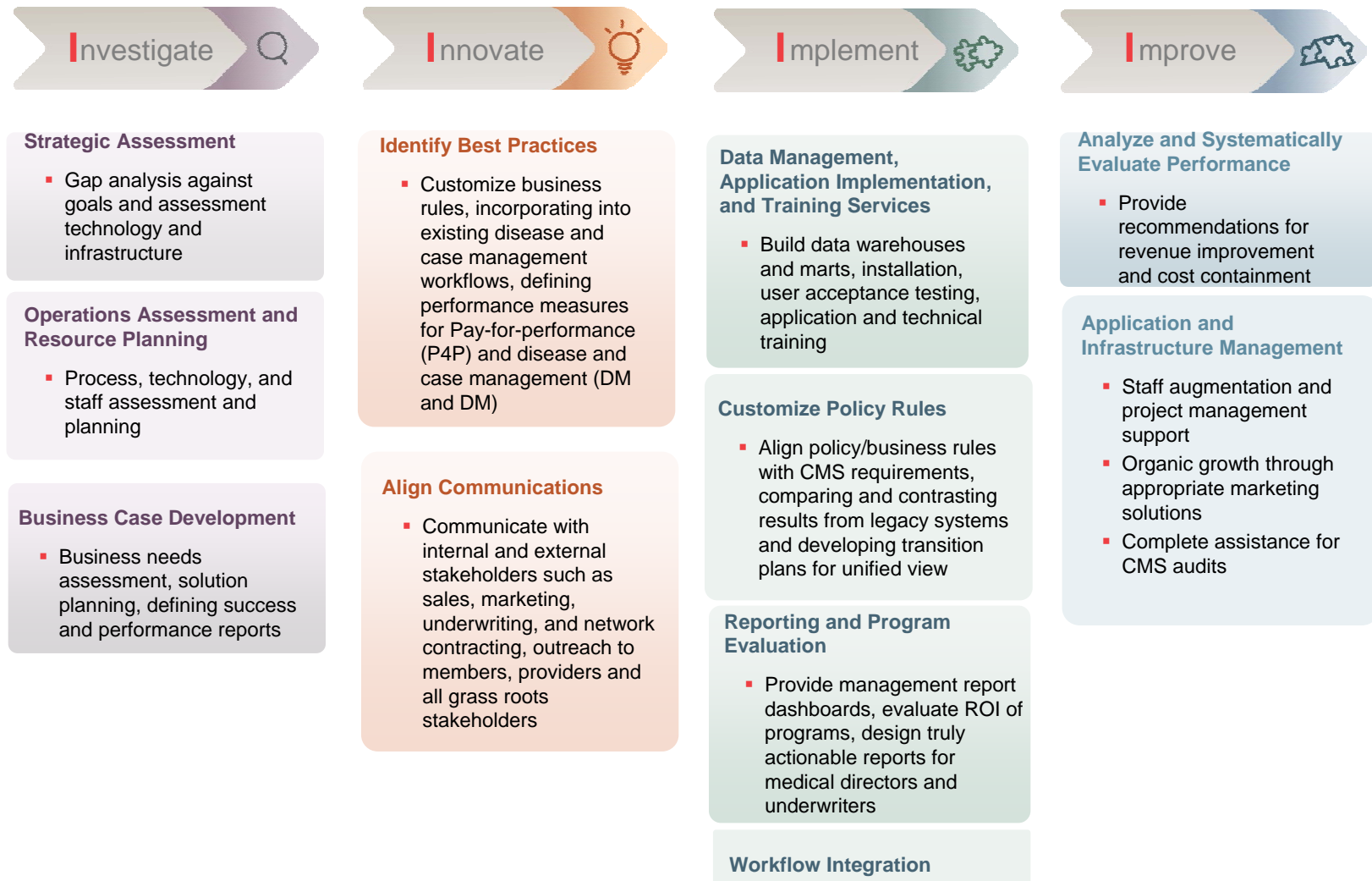


# Keys to Success in the New Medicare

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- Monthly revenue reconciliation/recovery
- Dedicated staff and infrastructure; organizational priority
- **Focused Care Management**
- Aggressive member service/retention programs and VIP service models
- Scalable, flexible data systems
- Vigorous monitoring of PBM, vendors
- Less than 20% “age-in” or FFS new growth in first two years

# What drives the Medicare Product Lifecycle



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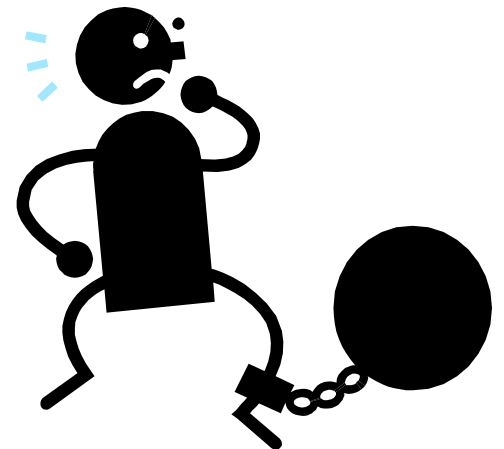
**There is no such thing as  
minimally compliant!**



# Potential Sanctions for Violations

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- Intermediate sanctions
  - Suspension of marketing
  - Suspension of enrollment activities
  - Suspension of payment for new enrollees
- Civil monetary penalties (CMS and OIG)
  - **\$25,000 per member per offense**
- OIG exclusion from the Medicare program.
- Contract nonrenewal or termination



# Avoid Compliance Problems

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- Make sure policies and procedures are implemented to support your compliance plan.
- CMS will look to internal mechanisms, work flow management, manuals, files, etc.
- Be able to provide proof of compliance and oversight
- Know your plan's "high risk areas"
  - Important issue areas identified by CMS and enforcement agencies
  - Past and current problem areas with the organization
  - Vulnerable areas because of staffing or organizational structure

# Avoid Compliance Problems (cont.)

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- Devote Adequate Resources to Interdependent Functional Areas
  - CMS compliance requirements are drawn from OIG compliance guidance from the 1990's
  - The volume of requirements has increased with Part D and under the MA program.
  - Contract performance entails collaboration across departments and with subcontractors (systems, CMS submissions, marketing, member materials)
  - Attention and resources needs to be expended to address these complexities

# ***How to Reach Us***

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