2020 Medicare Advantage e-Book

HOW TO WIN AT MEDICARE ADVANTAGE FROM PREPARING TO OPTIMIZING

Step #1: Conduct a Market Assessment
Step #2: Choose a Plan
Step #3: Understand Cost Structure
Step #4: Complete the Application Process
Step #5: Create a Network
Step #6: Establish an Operational Approach
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MA Solutions From Change Healthcare
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THE MEDICARE ADVANTAGE OPPORTUNITY

Medicare Advantage (MA) is one of the fastest-growing and most complex health plan lines of business representing significant growth opportunities for payers. Launching and maintaining a successful MA program requires careful, strategic planning to meet requirements, ensure compliance, and maximize the program benefits for your organization.
The Medicare Advantage Opportunity

Projections indicate that Medicare Advantage (MA) enrollment will reach 50% by 2025. Payers view MA entry as a clear avenue for growth, but must manage a wide range of considerations in order to be successful.

L.E.K. Medicare Advantage enrollment trend and projection

The Medicare Advantage Opportunity

Offering MA allows payers to retain their members and maintain long-term relationships with commercial, Medicaid, or exchange members as they age or disable into Medicare. MA plans tend to be much less restrictive than traditional Medicare, and the 2020 updates even allow benefits such as meal delivery, transportation for non-medical needs, and in-home services.

This benefit flexibility allows payers to invest in more personalized benefit designs that address specific health concerns for their population. The updates also cover more benefits that address social determinants of health (SDoH), which have a larger impact on member outcomes than pure clinical care. Payers have the opportunity to connect beneficiaries with local resources which are ideal for addressing SDoH such as socialization, prescription support, and housing assistance.

Programs like these help payers connect to and build relationships with providers, and establish the resources they need to engage in value-based care (VBC) agreements. VBC is further supported by coupling MA’s star rating system with the health plan’s internal quality metrics.
Entering the complex MA market is overwhelming and rife with regulatory and operational requirements essential for success. This eBook breaks down the complicated process of launching and optimizing MA plans into 10 clear steps for payers.
STEP #1: CONDUCT A MARKET ASSESSMENT

A comprehensive market assessment is the first critical step to identifying your opportunity. An assessment will help you explore your rationale, understand current market conditions, and determine if you can compete.
**STEP #1: Conduct a Market Assessment**

Examine your rationale before committing to entering the MA market. Begin your market research with a thorough assessment of the areas and membership you serve—or would like to serve. Explore the competition, recognizing that in some counties, more than a dozen plans might be competing for the same members. Determine which plans are already offering MA plans, and understand their value to consumers. Your potential competitors may be offering similar or vastly different benefit packages. Before entering the market, you should feel confident that your plan can either compete with existing packages or provide a different, more attractive package.

You will then want to determine if your plan can be competitive in this space. Surprisingly, the size of your health plan should not factor into your ultimate decision. Many small, regional players are successful in MA precisely because they are regional, and therefore thoroughly understand their market and the provider community.

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**Your Market Assessment**

Why do it?  
Who is the competition?  
What are their benefits?  
Can you compete?
STEP #2: CHOOSE A PLAN

Identify where you will serve your members before you evaluate plan types, select your MA plan, and design your benefits. Stay focused on ensuring that your plan design and benefits provide what your members want.
**STEP #2: Choose a Plan**

Considering what kind of plan to offer begins with identifying the locations in which you will serve members. What is the service area? Which counties—or parts of counties—will you be in? What will your reach be?

1. **Identify where you will serve your members**
   
   Evaluate what type of plans you should offer based on the needs of your membership. There are a variety of plans within MA to consider, including inpatient and outpatient care, prescription drug coverage, and MA Part D. Additional subsets to consider include dual-eligible, MMP hybrid, institutionalized special needs, and assisted living, etc. Explore them all to determine which plans will allow you to best serve members.

2. **Evaluate what type of plans you should offer**
   
   You will then need to design the benefit. CMS provides more leeway with MA, and does not dictate what benefits need to be offered. You will need to design benefits that appeal to your market and that you are capable of administering. For example, offering a new benefit for routine foot care will require that you can process a reimbursement request for a pedicure. That might mean adding a code for routine foot care. If you design compelling benefits that offer desirable care services for the population you hope to serve, your plan will be more competitive.

3. **Design your benefits**
   
   About the Expert
For a full view of the costs associated with launching a MA plan, payers need to determine how much reserve money is required to become licensed as a risk-bearing Medicare plan in each applicable state. There will also be significant startup expenses in a variety of areas.
STEP #3: Understand Cost Structure

Startup expenses should not be underestimated. Research recommends that payers plan on investing at least $3-$5 million to launch an MA plan.\(^1\) Staffing, software, and investments in organizational changes will be required.

For example, your plan might need to hire more on-call physicians. MA plans require that physicians be available at all times, even if you have only one member enrolled.

Predicting when you will become profitable is based on startup costs and activity. Typically, profitability takes 3-5 years due to the initial investments required.
The MA application process is long and arduous. There will be hundreds of pages of documentation requiring decisions and attestations from your organization, your board, your leadership, and your owners. They will need to verify their intent, current status, and completed tasks. We recommend allocating 16 months for this step. While the MA application process can be completed in shorter timeframes, it will be stressful and require significant resources.

In addition to completing all the necessary paperwork, you will need to select a Medicare actuary and, if you decide to offer prescription benefits, a pharmacy benefits manager (PBM). Both decisions require important considerations.
STEP #4: Complete the Application Process

As part of the application process, you will then need to select a Medicare actuary who will be an essential collaborator in crafting your bid. Your actuary has the important role of helping you price items within your benefit design, and can tell you how much specific benefits will add to the program cost. Choose an experienced actuary familiar with MA. You’ll also want to ensure your actuary values the benefits you need to include to be competitive in your market. They shouldn’t rule out potential options based purely on cost. Collaborate with your actuary to identify the benefits needed in your market and align costs.

If you decide to offer prescription coverage, you will need to select the PBM and explore contracting options. In addition to pricing, contracting is an important consideration that will be more complicated the first year. Brand-new plans must use PBMs not only to provide the pharmacy network, but also to handle all member grievances and appeals about prescription Part D drugs. This makes the PBM’s support services critical to your success. You will also want to ensure the adequacy of the network. Make sure your PBM is a true partner who can understand and advise you about CMS Part D requirements. CMS guidance changes often, which will directly impact your schedule. Choose a PBM partner that can help you successfully navigate these changes.

You should also build the role of compliance and CMS into the process. Your Medicare compliance team and the CMS plan manager assigned to your plan should be allies. The CMS team is there to help you succeed, so we recommend building an honest and forthcoming relationship with them.
While the application process is challenging, the longest lead time will be needed for creating your provider network.

Existing networks are likely insufficient for MA. Explore various contracting strategies and make sure that each contract is rewritten with Medicare-specific language. Creating the network is a significant task. Payers should consider if they have the right in-house resources and experience to complete this step without assistance.
STEP #5: Create a Network

Build relationships with your provider network during the contracting process. Consider which strategies to negotiate in your contracts, such as fee for service (FFS) and value-based contracting to align the quality of care.

Ensuring your network can serve each MA beneficiary is a very challenging requirement. CMS will indicate—based on population and time/distance standards for urban, suburban, or rural regions—how many providers of each specialty you will need per zip code. This includes primary care physicians, cardiologists, gastroenterologists, hand surgeons, hospitals, skilled nursing facilities, etc. It is very unlikely your current network will meet CMS requirements for MA.

You will need to meet the following challenging requirements using the health service delivery tables (HSD tables):

- If 90% of your beneficiaries can’t access providers in their own zip codes, you may not qualify.
- If you don’t have a specific specialty in your county, you can spill over to outside your service area, but you must prove that to CMS.
- Some provider types, such as oral surgeons or dermatologists, might be difficult to contract with, as they know you need them; therefore, they may ask for outrageous rates for commonly used services.

Creating your MA provider networks is a significant burden, as staff must be credentialed using the Medicare standards. Consider training staff or outsourcing this function.

When building your provider network, explore value-based contracting, or bundling payments for specific services such as joint replacement for shoulder, hip, or knee. Identify the network that will be included in the bundle and decide if you will select a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). With MA, an HMO will give you more control and allow you to align incentives with the providers that are part of your network.
STEP #6: ESTABLISH AN OPERATIONAL APPROACH

Establishing a clear strategy around six fundamental aspects of your MA plan will help you define and build a successful line of business.

This strategy includes determining your sales and marketing approach, deciding what functions to outsource and delegate, and clearly defining how you meet CMS compliance and operational requirements.
STEP #6: Establish an Operational Approach

Preparing for your MA launch requires a thoughtful strategy across key operational elements of your business. Six of the most important questions you will need to answer are:

Will you hire sales agents from your staff, or contract with an outside agency?
All agents must be trained in Medicare, trained on your benefits, licensed, and in many cases, appointed at the state level to qualify to sell your MA product. In-house employees will give you more control, but you will likely get more experienced professionals if you work with an outside agency.

What functions do you want to outsource in the short and/or long term?
Many functions can be outsourced or delegated, including communications, pharmacy, and member services (all hours or just after hours), etc. Remember that you retain responsibility for everything your delegates do. They need to be trained and monitored to ensure they meet CMS criteria.

How will you learn and meet operational requirements for Medicare?
The long list of requirements from CMS include Healthcare Effectiveness Data and Information Set (HEDIS) measures, quality improvement strategies, and detailed processes for matters such as how you must handle and document phone calls. Experienced Medicare staff can help you properly implement these excruciatingly complicated processes.
STEP #6: Establish An Operational Approach

What policies and procedures will help your compliance with ever-changing criteria?
CMS requires policies and procedures for everything, and the guidelines are dynamic. While CMS publishes manuals, they also use the health plan management system (HPMS) to communicate copious changes (420 or more) over the course of a single year. Payers must stay abreast of changing policies, procedures, training, desk aides, and reports.

How will you prepare for CMS audits?
As you prepare to enter the MA market, CMS will provide you with a readiness checklist and will verify your progress along the way. You can expect CMS site visits and requests for copies of policies and procedures throughout the process. MA payments are based on a hierarchical category code (HCC) and the number and types of conditions you have within your membership. Quarterly and annual reporting is required. CMS will verify this information for inpatient care, outpatient care, and your Part D prescription drugs. Expect an audit to ensure valid data capture.

How will you develop and implement your member and provider communications strategy?
After identifying the communications content and channels, you’ll need a system by which to monitor and track your outreach. While CMS is now letting members opt in to receive email, you must monitor email and establish a process for when a member does not open the email within a certain period; you must also send a hard copy. Your communications should be effective, clear, and easily understood by members. Provider network communications are also important and can help close gaps of care.
Software is essential for managing your MA plan and meeting CMS requirements. Identifying the right software will help you navigate the various databases, communicate enrollment information to CMS, get responses from CMS, generate the reports CMS wants, and track financial performance to ensure you are getting accurate payments from CMS.
STEP #7: Identify and Implement Software

Your software should integrate completely with your core system and help you meet CMS requirements.

### Identify a Single Integrated Partner
- Compliant Enrollment Software
- Billing Software
- Reconciliation Software

### Ensure Software Integrates Smoothly With Your Core System

#### Required Software for CMS Compliance
- Risk adjustment and encounter data
- Financial reporting
- Print and communications to meet unique MA requirements
- Care management

#### Use predictive analytics and machine learning
- Increase end-to-end payment accuracy and streamline operations
- Ensure CMS plan revenue accuracy

Required Software for CMS Compliance:
- Risk adjustment and encounter data
- Financial reporting
- Print and communications to meet unique MA requirements
- Care management

Your Core System

Identify and Implement Software

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STEP #8: DEVELOP A RISK ADJUSTMENT AND QUALITY PERFORMANCE STRATEGY

To manage risk and improve quality, you will need a comprehensive risk adjustment and quality performance strategy. This should include the ability to identify prospective and retrospective opportunities, and should define how you will execute the programs.

Software, analytics, and services addressing these capabilities will allow you to boost risk adjusted revenue and enhance quality outcomes.
STEP #8: Develop a Risk Adjustment and Quality Performance Strategy

To optimize your MA plan, you will need the ability to manage risk and continually improve quality. Your plan will need solutions that allow you to do the following:

**Optimize Performance**
Improving performance and optimizing revenue requires the ability to leverage analytics and insights to identify areas for improvement, ensure compliance, track profitability, and evaluate performance.

**Improve Quality Ratings**
Member health and satisfaction are critical for your CMS Star strategy. 5-star plans receive a 5% PMPM bonus from CMS and are rewarded with the ability to market all year long, not just during allotted enrollment periods.

**Increase Code Capture**
Consider using software that relies on historical claims data to identify claims before adjudication that might be missing codes. Leverage NLP-enabled coding to boost retrospective code capture.

**Manage Submissions**
Software and services can help improve the accuracy and efficiency of your data submissions. They'll help you reduce errors, meet requirements, and increase validations and acceptance rates.
STEP #9: COMPLETE ESSENTIAL ORGANIZATIONAL OPERATIONS

To ensure program compliance and optimization, your organization will need to establish and manage specific processes and operations. Read on for a helpful checklist of the six critical organizational steps you need to complete before launching your MA plan.
**STEP #9: Complete Essential Organizational Operations**

Completing forms and establishing teams and processes are essential for success with your MA plan. Here is a helpful checklist of the six most important organizational steps you need to complete:

1. **Provide Documentation and Evidence of Coverage (EOC):** This document defines the terms of your plan and outlines what you will cover and how you will cover it. The document must match your plan benefits and be delivered to all enrolled members.

2. **Keep Up With the Health Plan Management System (HPMS):** Identify a team and process to oversee the changes and manage the operations.

3. **Reconcile Coordination of Benefits (COB) Issues:** Ensure coverage data is correct to receive accurate payments from CMS.

4. **Complete Medical Evidence Forms:** These forms are required to verify some diagnoses. Completing the forms correctly is important, and requires a good working relationship with physicians. Due to the revenue impact, some plans might consider paying physicians to complete the forms appropriately.

5. **Monitor First-Tier, Downstream, and Related Entities (FDRs):** Establish a strategy for monitoring your delegates and your own performance. Identify the reports, metrics, and dashboards needed and conduct risk assessments annually. Monitor or audit all delegates on an ongoing basis to make sure they are meeting the regulatory and operational CMS criteria.

6. **Ensure CMS Compliance:** Pay attention to your relationships with CMS, and establish a process for addressing feedback sent to the complaint tracking module (CTM). The CTM is for members and providers to report issues with health plans such as payment delays, payment errors, and claim denials. If a complaint is reported, you will have to address it and share documentation for how it was handled. Some complaints might have short turnaround times, and you’ll have to process the case quickly. Compliance is required for your entire team and your delegates. Following the rules and using best practices will create your best chance of success as a Medicare plan.
After launching your MA plan, you will want to identify and establish the right resources to help you continuously optimize your MA plan.
STEP #10: Optimize Your MA Plan

Effective communication is key to member engagement, satisfaction, and retention—and an important component of your MA success. According to a J.D. Power 2020 Medicare Advantage Study, MA plans consistently miss the mark on communications. An effective communication strategy will help your plan meet rapidly evolving regulatory requirements related to MA marketing. Make sure to consider:

- Timing of communications
- Where and how communications are distributed
- Which topics are included
- How messages are written (language, tone, etc.)

More seniors are digitally connected than ever before, as smartphone ownership and internet usage has increased among this demographic.

87% of seniors use social media daily

94% of seniors use the internet every day

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2 J.D. Power Study: Medicare Advantage Plans Struggle to Communicate Effectively with Members
3 Medicare Marketing Insights: Senior Media Preferences
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**THE RIGHT MEDICARE ADVANTAGE PARTNER**

As one of the largest independent healthcare technology companies, Change Healthcare can be an MA partner for your organization. Our vision is to inspire a better healthcare system through value-based care enablement, consultative services, and risk-adjustment strategies. Change Healthcare helps payers launch and optimize successful MA plans.
We help health system leaders across the nation achieve their strategic objectives. We serve 5,500 hospitals and more than 1,000,000 physicians. We process 15 billion healthcare transactions and $1.5 trillion in healthcare claims. With over 2,400 payer connections, we reach nearly all U.S. government and commercial payers.

Through our interconnected position at the center of healthcare, we help provide a visible measure of quality and value for all major healthcare stakeholders. Our clients select us as their Medicare Advantage partner because we are committed to their operational and financial success. We can help you successfully navigate the MA process and launch or optimize your MA plan.

Learn More

Call 1-844-217-1199
Visit changehealthcare.com
Optimize Your MA Plan

Reduce and Control Costs
- Pre-Submission Alerts
- Primary Editing
- Cloud-Based Delivery
- Secondary Editing
- Pre-Payment Record Review
- Out-of-Network management
- Payment Settlement
- Post-Payment Audit and Recovery
- Third-Party Liability
- Episode of Care Administration
- Budgets and FFS vs. EOC Reconciliation

Create Efficiencies
- Member Payments
- Digital Disbursements
- Merchant Processing
- Member Correspondence
- Business Process Optimization

Manage Risk and Quality
- Risk and Quality Analytics
- Prospective Episode Care Management
- Episode Insights and Analysis
- Data Insights and Provider Outreach
- Care Gap Alerts
- Value-Based Enablement
- Decision Support
- Electronic Prior Authorizations with Clinical Intelligence
- Medical Records Retrieval
- Risk Adjustment Coding
- Clinical Chart Abstraction

Develop Network Strategy
- Medical EDI Network
- Dental EDI Network
- Medical Network for Pharmacies
- Pharmacy Benefit Services
- Provider Management
- Contract Management

Implement Scalable, Efficient Infrastructure
- Payer Connectivity Services (including CommonWell Health Alliance)
- API & Services Connection Marketplace
- Medical Attachments

Engage Consumers Throughout the Healthcare Journey
- Eligibility & Enrollment
- Transparency
- Provider Search
- Member Communications
- Member Outreach & Education

Create a Network
Complete the Application Process
Establish an Operational Approach
Implement Software
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About the Expert

Shelley Stevenson has more than 33 years of healthcare experience, including leadership positions in strategic and tactical planning, compliance, ACOs, Medicare, Medicaid, DSNP, MMP, organizational and workflow design, and CMS Program auditing.

Shelley has guided health plans new to Medicare Advantage through the application process for CMS approval all the way through to fully compliant launches, resulting in 4.5-5 Star ratings and accreditations with NCAQ, URAC, and AAAHC. Shelley has extensive experience in how to achieve compliance, earn high-quality ratings, and realize desired revenue in the Medicare Advantage space.