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System Focus

Medicare Advantage Enrollment Is Growing: How Health Systems Can Benefit

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Health systems have an opportunity to capitalize on the explosive growth of Medicare Advantage (MA) enrollment, but they need to be thoughtful about the markets they serve and how to best partner with MA plans for long-term success.

Enrollment in MA plans has more than doubled in the last 10 years, with total MA enrollment increasing by 9 percent from 2021 to 2022. Increased MA enrollment is driven by several factors, including expanded coverage for select services and attractive supplemental benefits (e.g., in-home support services, meals, and transportation). Government support for managed care has also expanded as a way to control rising healthcare costs.

The Congressional Budget Office projects that MA penetration—that is, the portion of Medicare beneficiaries enrolled in an MA plan—will rise to about 51 percent by 2030.[1] Today, 30 states have more than 40 percent of their Medicare beneficiaries enrolled in MA plans.[2]

MA Enrollment Growth in Rural Markets

The speed at which this shift occurs varies by county urbanization levels. An ECG analysis shows that while rural counties have lower total MA enrollment, growth in these markets is outpacing more urban areas. From 2020 to 2022, MA enrollment grew by 31 percent in non-metro counties versus 18 percent in metro counties across the country.

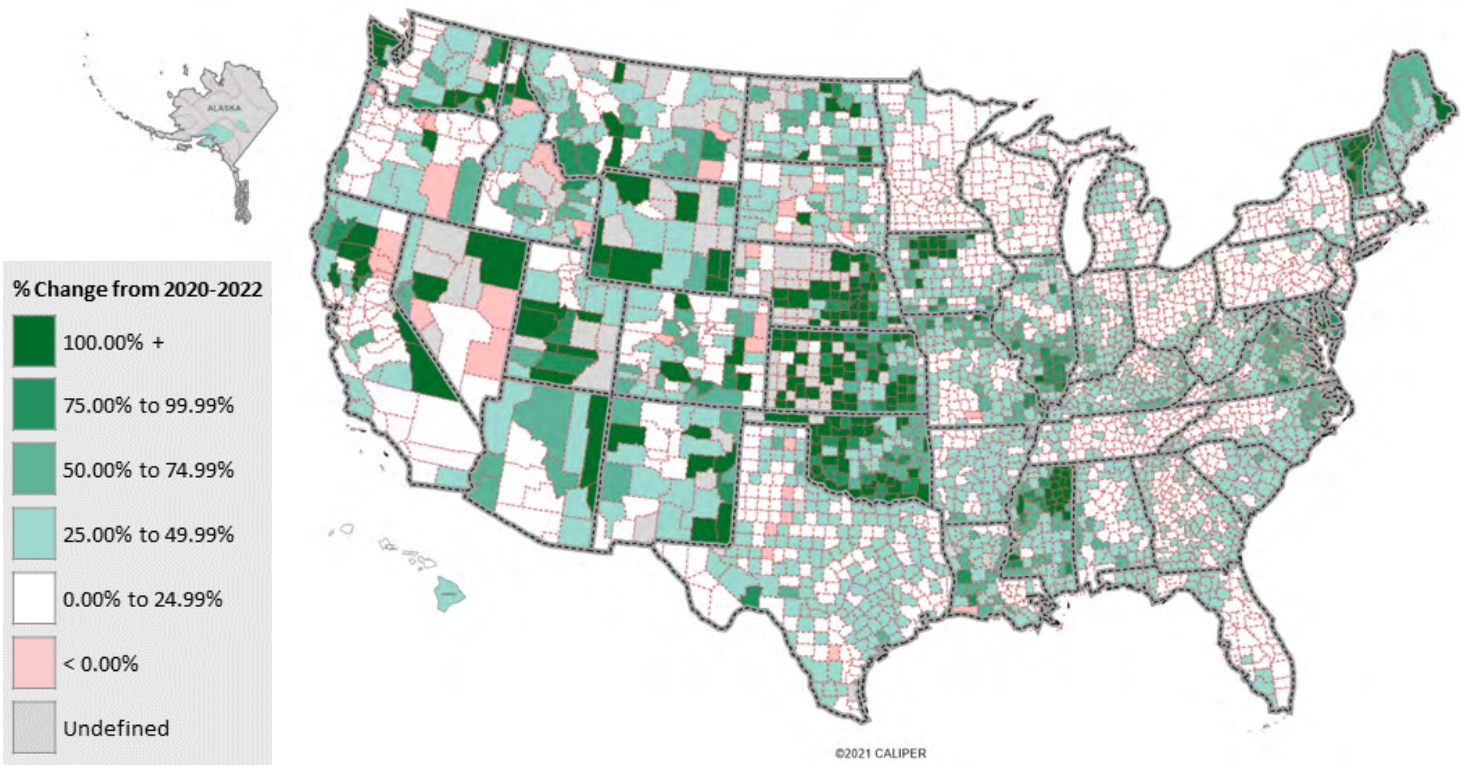
1 Meredith Freed, Anthony Damico, and Tricia Neuman, "A Dozen Facts About Medicare Advantage in 2020," KFF, January 13, 2021.
2 CMS, "MA State/County Penetration."

Rural areas are experiencing larger growth, yet their starting enrollment is often much lower. Specifically, non-metro counties increased their MA penetration from an average of 30 percent in 2020 to 38 percent in 2022, while metro areas grew from 42 percent to 47 percent on average. This disparity in growth could be driven by two main factors:

- Care in rural markets is often fairly concentrated in a limited number of large health systems that have been reluctant to transition to MA when compared to urban markets, which often contain far more provider competition.
- While early investment from payers focused on growing market share in urban areas, the growth of value-based care nationally provided payers with an opportunity to enter rural markets, and thus investment in these regions began to grow.

The pockets of highest growth are shown on the map in **Exhibit 1**.[3] ECG anticipates these areas will continue to experience accelerated growth in MA enrollment as markets begin to align with broader national averages.

Exhibit 1: Percentage Change in MA Enrollment, 2020–2022



3 *Ibid.*

Furthermore, counties with a population of 1 million or more show the *lowest* growth in MA enrollment, while the non-metro areas adjacent to metro areas show the *highest* growth in MA enrollment. Enrollment growth by county types is shown in more detail in **Exhibit 2**.

Exhibit 2: MA Enrollment and Change in Enrollment by County Type

County Description	Percentage Change 2020–2022
Metro: Population of 1 million+	15%
Metro: Population of 250,000–1 million	20%
Metro: Population of fewer than 250,000	25%
Non-metro Urban: Population of 20,000+, adjacent to a metro area	25%
Non-metro Urban: Population of 20,000+, ***not*** adjacent to a metro area	30%
Non-metro Urban: Population of 2,500–19,999, adjacent to a metro area	25%
Non-metro Urban: Population of 2,500–19,999, ***not*** adjacent to a metro area	23%
Non-metro Rural: Population of fewer than 2,500, adjacent to a metro area	24%
Non-metro Rural: Population of fewer than 2,500, ***not*** adjacent to a metro area	22%

Partnering with Health Plans

Health plans are capitalizing on this growth and entering new markets in record numbers. UnitedHealthcare, for example, has risen as a top payer by market share in metro and non-metro counties. As a result, healthcare providers and plans in rural markets that have long been unaffected by the shift toward MA are now seeing the impacts of managed care—and the need to participate proactively. They must negotiate reimbursement rates, focus on quality indicators, and contemplate adopting risk.

Not only is care delivered differently within the MA space, but the population enrolled in MA tends to be higher-need, lower-income beneficiaries:

- In 2019, approximately 50.3 percent of MA beneficiaries lived below 200 percent of the federal poverty level, compared to 40.1 percent of beneficiaries in traditional Medicare.

- About 21.4 percent of MA beneficiaries are also eligible for Medicaid, compared to 15.7 percent of traditional Medicare enrollees.[4]

To care for this higher-cost population, MA plans require accurate coding and documentation to capture the underlying illness of each individual and stratify the population. Using bidirectional data pipelines and advanced care management, health plans are engaging the provider community to create targeted interventions. Flexible supplemental benefits allow MA plans to use innovative means to address social risk factors, improve preventive care usage, and ultimately reduce costs and utilization.

These tools are proven to help MA plans successfully reduce utilization for their population. A recent study found that the first year of MA enrollment is associated with a decrease in Medicare Part A spending of $65 per member per month, largely

➜ Key Board Takeaways

- Ensure the board understands the system's current positioning as it relates not only to MA payers, but commercial and other lines of business as well. Are there areas where reimbursement rates are insufficient to cover the cost of delivering care?
- Evaluate the market to benchmark your organization's positioning relative to competitors and the shifting marketplace. Is your system poised for future changes in patient demographics and payer coverage in your region?
- Assess the ability of your system to succeed under a value-based arrangement. Is the clinical infrastructure in place to support long-term care management? Can the organization financially afford to assume risk? Are data-sharing and technology capabilities in place to operationally support the partnership?
- Demonstrate the value your system delivers to payer partners and how a partnership can deliver quality outcomes and cost savings. What differentiates your organization from others? How will you work with the plan to care for high-risk beneficiaries?

4 Better Medicine Alliance, "Summary of Report: Medicare Advantage Outperforms Traditional Medicare on Cost Protections for Low- and Modest-Income Populations," January 2021.

driven by reduced inpatient stays (roughly 63 fewer stays per 1,000 members per year). In contrast, MA enrollment did not result in a noticeable decrease in Part B spending.[5]

Preparing for MA Partnerships

To thrive in this shifting landscape, health systems and providers must 1) evaluate internal positioning and external landscape, 2) develop a targeted strategy, and 3) thoughtfully partner with MA plans.

Current-State Analysis

Health systems should first analyze the impact of MA on their current business—this includes MA patient volume, payer mix, utilization differences, MA spending, and generated cost savings based on patient medical expenses and corresponding revenue. Involving health system management and revenue cycle teams will be key to understanding nuanced differences in how the system interacts with various payers and how their patient population may differ. Upper management and the board of these systems can then support this effort by comparing this analysis to local trends in MA penetration rates, enrollment growth, major market plans, and benchmark reimbursement rates. This comparison will become the foundation for developing an MA strategy that will fill organizational gaps and highlight the system's value to the community. Furthermore, the current state analysis will ensure all levels of the organization are aligned on how the system is currently performing and how to best support future success.

Entrance Strategy

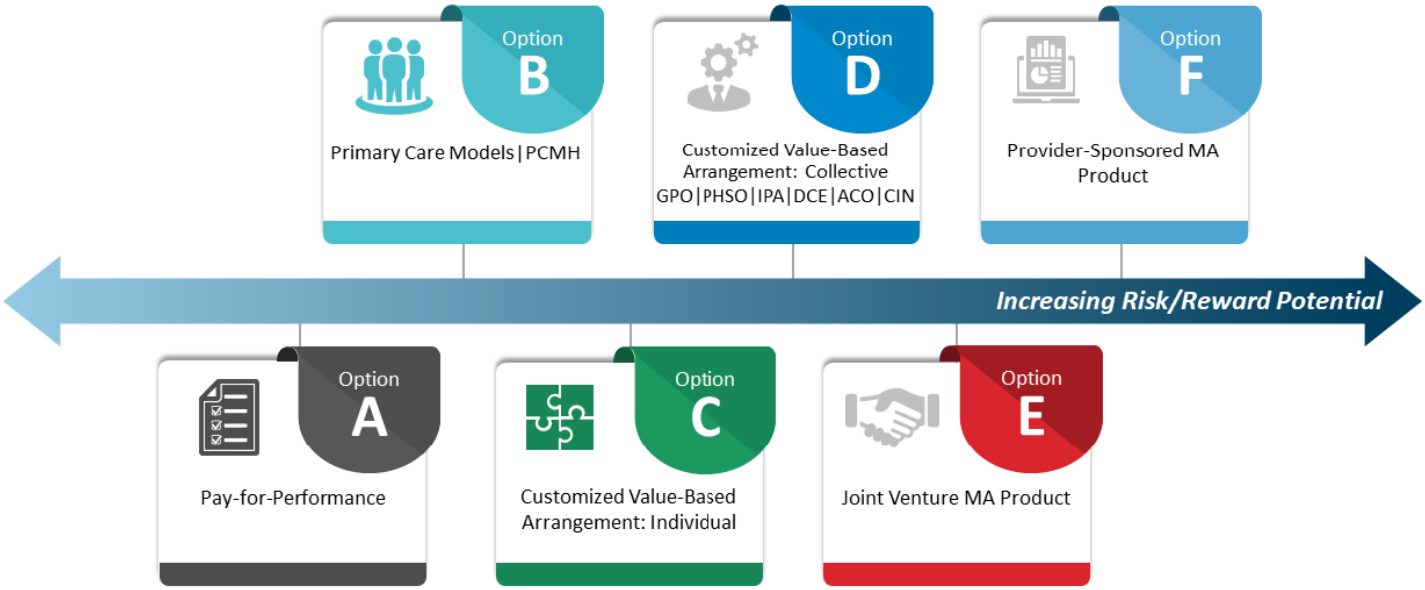
Systems must also assess organizational feasibility and appetite for risk to develop a suitable entrance strategy. To do this, the system will need to evaluate their technology infrastructure, care capabilities, current outcome and quality metrics, and financial standing. Input from the organization's clinical staff and management will be vital to accurately understand current care pathways and discharge patterns, identify barriers to successful downstream care management, and resolve infrastructure gaps needed to support value-based arrangements. System management must also consider the degree of ongoing support each partnership will require of the

5 Aaron L. Schwartz, et al., "Health Care Utilization and Spending in Medicare Advantage vs. Traditional Medicare," JAMA Network, December 10, 2021.

organization. This includes data integration, provider network assessment and development, and ongoing care management for high-risk beneficiaries— including for care delivered beyond the walls of the system.

Conducting this readiness assessment for value-based care partnerships is critical to ensuring the system is prepared for—and can support—the partnership while maximizing potential benefits. For stability, systems may structure a lower-risk agreement to enter the market and then progress through partnership structures to gradually increase risk and, therefore, additional reward potential. A high-level continuum of the partnership options is outlined in **Exhibit 3**.

Exhibit 3: MA Partnership Types and Degrees of Risk



Finding the Right Partner

Finally, systems must thoughtfully identify ideal MA partners and develop a compelling, data-driven value proposition for partnership. MA plans want health system partners that can reach, and manage care for, a high share of Medicare and MA beneficiaries. They look for partners that can boost their performance on key quality measures and, in turn, increase their CMS Star Rating and their ability to improve revenue and enrollment. Key metrics include:

- Low readmission rates

- Shorter lengths of stay
- Established discharge partners
- Patient satisfaction rates
- Innovative care pathways

Additionally, plans rely on provider partners to ensure accurate patient diagnosis coding and documentation, as this information determines the risk score assigned to each MA plan and ensures accurate reimbursement. This critical step in value-based care participation will require input from all levels of management and divisions to ensure the system is oriented for success from a clinical, operational, and financial perspective.

Since MA enrollment continues to grow nationwide and value-based care adoption is accelerating across lines of business, MA partnerships represent an opportunity for health systems to be at the forefront of care delivery reform.

Benefits of Partnering with MA Plans

Since MA enrollment continues to grow nationwide and value-based care adoption is accelerating across lines of business, MA partnerships represent an opportunity for health systems to be at the forefront of care delivery reform. Federal support for MA plans is also at a peak. CMS recently finalized an 8.5 percent revenue increase for MA plans in FY 2023.[6]

A successful MA partnership can bolster a health system's patient volume and network partnerships in the short term and, in the long term, provide an opportunity for revenue upside and quality improvement. Participating in these arrangements will also position the system for future success in value-based arrangements outside of MA, while accelerating organizational efforts to increase the coordination, quality, and efficiency of care for all patients.

6 Susan Morse, "Medicare Advantage Plans to Get 8.5% Revenue Boost in 2023," *Healthcare Finance*, April 4, 2022.

Absent active participation, health systems run the risk of declining utilization, decreased reimbursement, and trailing market innovation. As MA plans look toward a new plan year and seek ways to boost enrollment, generate cost savings, and improve member satisfaction, health system boards and senior leaders should begin planning now.

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