

EXECUTIVE BRIEFING

Provider-sponsored MA plans evolve as 2024 collabs take more ‘thoughtful’ tack

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Leading up to the Oct. 15 start of the Medicare Annual Election Period (AEP), news reports across the U.S. have depicted down-to-the-wire disputes between Medicare Advantage insurers and their network providers over sticking points like reimbursement and prior authorization policies. But another development in payer-provider relations is the evolving trend of regional health systems cosponsoring MA plans, which one industry expert says can take various forms and requires careful consideration.

Morgantown, West Virginia's **Peak Health**, for one, will launch a new MA plan that it says was designed in partnership with two West Virginia health systems, WVU Medicine and Marshall Health. According to the new insurer's website, the company is also owned by two other not-for-profit health care providers, Mountain Health Network and Valley Health. Peak is the only West Virginia-based insurance company to offer MA plans sponsored by West Virginia providers, the company said.

In Northeast Ohio, Cleveland-based University Hospitals and PrimeTime Health Plan have teamed up to offer a cobranded MA plan in Lorain, Lake and Cuyahoga counties, reports The Mourning Journal.

University Hospitals Medicare Advantage Plan by PTHP (UHMAP) is a partnership between University Hospitals and AultCare's PrimeTime Health Plan, which is one of 31 plans to receive a 5-star rating from CMS for 2024. Those three counties are new service areas for AultCare, which was launched by providers in Stark County in the 1980s.

Meanwhile, Peoria, Illinois-based integrated health system OSF Healthcare and Minnesota-based not-for-profit insurer Medica are marketing their new **OSF Medica Advantage** plans to eligible residents in the Illinois counties of De Witt, Marshall, McLean, Peoria, Stark, Tazewell and Woodford. Medica's Dean Health Plan, Inc. is one of three Medicare Cost contracts to earn a 5-star rating for 2024. OSF Healthcare said the new offering will "combine patient-centered localized care with a member-focused, community-based health plan." Plans with Part D coverage will feature \$0 copays for preferred generic versions of medications at preferred pharmacies, \$0 copays for 100-day fills for all generic medications, and quarterly allowances ranging from \$30 to \$65 for over-the-counter items.

Through a 10-year value-based pact with ApolloMed, **SCAN Health Plan** introduced a “provider specific plan” called Compass, according to an [exclusive report](#) by MedCity News. SCAN CEO Sachin Jain, M.D., told the news outlet that the full-risk, value-based arrangement is tied to patient experience, preventive health screenings, medication adherence and other outcomes and is focused on underserved communities. At the same time, the not-for-profit insurer unveiled the SCAN Inspired plan, which it said was designed for women, will be available in the California counties of Orange and Los Angeles and is “in partnership with Cedars Sinai.”

And though not a cobranded offering, Livonia, Michigan-based health system **Trinity Health** is reportedly entering the MA market with plans in Connecticut, Idaho, Iowa, New York and Ohio. According to the [website](#) for Trinity Health Plan of Michigan, plan options being marketed this fall include a flexible benefit card and a Part B give-back benefit.

Cary Badger, principal with HealthScape Advisors, a Convey company, says this flood of freshly inked pacts reflects an ongoing interest on the part of health systems and providers to control their own destiny as more Medicare-eligibles flock to MA. But it also shows that they are starting to do so in a “more thoughtful and deliberate” fashion.

“Health systems and health professionals are acutely aware of the migration of patients, revenue and managed care savings to Medicare Advantage,” which now enrolls more than half of Medicare-eligible beneficiaries and therefore represents a sizable chunk of Medicare business for these providers, observes Badger. “This shift in control of their patient volumes, revenues, and multiple aspects of the underlying operating model for Medicare beneficiaries is real. Providers want to play a more significant role in how the health care for these patients is financed, managed and covered.”

But how they go about it has greatly evolved from 10 or so years ago, when health systems started building provider-sponsored plans from the ground up, basically creating a subsidiary health plan, only to realize how expensive they were to operate.

“Systems came back and said, ‘No, we’ll partner with the competent health plans.’ And in the background, they’re probably thinking more of a Kaiser Permanente model where they have a dedicated provider system that contracts exclusively with a health plan — in their case, the Kaiser Foundation Health Plan, where I used to work — and they’re trying to emulate that integration,” Badger tells AIS Health, a division of MMIT. “What’s different now is that they’ve realized that things like the ability to share business processes across the care continuum is really important.”

For example, the hospital’s clinical information system must be able to communicate in real time with the plan’s claims and utilization reporting system to effectively manage a patient’s care. This is especially important in MA, where plans are paid more based partly on the risk profile of their members and rewarded for meeting quality measures through Star Ratings.

When advising providers that are interested in striking strategic partnerships with established plans, HealthScape asks would-be sponsors three key questions:

1. Have you considered an objective assessment of your partner's MA core capabilities?

In other words, consider the competency of each organization to identify and execute critical points of integration across the managed care continuum, or "what we characterize as 'Front Office, Middle Office and Back Office' functionality that focus on management of cost and quality more successfully than a current contracting model," says Badger. In such a model, each partner or delegate is not only responsible for their respective operational duties but may also be accountable for the performance of their partner and delegates as well. To that end, establishing and monitoring key performance indicators and having a joint governance commitment that can review both financial and operational performance at multiple levels of the operating model are both key to performance in the first few years of the model.

2. How will you differentiate your new offering's value in the market?

How will this new plan successfully compete when the health care system continues to contract with competing payers by launching a new, cobranded product in the same market? This involves performing due diligence on your value proposition and sales channels when planning for benefit and marketing investments and ensuring "a realistic expectation of member acquisition and growth rates that fuel the partnership."

3. Is your timeline realistic?

"It takes a lot of time and money to build out a health plan within a provider system," says Badger. And there are specific regulatory hurdles that sponsors must achieve such as filing new product or plan applications "while committing their people, resources, and as important, their brand(s) to a new market entry....It's not uncommon for this process to take 12-18 months, depending on the size and complexity of the organizations involved." And with shifting payment rates, Star quality measure changes and an ever-evolving competitive landscape, "this planning needs to be nimble," he adds.

There's also a spectrum of arrangements that providers are pursuing with the idea of controlling their own destiny. "Cobrands are at one end of the spectrum. There are certain Medicare rules that allow health plans and provider systems to cobrand a Medicare Advantage offering, or plan benefit package — that's when you see a specific set of benefits and pricing out there, and it's indicated that a particular health system is affiliated somehow."

And within the cobranding model, the structure can vary from an exclusive arrangement where the sponsoring provider is the sole in-network provider to something where the cosponsor simply exists as a prominent provider within the network. While the latter can generate more enrollees, that may not always be the case, particularly if there's no demonstrable differentiation beyond the branding in terms of benefits or the provider network, points out Badger.

On the other end of the spectrum, providers and plans teaming up to sponsor MA plans are also sharing risk, “because that allows the health system to participate in the managed care savings” that can be derived from outcomes such as lower inpatient admissions. And within that model, sponsors may choose a partnership option through a joint venture or by establishing a new legal entity that contracts uniquely with CMS, he says. An example of that would be Braven Health, an MA insurer created by two New Jersey health systems, Hackensack Meridian Health and RWJBarnabas Health, with Horizon Blue Cross Blue Shield of New Jersey. Introduced for the 2021 plan year, Braven Health is now offering PPOs in all 21 New Jersey counties for the second year in a row and features access to both sponsors’ systems as well as all the acute care hospitals in the state.

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