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Mastering growth with government contracts

Expansion in government programs creates new opportunities for growth

Government health programs are experiencing significant surges in enrollment. Currently, 34% of the U.S. population is covered by government insurance programs, and that number is expected to continue to increase in the coming years.[1] This expansion represents sizable, sustainable growth opportunities across the country. At the same time, some plans are seeing declines in their commercial populations, potentially shifting their organization's business mix – and economics.

Here's a quick look at emerging opportunities in Medicare and Medicaid populations and what health plans need to consider in order to win and successfully manage government contracts.

34%

of the U.S. population is now covered by government programs – and that trend is expected to continue.[1]

"Long-term success as a payer is predicated on the organization's ability to demonstrate mastery in the government space."

– Craig Savage

Introduction

Nationwide, Medicare enrollment now tops 62 million,[2] with 10,000 new seniors becoming eligible every single day.[3] Health plans have an important opportunity to acquire their share of these new members, who typically remain loyal for many years to come. The federal government will spend $800 billion supporting these programs, with expenditures expected to grow by 7.6% year over year.[3]

Medicaid is also growing and will serve 78.9 million consumers,[4] including 10.8 million dually eligible enrollees.[5] This means one in four people will now be covered by Medicaid — many with complex and costly conditions. Several states have more than 50% of their population moving onto Medicaid, which will add pressure to be vigilant on costs.[4] Serving this population in 2021 is expected to necessitate $684.4 billion in Medicaid government expenditures.[6] This represents another significant opportunity for plans that can cost-effectively manage these populations.

Growth in government membership is clear. And so are the ongoing cost pressures to make it affordable. This current environment offers several opportunities for growth — as long as plans are properly prepared.

For health plans to tap into this growth, they will want to run models based on their current state of business and project a full range of possible scenarios. With government contracts, understanding the myriad details is paramount to success. They will need to examine pricing, risk adjustment, reserve settings and potential competitive threats for existing lines of business. This modeling allows plans to consider each opportunity strategically and view the near- and long-term implications that might otherwise remain unseen. Plans should preview what the impact will be to their organization from all angles. Then they can build the financial framework and operational platforms that makes sense for them and the agencies they serve.

30%

of Medicare spend is focused on the dually eligible population.[7]

Preparing for growth opportunities

In order to successfully realize new growth opportunities in government contracts, health plans will need to show preparedness in key categories, such as: experience with the population, clinical and administrative excellence, community partnerships, and an understanding of the complexities of the RFP process. Depending on which growth opportunity organizations intend to pursue, these success factors will vary in importance and have specific nuances.

On the following pages, we will first introduce some context for identifying potential growth opportunities, in particular whether a plan has existing government contracts, or is new to government. Then, we'll explore several scenarios and for each: examine what the government expects, assess (using Harvey Balls) the level of preparedness that plans have likely achieved, and propose questions to consider that can help health plans close the gaps.

Determining a health plan's opportunities for growth

Health plans with existing government contracts

The many plans that already have government business have several opportunities to build on their existing knowledge and expand their current plans. In addition to considering internal factors, they will also need to take into account increasing competition. Finding ways to differentiate is crucial to success.

They can:

Extend Medicaid or ACA programs to other counties or states

Develop beyond Medicare Fee-for-Service to duals, Medicare Advantage and into broader Medicaid populations

Grow from basic to complex Medicaid populations

Expand through the state procurements

Whether they maintain or grow their existing government contracts, these plans will likely need to scale efficiencies to reduce their cost structure. For smaller plans that rely on government programs and for self-funded employer plans, optimizing operations is paramount to survival. And if required by the contracts, they'll need to invest in platforms and programs that improve their clinical, risk and quality programs. All three are required to stay competitive, win contracts and deliver on their mission.

Health plans that are new to government

Plans without government experience can still succeed, but they will require more lead time to prepare.

They need to:

Recognize the size of their learning curve

Conduct a readiness assessment

Evaluate state Medicare/ Medicaid populations

Evaluate their network

Analyze the competition

Identify areas of strength and potential for growth; e.g., Stars, HCC accuracy, cost of care management

Regardless of whether the health plan has experience or not, every opportunity should be grounded in a clear, comprehensive financial and strategic exercise (see Readiness Assessment on page 9).

Let's explore our scenarios in detail.

Building on existing experience

Scenario 1: Expanding your government footprint

Health plans with government experience want to protect and grow their business. But as members continue to shift into public programs, the competition for government business is rapidly heating up. At the same time, pressure on budgets has never been higher. So plans need to demonstrate both clinical quality and administrative excellence. It is more challenging than ever to be awarded state and federal contracts. Nothing can be taken for granted.

Federal and state agencies are looking for health plans that excel in operational efficiency, innovation and community partnerships. They want evidence of ongoing compliance and high first-pass adjudication rates. Metrics that reflect a modern operational platform give government decision-makers confidence in a plan's ability to control costs at scale. They also want verification of secure, up-to-date provider management and evidence that the health plan can manage enrollment, training, credentialing and abrasion. Plans need to be able to anticipate shifts in the member mix and verify that their provider network has the specialists, capacity and accessibility these new members will need. They will want to look ahead for new variables in regulatory compliance and timeline requirements.

Winning RFPs may require new capabilities or partnerships. Plans will need to identify potential short-term improvements they can make as they advance on other long-term competitive strategies. The greatest business value is likely to require some investment in market analysis and modernization. Plans can benefit from a staged approach to building new competencies. This lets them stay competitive now while they work to expand their public footprint.

"As the competitive frame for Medicare Advantage continues to explode, it will be critical for plans to differentiate their products and services to grow."

— Krista Bowers

Health plan gaps to close

Geographic footprint: Benchmark your capabilities against new competitors entering your government market.

Network management: Show how you can respond to member shifts. Identify providers who are able to share risk.

Information technology: Outline your roadmap for continual clinical and operational improvement. Identify specifically how these improvements meet criteria established in each RFP.

Community involvement: Determine which community relationships are required to address social determinants, cultural considerations and in-home services.

RFP experience: Pre-score your capabilities against state or federal criteria. Then develop your roadmap for quick wins and long-term success.

Questions to help you close the gaps:

- How well can you present your experience managing the health care needs of high-risk populations?
- What new competitors are entering your region?
- How well have you assessed your competitive strengths in the short term?
- Do you have a forward-thinking approach to investing in innovation?
- Have you compared your capabilities against national Key Performance Indicator benchmarks and industry best practices?
- Do you have a combined quick-win/long-term approach to the business?
- Do you have the resources to research and review thousands of pages in detail?
- Do you have reviewers who can audit your proposals and provide scoring feedback?

Scenario 2: Growing from Medicare to dually eligible to Medicaid

Organizations already serving Medicare members may be well-positioned to expand into Medicaid by focusing on those members who are dually eligible. If risk and quality have been well-managed for these members, health plans can make a case to their state agencies that they are already knowledgeable and proven. Serving the dually eligible population establishes credibility with the state for being able to manage complex, vulnerable populations. Proving competency with this population makes expansion into other complex Medicaid populations a natural next move.

One of the greatest risks comes from an eagerness to get into the business without fully understanding the financials and the mechanics of the contract. Health plans that don't examine the rating tables developed by the states may find the win ultimately translates to a financial loss. To fully assess the risk and mitigation tactics required to serve a new Medicaid population, a plan must proactively put together models that accurately predict costs and benefits. Plans may need infrastructure investment to manage new populations.

"A duals program gets health plans started … it gives them some Medicaid experience in dealing with the state. It shows they can serve complex members. This then gives them the right when they come back around for state bids to claim, 'We know Medicaid.'"

— Nathan Funk

Health plan gaps to close

Medicare experience: Leverage your geographic footprint and high quality scores to assert you have the capabilities to serve your state's vulnerable populations.

Size of dual population: Examine your existing Medicare population and size up the membership who are dually eligible. Overlay how this compares to the segment you seek to serve and determine any adjustments you need to make.

Network management: Model the Medicaid populations cited within the RFPs to confirm you have the network specialists, volume and access to match.

Medicaid requirements: Determine what is needed to scale your operational and clinical excellence to meet state requirements and maintain a competitive advantage.

State RFP experience: Consider what is required to properly prepare for the RFP process. Examine the rating tables to confirm the financial opportunity.

Questions to help you close the gaps:

- How are you currently serving complex, low-income or vulnerable populations?
- What is the size of your current dually eligible population?
- How can you demonstrate mastery of risk, quality and access for these members?
- What managed care situation can you improve? What new care models are required?
- Which segment of the Medicaid population are you best equipped to serve? How will you size this new population?
- How well do you manage social determinants of health (SDOH) and what community relationships do you have?
- How can you build on existing competencies to make sure your capabilities are aligned? Where are your gaps?

Scenario 3: Growing from basic to complex Medicaid populations

Plans with existing Children's Health Insurance Program (CHIP) or Temporary Assistance for Needy Families (TANF) contracts may also see rising challenges from national competitors. And plans may face further risk as states restructure their rates. Now is the time to consider the broader Medicaid contracts as a means to diversify opportunities and risk. Health plans can leverage their state agency relationships, managed care experience and quality scores to earn new contracts.

In addition, plans that already have a good reputation can leverage their provider network. As providers see patient volume shift out of commercial into Medicaid, they may also be more willing to adapt. Actuarial analysis can project local shifts from commercial to Medicaid and confirm that the right networks are — or could be — in place to serve a more diverse Medicaid population. Plans can then identify if they need to update their clinical platforms, support new contract requirements, or resolve utilization issues that may be hurting their quality scores.

Health plans can also consider their community relationships for insight and influence. Working with local faith-based organizations, health advocates and community care givers, plans can build a holistic network that connects with the community and supports better preventive, in-home care management. Plans will want to understand how social determinants and other inequities are impacting utilization and clinical outcomes for these populations. And any health plan expanding more broadly into Medicaid should possess a solid capacity for value-based contracts and proven operational efficiencies to compete.

"Each state has its own unique requirements for managing their populations. These are stipulations you just have to figure out and make sure that you can adhere to."

— Nathan Funk

Health plan gaps to close

Experience with CHIP/TANF: Model population shifts into Managed Medicaid and define how your experience indicates your ability to match demand.

Network management: Demonstrate the ability to effectively manage ongoing training, credentialing, capacity and accessibility of a broader network.

Administrative excellence: Map what operational capabilities need to be acquired or developed to gain efficiency and control costs as you scale.

Community relationships: Determine which community relationships should best support this expansion.

State contract experience: Identify any new budgetary pressures that may impact how your state awards Medicaid contracts.

Questions to help you close the gaps:

- How mature is your book of CHIP/TANF business?
- How strong are your HEDIS® measures?
- Who is currently serving your target population?
- What experience do you have with that segment?
- What kind of performance metrics do you have to demonstrate quality and low cost?
- How do you know your network will be accessible?
- Have you anticipated the investments required and accommodated them in your financial projections?
- What community relationships have you developed to address social determinants?
- What in-home and community-based services are part of your offering?

Scenario 4: Using Medicare Advantage experience to re-enter ACA market

The American Rescue Plan Act of 2021 includes funding to expand affordability and access to state marketplaces. Like Medicaid, membership in the Affordable Care Act (ACA) marketplace is expected to see significant growth over the next few years.

Plans serving Medicare Advantage members may see an opportunity to re-enter their state exchange. They can build upon their managed care expertise and administrative competency to expand their product offering to match exchange populations. As in the scenarios previously presented, the states will want to assess the payer's clinical and quality programs. Health plans will need to ensure they have the network specialties and access to match. But the infrastructure investment should be less for ACA than for Medicare.

New legislation provides coverage to a diverse range of individuals. Health plans will want to know they have the people, processes and technology to meet their requirements. Competitive advantages include: strong, value-based relationships; an integrated clinical platform; a modern, automated administrative platform; and strong Healthcare Effectiveness Data and Information Set (HEDIS) measures and Star Ratings.

"Health plans must think strategically about government regulatory areas like interoperability and price transparency. They can use these requirements to build the member-centric model that drives engagement and satisfaction."

— Mallory Van Horn

Health plan gaps to close

Medicare experience: Leverage your geographic footprint and high quality scores. Demonstrate your managed care and value-based contract success.

Product offering: Model the projected populations entering the exchange and confirm you have (or could have) the product offerings to match.

Network management: Model the populations cited within the government's RFP to confirm you have the network specialists, volume and access to match the exchange population.

Operational excellence: Determine what is needed to scale administrative and clinical excellence to meet state requirements and maintain a competitive advantage.

State RFP experience: Consider what is required to properly prepare for the RFP process. Examine the rating tables to confirm the financial opportunity.

Questions to help you close the gaps:

- What are your current quality scores? What needs to happen for them to improve?
- Do you have the capabilities to handle a more advanced network arrangement? A more complex clinical program?
- Is your product offering well-developed? How will you evaluate that?
- Is your administrative system modernized to support this growth initiative?
- How efficient is your claims processing system? Can you contain costs while you grow your membership?
- How engaged are your members?

New to government: How to approach the opportunities

Those with no government experience can still pursue opportunities. Government agencies are attracted to health plans with efficient, high-performing administrative systems, modern clinical platforms, high quality scores and value-based network relationships.

In fact, officials see these as the core competencies needed to successfully fulfill government contracts. Health plans can demonstrate clinical and quality outcomes on "look-alike" members to demonstrate how existing experience translates it into Triple Aim success.

The biggest risk is a lack of awareness of the complexity. Health plans new to Medicare and Medicaid may underestimate the application or RFP process and the systems required to accommodate and maintain state and federal requirements. Each state has specific criteria for their populations that can require reconfiguring entire systems. A common pitfall is that even if new health plans are willing to meet those requirements, they may not be aware of the timing expectations for when they need to demonstrate adequacy.

"Those considering Medicare should be careful not to underestimate CMS' network adequacy requirements. Health plans new to Medicare may assume they can just shift their commercial network over and not recognize the rigor required to meet network requirements."

— Elena White

Health plan gaps to close

Population overlap: Identify the population you want to serve. Then find the "look-alikes" within your existing population to demonstrate your competence.

Clinical quality: Provide the clinical data and quality scores to demonstrate clinical outcomes, satisfaction scores, preventive services and care innovation.

Administrative excellence: Showcase your modern administrative platform. Highlight adjudication accuracy rates and your capacity to reduce fraud, waste and abuse.

Value-based relationships: Present your experience in risk-bearing contracts. Demonstrate population management, care coordination and network design.

Government RFP experience: Be careful not to underestimate the complexity or time-sensitivity of the application process.

Questions to help you close the gaps:

- As you consider the population(s) you are best suited for, do you understand the associated rules and requirements down to the smallest detail?
- Have you considered any state waivers, and do you understand how these differ from the standard federal program?
- Are you familiar with the RFP schedule and all interim milestones and dependencies?
- Are there new or unique dynamics in your state that could compel a more competitive bidding environment?
- Are you prepared for all scenarios if you win the contract?
- Do you have risk-mitigation strategies in place?
- Are you confident in your value-based competencies?

Readiness assessment

Regardless of whether you have experience or are new to the government arena, you will benefit from thorough preparation

Spotting the opportunities

CMS is a rich resource. It tracks populations, waivers, budget approvals – anything that has impact at the state level. State websites, while complex to navigate, offer a wealth of information on how each one has focused its spend and defined its rates. But there is so much information available that you'll need to dedicate research time to assess the opportunities, pricing, competition and requirements. Here are some tips:

- Examine all the opportunities within your state. Some may more closely align to your capabilities and strengths. Be sure to closely examine the timeline requirements.
- Budgets are under pressure and both the state and federal governments are reprioritizing their spend. Determine if and where your state is pushing back on rates.
- With a new administration and a new contract period, there will be regulatory and compliance changes. Can you view them as more than a mandatory hurdle and consider them an area where you can demonstrate leadership?

The goal is to take on a manageable amount of risk and match that with the appropriate population. Stretch goals are fine as long as they don't stretch beyond your capacity to control costs, achieve quality and maintain compliance. As you consider your growth goals, take a close look at how your book of business will balance out once you have dedicated resources to government programs.

Assessing the competition

State and federal websites are full of competitive information, including pricing and performance metrics. Take the time to do the research and understand how your competition scored on the last round of RFPs and how you might compare.

- See if you have already bid against them and how you compared with them.
- Look for the capability or performance measure that you lacked.
- Validate that you're as strong as you think.

Action items: Building your roadmap for growth

- Consider the internal appetite to pursue this business. Is your organization agile and resourced enough to make the needed adjustments to compete?
- Find out who has the current contract and identify ways you can prove you are better. Consider partnerships or new capabilities that could help you win.
- Assess how you contribute to the local economy.
- Look for opportunities where you can demonstrate ways you help to ensure health equity.
- Examine your networks and confirm that you have the required specialists to meet the needs of this population. Confirm that they meet access regulations. Look for new ways to reduce payer/provider friction and increase visibility into the health of each patient.
- Finally, run scenarios to be sure your strategy will increase your revenue at a faster pace than it will increase your cost structure.

Conclusion

Ensuring ongoing success

Regardless of your current level of experience or the opportunities you ultimately target, future success will require a commitment to transforming member experience.

Holistic end-to-end consumer engagement — servicing the member from point of entry to the ongoing ownership of their own health. This involves virtual tools and programs and may require services that address each member's social determinants of health.

Clinical quality — a clinical platform where providers can spot risk or identify gaps in care directly from their workflow.

A culture of continual modernization — finding more ways to improve outcomes and lower costs.

Partnerships — ensure that there are performance-level and service-level guarantees, and that those contracts are oriented to outcomes-based performance metrics.

Why Optum Advisory Services

With breadth of industry knowledge and depth of experience, Optum® Advisory Services is uniquely positioned to offer comprehensive services that support you across a wide range of interconnected strategic and operational domains. We bring together incomparable data and analytics with years of experience both in consulting and on the front lines of health care. Our team of consultants is ready to help you design your organizational response to the current environment and enable a secure future.

1. U.S. Census Bureau. Health Insurance: Tables 2019 H-01. Accessed May 11, 2021.
2. CMS. National Health Expenditure Projections. Accessed May 10, 2021.
3. CMS. NHE Fact Sheet. Last modified December 16, 2020. Accessed March 5, 2021.
4. Medicaid.gov. November 2020 Medicaid & CHIP Enrollment Data Highlights. Accessed May 10, 2021.
5. CMS. Medicare Beneficiaries at a Glance 2020 Edition. Accessed May 10, 2021.
6. CMS. NHE Projections 2019-2028. Last modified April 15, 2020. Accessed May 10, 2021.
7. MedPAC. July 2020 Databook. Accessed May 11, 2021.

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