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Tech-Focused MA Startups Chase Tailwinds in New Markets

In advance of the 2021 Medicare Annual Election Period (AEP) that starts on Oct. 15, venture-backed Medicare Advantage firms like Alignment Healthcare and Clover Health are unveiling their plans for expansion while new startup insurers are declaring their intentions. Although the collective membership of startups is a drop in the bucket compared to the five major insurers that dominate two-thirds of the MA market, one expert says their focus on technology positions them for enrollment success during the COVID-19 pandemic, as long as they can follow through on the clinical side.

Given the increasing share of Medicare beneficiaries who select MA over fee-for-service Medicare, the maturity of the program, and the aging baby boomer population, "organizations are comfortable with both the costs and the revenue streams associated with [MA] and are building infrastructures from the ground up to be able to be successful," observes Jason Montrie, president of Pareto Intelligence, a Convey Health Solutions company. "And I think we're seeing there's a lot of available capital. [Startups] are looking in new markets…where they think they can be successful, they can acquire new investors, and they can grow in a market that has a lot of tailwinds."

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Plans, Providers Pursue Lasting Change to MA Telehealth Policy

Before a pandemic forced the rapid adoption of telehealth in the U.S., the Trump administration had already implemented or was taking steps to support the use of telehealth in the Medicare Advantage program. But one remaining barrier for plan adoption of telehealth was the inability to collect diagnosis codes for risk adjustment purposes. CMS temporarily addressed this issue during the pandemic, but as providers anticipate telehealth to play a more permanent role in health care delivery, they are joining with plans to advocate for a permanent shift in MA telehealth policy.

CMS in an April 10 memo to plans stated that MA "organizations and other organizations that submit diagnoses for risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter" *(RMA 4/16/20, p. 3)*. The document said little else, other than specifying that such diagnoses would count only when the services are provided using an interactive audio and video telecommunications system that allows for "real-time interactive communication."

Prior to this, CMS had required that all International Classification of Diseases diagnoses submitted for risk adjustment purposes must come from a face-to-face

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encounter with an acceptable provider type.

Telehealth already got a major boost in the MA program when CMS in 2019 implemented CHRONIC Care Act provisions allowing plans in 2020 to begin offering "additional telehealth benefits" beyond what is available to Medicare fee-for-service (FFS) beneficiaries as part of the basic benefit package *(RMA 4/18/19, p. 1)*. More recently, CMS finalized a proposal to count telehealth providers in certain specialty areas toward meeting CMS network adequacy standards *(RMA 6/4/20, p. 6)*.

But as plans were rolling out their benefits for 2020, it appeared that they weren't fully embracing and adopting telehealth, observes Megan Herber, a director with Faegre Drinker Consulting and a former legislative director in the office of U.S. Rep. Doris Matsui (D-Calif.). "I was on the Hill before I joined the firm and helped work on the policy that allowed MA plans to include telehealth in the base bid rather than as a supplemental benefit and I was kind of looking at plans [last fall] asking, 'Why aren't you implementing this? What's going on?'" she recalls. Granted, they had other new things to consider adopting like Special Supplemental Benefits for the Chronically Ill, but a major issue Herber identified was the risk adjustment policy, she tells AIS Health.

"It's a huge disincentive if you all of a sudden fully adopt and conduct more telehealth and you end up getting a bunch of your diagnoses over telehealth visits, and it's not going to count toward your risk adjustment," says Herber. "That's a significant reason not to more fully adopt telehealth visits for a lot of different services. CMS has done a number of things to encourage telehealth, but I feel like this is the one big, outstanding barrier that they could and should address on a more permanent basis to make sure the MA plans can fully adopt."

As a result, Faegre Drinker has convened a small group of industry players around advocacy on the issue. That includes telehealth provider Doctor On Demand, CVS Health Corp. and its Aetna subsidiary, Humana Inc., and Ochsner Health.

The latter is Louisiana's largest nonprofit, academic health system, which serves patients across the state through a network of 40 hospitals and more than 100 health centers and urgent care centers. Executives tell AIS Health that the health system is interested in the issue of telehealth and risk adjustment primarily to ensure that program policies align with patient care goals.

"From a care perspective, [telehealth has] become a liberating access point that has made it easier to take care of folks, especially seniors who have complex needs and potentially transportation challenges," says Ochsner Health Network President David Carmouche, M.D., who oversees the health system's primary care, urgent care and population health programs. "And we're in a rural state, so extending our care into those markets has been great and I think has become part of our care model and will continue to be."

Ochsner Saw Major Telehealth Uptake

Ochsner already had a well-established, comprehensive telehealth program called CareConnect 360 that helps partner hospitals provide personalized, on-site coverage for patients requiring access to specialty services. While much of that existed to serve rural patients, "what we really in earnest were building over the last couple of years was that direct to consumer model…where we could see patients in their homes, places of work, assisted living facilities, post-acute care centers…meeting them where they are to bring that access and convenience and ultimately provide a higher level of quality care at a lower price point,

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which when you are at risk is so critical," explains David Houghton, M.D., medical director for telehealth and digital medicine.

As a result, Ochsner was prepared for the public health emergency and saw home-based telehealth visits rise from about several thousand per year to an anticipated 250,000 in 2020. When the risk adjustment memo came out from CMS in mid-April, Ochsner's telehealth program also saw peak utilization and accounted for nearly 70% of all visits conducted. And from a value-based contracting perspective, the application of diagnoses gathered during those visits is important to Ochsner, which works with multiple MA plans but does not sponsor its own.

Risk-Bearing Provider Supports Change

"We take full capitated risk in our Medicare Advantage program, so to the degree that the premium is tied to the complexity of the illness burden of the patients we take care of — and because that risk has been delegated from the insurance plans to us, the provider — we obviously want to make sure that we have the right resources to take care of these patients," explains Carmouche.

"If our model has evolved to where it is now increasingly virtual and we're going to continue to bear the risk for our Medicare beneficiaries, then I think the risk adjustment methodology tied to the premium reimbursement based on an illness burden has to come alongside, or else you'll have a mismatch of how we take care of patients and the rules that govern the economics of Medicare Advantage," he continues.

Given that face-to-face utilization will eventually return to normal levels, the "remarkable growth pattern" in telehealth isn't expected to continue at the same rate, but Ochsner is now projecting that at least 15% to 20% of its visits going forward will be done virtually, adds Houghton. "And it may even go beyond that when we find new use cases and new opportunities to really bring the care to the patients where they are," he says. While usage will vary across specialties and subspecialties, Houghton says telehealth presents "opportunities that we can't ignore… and nobody wants to go back."

When submitting comments on the 900-plus page rule that CMS finalized in May, several insurers recommended the agency allow diagnoses gathered through telehealth visits to apply to MA risk adjustment. HealthPartners, a Minnesota integrated health care organization and MA plan sponsor that is not working with Faegre Drinker and Ochsner, at the time urged the agency to update the MA risk adjustment models "on a permanent basis," given the expanded role of telehealth in the government's response to COVID-19 and CMS's recognition of telehealth as an "appropriate care delivery option for MA enrollees."

Organizations Are Preparing a Letter

Alongside other organizations, Ochsner and Faegre Drinker are compiling a letter to CMS requesting the permanent policy change, which would likely be accomplished via a second memo. Unlike other Medicare telehealth policies enacted during the pandemic that would require congressional authorization to continue, "We believe CMS has the authority to do this immediately through subregulatory guidance, as they already did for the April 10 memo," says Herber. "Our most ideal outcome would be a second memo (plus updates to technical guides/manuals) that says the policy from [the] April 10, 2020, memo counts for all dates of service going forward rather than just 2019 and 2020."

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OIG Seeks Tweak to Encounter Data System to Avoid Fraud

In its latest review of the Encounter Data System (EDS) that is used largely to determine Medicare Advantage plan payments, the HHS Office of Inspector General (OIG) urged CMS for the second time to incorporate National Provider Identifiers (NPIs) into its collection of data from MA organizations. Despite their potential to improve program integrity in certain fraud-prone areas, NPIs for ordering providers are still not required in encounter data submissions and continue to be "largely missing" from records submitted by MAOs, observed the new OIG report.

CMS in 2012 began collecting encounter data from MAOs and, with the goal of eventually replacing the legacy Risk Adjustment Payment System, in 2016 began using it to determine risk-adjusted payments to MAOs. But the agency has always maintained that it could be used for program integrity and research purposes and in 2018 began making MA encounter data available to researchers. Last year, the Medicare Payment Advisory Commission suggested that encounter data also be used to determine star quality ratings at a local level *(RMA 3/21/19, p. 3)*.

In the August issue brief, "CMS's Encounter Data Lack Essential Information that Medicare Advantage Organizations Have the Ability to Collect," OIG explained that a prior analysis of the EDS found that order-

ing provider NPIs were missing from 63% of records for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); clinical laboratory services; imaging services; and home health services for MA enrollees. "Ordering provider" in this case refers to physicians and nonphysician practitioners who order and/or refer these services, OIG clarified.

OIG Recommends 'Reject Edits'

That analysis led OIG two years ago to suggest that CMS establish and implement "reject edits" for certain types of encounter records, such as those related to DMEPOS, laboratory, imaging and home health services, which all have a history of being vulnerable to fraud. Such edits would: (1) reject records in which the NPI and/or name for the ordering provider is not present; and (2) reject records that contain an ordering provider NPI that is not a valid and active NPI in the National Plan and Provider Enumeration System (NPPES) registry. CMS at the time said it would explore whether identifiers for ordering providers are needed for program integrity but did not agree to implement reject edits.

In its recent analysis of 2018 MA encounter data from CMS's Integrated Data Repository, OIG found that encounter data continued to lack ordering provider NPIs on records for DMEPOS, laboratory, imaging and home health services. And although nearly all MAOs have data systems that can receive and store these NPIs when they are submitted on claims or encounter records, CMS requires NPIs for ordering providers on DMEPOS, etc., only in Medicare fee for service and not in MA, pointed out OIG.

This is despite their potential to flag inappropriate billing and ordering patterns among providers, the agency continued. In fee for service, CMS uses NPIs as part of its analysis to identify actual or potential payment errors or fraud, OIG explained. "Examples of these analyses may include identifying telemedicine providers who order unlikely combinations of items or services that are at high risk for fraud (e.g., orthotics, genetic testing, and compound medicines) or identifying providers who have ordered unusually high volumes of items or services," OIG wrote.

Specifically, the report observed that:

✦ ***More than 60% of the 2018 records for DMEPOS, laboratory, imaging and home health services were missing an NPI for an ordering provider.*** DMEPOS identifiers were missing at a greater rate than records for the other three types of services. Of the 25.4 million records for DMEPOS, 18.1 million (71%) were missing an NPI for an ordering provider. By contrast, 62% of lab records, 58% of imaging records and just 17% of home health records were lacking such information.

✦ ***Out of 179 MAOs surveyed by OIG, 98% (176) of plans reported that their data systems are capable of accepting and housing ordering provider NPIs*** when they are included on claims or encounter records submitted by physicians. Fifty-eight percent (103) said their providers or suppliers of DMEPOS, lab services and imaging services submit an ordering NPI on at least half of MA claims/encounters, yet most of these MAOs do not submit such information in their MA encounter data since they are not required to.

Anne Crawford, senior vice president of compliance solutions with ATTAC Consulting Group, says she's surprised that NPIs for referring providers of DMEPOS and other fraud-prone areas are still not a required component of EDS submissions. "I'm not sure what further exploration really needs to be done," particularly since providers are already including the identifiers when submitting claims for fee-for-service reimbursement, she points out. "I don't know why it would be good on one side of the house of CMS and not the other."

NPIs Could Reveal Patterns of Care

Michael Adelberg, a principal with Faegre Drinker Consulting and a former top CMS MA official, agrees. "It makes sense that OIG and academic researchers interested in comparing fee for service and MA patterns of care want the NPIs," he tells AIS Health. "CMS has not made it a priority to include the NPIs, so neither have the plans."

Given that nearly half of OIG's MAO sample said they're receiving the NPIs but not submitting them because it's not required, Crawford says adding a requirement should not create a major hassle for plans.

However, the timing of CMS implementation depends on a few factors, she points out. How long it would take CMS to reconfigure the EDS to include a field for NPIs is one question. Moreover, CMS has just implemented new audit protocols for 2020 and received comments on the 2021 protocols *(RMA 7/16/20, p. 1)*, so the agency "may be trying to weigh how much IT changes an organization can handle," she suggests. "But it doesn't seem like it has a real heavy lift if you're just looking at it on its own."

In a response letter dated Aug. 6, CMS Administrator Seema Verma explained to OIG that CMS initially focused the use of encounter data on payment purposes but recognizes that information collected through encoun-

ter data can be "an important part" of maintaining program integrity. Out of a desire to reduce plan and provider burden, however, the agency historically has not required referring provider NPIs since they are not necessary to determine plans' risk adjusted payments, she stated. Instead, CMS has in previous guidance encouraged MAOs to "include the referring provider NPIs for these types of encounters as well" and in December 2019 began rejecting encounter data that contained an NPI that cannot be found or is inactive in the NPPES.

CMS concurred with OIG's recommendation to begin requiring ordering provider NPIs in the submission of encounter data records for DME-POS, lab, imaging and home health services and said it is "exploring implementation" of such a requirement. Verma said the agency will not, however, implement reject edits suggested by OIG as it "would be premature to establish and implement such changes prior to the exploration of a requirement discussed in the aforementioned OIG recommendation."

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MA Startups Plan 2021 Moves

continued from p. 1

Alignment Healthcare, Bright Health, Clover Health, Devoted Health and Oscar Health collectively have raised $3.9 billion in private funding, estimates the blog Healthcare Pizza. Combined with the other factors Montrie mentions, the "opportunity of technology-first MA startup plans to better reduce administrative fees ('Administrative Loss Ratio' or 'ALR') and control medical spend ('Medical Loss Ratio' or 'MLR') seems too good to pass up," writes Andy Mychkovsky, who authors the blog devoted to health care startups.

Proposed MCIT Rule Aims to Speed Senior Access to Breakthrough Devices

Carrying out another directive from President Trump's Medicare-focused executive order issued last fall *(RMA 10/17/19, p. 3)*, CMS on Aug. 31 released a proposed rule that aims to fast-track Medicare coverage of certain innovative FDA therapies once they are approved. Although the rule applies to Medicare fee for service, it has implications for Medicare Advantage organizations that are required to cover Medicare Parts A and B approved services.

According to a CMS fact sheet on the rule, CMS is proposing a new Medicare coverage pathway, Medicare Coverage of Innovative Technology (MCIT), for medical devices that are granted breakthrough designation by the FDA. The MCIT proposal would allow for national Medicare coverage on the same day as a breakthrough device receives FDA approval. CMS proposes a coverage duration of four years, which it suggests will "encourage manufacturers to voluntarily develop evidence to show these treatments improve the health of Medicare patients."

As determined by the 21st Century Cures Act, "a breakthrough device must provide for more effective treatment or diagnosis of a life-threatening or irreversibly debilitating human disease or condition and must also meet at least one part of a second criterion, such as by being a 'breakthrough technology' or offering a treatment option when no other cleared or approved alternatives exist," according to the fact sheet.

"If the rule finalizes as proposed, Medicare will cover more expensive FDA-approved devices and products. MAOs will need to follow suit," notes Michael Adelberg, a principal with Faegre Drinker Consulting and a former top CMS MA official. "MAOs should see this reflected in their base payment rates, but there may be a lag."

At the same time, the proposed rule seeks to codify a definition of "reasonable and necessary" as it applies to items and services that may be covered under Parts A and B, which CMS suggests would "bring clarity and consistency to the existing coverage determination processes for items and services under Part A and Part B."

CMS is seeking public comment — specifically on the duration of the MCIT, what CMS proposed to cover through the policy and whether coverage should be expanded to include all diagnostics, drugs and/or biologics — through Nov. 2.

View a fact sheet on the rule at https://go.cms.gov/2QG2CE6. Contact Adelberg at michael.adelberg@faegredrinker.com.

"There's a lot of energy and excitement around, how can organizations serve the customer better and do so in a modern way and disrupt the market?" says Montrie. "And the thesis around a lot of these organizations is, how can they build a purpose-filled platform for a segment of the population that they feel is either underserved by the current market participants or there's a current unmet need that can be served? And so, we see a lot of organizations leading with technology" and building the IT infrastructure from the ground up rather than redesigning a legacy system, giving them an edge over established MAOs, he observes.

Clover Plots Major Geographic Expansion

After a wildly successful 2020 AEP, ***Clover Health*** says it plans to triple its geographic footprint, pending CMS approval, by increasing its MA service area to 108 counties in eight states. Sixty-nine of the new counties are in Clover's existing markets of Arizona, Georgia, New Jersey, Pennsylvania, South Carolina, Tennessee and Texas, while five are in Mississippi — a new market for the company. The MA-focused health care technology organization currently serves 57,000 members in 34 counties across seven states.

The expansion brings Clover's MA offerings to a potential 5 million Medicare eligibles, estimates the company. President and Chief Technology Officer Andrew Toy tells AIS Health that Clover believes its combination of low out-of-pocket costs and an open provider network has been a significant driver of past growth and will contribute to future growth.

"We're incredibly proud of the ways we've been able to embrace our DNA as a technology company to support our members during Covid-19," he adds in an email to AIS Health. During the first two weeks of the pandemic, the firm rolled out functionality to support the use of telehealth for its providers and supplied them with lists of their most at-risk patients so that they could proactively reach out to them. "Our ability to quickly ramp up telehealth capabilities and integrate them into our Clover Assistant platform has allowed us to stay almost at parity with the number of primary care visits taking place pre-pandemic, where other insurers have seen a 40-80% drop in visits," he adds. The Clover Assistant app assists primary care providers at the point of care by using machine learning to prioritize care recommendations and deliver evidence-based protocols.

Meanwhile, Clover has identified a significant percentage of members who don't have the technology to engage in a video visit, so it is "looking at creative ways to make sure this population is properly managing their health," adds Toy.

Oscar, Providers Prepare Florida Launch

Following its 2019 entry into the MA market with plans in Houston and New York, ***Oscar Health*** recently unveiled plans to launch a co-branded MA plan with two providers in Broward County, Fla. This is the not the insurer's first foray into the "payvidor" space; it launched a joint venture with Cleveland Clinic in 2018 to offer co-branded products both on and off the Ohio health insurance exchange. Oscar's membership in MA remains small, with just under 1,800 members, while it has upwards of 410,000 members in the individual market.

Ananth Lalithakumar, vice president and general manager for Medicare Advantage products, says the 2020 expansion into MA tested a thesis that it could increase adoption of its health care technology tools among seniors, and that Oscar is "incredibly excited" to team up with Holy Cross Health and Memorial Healthcare System in Broward to offer the Oscar + Holy Cross + Memorial Health Medicare Advantage plan. He tells AIS Health that the value-based partnership is built on an aligned view of the "quadruple aim" (i.e., improved member experience, lower cost, higher quality, better empowerment of physicians) and will leverage Oscar's established technology platform with "trusted providers in the community who seniors are used to seeing."

Oscar Seeks Partners With Aligned Goals

When considering a new market, Oscar looks at the usual business model variables, such as whether the market is strong, competitive and/or growing, what the MA benchmark rates are there and whether the company can see a path forward for "delivering better experiences and also becoming profitable in a short time frame," explains Lalithakumar. But it also considers whether a provider system there can align with its goals of engaging members through technology tools and service support, and Oscar believes it found that with Holy Cross and Memorial, he adds.

Lalithakumar notes that Oscar has an industry-leading net promoter score of 36 in the Affordable Care Act market and believes it can "take many of those same ingredients" that worked there to engage members and apply them in MA. "What we've seen in the adoption of our tech solutions doesn't necessarily vary by age," he says. "The millennials tend to use our solutions in the same range as the 55-plus population, and the early indicators based on the 1,800 members we have in MA reflect the same thing.

"The pandemic accelerated the need for technology-enabled, visually enabled virtual solutions and we've done a great program to roll out and engage our members through this pandemic in New York and Houston, two of the markets that were hit [hardest] by the pandemic," he continues. "And we've seen increased use of our tech tools and virtual platform, and we believe that the thesis holds stronger on why Oscar would be able to serve the Medicare population." Lalithakumar adds that Oscar is still "having a lot of conversations" around additional MA expansions but cannot comment on them at this time.

Alignment Healthcare, which was founded in 2013 with a sole focus on MA and had a strong 2020 AEP and Open Enrollment Period (OEP) with the addition of about 14,000 members in California, recently unveiled its intention to enter several new markets across California, Nevada and North Carolina. Pending regulatory approval, the product expansion would enable Alignment to reach more than 5.9 million Medicare-eligible beneficiaries, according to an Aug. 6 press release.

The insurer said it plans to introduce several new products, "most notably a signature virtual health plan to provide seniors a safe, convenient and personalized virtual care option," and at press time unveiled a new plan option in San Diego County featuring Scripps Health. Alignment currently serves about 65,000 MA members in California, a 34.9% increase from last year, according to AIS's Directory of Health Plans. In a June interview with AIS Health, Alignment attributed that success in large part to geographic expansion and new co-branded offerings with Sutter Health, as well as an "on-demand personalized concierge" feature and its data-driven approach to closing care gaps *(RMA 6/18/20, p. 1)*.

"It's a really powerful combination when done well because I think time and time again studies and choosing patterns have shown that provider brand can and often does trump payer brand," says Montrie of payer-provider pacts like Alignment's with Sutter. "So for your ability to attract customers,

MA, Cost, PACE, Demo and Prescription Drug Plan Contract Enrollment Report (August 2020)

Enrollment in Medicare Advantage plans reached 25.2 million enrollees as of the Aug. 1, 2020, payment date, according to new monthly summary data from CMS. The payment reflects enrollments accepted through July 10. In an Aug. 19 research note from Credit Suisse, securities analyst A.J. Rice observed that year-to-date (YTD) enrollment growth is 8%, beating the pace of the previous two years, which was 6.4% and 6.6%, respectively. "The five major MCOs (including CVS), which account for roughly 61.7% of total MA enrollments, have cumulatively grown 10.0% YTD vs. 4.9% YTD growth for the remaining MA plans," he noted.

		Drug Plan Enrollment			Special Needs Plan Enrollment			Employer Plan Enrollees		
Current Contract Summary:	Number of Contracts	MA Only Enrollees	Drug Plan Enrollees	Total Enrollees	SNP Enrollees	Non-SNP Enrollees	Total Enrollees	Employer Plan Enrollees (800 Series Plans)	Non-Employer Plan Enrollees	Total Enrollees
Total *"Prepaid"* Contracts (1)	**822**	**2,829,808**	**22,372,985**	**25,202,793**	**3,522,620**	**21,680,173**	**25,202,793**	**4,760,497**	**20,442,296**	**25,202,793**
Local CCPs	590	2,495,669	20,763,829	23,259,498	3,115,714	20,143,784	23,259,498	4,754,408	18,505,090	23,259,498
PFFS	5	23,279	56,934	80,213	0	80,213	80,213	0	80,213	80,213
MSA	4	8,485	0	8,485	0	8,485	8,485	27	8,458	8,485
Regional PPOs	28	89,153	1,060,095	1,149,248	406,906	742,342	1,149,248	3,440	1,145,808	1,149,248
MA Subtotal	***627***	***2,616,586***	***21,880,858***	***24,497,444***	***3,522,620***	***20,974,824***	***24,497,444***	***4,757,875***	***19,739,569***	***24,497,444***
Medicare-Medicaid Plan	40	0	395,711	395,711	0	395,711	395,711	0	395,711	395,711
1876 Cost	9	142,274	47,032	189,306	0	189,306	189,306	2,622	186,684	189,306
1833 Cost (HCPP)	9	70,948	0	70,948	0	70,948	70,948	0	70,948	70,948
PACE	137	0	49,384	49,384	0	49,384	49,384	0	49,384	49,384
Other Subtotal	***195***	***213,222***	***492,127***	***705,349***	***0***	***705,349***	***705,349***	***2,622***	***702,727***	***705,349***
Total PDPs	**65**	**0**	**25,164,455**	**25,164,455**	**0**	**25,164,455**	**25,164,455**	**4,713,974**	**20,450,481**	**25,164,455**
Employer/Union Only Direct Contract PDP	3	0	116,582	116,582	0	116,582	116,582	116,582	0	116,582
All Other PDP (1)	62	0	25,047,873	25,047,873	0	25,047,873	25,047,873	4,597,392	20,450,481	25,047,873
TOTAL	**887**	**2,829,808**	**47,537,440**	**50,367,248**	**3,522,620**	**46,844,628**	**50,367,248**	**9,474,471**	**40,892,777**	**50,367,248**

CCPs=Coordinated Care Plans; PFFS=Private Fee-for-Service; MSA=Medical Savings Account; PACE=Program of All-Inclusive Care for the Elderly; SNP=Special Needs Plan.
(1) Totals include beneficiaries enrolled in employer/union only group plans (contracts with "800 series" plan IDs). Where a beneficiary is enrolled in both an 1876 cost or PFFS plan and a PDP plan, both enrollments are reflected in these counts.
SOURCE: CMS's Monthly Contract and Enrollment Report, August 2020. Visit https://go.cms.gov/2QHhEJC. Contact Rice at aj.rice@credit-suisse.com.

being able to leverage in many communities what is one of the largest employers and a well-respected entity is a really powerful way to have a new market entrant with not a lot of brand equity enter a marketplace and to do so in a way that consumers trust."

The steps beyond member acquisition, however, are where new entrants' capabilities will really be tested, suggests Montrie. "How do you integrate the clinical capabilities and capacity of the delivery system and the providers with your plan offering and do so in a way that can maximize the benefits to the member? [How do you] take the best care of that member [in a way] that ultimately results in better star ratings and risk adjustment capabilities?" he asks.

There are other challenges as well. "It's not easy to build an entire infrastructure for a health care system and an insurance organization in a very highly regulated market," adds Montrie. "You can go in with a lot of great ideas and notions that you're going to disrupt the entire category, but understanding and making sure that you're doing so in a way that is respectful and taking into account the regulatory environment is a real challenge."

Clover, for one, made headlines last year when the tech startup laid off about a quarter of its workforce with the intent of acquiring more health care experts *(RMA 4/4/19, p. 1)*. The company, which launched its first MA plans in New Jersey in 2015, was fined for a marketing violation the following year and made a few other reported missteps that led to some restructuring. But after a major service area expansion in 2020, Clover picked up more than 14,000 members during the 2020 AEP and OEP.

When asked how the restructuring has strengthened the organization, Toy responds: "We believe our performance over the past year speaks for itself. Last year we were the fastest-growing Medicare Advantage [plan with] over fifty thousand members, and our unit economics and maturity as a company has continued to improve. However, what's most important is that, through the Clover Assistant, we're raising the quality of care delivered to our members so they can be as healthy as possible."

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News Briefs

✦ ***Anthem Blue Cross and Blue Shield and Centene Corp.'s Managed Health Services (MHS) secured new four-year contracts to serve the Indiana state Medicaid program, Hoosier Care Connect.*** The new pacts, which start in April 2021, include the option for two one-year renewals, according to a press release from Centene. Anthem currently serves more than 500,000 Medicaid members across the state, while MHS serves more than 330,000 enrollees. View the releases at https://bwnews.pr/32hnW84 and https://prn.to/2YxNbSS.

✦ ***After successful ballot initiatives in Missouri and Oklahoma, South Dakota voters may decide the fate of Medicaid expansion in that state.*** South Dakota Attorney General Jason Ravnsborg (R) posted explanations for two petitions that will circulate in an effort to gain enough signatures for a ballot initiative in 2022. One of the measures would create a constitutional amendment (similar to Oklahoma's approach) and the other would direct the state legislature to expand Medicaid. Expansion advocates have until November 2021 to collect enough signatures. Visit https://bit.ly/2EXnd42.

✦ ***CVS Health Corp.'s Aetna has teamed up with WellBe Senior Medical to deliver home-based primary care in the Chicago and Atlanta metropolitan areas and Landmark Health to offer in-home services in New York.*** WellBe's services will be available to seniors with multiple complex health conditions. The program will offer "old-fashioned house calls" as well as the option to schedule virtual visits conducted by a WellBe clinician. In the New York City boroughs and Long Island, Albany, Rochester and Buffalo, Aetna's Medicare Advantage members with chronic conditions will receive access to in-home services such as wound care, home safety checks and health screenings furnished by Landmark clinicians. Visit www.wellbeseniormedical.com or www.landmarkhealth.org.

✦ ***PERSON ON THE MOVE:*** Centene Corp. promoted ***Jonathan Dinesman*** from senior vice president to executive vice president of government relations.