

When It Comes to Medicare Advantage, It's Time to Focus on Collaboration



Stop Avoiding & Start Partnering

Devin Woodley, February 12, 2025

Medicare Advantage (MA) health plans were designed to simplify health care and help seniors manage their evolving needs as they age. Today, many MA plans have attractive long-term care and supplemental benefits, including access to healthy food, in-home assistance with activities of daily living, assistive devices and more. In recent years, many MA plans have begun to recognize the value of providing care in the home, which has been signaled through national payers' acquisitions of large home health organizations. The homecare industry needs to capitalize on this trend by finding opportunities to demonstrate the value of collaborations between providers and MA plans.

As the health care industry continues to consolidate and adapt to government regulations, there can be real advantages for home health care organizations that expand their business models by adding MA plans to their lines of business. VNS Health, the New York home- and community-based health care nonprofit I work for, is just one example. Structured as both a provider and a payer, our 130-plus years of experience providing clinical care coordination drives our certified home health agency and our health plans business, which together support care for New Yorkers with chronic conditions.

In the coming year, MA plan growth and increased market penetration seem solid and certain. Below are some guidelines for rethinking managed care, providing better care to aging seniors with complex, long-term care needs and moving home health businesses beyond visit-based reimbursement limitations toward a business model that provides new symbiotic growth.

1. Partnerships are key.

Partnering with other organizations to improve capacity, capabilities and reporting practices is a pathway toward greater strength and sustainability.

The secret to success in managed care is to create meaningful conversations with potential MA plan partners that focus on value. Payers are looking to decrease or avoid unnecessary costs, which can be achieved by lowering hospitalization rates. The ability of home health agencies to accept and initiate post-discharge care quickly and to provide high-quality clinical interventions can significantly decrease potentially avoidable hospitalizations. While in the member's home, clinicians also provide services that can increase payer quality metrics, such as medication reconciliation post-discharge. Accurately reporting this data can impact Centers for Medicare & Medicaid Services quality scores, which ultimately result in more benefit options for members.

Additionally, partnering with referral sources is a good move. Home health agencies that receive the highest rates often partner with hospital systems that help them with payer negotiations. Clinical collaborations between organizations can increase quality and member experience, especially when hospital infrastructures support the agency with administrative tasks like bundled authorizations and payments. Forming partnerships with other home health agencies and referral sources helps open the door to more meaningful partnerships with payers.

MA plans often look for a single source of contact, expedited referral acceptance rates, timely start of care and quality outcomes. Providing these key performance metrics to an MA payer will set the stage for growth.

2. Explore multiple paths.

Growing admissions might seem like the most direct route to increased revenue, but sustaining your margin as your payer mix changes is critical. Increased reimbursements are also necessary for financial growth. Given that payers face financial pressures, too, understanding and solving critical pain points can be the most straightforward way to successfully engage with payers.

Consider providing more than your organization previously has and better understanding your patient population's needs. Consider options such as changing your reimbursement structure or adding a value-based program, like a disease-specific improvement initiative targeted for congestive heart failure, chronic obstructive pulmonary disease, sepsis, wound care or diabetes foot care.

3. Fill the gap.

With increased admission, margins and quality, your organization will be ready for the next level of growth: program expansion and diversification. Launching new clinical programs that address the specific needs of the individuals and families in your market can make your agency very attractive to payers and plan members.

All payers have gaps, so the question is: How can you help close them? If you have a solution that can save a payer three times the cost of delivering care, they are certain to entertain it. Clinical program strategy is possibly the strongest growth engine for any organization.

4. Make a safe bet.

Where does one start? Once you've done your research, start small and keep it safe. Start with your strengths, such as areas where you are confident in your performance and can show meaningful impact. For example, you might want to consider asking a payer to start out with a pay-for-reporting arrangement to help them close important health care effectiveness data and information sets (HEDIS) or Medicare star rating gaps. Then you can step into pay-for-performance by negotiating bonuses for timely start-of-care and reduced hospitalization rates.

As your relationships grow, you might explore bundled arrangements with episodic reimbursement that can cover all services in a given patient or member episode. A multiyear strategy often starts small, but with strategic focus, partnerships and diversification, both revenue and margin growth can be achieved.

Partnerships with accountable care organizations (ACOs) are another friendly approach for home health agencies that want to explore MA plan growth opportunities. ACOs are provider-driven and look to partner with home health agencies to help them build their networks. An ACO is very likely to be interested in quality and in sharing savings with their partners. Developing a solid track record through an ACO partnership can be a great vehicle for heading down the value-based road with payers.

Expansion into managed care contracting is a journey that requires thoughtful strategic planning. An added benefit is that you are not only growing your business—you are helping to keep standards of care high for those you serve.

Taking It to the Next Level

Once partnerships are in place, there are several key ingredients to ensure long-term success. The three most important capabilities a home health agency needs to leverage for success are: the technology stack (the set of technologies used to deploy solutions), clinical innovation and the ability to negotiate contracts with payers.

Today's technology stack necessities begin with the electronic medical record. An organization should have technology that can be easily integrated, perform data reporting and have predictive analytics that alert teams when interventions are needed. Predictive analytics are necessary in today's world and keep care teams informed about critical data. Our teams at VNS Health have developed analytics that help predict when a patient may be approaching end of life and should be transitioning to hospice care. These analytics can also help clinicians determine a homecare patient's potential risk of rehospitalization. Preparing the clinical team with this guidance allows them to make quick decisions and changes in their care plans that not only improve the quality of care for the patient but also drive cost savings for the payer, which can then be shared through a value-based contract.

Other technology products that promote growth and success include remote patient monitoring (RPM), which provides the ability to manage care outside of a standard care plan or goal by leveraging automation, referral management tools and the ability to develop and deploy predictive analytics. RPM also ensures members are in the right care setting at the right time, while receiving appropriate interventions required for their disease state. Being able to capture and report pertinent data, such as G codes and HEDIS quality metrics, verifies this critical work has been done. Having this type of technology capability is necessary to successfully perform and meet payer expectations when entering the value-based arena.

In any work tied to clinical services, the real partnership magic comes from clinical strategies that keep patients comfortable and stable in their own homes. MA plan partnerships that do this effectively reduce costs for the payer and offer savings that can be shared with the provider. Innovations that deliver current services more efficiently, capture more data, close quality gaps and decrease potentially avoidable hospitalizations are not only building blocks for high-quality patient and member care—they are the foundation for growth and for programs that close emerging gaps to create increased value in your market over time.

Finally, having a strong managed care contracting team that is aware of the payer's areas of interest and has a clear understanding of provider capabilities is critical for successful managed care partnerships. Managed care teams should be involved from the clinical program development stage through financial

modeling and creation of sales materials so they are fully prepared to pitch—and win—potential payer partnerships.

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