INVESTING IN THE FUTURE:
A DEEPER LOOK INTO THE BUSINESS FUNCTIONS OF D-SNPS

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Health Plans

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Julie Smith is a senior executive with a broad range of entrepreneurial, industry, government, and consulting experience.

After receiving government-sponsored health care as a child, Julie focused her business capabilities and entrepreneurial spirit on serving vulnerable populations. This passion began during her tenure serving the Administrator of CMS and led her to create innovative solutions driving shareholder value while maximizing taxpayer dollars.

Julie has served as Senior Vice President for Blue Cross Blue Shield of Michigan (BCBSM), and President of Advantage Solutions, as well as President, Senior Business, for Anthem Inc., managing a multi-state $9 billion business segment.

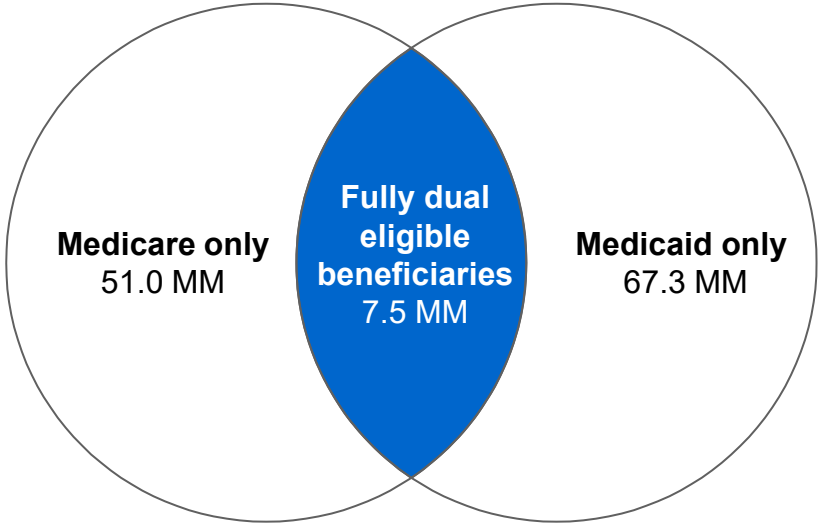
Today, Julie influences regulatory agendas and business outcomes by blending public policy and business strategies to support health care innovation for Private Equity, Small Cap companies, and Oliver Wyman clients as a Senior Advisor and interim executive. Most recently, she served as interim CEO of Gateway Health Plan.

1 National D-SNP Market Overview

There are 7.5 million fully dual eligible beneficiaries, of which 26% are enrolled in D-SNP plans

Medicaid, Medicare, Duals Overlap
National level, 2017

Total Medicare beneficiaries: 58.5 MM



Total Medicaid beneficiaries: 74.8 MM[1]

1. Calculated as average monthly enrollment for 2017
2. Data represents estimates of May 2017 enrollment

Sources: CMS 2017, Kaiser Family Foundation 2017

D-SNP Overview (1 of 3)

D-SNPs are a type of MA plan designed to alleviate care coordination issues and administrative complexity inherent in dual-eligible populations

D-SNP Overview	• A Dual Eligible Special Needs Plan (D-SNP) serve the needs of members that are eligible for both Medicare and Medicaid • D-SNPs were created as a way to address the administrative complexities and care coordination issues of having different benefits covered by Medicare or Medicaid
Eligibility	• Enrollees must meet CMS eligibility requirements for Medicare and state-specific Medicaid requirements • Beneficiaries receiving both full and partial Medicaid benefits may qualify for D-SNPs • Some states allow D-SNPs to exclude certain populations (e.g., those under 65); others require D-SNPs to take all dual-eligibles

Sources: CMS, Integrated Care Resource Center

D-SNP Overview (2 of 3)

Eligibility and payment models vary by type of D-SNP; both state and federal regulatory considerations must be taken into account

Types of D-SNPs	• Traditional D-SNPs include: – All-dual D-SNPs: open to beneficiaries enrolled in both Medicare and Medicaid. – Full-benefit D-SNPs: open only to beneficiaries who receive full Medicaid benefits – Medical Zero Cost Sharing D-SNPs: open to beneficiaries who receive partial Medicaid benefits – Dual Eligible Subset D-SNPs: approved for subsets of other populations on a case by case basis • Fully Integrated Dual Eligible (FIDE)-SNPs fully integrate Medicare and Medicaid benefits
Regulatory Considerations	• D-SNP operators must meet both CMS and state-specific requirements • Timelines between CMS and state Medicaid agencies may not always be in alignment

Sources: CMS, Integrated Care Resource Center

D-SNP Overview (3 of 3)

Eligibility and payment models vary by type of D-SNP; both state and federal regulatory considerations must be taken into account

Covered Services

- D-SNPs must cover all Medicare primary and acute services
- Covered Medicaid benefits are at each state's discretion, however LTSS and behavioral health are generally required to be covered
- D-SNPs must coordinate the delivery of both Medicare and Medicaid services (e.g., by enrolling beneficiaries in Medicaid plans operated by the same company)

Payment Models

- All D-SNPs receive Medicare reimbursement through a capitated payment determined by a CMS formula, as with traditional MA plans
- Medicaid reimbursement depends on the type of plan:
  - Traditional D-SNPs follow a FFS model for Medicaid
  - FIDE-SNPs receive a capitated payment for Medicaid
  - Recent guidance by CMS indicates that all D-SNPs will be required to either coordinate or take risk on basic Medicaid services (LTSS and behavioral health)

Sources: CMS, Integrated Care Resource Center

All this assumes you can also do the basics well—in a Medicare environment—so you can focus on the specialized elements

Engage with Members & Providers	• Right sales / outreach model for members • Right network of providers
Process transactions accurately and at scale	• Benefit configuration specific to Medicare • Meet Medicare enrollment and claims specifications • Pay providers at Medicare's specifications
Engage with regulators	• Proper filings and reporting for CMS\ • Communication standards • Compliance activities

2 D-SNP California Market

D-SNP California Market – An Analysis

CA is **one** of **ten** states that make up 63% of DSNP enrollment

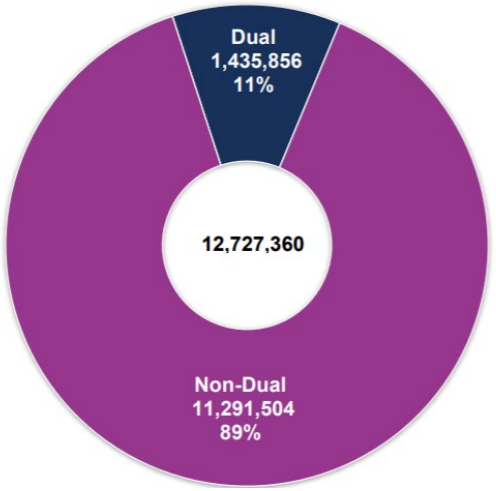
Average heath care costs of dual eligible is **$30,000** per year

More than **HALF** of Duals have cognitive or mental impairments

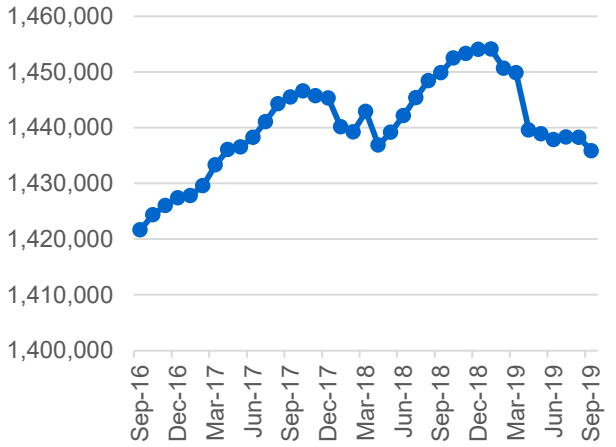
Duals cost **4X MORE** than Medicare only enrollees

California has the **largest** dual eligible population at **1.45 million**

11% of Medi-Cal Enrollment Was Dual Eligible in 2019



Medi-Cal Dual Eligible Enrollment (2016-2019)



55% of Dual Eligible members have 3 or more chronic conditions

10-19% of dual eligible individuals are enrolled in DSNP in CA currently

70% of Dual Eligible populations is age **65+**

3 Capabilities required to successfully operate a D-SNP

Summary of Additional D-SNP Capabilities

D-SNPs must have the same capabilities as MA plans plus capabilities to manage care for a more complex and challenging population

Key differences in MA and D-SNP capabilities

	Capability	Considerations
1	**Care Management / Coordination**	• Robust care team and patient plan are needed to coordinate care across Medicare and Medicaid services • Care management must also adapt to the complexities of the duals population (e.g., greater pyscho / social needs, more acute health needs)
2	**Clinical Model / Social Services**	• In addition to ongoing clinical care, duals need additional services (e.g., non-emergent transport) that a D-SNP must provide
3	**Provider Network Development**	• MA networks must be expanded to cover the required services in a D-SNP; not all Providers can / want to manage this population
4	**Analytics and Data**	• The additional services in a D-SNP introduce new types of data to be tracked, analyzed and integrated into a holistic member profile that can be used to coordinate care
5	**Quality Programs**	• SNPs have CMS and state-specific reporting requirements, as well as an additional Stars measure
6	**Risk Score Programs**	• Risk-scoring the duals population typically involves higher touch, more intensive coding with more frequent and deeper assessments of members

D-SNP Capabilities
Provider Network Development

Consideration	Business Process
MA networks must be expanded to cover the required services in a D-SNP; not all Providers can / want to manage this population	• Contract Support • Credentialing • Data Maintenance • Network Analytics

Tools & Tech

- **BPaaS**
  - Utilizing outside services to make provider contract data-entry a low-cost commodity
- **Integrated Platforms**
  - User friendly interfaces to reduce manual work required for credentialing
- **AI & Automated Workflows**
  - Creating proactive automated cadences for updating provider records
- **Predictive Analytics**
  - Facilitate shared savings goals by monitoring network analytics to obtain a 360 degree view of providers

Summary of Additional D-SNP Capabilities
Analytics & Data

Consideration	Business Process
The additional services in a D-SNP introduce new types of data to be tracked, analyzed and integrated into a holistic member profile that can be used to coordinate care	• Data Analysis • Data Warehousing & Big Data • Medical Cost Management

Tools & Tech

- **Predictive Models**
  - Utilizing disparate data sources to analyze members health and forecast future possible events
- **Data Warehousing & Big Data**
  - On prem and cloud based automated data management systems for improved decision making
- **Medical Cost Management**
  - Analytical systems for uncovering the core cause of medical cost increases and facilitating value based care

Summary of Additional D-SNP Capabilities
Quality Programs

Consideration	Business Process
SNPs have CMS and state-specific reporting requirements, as well as an additional Stars measure	• Customer Experience • Data Collection & Storage • Data Analysis

Tools & Tech

- **Quality Metric Tracking**
  - Member-level roadmaps for actionable intervention across the healthcare journey to keep members engaged in their care
- **Analytics Platforms**
  - Analytical assessment systems for identifying health cost drivers, forecasting future costs and calculating ROI for wellness programs

Summary of Additional D-SNP Capabilities
Risk Score Programs

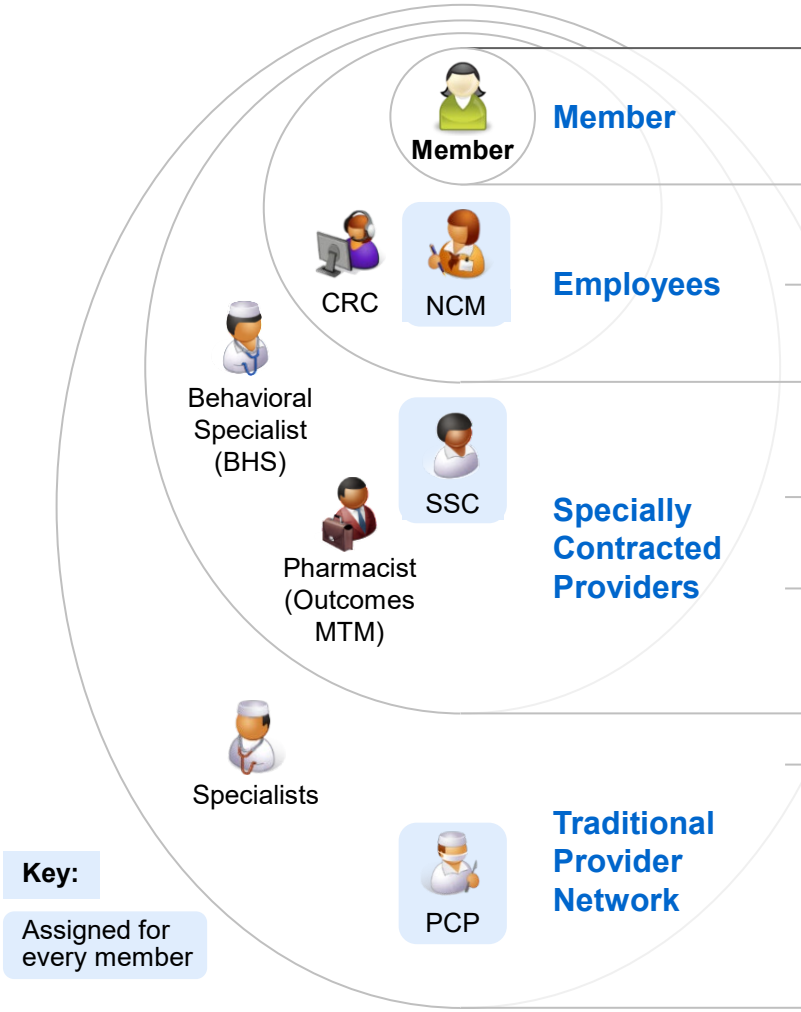
Consideration	Business Process
Risk-scoring the duals population typically involves higher touch, more intensive coding with more frequent and deeper assessments of members	• Customer Experience • Data Collection & Storage • Data Analysis

Tools & Tech

- **Predictive Models**
  - Utilizing disparate data sources to define social determinants of health and forecast future possible events for members
- **Engagement Platforms & Applications**
  - Driving member engagement and data collection through the use of wearables, messaging services, and educational resources

Example Care Model

Reminder: The duals care model utilizes a core team that coordinates across a broader suite of provider services than MA



Member	
Nurse care manager (NCM)	• Assigned upon enrollment • Single point of contact for members
Community resource coordinator (CRC)	• Integrates non-clinical support (transport) • Coordinates with SSCs
Support services coordinator (SSC)	• Assigned upon enrollment • Regularly assesses long-term health and functional needs
Behavioral health specialists (BHS)	• Outsourced services, with 2 specialists embedded in offices
Pharmacist (Outcomes MTM)	• Outsourced service for qualifying members • 20-min in-person consults with local pharmacists
PCP	• Assigned upon enrollment
Additional optional team members	• Specialists • Medical home care coordinator (MHCC) • Discharge planner • Social workers, advocates • Physical therapists • Nutritionists • Personal care attendants

In order of decreasing strategic control

Example Care Model

Each care team member carries a unique role in managing the duals population and engaging with the broader provider network

Team Member	Key Characteristics	Key Activities / Processes
Nurse care managers (NCMs) 	• ~120:1 staffing ratio on average • Assigned to each member with more attention for acute patients • RNs hired from home health / ambulatory companies • Home and phone communication	• Care coordination, not delivery • 24/7 availability to providers • Develop Integrated Care Plans (ICPs) – approved by PCP • Conduct regular assessments of members
Community resource coordinators (CRCs) 	• ~325:1 staffing ratio on average • Not assigned to each member • Hired from community - Cultural fit - Multilingual • Phone communication	• Facilitate appointments and re-assessments (likely for members with cultural and linguistic needs) • Coordinate with SSCs to provide community resources
Support Services Coordinator (SSC) 	• State employees • Assigned to each member • Employed by community- or state-owned centers where possible • Similar skills to CRCs	• Support NCMs and CRCs • Make home visits every 6 months
PCPs 	• Non-plan employees • NCQA-credentialed • Contracted under FFS or value-based arrangements	• Approve ICPs developed by NCMs • Conduct initial risk assessment upon enrollment

Additional Services Required

Reminder: The duals care model requires different services than MA, and in some cases more intense versions of some existing services

Additional Services for Most Vulnerable Beneficiaries (Non-Exhaustive)

Adult day health	**Environmental accessibility adaptations**
Adult foster care	**Home health aide services**
Adult group care	**Homemaker services**
Chore services	**Institutional Long-term Care**
Community-based home care services	**Non-emergency transportation**
Companion services	**Personal Care Attendee (PCA) services**
Companion respite care	**Personal care homemaker services**
Day habilitation	**Social day care**
Dementia day care	**Vision, Dental, and Hearing Services**

The following slides provide additional detail on highlighted services above

Additional Providers Required

In order to cover required services for D-SNP members, MA provider networks have to be significantly expanded

Services and providers required to be covered by D-SNPs (in addition to PCPs / specialists / hospitals)

INSTITUTIONAL LONG TERM CARE

- Facilities providing long-term services and supports (e.g. nursing homes)
- Long-term private-duty nursing

COMMUNITY-BASED HOME CARE SERVICES

- Skilled nurses in home / community
- OT / PT / ST
- Chore services
- Respite care
- Meal delivery
- Personal care assistants

ADULT FOSTER CARE / DAY CARE

- Senior centers
- Adult daycares
- Community meal sites
- Adult foster care

VISION, DENTAL, HEARING SERVICES

- Ophthalmologists
- Dentists
- Audiologists

NON-EMERGENT TRANSPORT

- Community vans
- Public transport (buses, trains)
- Uber/Lyft
- Transportation broker / taxi service coordinator

In addition D-SNP plans require expanded networks for certain services (e.g., behavioral health, substance abuse, etc.)

1. Includes services covered in the Michigan demonstration

Source: MDHHS, KFF

Data and Analytics Capabilities Required

Crucial to managing the D-SNP population is gathering data from additional sources and integrating them into a holistic profile of each member

Member data collected on D-SNP population (non-exhaustive)

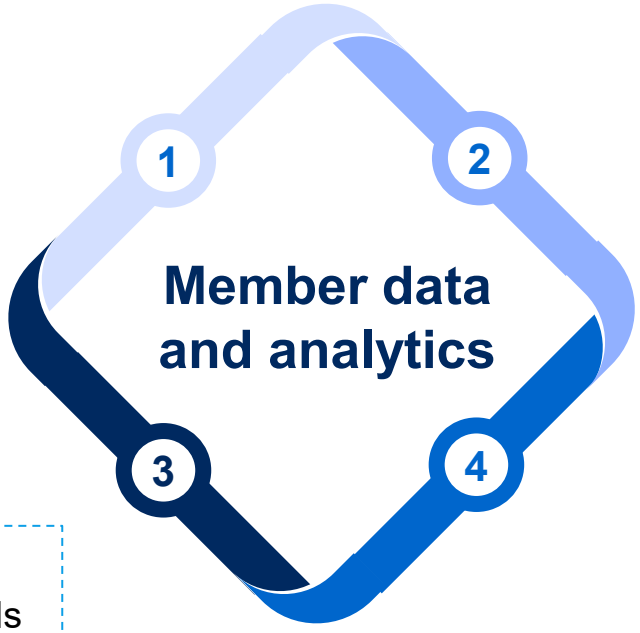
Increased importance in D-SNP compared to MA

Medical

- Medical records (IP, OP, and professional)
- Lab results
- Family health history
- Medical records (LTSS)
- Vision and dental records

Pharmacy

- Prescription drug history and current medications
- Proximity and access to pharmacy
- Medication allergies
- Abnormal prescription use



Behavioral

- Mental health history
- Cognitive disability record
- Inpatient mental health records
- Substance abuse / rehab history

Social

- Socioeconomic status
- Education
- Family / home situation
- Level of transportation access
- Preferences, interests, goals

Diverse data can also help to segment the population, which can be used to create more tailored health plans

4 Case Study

Multi-state health plan operating Medicare programs:

Seeing the opportunity to “white label” its high quality MA program, this plan needed to create the model to support scale and quality

Business Need

- As part of a major program expansion, implement a new core platform tailored to Medicare Advantage
- Operate the transactional business at scale in an affordable manner
- Build a best-in-class MA program on this foundation
- Diversified health plan Medicare Advantage services for other payors

Solution

- Selected (and later purchased) a platform tailored for Medicare Advantage
- Engaged a delivery partner to create the “invisible operations engine”
- Created a centralized quality team that focused on MA (and later D-SNP) program outcomes
- Provided end-to-end Government Business operational services

Outcomes

- Revenue enhanced by more accurate risk scores
- Enrollment growth of more than 50% moving the plan into the top 10 nationally
- Billing and enrollment direct costs reduced by 60%
- Claims administration costs reduced by 45%
- Financial accuracy exceeded by 99%
- Enrollment and disenrollment notices mailed within CMS guidelines greater than 99%
- Consistent 4 Star performance

5 D-SNP illustrative financials

D-SNP Profit Levers

Typically D-SNP plans can pull the following levers to improve profitability

Profit lever	Description
MA capitation rates	• Baseline capitation rates set by CMS each year and vary by county • Plans select counties to operate in
Medicaid capitation rates	• Medicaid capitation rates largely dependent on state budgets and various analyses done by states
Risk scores	• Increased risk scores lead to higher MA reimbursement from CMS • Risk scores can be increase through prospective and/or retrospective assessment and/or member engagement • Duals generally require prospective given higher average level of acuity
Medical management and care model savings	• Medical management savings improve MLR; allows for reinvestment in benefits to attract new members • Relies on identifying high-risk / cost members to be managed
Stars quality bonus	• 4+ Stars score leads to 5% higher baseline capitation payment • Opportunity to improve Stars scores via provider engagement (e.g., financial incentives for closure of gaps in care)

Illustrative

Illustrative D-SNP Financials

D-SNP plans typically offset losses in MA with strong management of Medicaid services

High level P&L for an illustrative integrated D-SNP (65+ only)

	MA	Medicaid	TOTAL
PMPM revenue (capitation)	$1,523	$1,997	$3,520
PMPM medical cost	$1,343	$1,460	$2,803
MLR	*88.1%*	*73.1%*	*79.6%*
PMPM administrative cost[1]	$222	$222	$444
ALR	*14.6%*	*11.1%*	*12.6%*
Total PMPM profit	($42)	$315	$273
% margin	(2.8%)	15.8%	7.8%

Assumptions

- 4-star integrated D-SNP plan with Part C risk score of 1.40
- Profitability achieved by offsetting MA losses with Medicaid profits
- Integrated D-SNP receives capitation for both MA and Medicaid
- In a traditional D-SNP, no P&L for Medicaid (Medicaid services covered on FFS basis by state)
- 65+ only plan; D-SNPs that cover members under 65 typically have less favorable financials

1. Admin cost of $444 PMPM split evenly across MA and Medicaid for illustrative purposes

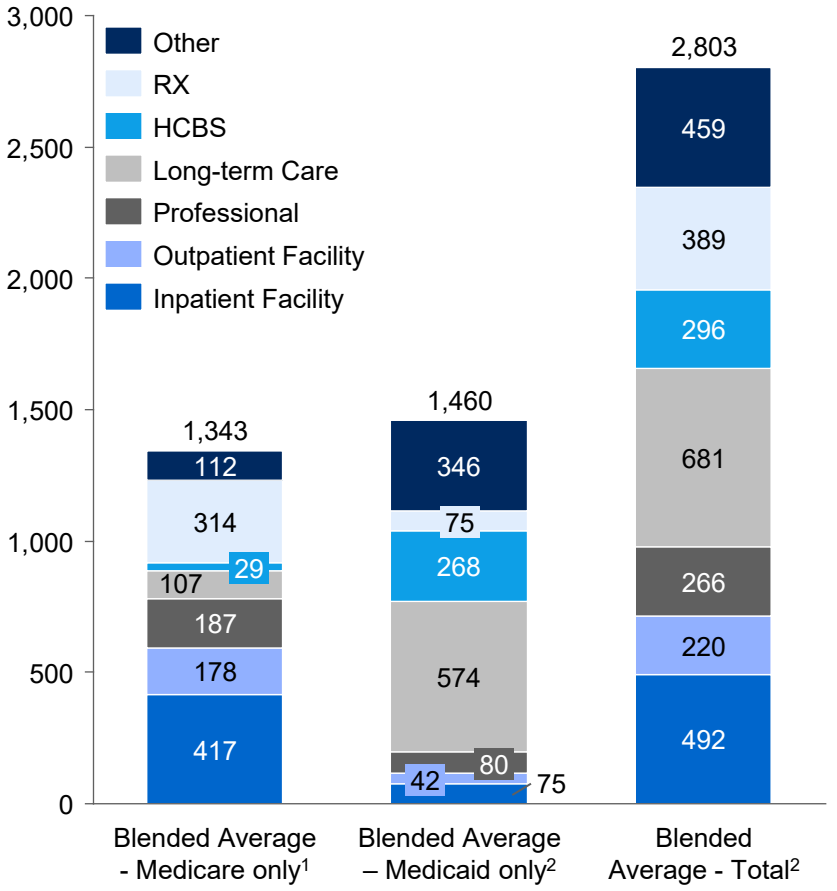
Illustrative

Illustrative D-SNP Financials

Medicaid reimbursement for D-SNPs raises revenue, but also dramatically increases spend, requiring careful medical cost management

D-SNP Cost of Care – Medicare spend vs. total spend ($PMPM)

Example Plan Claims Data, Rx added



- While the majority of reimbursement for a D-SNP comes from Medicaid, these services also make up the majority of the cost of care
- In this plan, Medicaid costs are 109% of the Medicare costs, even after successful cost management below the state benchmark
- Failure to manage total cost of care can break a plan's profitability

1. Other includes ED, Labs and all other services 2. Other includes senior services and all other services

Final Thoughts

Consider your plan's capabilities and develop a multi-year plan for launching a D-SNP plan - treating the holistic profile of each member is critical to success

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