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SNP Webinar Series Part 1 – Medicare Advantage and the Rising Interest in SNPs

July 16, 2019

Jennifer Boese, MS
Director, Health Care Policy

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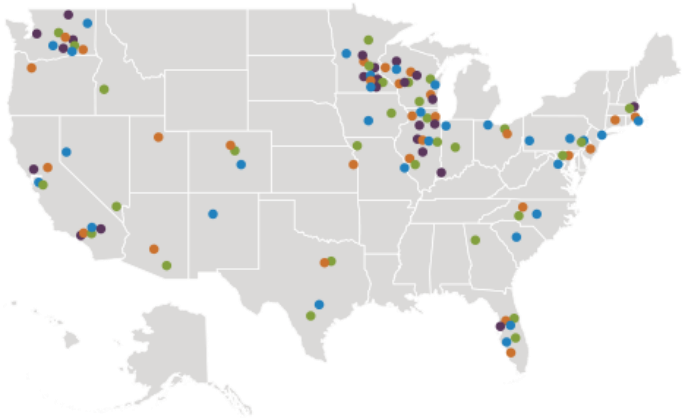
- A professional services firm with three distinct business lines
  - Wealth Advisory
  - Outsourcing
  - Audit, Tax, and Consulting
- More than 6,100 employees
- Offices coast to coast
- Serving 8,700+ health care organizations



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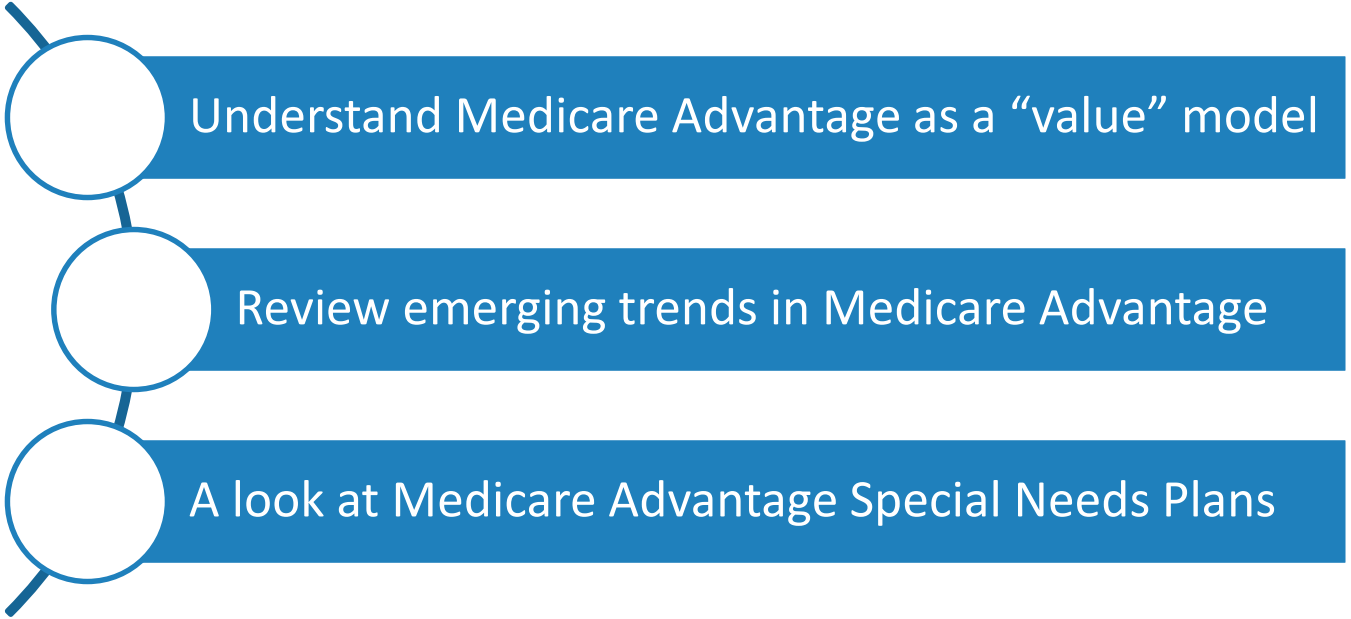
Speaker Introductions

- Jennifer Boese is the director of health care policy at CLA. She provides thought leadership, policy analysis, and strategic insights to health care providers across the continuum related to the industry's ongoing transformation towards value. A key focus of that work is on market innovations and emerging payment models. Her goal is to help clients navigate and thrive in an increasingly dynamic health care environment.

Webinar Objectives




Create Opportunities
Medicare Advantage:
Growing in Popularity and Flexibility
CLA exists to
create opportunities —
for our clients, our people,
and our communities.
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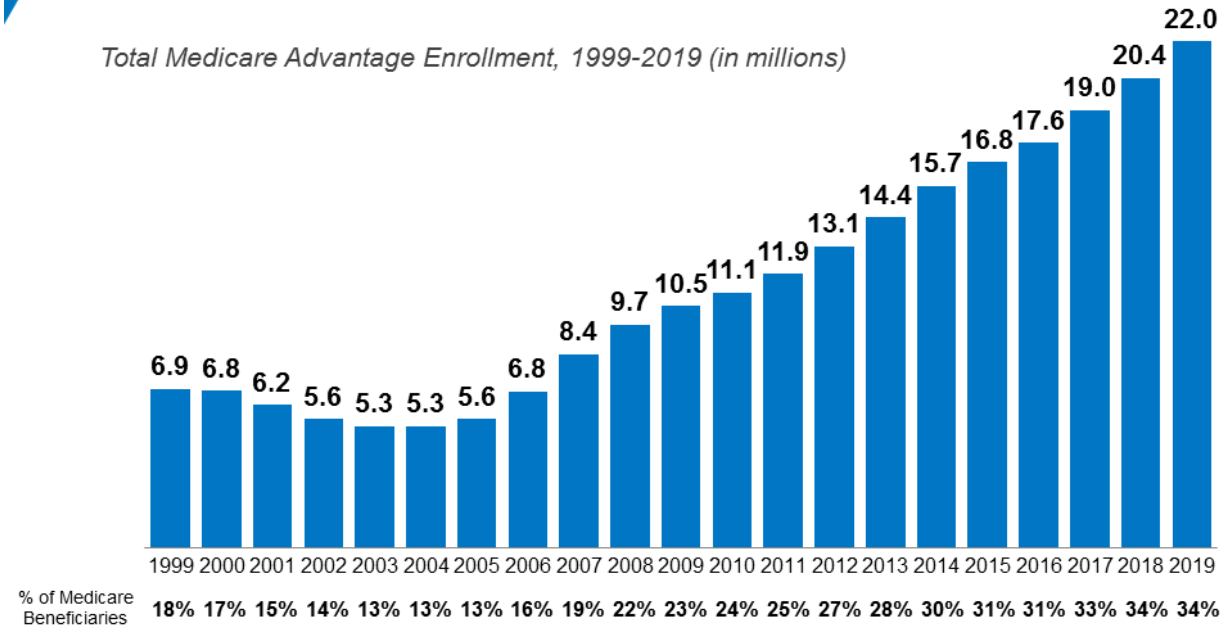
Medicare Advantage

Enrollment 1999 - 2019

Figure 1

Enrollment in Medicare Advantage has nearly doubled over the past decade

Total Medicare Advantage Enrollment, 1999-2019 (in millions)

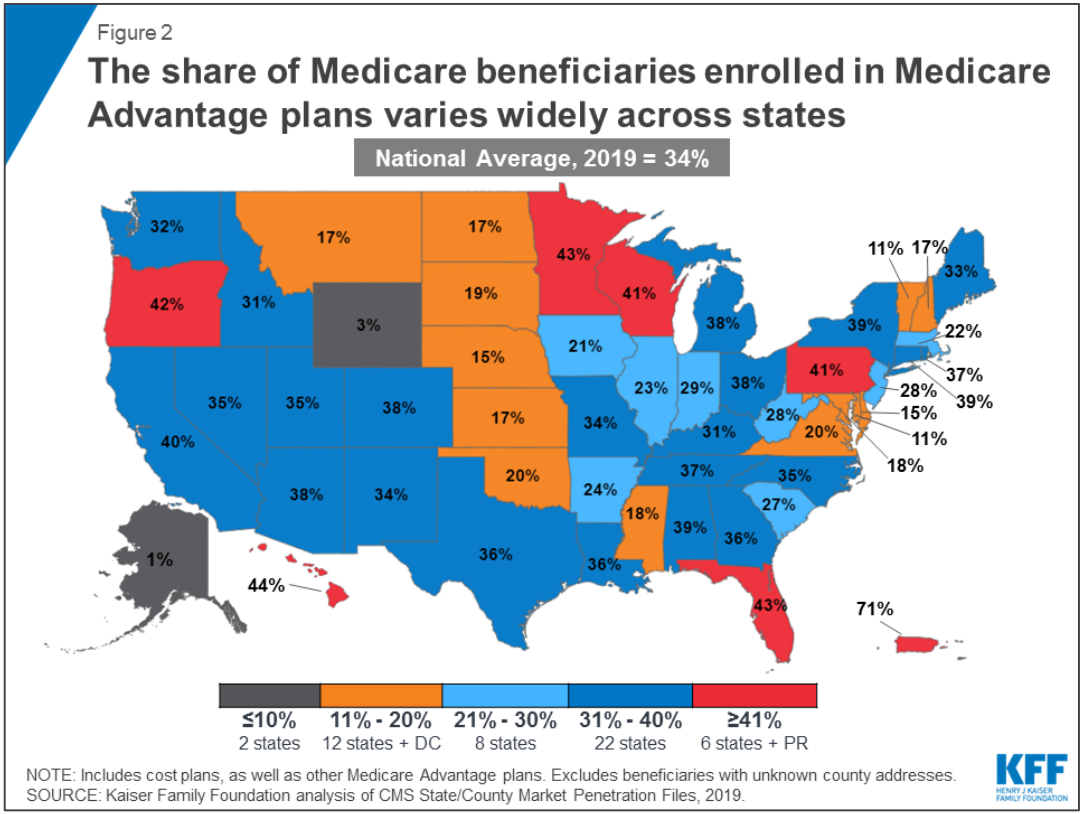


NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

KFF
HENRY J KAISER FAMILY FOUNDATION

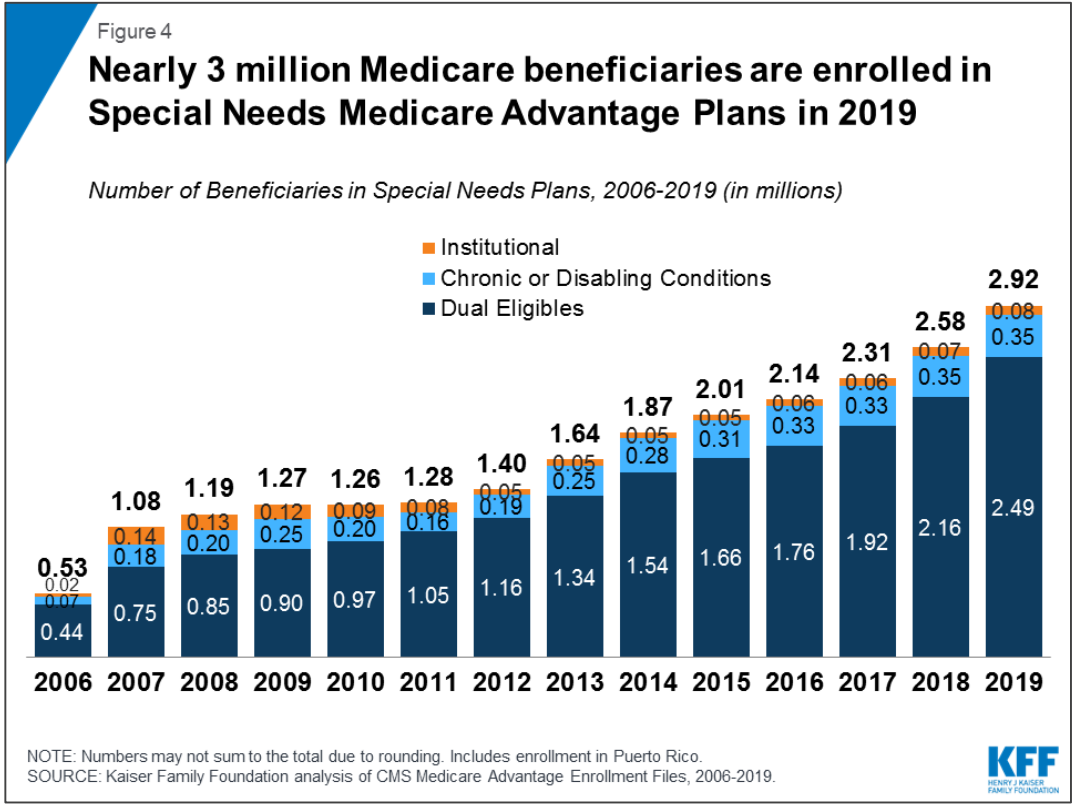
Medicare Advantage Profile

- National average is 34 percent penetration
- Large variation by state
- Popularity continues to grow



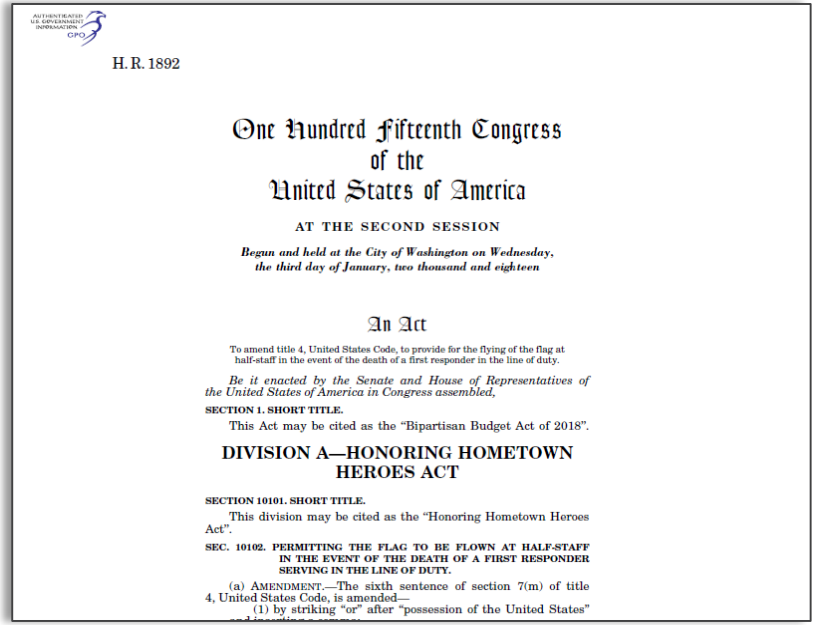
Medicare Advantage SNPs Profile

- Increase in SNPs
- Approaching 3 million beneficiaries
- Most are currently D-SNPs



Bipartisan Budget Act of 2018 (BBA 2018)

- HR 1892 enacted into law as Public Law 115-123 on February 9, 2018
- Among other provisions, included over 60 health care policies or payment changes
- Among these changes, were provisions that made Special Needs Plans permanent
- Arguably, these changes created an avenue of new opportunities for providers across the continuum of care



H. R. 1892

One Hundred Fifteenth Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Wednesday, the third day of January, two thousand and eighteen

An Act

To amend title 4, United States Code, to provide for the flying of the flag at half-staff in the event of the death of a first responder in the line of duty.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Bipartisan Budget Act of 2018".

DIVISION A—HONORING HOMETOWN HEROES ACT

SECTION 10101. SHORT TITLE.

This division may be cited as the "Honoring Hometown Heroes Act".

SEC. 10102. PERMITTING THE FLAG TO BE FLOWN AT HALF-STAFF IN THE EVENT OF THE DEATH OF A FIRST RESPONDER SERVING IN THE LINE OF DUTY.

(a) AMENDMENT.—The sixth sentence of section 7(m) of title 4, United States Code, is amended—

(1) by striking "or" after "possession of the United States"

Public Law 115-123
www.congress.gov

What is a SNP?

- SNPs are a type of Medicare Advantage Plan and receive payments (i.e. PMPM) and go “at-risk” for coordinating/managing care of enrolled beneficiaries
- “Per-member per-month” (PMPM) payments based on risk-adjusted characteristics of enrolled beneficiaries
- They were originally created by Medicare Prescription Drug, Improvement, and Modernization Act of 2003, made permanent under BBA 2018

Three Basic Types of SNPs:

— C-SNP = For individuals with one or more chronic conditions

— I-SNP = Individuals who live in an institutional setting, such as a nursing home, or require nursing care at home

— D-SNP = Individuals that are eligible for both Medicare and Medicaid (i.e. dual eligible beneficiaries)

A Look At Chronic Condition SNPs (C-SNPs)

- Designed to manage individuals with an approved chronic condition. C-SNP can be:
  - A single CMS-approved chronic condition
  - A CMS-approved group of commonly co-morbid and clinically-linked conditions
  - A MAO-customized group of multiple chronic conditions
- Must include Part D coverage

Group 1: Diabetes mellitus and chronic heart failure;
Group 2: Chronic heart failure and cardiovascular disorders;
Group 3: Diabetes mellitus and cardiovascular disorders;
Group 4: Diabetes mellitus, chronic heart failure, and cardiovascular disorders; and
Group 5: Stroke and cardiovascular disorders.

What Conditions Are Covered By A C-SNP?

1. Chronic alcohol and other drug dependence;

2. Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus;

3. Cancer, excluding pre-cancer conditions or in-situ status;

4. Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, Chronic venous thromboembolic disorder;

5. Chronic heart failure;

6. Dementia;

7. Diabetes mellitus;

8. End-stage liver disease;

9. End-stage renal disease (ESRD) requiring dialysis;

10. Severe hematologic disorders limited to: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplatic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder

11. HIV/AIDS;

12. Chronic lung disorders limited to: Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, and Pulmonary hypertension;

13. Chronic and disabling mental health conditions limited to: Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, and Schizoaffective disorder;

14. Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit; and

15. Stroke

A Look At Dual-Eligible SNPs (D-SNPs)

- Designed to manage individuals who are dually eligible for Medicare and Medicaid
- Medicaid programs
  - State-specific coverage/eligibility levels apply
  - Must have an executed contract with the state
  - Various other requirements
- FIDE D-SNP are fully integrated Medicare/Medicaid SNPs
- Supplemental benefit flexibilities for certain D-SNPs

- Full Medicaid (only)
- Qualified Medicare Beneficiary without other Medicaid (QMB Only)
- QMB Plus
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only)
- SLMB Plus
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)

A Look At Institutional SNPs (I-SNP)

- Designed to manage individuals who are the institutional setting
- Institutional Equivalent I-SNPs have institutional level of care (LOC) but enrollees still live in the community
- I-SNPs serving residents of long-term care facilities must own, operate, or have a contractual arrangement with the facility; facilities must adhere to the I-SNP's approved model of care

For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional LOC, the following two conditions must be met:

- A determination of institutional LOC that is based on the use of a state assessment tool. The assessment tool used for persons living in the community must be the same as that used for individuals residing in an institution. In states and territories without a specific tool, I-SNPs must use the same LOC determination methodology used in the respective state or territory in which the I-SNP is authorized to enroll eligible individuals.
- The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

Medicare Advantage (MA): What's the Attraction?

Beneficiary Perspective: MA Benefits and Flexibility

- Lower (out-of-pocket) cost, in some instances
- Additional benefits, beyond those offered by Medicare fee-for-service
- Greater flexibility in benefit design by law – benefits continue to expand

CMS Perspective: Value

- Fixed health care costs (PMPM), resulting in shared risk
- Better outcomes, especially for beneficiaries with chronic or multiple chronic conditions

Beneficiary Perspective: Greater Benefits and Flexibility

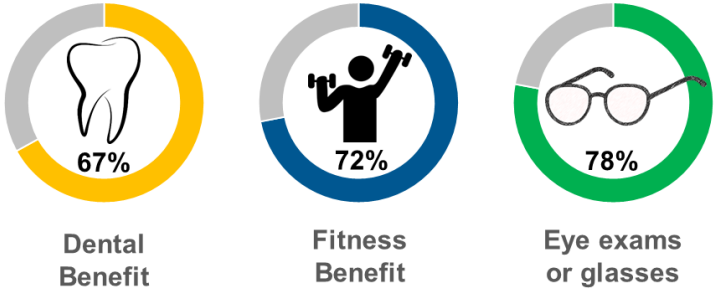
- MA Plans have had flexibility to provided benefits not available under Traditional Medicare

- 2019 Additional Supplemental Benefits
  - "Reinterpretation" of primarily health related expands potential supplemental benefits
  - Supplemental health care benefits must:
    - ◊ Diagnose, prevent, or treat an illness or injury
    - ◊ Act to improve the function/psychological impact of injuries or health conditions
    - ◊ Reduce avoidable emergency and health care utilization

- Uniformity requirements adjusted

Figure 8

Most Medicare Advantage enrollees have access to some benefits not covered by traditional Medicare in 2019



SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment and Benefit Files, 2019.

KFF

Increased Flexibilities in 2020 Plan Year

Telehealth Expanded

BBA 2018 included an expansion of telehealth. CMS finalized regulations on:

- Allows telehealth as a base benefit. CMS defines this as MA "additional telehealth benefits."
- If covered under Part B, Plan can cover. This means it is far broader than what is allowable/reimbursable under FFS
- No geographic requirement (which is in FFS)
- Home can be an originating site (which is not generally allowed in FFS)
- Plan may set up different cost-sharing requirements (in person vs tele)
- Plan determines annually what telehealth services are "clinically appropriate"
- Technology term (electronic exchange) is defined broadly to allow flexibility and future technology
- Plans must use contracted providers for additional telehealth benefit, non-contracted providers could only be used via supplemental benefits)

Increased Flexibilities in 2020 Plan Year

Special Supplemental Benefits for Chronically Ill (SSBCI)

- Benefits are designed to *not* be primarily health related and/or offered non-uniformly to eligible chronically ill enrollees if item/service to chronically ill enrollees has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease
- Some examples CMS uses are transportation for non-medical needs, food delivery, groceries. Benefits can potentially increase property value (ex: a wheelchair ramps leading to the house)
- Plans can partner with community based organizations and help to identify who is eligible, seeks additional feedback on limitations around this
- Benefits must be targeted at individuals who meet all three of the following chronically ill criteria:
  - has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee
  - has a high risk of hospitalization or other adverse health outcomes
  - requires intensive care coordination

Increased Flexibilities: Value-Based Insurance Design

VBID Intervention (2020 models)	Description
Value-Based Insurance Design by Condition, Socioeconomic Status, or both	Non-uniform benefit design to provide reduced cost-sharing or additional supplemental benefits for enrollees based on condition and/or certain socioeconomic (i.e. low-income subsidy eligibility or dual-eligible) status
Medicare Advantage and Part D Rewards and Incentives Programs	Meaningful and focused Medicare Advantage and Part D Rewards and Incentives programs
Telehealth Networks	Increased access to telehealth services by allowing plans to propose using access to telehealth services instead of in-person visits, as long as an in-person option remains, to meet certain requirements for the provider network. NOTE: This may include telehealth to meet network adequacy requirements, there is a focus on rural and underserved areas
Wellness and Health Care Planning	Timely, coordinated approaches to wellness and health care planning, including advance care planning. This is a required component for all VBID participating MA plans.

2021 Model: Carving-In Hospice under Medicare Advantage

CMS Looking For Value: Does MA Really Deliver It?

- Avalere Health Study:
  - Independent analysis that compares the performance and value of Medicare Advantage (MA) vs. Medicare Fee-for-Service
  - Key characteristics analyzed:
    - ◊ Demographic
    - ◊ Clinical
    - ◊ Healthcare utilization
    - ◊ Clinical quality outcomes
    - ◊ Costs between similar cohorts
  - Study released July 2018, based on 2015 data

- Study provides first ever insights of the two programs and will undoubtedly influence future policy discussions.

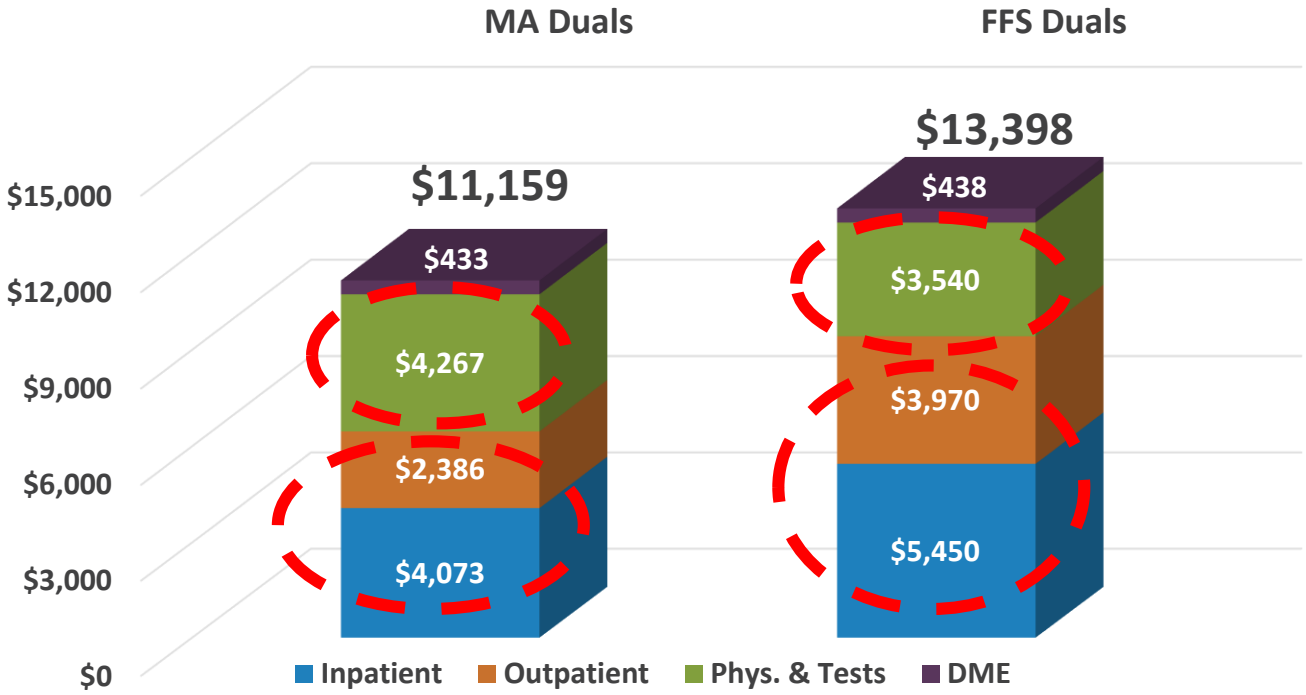
Medicare Advantage Achieves Better Outcomes:*
Dual Eligible w/Chronic Conditions

- MA dual eligible beneficiaries w/chronic conditions experienced significantly better patient outcomes and lower costs to similar beneficiaries in Medicare FFS
  - **33% fewer** hospitalizations
  - **42% fewer** ED visits
  - **49% fewer** potentially avoidable hospitalization for acute conditions
  - **46% higher** rate of preventive services and testing

- As a result of better outcomes and reduced utilization, MA dual eligible beneficiaries achieved a 17% lower annual costs per beneficiary than FFS beneficiaries.

*** Source: Avalere Health: *"Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Medicare Fee-for-Service"* A first ever, comprehensive report that compares cost and outcomes between beneficiaries enrolled in Medicare Advantage and Medicare Fee-for-Service, dated July 2018.**

MA Better Outcomes Result in Lower Costs for Dual Eligible Beneficiaries w/Chronic Conditions *



** Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare; by Avalere Health, July 2018*

CMS Perspective of Medicare Advantage (MA): The *"Godfather"* of Value Based Payment?*

"…..Medicare Advantage demonstrate the success possible when we harness consumer choice and private sector innovation to improve care and lower Cost …..significant steps to maximize competition……and empower Medicare beneficiaries are a crucial piece of allowing patients to define and drive value."

Alex Azar,
Secretary of HHS**

"Our vision is for plans to be able to design new benefit packages and provide services that keep people healthy and independent. Advantage plans will be better able to address social determinates of health and increase access to important supplemental benefits……adult day services, in-home support services, caregiver support services, and home based palliative

Seema Verma,
CMS Administrator***

*** CLA article by Jennifer Boese, Director:**

"Medicare Advantage: The "Godfather" of Value-Based Models? A Risk-based, capitated model at the center of HHS move towards value

**** Press Release: September 28, 2018 titled: *"Medicare Advantage premiums continue to decline while plan choices and benefits increase in 2019"***

***** Speech to America's Health Insurance Plans 2018 National Conference October 16, 2018**

Key Takeaways Behind MA Growth

Enhanced benefits and financial incentives to beneficiaries

Statistically better quality at lower costs for high risk populations

CMS views them as a risk-based model delivering positive results

New flexibilities and opportunities for plans to utilize

CLA expects MA to play an increasingly prominent role for Medicare beneficiaries

CLAconnect.com

Show Me The Money!

Managing Cash Flow Under a PMPM Payment Stream

Medicare Advantage: A “Risk” Based Model

- MA Plans, including SNPs, receive a “per-member per-month” or “PMPM” payment for each enrollee
- The MA plan uses the PMPM payment to pay for the overall healthcare needs of their members
- Success in managing “risk” means effective management of overall healthcare spending by:
  - Reducing average length of stays – both acute and post-acute
  - Reductions in payment rates
  - Utilization of different care settings (i.e. lower cost settings)
  - Narrowing of provider networks
  - Managing populations and conditions better (i.e. duals, chronic conditions)

Our Take?

SNPs are just one road to the future a provider can take, there are others to consider as well; but, it's understanding the destination that is MOST critical!

Multiple Roads; One Destination

"We envision a spectrum of risk: Different sizes and types of practices can take on different levels of risk. As many of you know, even smaller practices want to be, and can be compensated based on their patients' outcomes. We want to incentivize that with a spectrum of flexibility too. The more risk you are willing to take, the less we'll micromanage your work."

- Alex Azar, November 2018

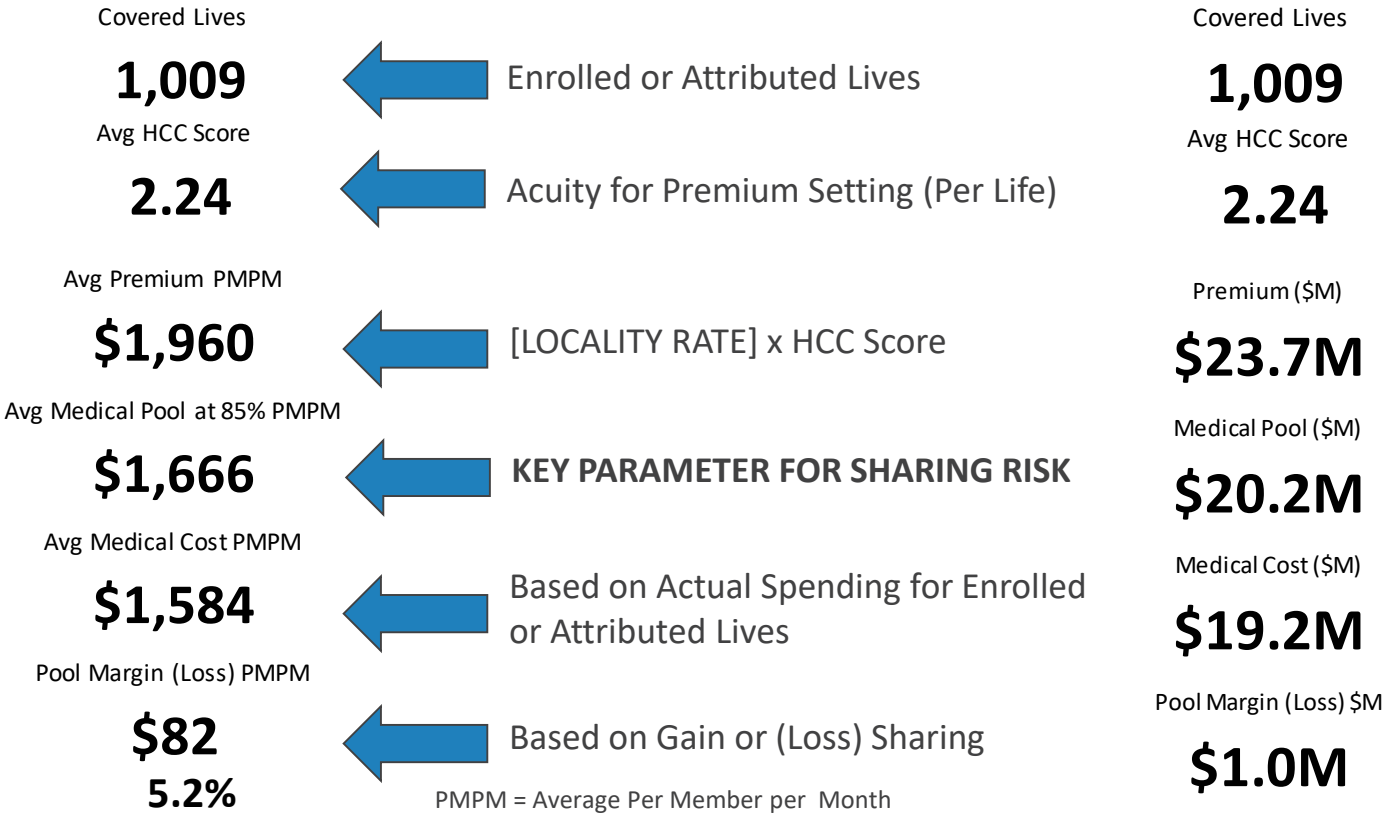
Patient-Centered Primary Care Collaborative Conference

Understanding Patient Profile

Lower Risk	Moderate Risk	High Risk
• Minimal health conditions • Low rate of hospitalization • Minimal to no need for therapy services • Minimal utilization of pharmaceuticals/other ancillaries	• Some clinical complications • Minimal risk of hospitalization • Occasional therapy utilization • Minor utilization of pharmaceuticals/other ancillaries	• Multiple chronic conditions • High or frequent rate of hospitalization • High user of therapy services • High utilization of pharmaceuticals/other ancillaries

Risk mitigation includes effective utilization of MOCs, advanced clinical capabilities, timely and complete HRAs, and accurate HCC's to ensure PMPM payments are sufficient.

Risk Based Arrangements: Follow the Money



PMPM = Average Per Member per Month

Risk Based Arrangements

Following the Money – Patient Spending vs. Premium

Covered Lives

1,009

Avg HCC Score

2.24

Avg Premium PMPM

$1,960

Avg Medical Pool at 85% PMPM

$1,666

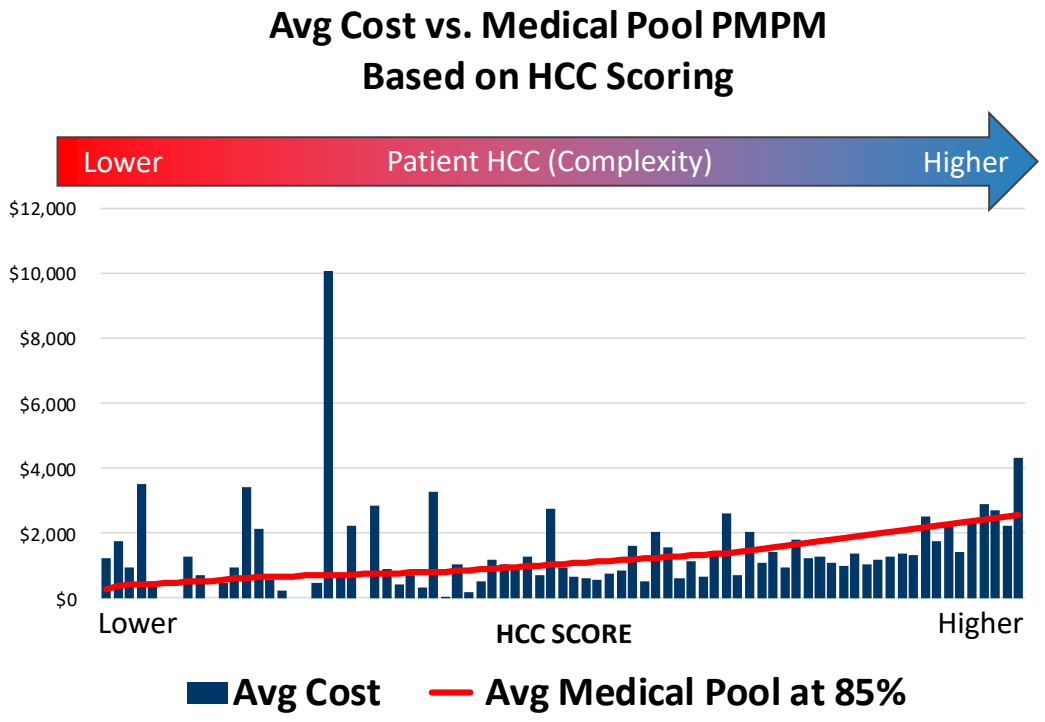
Avg Medical Cost PMPM

$1,584

Pool Margin (Loss) PMPM

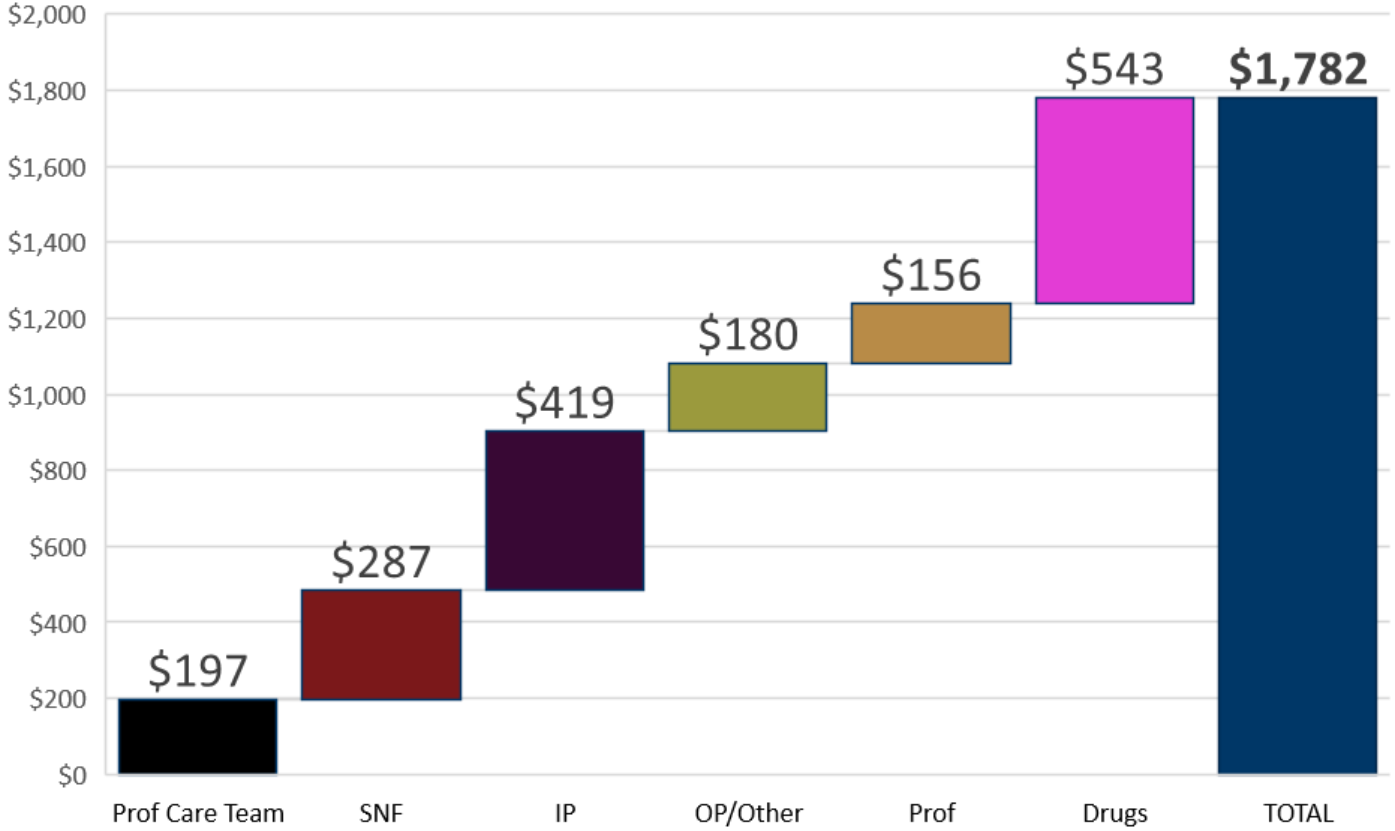
$82

5.2%



PMPM = Average Per Member per Month

Sample SNP Medical Costs PMPM



PMPM = Per Member Per Month

Clinical Considerations

- Models of Care (MOC)
  - Provide guidelines for how care provided to enrollees
  - Designed to provide care management, care coordination, improve quality and reduce costs by focusing on key target areas like:
    - ◊ Reduce avoidable hospital admissions
    - ◊ Reduce hospital readmissions
    - ◊ Reduce emergency room visits
    - ◊ Provide care in nursing facility when clinically feasible

- Success will require elevating clinical management capabilities
- Annual Health Risk Assessments (HRAs) drive Hierarchical Conditions Category (HCC) which in turn drives revenue
- Use of technology, like telehealth, care management tools, etc.

Key Considerations for Taking Risk with SNPs

- Understanding financial implications
- Contract negotiations
- Provider Network
- Current and potential clinical capabilities
- Assessing patient/resident clinical profile and utilization
- Willingness/ability to invest in additional resources
- Information technology and care management tools investments

Summing It All Up

- Among all the models tested, in general are not delivering results
- There is renewed determined to drive health care to a value based system
- HHS views Medicare Advantage as a key to driver towards value
- Unlike no other time in history, HHS/CMS is open to new and innovative ideas
- Willingness to accept risk and take accountability is gaining popularity (and longer-term a growing necessity)
- Fundamentals of a value based system apply to all, even if not directly involved
- SNPs offer the opportunity for all types of organizations to get closer to the premium dollar and better control their futures in a rapidly changing health care world

"…maybe sometimes it's riskier to not take a risk. Sometimes all you're guaranteeing is that things will stay the same."

Danny Wallace, Yes Man

Questions?

Thank you!

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