Get ready to expand to new areas

Best practices for Medicare Advantage organizations

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Introduction

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Strategic considerations for new / expanding plans

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Numerous interdependent factors impact plan performance

CMS Revenue + Member Premium

- Risk Adjustment
- Stars
- Capping of Benchmarks

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Benefit expenses

- Care management
- Provider contracting

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Non-benefit expenses

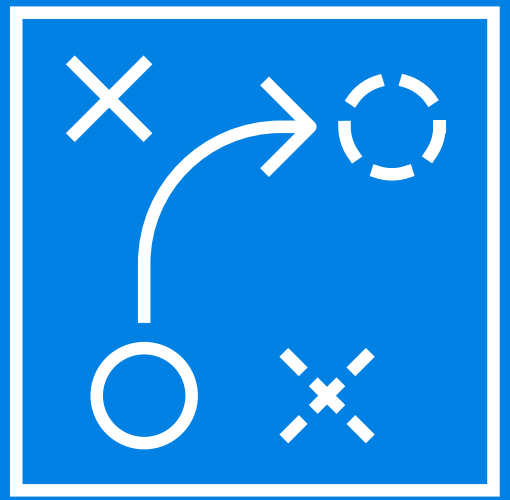
- Membership growth
- Other efficiencies

Strategic considerations for new / expanding plans

CMS provides an abundance of guidance

CMS generally provides a structured framework for new or expanded MA offerings through the Medicare Managed Care Manual and supplemental guidance

- Licensure requirements
- Service area / full and partial county
- Plan tenure – e.g., full year of operations prior to expansion or new product launch
- Membership thresholds
- Network access and adequacy
- Quality programs and risk adjustment
- Operational readiness
- Special requirements for selected plan types – e.g., Model of Care (MOC) for C-SNP plans
- Emergency rules during the COVID-19 public health emergency (PHE)
- And more…



Strategic considerations for new / expanding plans

Market opportunity

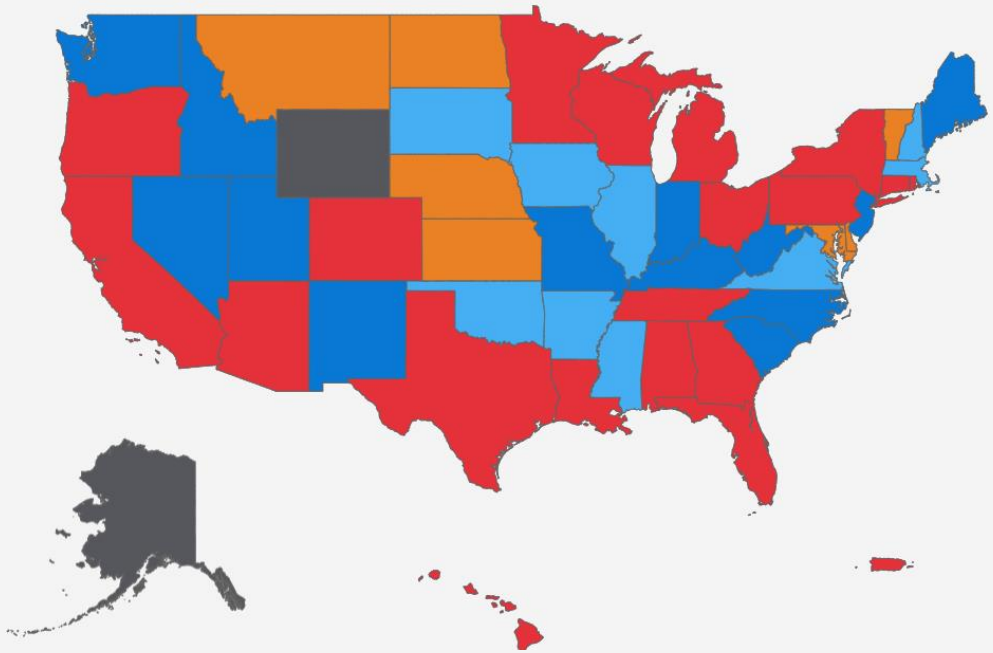
Sizing the market opportunity

- Existing MA market share in target market
- Competitor MA plans and product offerings
- MA plan structure and provider alignment
- Characteristics of MA beneficiary population
- Financial feasibility evaluation

Attracting and retaining members

- Marketing and sales model - and cost of sales
- Region-specific strategies
- Leveraging network strength and partnerships
- Brand and reputation strength

Medicare Advantage penetration, by State, 2020



Note: 1. M. Freed, A. Damico, T. Neuman (2021). A Dozen Facts About Medicare Advantage in 2020. Kaiser Family Foundation.

Strategic considerations for new / expanding plans

Network strategy and relationships

Adequate networks are a CMS “must have”

Strategically designed networks help plans

- Attract and retain members
- Provide a superior member experience of care
- Optimize health outcomes
- Support financial viability through cost of care and risk adjustment optimization

Strong plan / provider relationships can support positive outcomes

- Joint operating committee model for aligned goals, issue identification, and strategic planning
- Data and information sharing to support cost of care, quality, and risk adjustment
- Cohesive member / patient education and communication
- Program innovation for competitive differentiation

Strategic considerations for new / expanding plans

Leveraging strategies to improve clinical outcomes

Care management program design to support **population**

- Data driven to identify sub-population needs – “senior” seniors, new age ins, special needs plans
- Trade offs of build, buy, delegated models and resources integrated in the community

Program design to leverage population needs

- Disease prevalence and geographies
- Health care gaps and disparities
- Community resources, e.g., community health needs assessments – food deserts, transportation
- Vendor programs to engage and connect members – health awareness, physical and social activity

Provider capabilities and steerage

- Preferred providers / "gold" providers – DME
- Transitions of care – SNF and home health capacity
- Pharmacy integration strategy – specialty drug spend (as a percent) has nearly doubled in the past decade and will continue to grow[2,3]

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[2] Adams (2020). Specialty drug price caps drastically reduce out-of-pocket costs without increasing health plan spending. Becker’s Hospital Review.
[3] Anderson-Cook, J. Maeda, L. Nelson (2019). Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid: An In-Depth Analysis. Congressional Budget Office.

Strategic considerations for new / expanding plans

Telehealth and the side-effects of COVID-19 accessibility

CMS expanded telehealth across Medicare during COVID-19 pandemic[4,5]

- MA plans could offer telehealth before COVID-19, but HHS 1135 waiver expanded opportunity
- 98% of MA plans offered telehealth in 2021, with 45% beneficiary utilization in last 12 months
- Provider reimbursement continuity during PHE – i.e., same capitated amount as in-person visits with additional telehealth offerings. Will this continue?
- The PHE was renewed in April 2021 with plans for continued flexibility to extend through end of year

Evolving thinking and emerging evidence on efficacy in a senior population

- Can an annual physical be conducted effectively via telehealth?
- Some seniors may be challenged with equipment and access – default to phone calls

Expanding range of modalities

- Biometric remote monitoring
- Medication and appointment reminders
- Health engagement apps for self-care management

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[4] W. Koma, J. Cubanski, T. Neuman (2021). Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Kaiser Family Foundation.
[5] Centers for Medicare and Medicaid Services (2020). Medicare Telemedicine Health Care Provider Fact Sheet. Centers for Medicare and Medicaid Services.

Case study – integrated focus to optimize performance

Declining performance across HEDIS and CAHPS with unknown root cause

Plan areas of focus

Plan commitment and culture

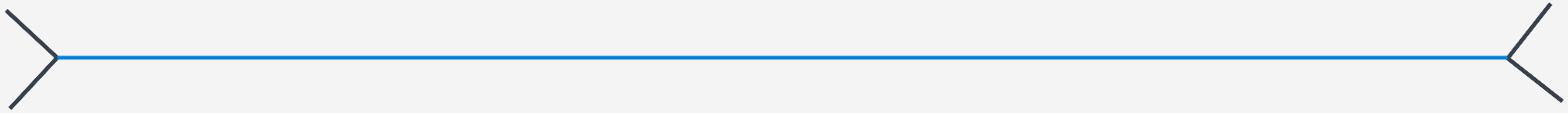
- Leadership engagement, sponsorship, and funding
- Plan-wide engagement, training, team champions, and accountability
- Quality leader assigned to facilitate and lead plan-wide engagement, plan, training, and culture transformation
- Consistent communication, and messaging
- Pre-survey to identify CAHPS measures needing improvement

Member experience

- Customer-service training across all departments
- Expanded member contact and engagement options and capabilities
- Department/team tailored training, job aids, scripts and standards
- Visibility to missing Health Risk Assessments and care gaps to customer service with clinical system flags to offer assistance or warm transfer
- Focus on timely access

Health outcomes

- Plan and provider-level HEDIS measure dashboard and detailed “Care Gap Worksheets”
- Provider incentives per gap closure
- Clinical team addresses care gap flags with member
- Care coordination across plan, facility, and provider to ensure resources and services without duplication
- Post discharge outreach, care and disease management, health coaching, and preventive care



Result

Structured assessment across the organization resulted in broad organizational engagement and prioritization of work to improve STAR ratings

Plan on track to achieve a 4.0 STAR rating with plans for continued improvement over time

Focused MA program considerations

2022 Stars source timing

The majority of measures for the 2022 Star Ratings are based on the 2020 measurement year

The 2022 Star Rating is recognized in the 2023 Quality Bonus Payment

Data source	Most up to date enrollment requirements	Data timeframe for 2022 Stars measures
Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)	600 enrollees as of July 2020	03/2021–05/2021
CMS call center	None	02/2021-06/2021
CMS disenroll Medicare Beneficiary Database Suite of Systems (MBDSS)	None	01/01/2020-12/31/2020
Complaint Tracking Module (CTM)	None	01/01/2020-12/31/2020
Healthcare Effectiveness Data and Information Set (HEDIS)	If 7/1/20 enrollment ≥500 but <1,000 & measure score reliability ≥0.7, included in metrics	01/01/2020-12/31/2020
Health Outcomes Survey (HOS)	Contracts in effect on or before 1/1/19, and ≥500 members report Baseline HOS in 2020	08/020-11/2020
Independent Review Entity (IRE)	None	01/01/2020-12/31/2020
Prescription Drug Event data submitted to CMS by the plan (PDE)	None	01/01/2020-12/31/2020

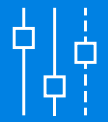
2022 Star Rating adjustments related to COVID-19

Anticipated impact to 2020 measurement year measure-level scores

- Increased healthcare utilization specific to COVID-19,
- Reduced or delayed non-COVID-19 care due to advice to patients to delay routine / elective care, and
- Changes in non-COVID-19 inpatient utilization due to delays in treatment and elective surgeries

CMS announced modifications for the 2022 Star Rating

- Removal of guardrails (i.e., measure-specific caps on cut point changes by > or < 5% from one year to the next) until the 2023 Star Ratings
- Expands the existing hold harmless provision for the Part C and D Improvement measures to include all contracts, not just 4 and above Star contracts
- Modified elements of its extreme and uncontrollable circumstances policy to apply to the COVID-19 Public Health Emergency (PHE) as follows:
- Applies to **all** contracts with at least 25% of their service area in a FEMA designated Individual Assistance area in 2020
  - The **higher** of the measure-level rating from the current and prior Star Ratings years to calculate the ' 2022 Star Ratings, (e.g., measure-level ratings from 2021 or 2022)
  - For the 2020 measurement period, most MA and Part D contracts qualify for the disaster adjustments



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Source: Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

New Plan Star rating assignment

MA contract offered by a parent organization that has not had another MA contract in the previous 3 years is designated a new plan

- New plan designation for 3 years
  - 65% Part C rebate (same as a 3.5 Star Plan)
  - 3.5% Quality bonus
- Exception: For 2022 quality bonus payments based on 2021 Star Ratings only, a new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 4 years
  - New plans that started in 2019 would have reported HEDIS and CAHPS for the first time in 2020 for the 2021 Star Ratings; but CMS eliminated the 2019 HEDIS and CAHPS data submissions

A parent organization that has had a contract with CMS in the preceding three-year-period (or four-year period for 2022 QBP ratings),

- Any new MA contract under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.
- Such plans may qualify for a QBP increase based on the enrollment-weighted average rating of the parent organization.

Expanding offerings to include Special Needs Plans

SNP overview

Special Need Plans (SNPs) are a type of Medicare Advantage (MA) Plan

SNPs limit enrollment to the following subgroups:

- Dual-Eligible SNPs (D-SNP) enroll beneficiaries eligible for Medicare and Medicaid
- Institutional SNPs (I-SNP) enroll beneficiaries who are:
  - Institutionalized, or
  - Are determined to meet an institutional level of care and live in the community
- Chronic SNPs (C-SNP) enroll beneficiaries with certain chronic or disabling conditions

SNPs tailor their benefits, provider choices, and drug formularies to meet the needs of the groups they serve

The SNP service area may not exceed the existing or pending service area for the MA contract

SNPs continue to grow in popularity

- In 2021 there was a 14% increase nationwide in SNPs, with a 23% increase in C-SNPs, 11% increase in D-SNPs and 16% increase in I-SNPs.
- D-SNPs represent the majority of SNPs

Expanding offerings to include Special Needs Plans

Key considerations

Marketing and sales may significantly differ from current approach

- Approaches: targeted to the population (e.g., transit, social media, community-based grass roots focused)
- Sales agents: specialized training and year-round engagement
- Community involvement
- Relationships with community influencers
  - Community resources (e.g., meals on wheels, food banks)
  - Advocacy (e.g., agency on aging, disability rights)
  - Health (e.g., mental health services)

Anticipate all functions will need to makes some changes (e.g., tools, systems, policies and procedures, workflows) to add a SNP product

Initial and annual health risk assessments

Will need to develop and implement a CMS Model of Care (MOC), which is a care coordination model to include individualized member care plans, interdisciplinary care team, care transition protocols, etc.

- NCQA is responsible for the approval
- CMS audits the MOC

Will need to add SNP specific processes for additional SNP Stars and Part-C reporting requirements

Expanding offerings to include Special Needs Plans

Key considerations

- Benefits will need to be tailored to the population's needs and competitive with the market
- Provider Network may need augmented:
  - Concentration of specific ethnicities / languages
  - Unique needs of the population
  - Member location may vary from current population within the same service area

D-SNP requirements

- Determine the State Medicaid Agency's Medicaid / Medicare integration requirements to understand the qualifications
  - Fully Integrated Dual Eligible (FIDE) SNP - provides Medicare and Medicaid benefits under a single entity
  - Highly Integrated Dual Eligible (HIDE) SNP – provides coverage of MLTSS or Behavioral Health through the MA plan, the MA plan's parent or a related entity
  - D-SNP coordinated care
- Must have an executed State Medicaid Agency Contract
- Meet the new D-SNP integration requirements, based on the D-SNP plan type

Actuarial considerations for new or expanding plans

Financial outcomes (margin) =

CMS Revenue + Member Premium – **Benefit expenses** – **Non-benefit expenses**

A note on **sequestration:** Provider payments and CMS revenue (excluding member premiums) will be subject to sequestration by the government. Sequestration is not explicitly illustrated in this example for simplicity.

Financial outcomes (margin) =

CMS Revenue + Member Premium

- Risk Adjustment
- Stars
- Capping of Benchmarks

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Benefit expenses

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Non-benefit expenses

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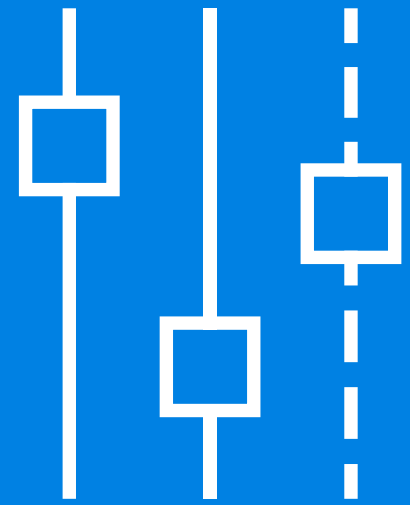
Risk adjustment

Established plans generally have higher risk adjustment coding intensity than new plans

- Risk scores based on diagnosis codes recorded in the **prior year**
- MedPac[1] study: 2019 MA risk scores were approximately **9% higher** than FFS risk scores for equivalent health status
- Risk scores for some members cannot be managed:
  1. New to Medicare without a full year of Medicare experience
  2. Migrating from Original Medicare
- New or expanding MA plans often have a **high concentration of members whose risk scores cannot be managed.**

Risk adjustment management is an essential function of a Medicare Advantage plan.



[1] http://medpac.gov/docs/default-source/meeting-materials/ma-status-medpac-dec-2020.pdf?sfvrsn=0

Risk adjustment

Hypothetical example

Coding intensity – New vs. established plan

	Coding	Risk	Membership distribution	
Population cohort	**Intensity[1]**	**Score[2]**	**New**	**Established**
Enrollees new to Medicare	0%	0.6	60%	20%
Original Medicare FFS	0%	1.0	10%	5%
Existing MA plan	11%	1.2	30%	75%
Plan Coding Intensity			**4.5%**	**9.1%**
MA Coding Pattern Adjustment			5.9%	5.9%
Coding Intensity after MA Coding Pattern Adjustment			**-1.6%**	**2.6%**

1. Excess coding intensity measured relative to coding levels for a fee-for-service population with an equivalent health status.
2. Assume risk scores are normalized using the FFS Normalization factor.

Impact of Stars on revenue

MA plans generate **savings** when they bid below a **benchmark** established by CMS.

Benchmarks are established at the county level and adjusted for Quality Bonus Payments

Rebates are a **portion** of the **savings** an MA plan may use to offer supplemental benefits.

Quality bonus payments and rebate % by Star Rating

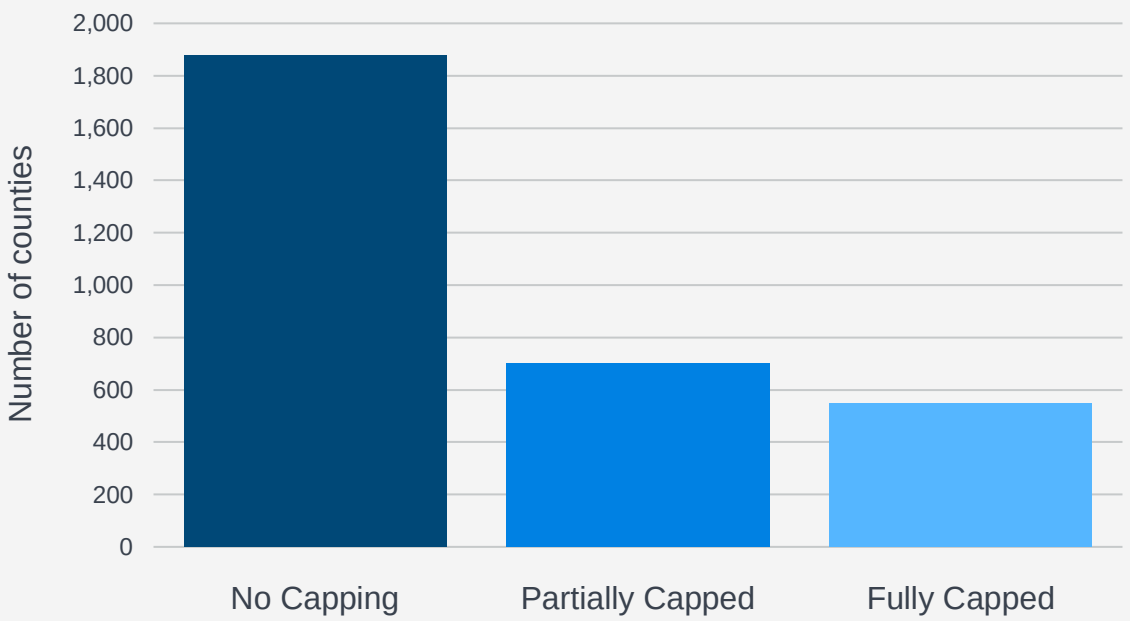
Plan Star rating	Rebate %	Quality bonus % [1]
Less than 3.5 Stars	50%	0%
3.5 Stars	65%	0%
4.0 Stars	65%	5%
4.5 Stars	70%	5%
5.0 Stars	70%	5%
New or low enrollment plans	65%	3.5%

[1] "Qualifying" counties eligible for double bonus.

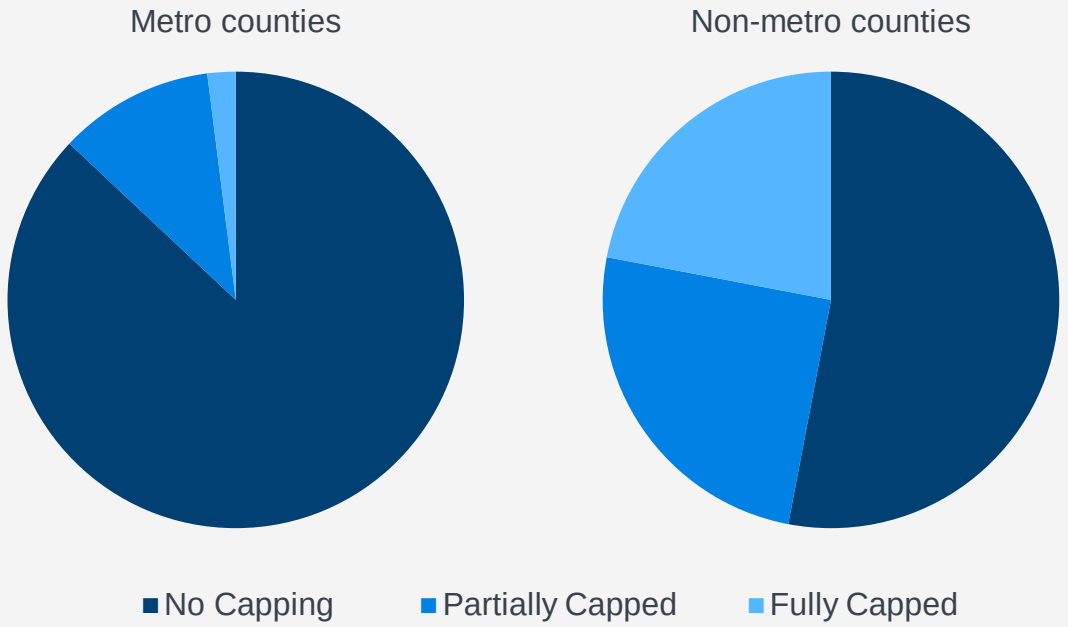
Capping of benchmark payment rates

Final Benchmark Rates are capped at the **"applicable amount"** (benchmark under pre-ACA rules)
Capping may partially or fully eliminate Quality Bonus Payments

QBP capping – count of counties



Capped counties metro vs. Non-metro areas



Source: https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2022

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Estimating benefit expenses

Provider reimbursement rates directly affect claim costs

- Larger plans may have negotiation leverage
- Provider negotiations may still be underway during bid development for new / expanding plans
- Opportunities to align incentives through risk sharing arrangements

Care management may be difficult to predict in a new provider network or under new / expanded care management programs

Lack of experience data increases pricing risk

- May need to rely on benchmark manual rates or experience from other plans
- Membership projections are key and may be difficult to predict
- Estimating supplemental benefits
- Cost sharing configuration
- Potential Total Beneficiary Cost (TBC) constraints in future years if results emerge unfavorably

Financial outcomes (margin) =

CMS Revenue + Member Premium

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Administrative expenses / startup costs

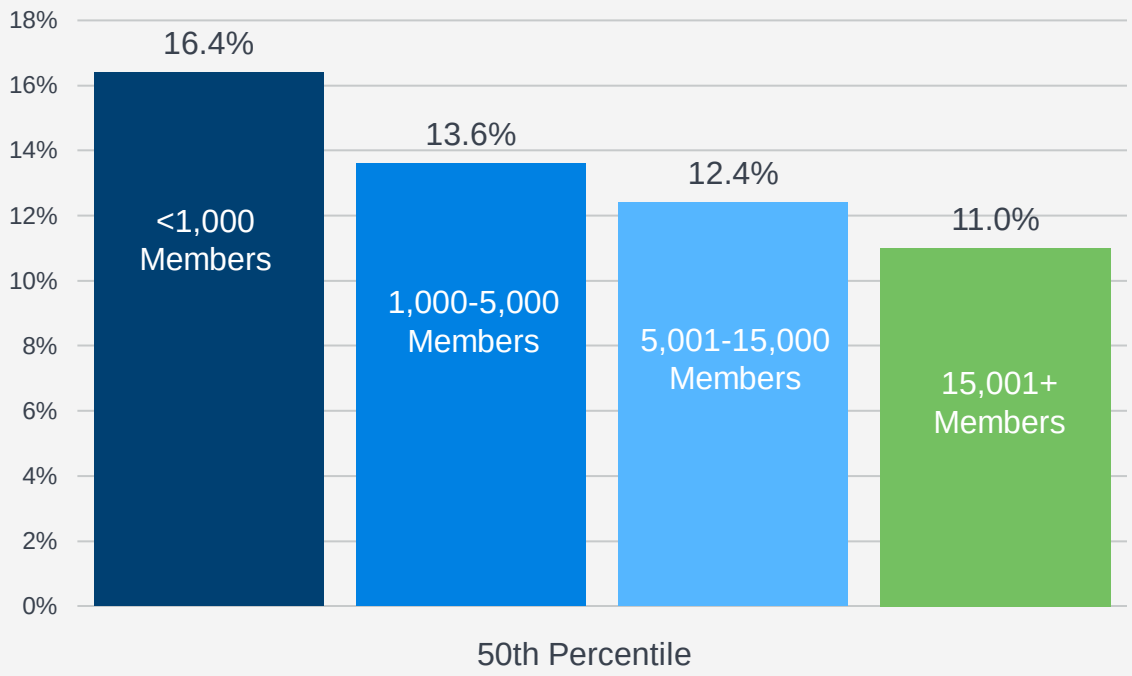
Higher administrative expenses increase the bid and may cause margin strain for new or expanding plans

- **New expenses** for startups
- Less **economy of scale** with lower membership to spread fixed expenses

According to a Milliman study published January 2021, most MA startups enrolled about **2,000 members** in their **first five years**, and many were able to capture about **1% market share** in their service areas[1].

[1] https://us.milliman.com/-/media/milliman/pdfs/2021-articles/1-31-21-so-you-want-to-start-a-medicare--plan-v1.ashx

Actual 2019 50th Percentile Administrative Expense % of Revenue by Plan Size



Source: Milliman 2021 MA Bid Survey (2019 base period data reported in 2021 BPTs)

Keys to success

Plan ahead

- CMS contracting, provider negotiations, PBM contracting, market research, feasibility analyses

Have a clear and coordinated strategy consistent with the organization's mission

Invest in Stars and risk adjustment management efforts

For new or expanding plans, consider the long-term goals

Collaborate, coordinate, and communicate

- Effective communication and coordination among many segments of an organization is key
- Identify, educate, engage, and generate buy-in from key stakeholders

Repeat

- Prepare for each year's bid cycle in the off-season

Caveats, limitations, and qualifications

- The information contained herein does not constitute a legal opinion. It is important to seek guidance from counsel before making any decisions with respect to the determination of the impact or likelihood of any legislative or regulatory change to the Medicare Part C and Part D programs
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- Lindsy Kotecki is a member of the American Academy of Actuaries, and meets its qualification standards to provide this analysis. To the best of her knowledge and believe, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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Thank you

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