Dual special needs plans — beyond the bid

Nicholas Johnson, FSA, MAAA
Penny Edlund, RN, BSN, MBA, CPHQ
Barbara Culley, MPA, NHA

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Agenda

1 **Introductions**

2 **Landscape**

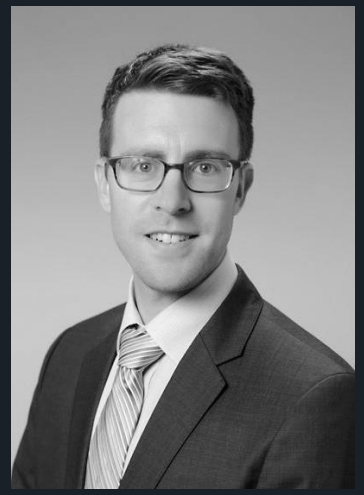
3 **Implementation**

4 **Model of care**

5 **Policy**

6 **Questions**

Presenters



Nicholas Johnson
FSA, MAAA
Principal & Consulting Actuary

Penny Edlund
RN, BSN
Healthcare Management Consultant

Barbara Culley
MPA, NHA
Healthcare Management Consultant

Landscape

D-SNP market overview

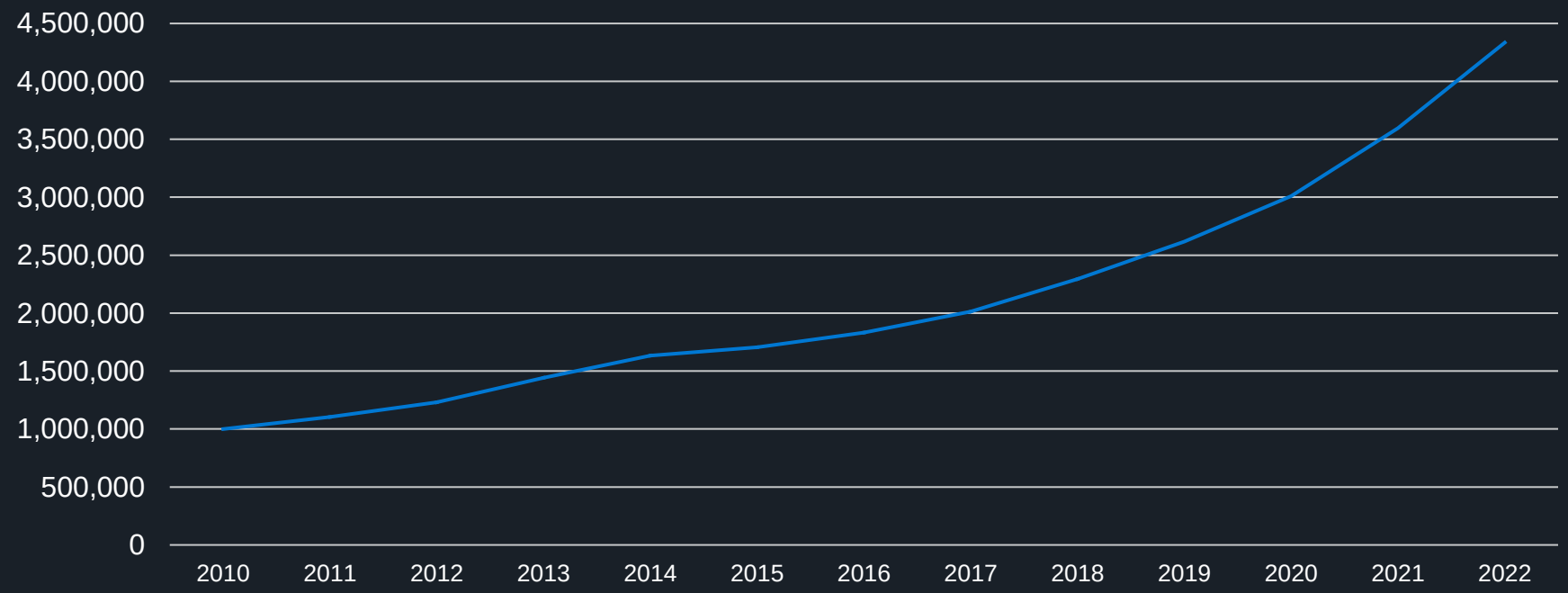
Enrollment

4M

Enrolled D-SNP beneficiaries

- Enrollment has historically increased by 10%+ per year.
- Enrollment growth exceeded 20% in 2021 and 2022.

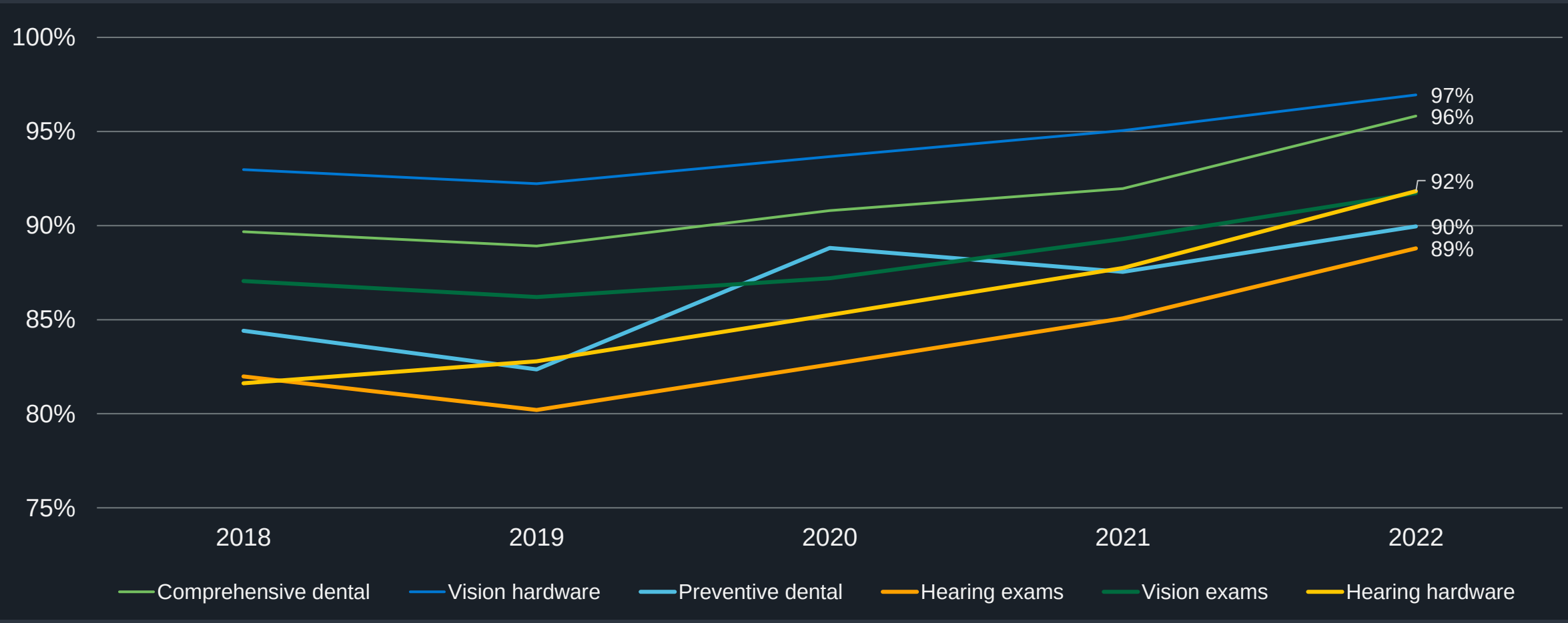
D-SNP enrollment by year



Source: CMS SNP Comprehensive Reports
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

D-SNP supplemental benefit prevalence over time

Nationwide – “Core” benefits

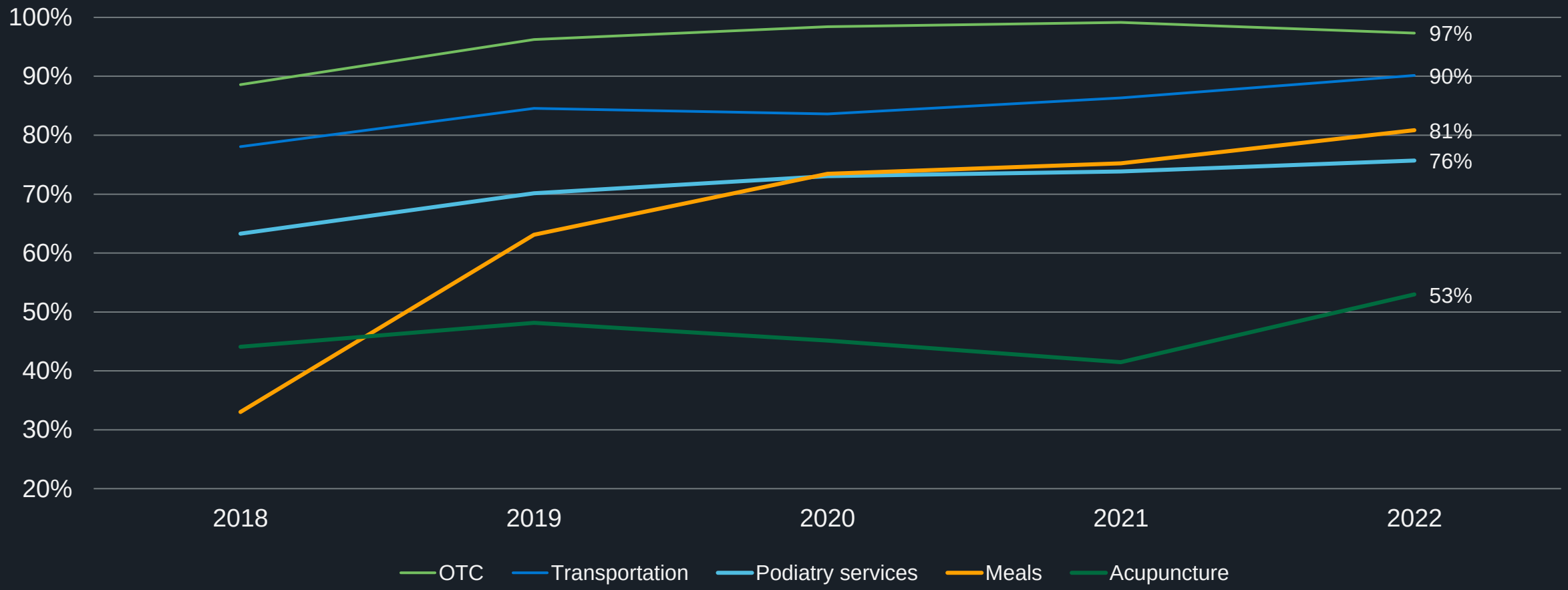


Source: 2022 Milliman MACVAT®

Prevalence of supplemental benefits in the D-SNP Medicare Advantage marketplace: 2018 to 2022 (milliman.com) Milliman MACVAT

D-SNP supplemental benefit prevalence over time

Nationwide – Other supplemental benefits



Source: 2022 Milliman MACVAT®
Prevalence of supplemental benefits in the D-SNP Medicare Advantage marketplace: 2018 to 2022 (milliman.com) Milliman MACVAT

D-SNP market overview

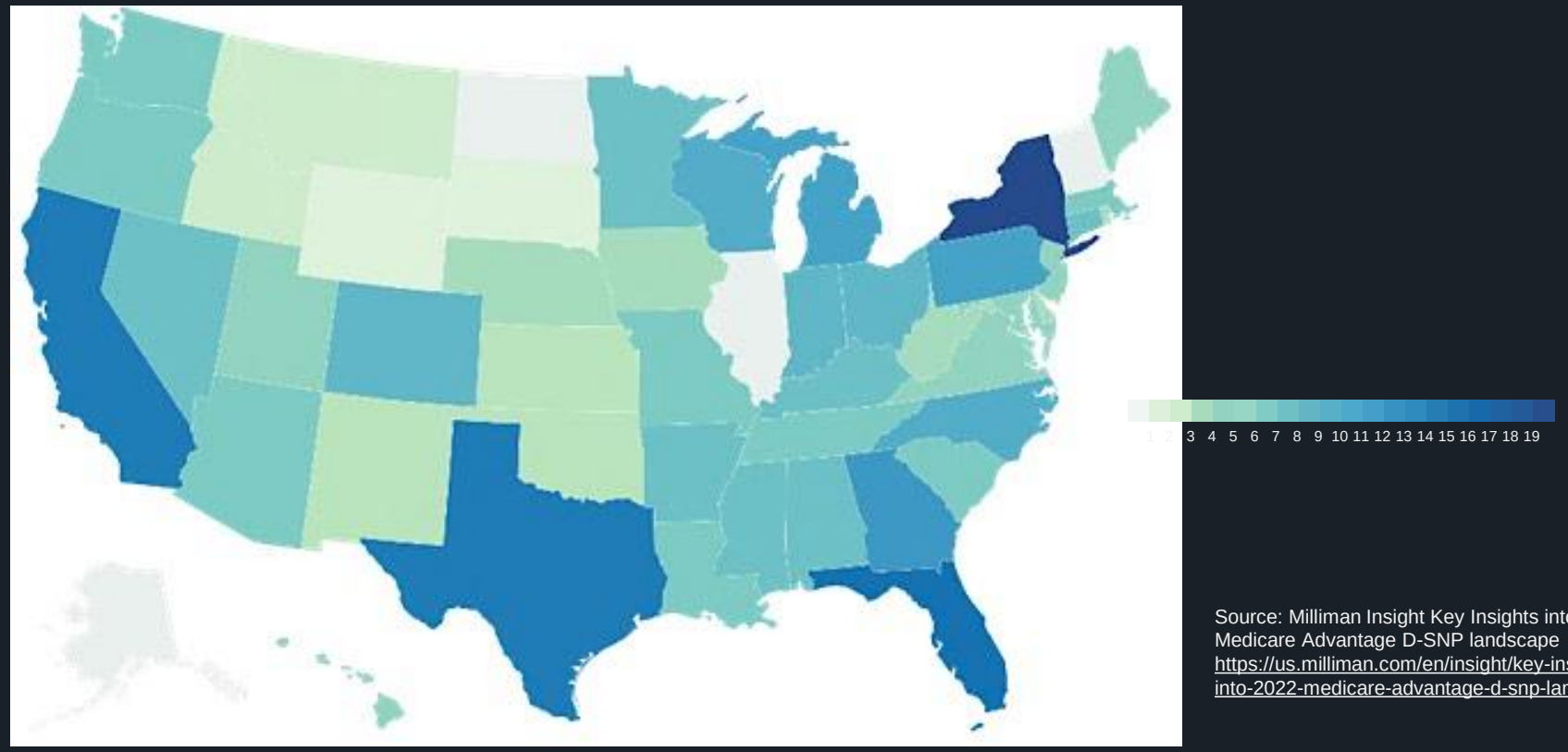
State-level coverage

47

States (incl. DC, PR) with at least one D-SNP

- Only states without D-SNPs are AK, IL, NH, ND, and VT.
- Coverage may differ at county level.

Number D-SNP MAOs by state (CY2022)



Source: Milliman Insight Key Insights into 2022 Medicare Advantage D-SNP landscape https://us.milliman.com/en/insight/key-insights-into-2022-medicare-advantage-d-snp-landscape

Dual eligible beneficiaries

Proportion of MA and Medicaid market

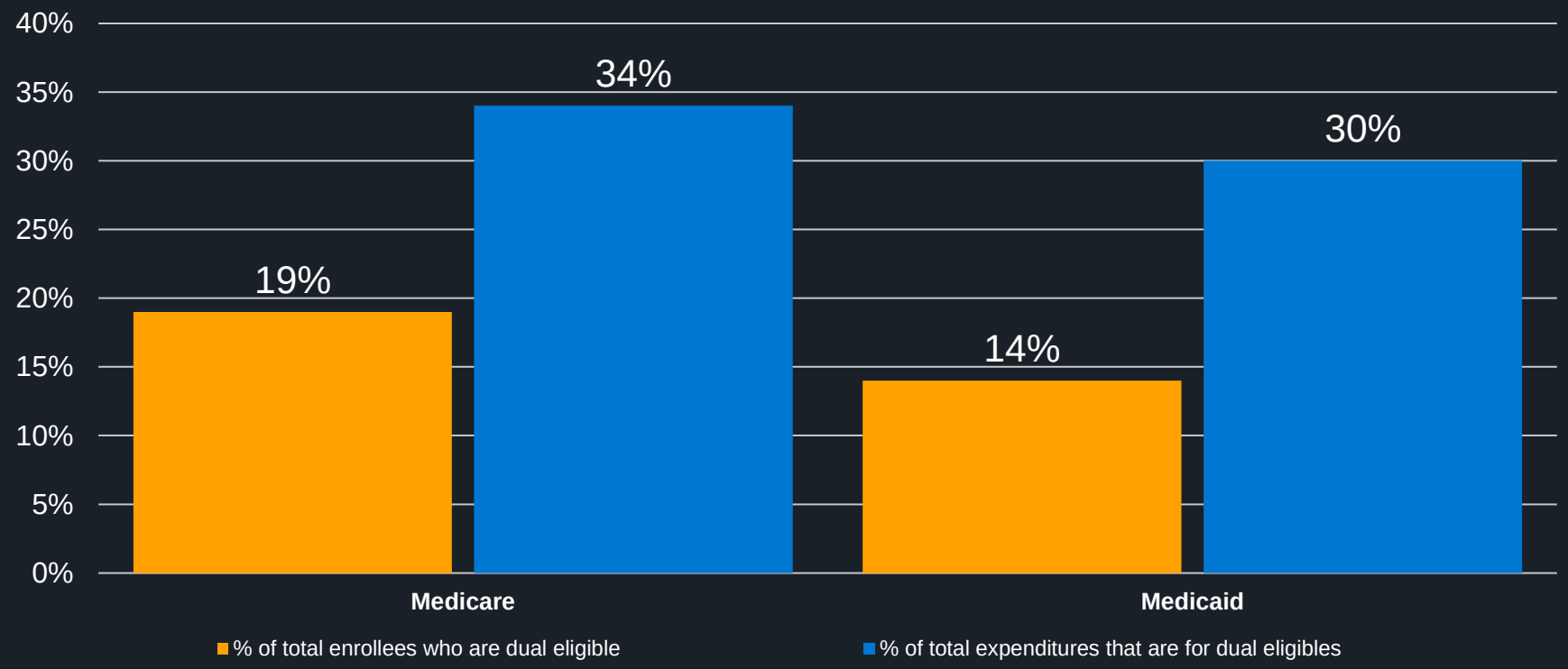
30%

Proportion of total Medicare and Medicaid expenditures

- Higher prevalence of many health conditions than either Medicare-only and Medicaid-only peers

Sources: Medicare-Medicaid Coordination Office Fiscal Year 2021 Report to Congress (cms.gov)

Dual eligible beneficiaries, 2019



Financial feasibility

Key drivers

Revenue drivers

- Star ratings
- Risk Scores
- County-specific benchmarks

Cost drivers

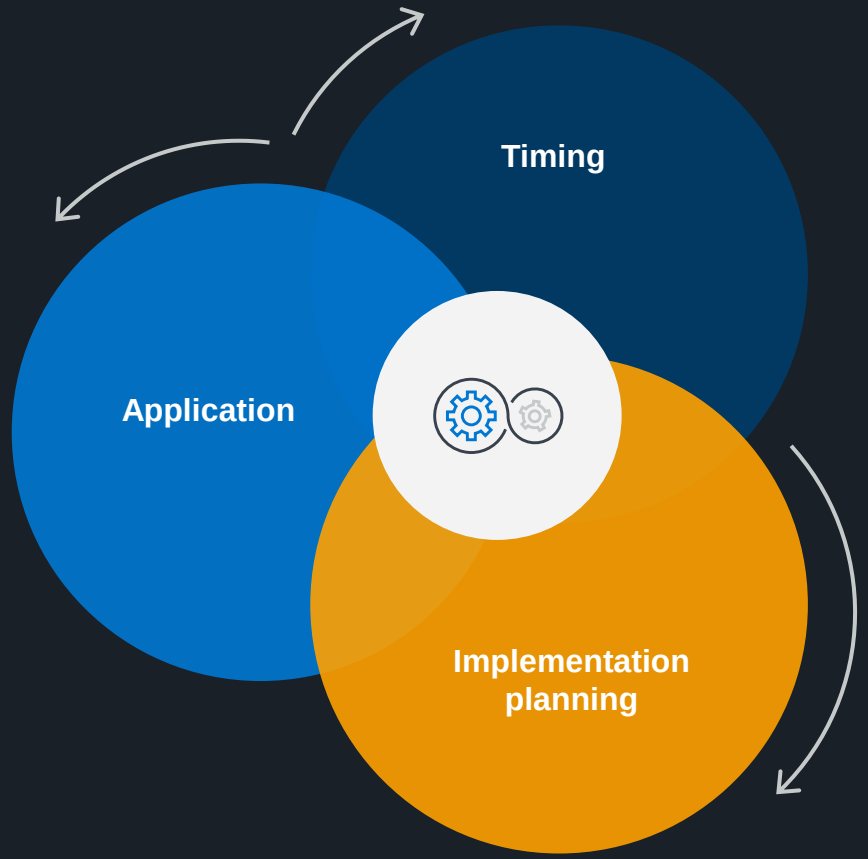
- Medical management
- Benefits
- Provider reimbursement
- PBM contracting
- Administrative costs

Enrollment growth

Implementation

Key implementation considerations

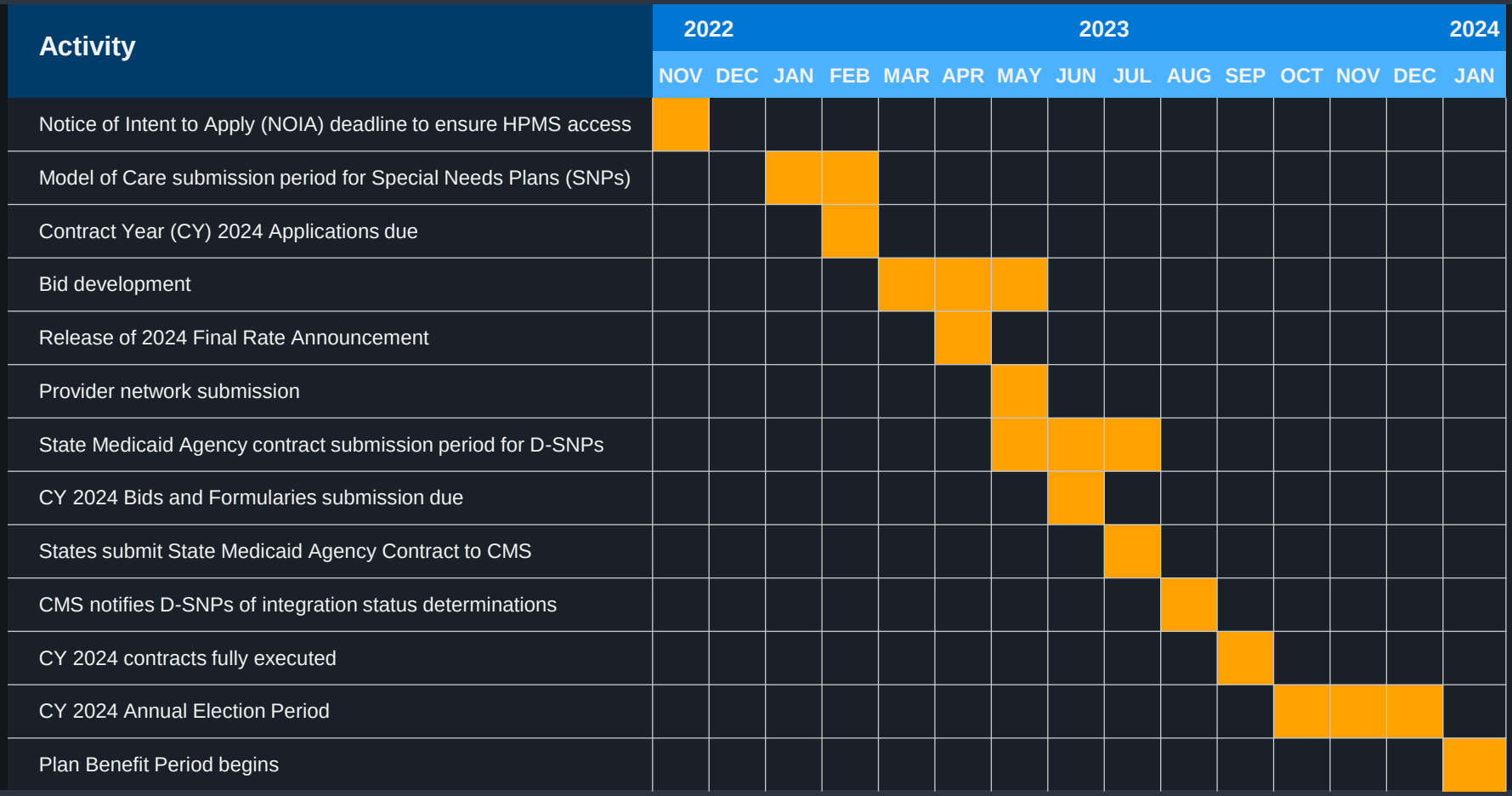
- D-SNP **timing** is aligned with Medicare Advantage timing
- **Application** process is defined
- **Implementation** planning factors



Insight: Start early, develop an implementation project plan, designate resources, and manage to meet key milestones.

SNP Milestones are the same as Medicare Advantage

- Medicare Advantage (MA) plans **begin application development activities** at least one year in advance of the plan benefit period start date
- CMS required to release Final Rate Announcement providing information on **capitation rates and methodologies** no later than the April prior to the benefit year start
- **Advance Notices** are released at least 60 days prior to the Final Rate Announcements and provide early guidance and opportunity for public comment



Source: CY 2023 Medicare Parts C and D Annual Calendar (cms.gov)
Contract Year 2021 Medicare Medicaid Integration and unified appeals and grievance requirements for dual eligible special needs plans (D-SNPs) (cms.gov)

D-SNP application

CMS accepts applications for SNPs using requirements set by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

SNPs must **follow existing MA program rules** (MA regulations at 42 CFR 422) regarding Medicare-covered services and Prescription Drug Benefit program rules.

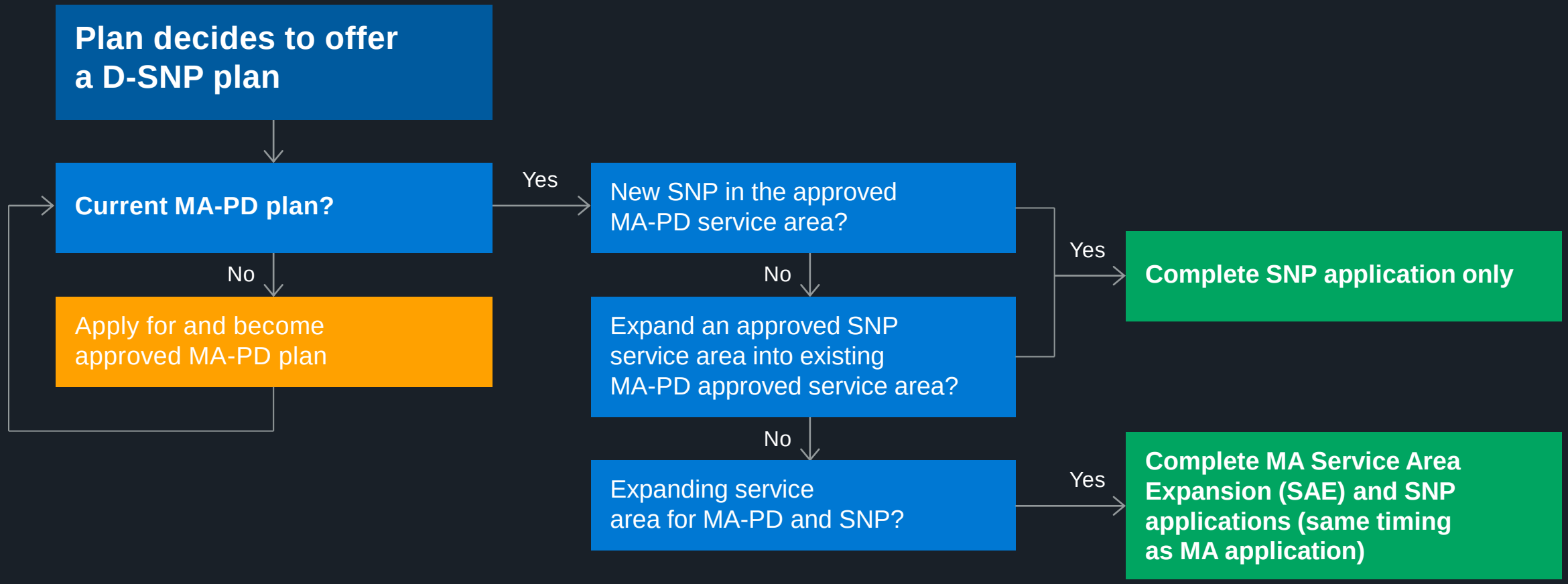
All SNPs **must provide Part D prescription drug** coverage as special needs individuals require access to prescription drugs for their special health care needs, even in a single Pharmacy Benefits Manager Medicaid state.

SNPs must **prepare and submit bids like other MA plans**. Plans are paid in the same manner as other MA plans based on the plan's enrollment and risk adjustment payment methodology. All SNPs must follow CMS guidance on cost sharing requirements.

Each D-SNP **must identify if it will offer Medicare zero-dollar cost sharing** at the time of plan creation and in the HPMS system.

Insight: Assume existing Medicare Part C and D rules apply unless otherwise indicated.

D-SNP application process flow



Implementation challenges and leading practices

Starting a CMS and State approved D-SNP plan

Challenges	Leading practices
Collaboration with the State and CMS: Contract terms that identify and meet D-SNP requirements. Maintain/develop relationships and establish processes, e.g., eligibility verification	Start the process early to allow time for contract iterations. Identify program leaders as key points of contact for consistency and relationship building
Numbers: Manage to a capitated monthly payment – understand the needed enrollment to spread risk and attract enrollment	Develop rate model with high confidence in rates. Significant communication to existing plan enrollees and providers to build membership volume. D-SNP eligibility may change at any time requiring regular, ongoing outreach and communication
Coordination and integration: D-SNP programs have a heavy emphasis on coordination; additional reporting responsibilities	Early development and testing of reporting and establishing care coordination protocols

Implementation challenges and leading practices

Challenges	Leading practices
Operational readiness: Systems, tools and process needed to support the management the population	Develop infrastructure and processes for efficiency and effectiveness of systems and processes
Knowledge, skills, and abilities: Team abilities to serve this population who have unique requirements	Begin educating the health plan team now to develop knowledge; recruit for Subject Matter Experts for essential roles as feasible
Competing operational priorities: Maintain focus on current members and processes	Develop a project team with identified roles and project oversight to provide decisions, monitor progress, and assist with resolving barriers
Reporting: Must meet both CMS and state reporting requirements, e.g., encounter submission.	Develop and refine reporting processes early to meet all state and federal requirements.

Insight: Significant work requires time and focus – start now with a plan, establish a dedicated team, and identify and authorize a designated D-SNP program owner

Insource and outsource considerations

- Develop a list of all functions required to support D-SNP implementation
- Assess current capability and scalability to add new D-SNP population
- Determine current system / infrastructure efficiencies and processes in place that support internal work
- Identify areas where external expertise and/or system efficiencies may be beneficial
- Clarify functions that are best retained internally based on leading practice and internal capacity assessment
- Evaluate cost / benefit for options
  - Internal: What people, processes, and technology are required to build the D-SNP program? What funding is available? How much time is required to build internal capacity? What are competing operational priorities?
  - External: What is the cost and timing options, e.g., short term outsource while building the internal capacity? Are there available, proven vendors? Can existing vendors be leveraged for added D-SNP population?

Insight: Outsourcing can speed solutions but can be costly; internal development can take time and face competing priorities… and effective delegation oversight is mandatory for outsourced functions.

Preparing for D-SNP

Significant work across the organization and structure will support successful implementation of a new D-SNP including:

- Establish and communicate **corporate vision for D-SNP** services
- **Designate resources** to focus on implementation
- Develop a **detailed workplan** with key milestones spanning all effected operational areas
- Create an **interdepartmental team** to collaboratively solve problems and move the work forward
- Complete an **operational readiness assessment** for gap identification
- Develop a **prioritized gap closure strategy**
- **Monitor and report progress** toward readiness

Insight: Build milestones into implementation plan to avoid missed deadlines or rushed submission

Model of Care

The Model of Care

The D-SNP MOC is a **framework of care with four key components**

D-SNP requirement

The MOC is “considered a **vital quality improvement tool** and integral component for ensuring that the **unique needs** of each beneficiary enrolled in a SNP **are identified and addressed**” NCQA

Quality focused and comprehensive

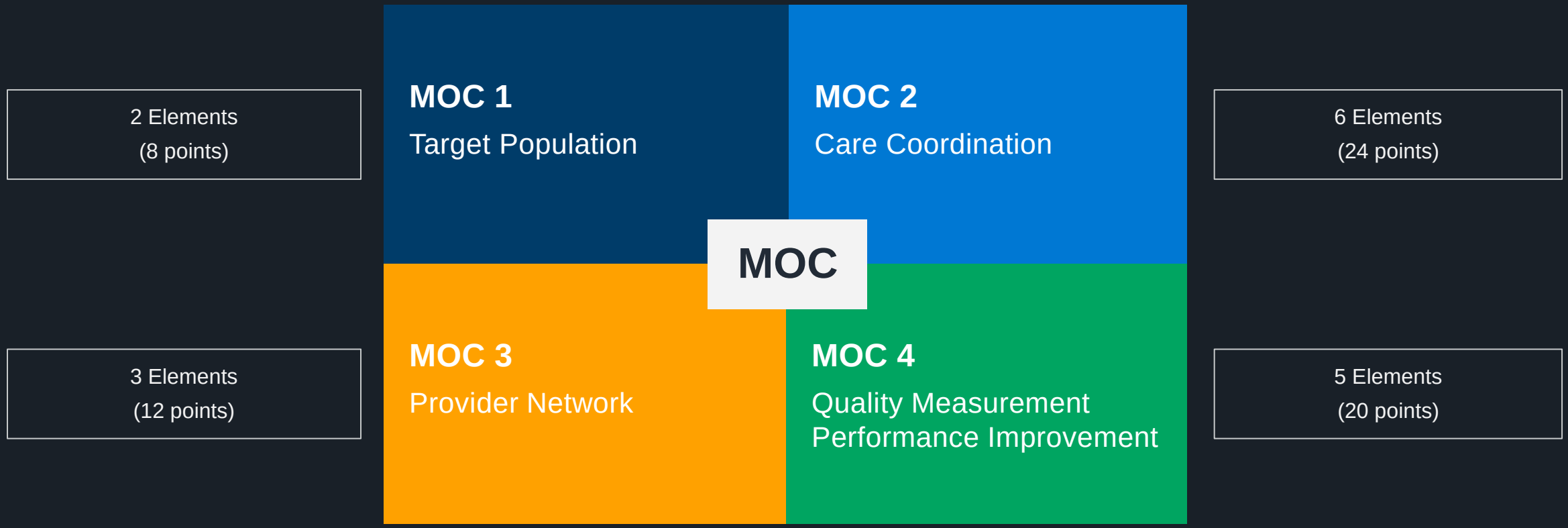
The MOC reflects the move to **Population Health** and holistic, integrated, individualized **Person-Centered Care**

Population and person centered

Model of Care framework

The four components

The framework for meeting all SNP member needs



Insight: In the MOC design and implementation, every element counts

Model of Care approval

Scores and approval status

85% – 100%	3-year Approval
75% – 84%	2-year Approval
70% – 74%	1-year Approval
< 70%	Fail May resubmit MOC one time (Cure)

Each element and factor needs to be supported by evidence that the requirement is met

Plans must obtain a score of 50% on each element to obtain approval, regardless of final overall score

https://snpmoc.ncqa.org/wp-content/uploads/Model-of-Care-Scoring-Guidelines-for-CY-2023_FINAL-3.pdf
https://snpmoc.ncqa.org/model-of-care-scores/?fwp_plan_type=dual-eligible

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Insight: Every SNP must have an NCQA-approved MOC and MOC scores count. Set the target, have a strategy, and commit resources to the MOC design and implementation

The Model of Care

Design and implementation

MOC 1

Description of SNP population

https://snpmoc.ncqa.org/wp-content/uploads/Model-of-Care-Scoring-Guidelines-for-CY-2023_FINAL-3.pdf

SNP population description

2 Elements (CY 2023)

a) Description of overall SNP population

b) Subpopulation – Most vulnerable beneficiaries

Design and implementation considerations

The comprehensive description of the local target population is the foundation that all other MOC elements depend on.

The unique characteristics and needs of the target population, and most vulnerable subsets of the population, drives the entire MOC – the design and the ongoing execution.

Consider the local community resources and process for partnering to support the population.

Model of Care framework

Design and implementation

MOC 2

Care coordination

https://snpmoc.ncqa.org/wp-content/uploads/Model-of-Care-Scoring-Guidelines-for-CY-2023_FINAL-3.pdf

Care coordination

6 Elements (CY 2023)

a) SNP Staff Structure
b) Health Risk Assessment Tool (HRAT)
c) Face-to-face encounters
d) Individualized Care Plan (ICP)
e) Interdisciplinary Care Team (ICT)
f) Care Transition Protocols (CTP)

Design and implementation considerations

Care coordination and person-centered care are to improve overall health care outcomes.

Staff structure and infrastructure can include internal and contracted / outsourced resources.

- Consider the relative costs, capacity, capabilities, ease of integration and management overtime e.g. – HRA administration, face-to-face visits, care transitions.

The plan is responsible for the provision and oversight of all elements, non-duplication of services, and measurement of effectiveness.

Model of Care framework

Design and implementation

MOC 3

Provider network

https://snpmoc.ncqa.org/wp-content/uploads/Model-of-Care-Scoring-Guidelines-for-CY-2023_FINAL-3.pdf

Provider network
3 Elements (CY 2023)

a) Specialized expertise
b) Use of clinical practice guidelines and care transition protocols
c) MOC training for the provider network

Design and implementation considerations

Network must have the specialized expertise—including facilities and providers—that corresponds with the unique population and subpopulations.

Providers collaborate with the enrollee's ICT and contribute to the ICP.

Consider the network and infrastructure needs for monitoring use of appropriate clinical practice guidelines and decisions to modify for clinically complex members.

Model of Care framework

Four components (CY 2023)

MOC 4

Quality measurement and performance improvement

https://snpmoc.ncqa.org/wp-content/uploads/Model-of-Care-Scoring-Guidelines-for-CY-2023_FINAL-3.pdf

Quality measurement
5 Elements (CY 2023)

a) MOC quality performance improvement plan

b) Measurable goals and health outcomes for the MOC

c) Measuring patient experience of care (SNP member satisfaction)

d) Ongoing performance improvement evaluation of the MOC

e) Dissemination of SNP quality performance related to the MOC

Design and implementation considerations

MOC 4 requires a comprehensive quality improvement program with goals appropriate to the population and ongoing measurement of performance.

Goals for improving access and affordability and health outcomes are specific to the D-SNP population.

Developing and implementing the MOC

A comprehensive MOC entails work across the organization and service area and ongoing attention to detail

Design and implementation begins with MOC 1– the target population and most vulnerable enrollees

The unique needs of the local target population drives the entire Model of Care, and the individual needs of enrollees need to be addressed.

Plans need to be able to implement and efficiently deliver all components of the MOC they design

Consider existing capabilities, resources, relationships, relative costs and efficiencies when designing and implementing all the MOC elements.

Focus on quality and performance improvement can improve overall efficiency and effectiveness

Plans can leverage the MOC framework and requirements' value to the organization.

Insight: D-SNP MOC must be comprehensive, tailored to the local population, and feasible to execute

Policy

Recent federal legislation

Bipartisan Budget Act of 2018

Permanent SNP reauthorization

- Originally authorized by Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Multiple temporary reauthorizations

D-SNP integration standards

- Mandatory Medicare-Medicaid integration standards for all D-SNPs

Fully Integrated D-SNP (FIDE)

- Plan provides both Medicare and Medicaid benefits (including LTSS)
- Additional aligned enrollment and Medicaid coverage requirements per 2023 Medicare final rule

Highly Integrated D-SNP (HIDE)

- MAO is a Medicaid MLTSS or behavioral health plan

Coordination only D-SNP

- State / MCO notified when high-risk enrollees admitted to hospital or SNF
- Definition of high-risk and operational mechanics at state discretion

Recent CMS rulemaking

CY 2023 Medicare final rule

On May 9, CMS published a final rule for CY 2023 policy and technical changes to the MA and Part D programs

Source: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

Major D-SNP provisions
Enrollee participation in D-SNP plan governance
Standardizing Housing, food insecurity, and transportation questions on Health Risk Assessments (HRAs)
Refining definitions for FIDE and HIDE D-SNPs
Converting MMPs to integrated D-SNPs
Adjudication of the Maximum Out-of-Pocket (MOOP) limit for dual eligible beneficiaries
Flexibilities and requirements for exclusively aligned D-SNPs including separate contracts, HPMS access for state Medicaid agency, and integrated marketing materials

Future federal legislation

Recently proposed federal legislation

Supporting Care for Dual Eligibles Act

Introduced February 2022

- Provide grants to State Medicaid programs to improve their capacity to ensure the provision of quality integrated care for dual eligible beneficiaries.

https://www.congress.gov/bill/117th-congress/senate-bill/3630

Advancing Integration in Medicare and Medicaid (AIM) Act

Introduced May 2022

- Require States to develop strategy to integrate and coordinate Medicaid and Medicare coverage for full benefit dual eligible beneficiaries
- Aligns to MACPAC Recommendations (March draft and June 2022 Report to Congress)

https://www.scott.senate.gov/imo/media/doc/Dual%20Integration%20Plan%20Bill%20v41.pdf

Comprehensive Care for Dual Eligible Individuals Act

Introduced July 2022

- Create a new program that integrates Medicare and Medicaid.
- States can opt-in.

https://www.brown.senate.gov/imo/media/doc/comprehensive_care_for_dual_eligible_individuals_act_of_2022_bill_text.pdf

State Medicaid policy

State-specific D-SNP policy

- **Selective contracting**
- **Enrollment policies**
- **Leveraging SMAC**
- **Future MMP transitions***

California

CalAIM

- MMPs transition to D-SNPs in 2023
- Medi-Cal MCOs required to operate D-SNPs starting in 2026
  - Exclusively aligned enrollment requirement
  - Default enrollment
- Statewide MLTSS in 2027

https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Launch-Timeline-July-Update.pdf

Questions?

Caveats and limitations

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Nick Johnson is a Consulting Actuary for Milliman, member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of his knowledge and belief, 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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