A Vehicle for Success

Exploring Medicare Advantage as an Alternative Revenue Source for Nursing Homes and Other Post-Acute Providers

July 17, 2020

HMA Medicare Practice

Medicare@healthmanagement.com

HMA

HEALTH MANAGEMENT ASSOCIATES

Jon Blum
Managing Principal

Mary Hsieh
Managing Principal

Michael Engelhard
Managing Principal

Margaret Tatar
Managing Principal

Sarah Barth
Principal

Trudi Carter MD
Principal

Julie Faulhaber
Principal

Deb Gracey
Principal

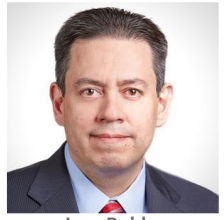
Eric Hammelman
Principal

Julie Johnston
Principal

Linda Lee
Principal

Dana McHugh
Principal

Tom Murar
Principal



Jose Robles
Principal

Sarah Owens
Principal

Maddy Shea
Principal

Mindy Cohen
Senior Consultant

Zach Gaumer
Senior Consultant

Narda Ipakchi
Senior Consultant

Aimee Lashbrook
Senior Consultant

Danielle Pavliv
Senior Consultant

Jennifer Podulka
Senior Consultant

Mary Russell
Senior Consultant

Elaine Henry
Consultant

Samantha DI Paola
Research Assistant

Key webinar takeaways

Our webinar will address the following questions:

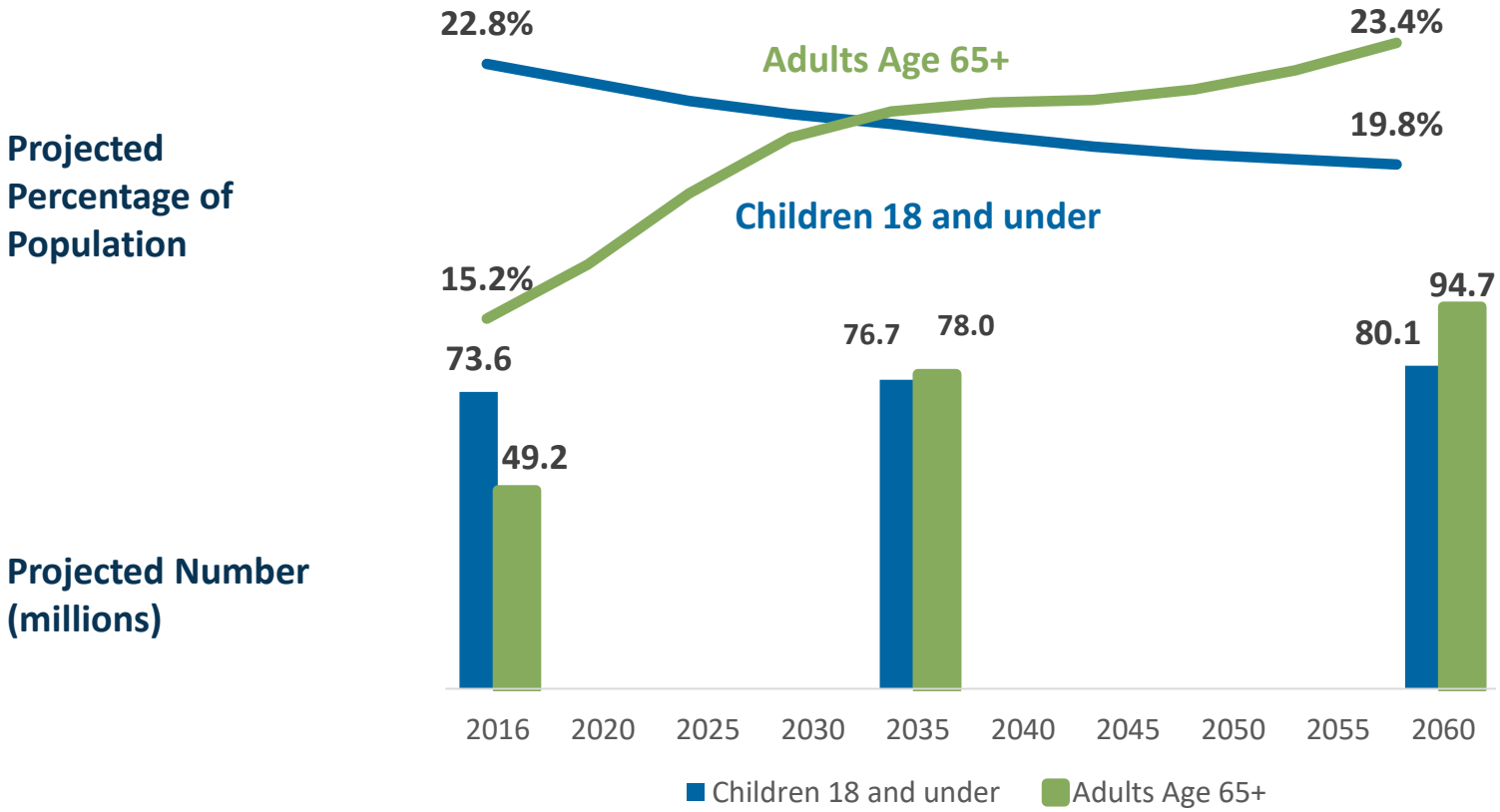
1. What is Medicare Advantage? What is its significance and growth trajectory?
2. What are the types of Medicare Advantage options for residents and community-based beneficiaries (Institutional Special Needs Plans and Institutional-Equivalent Special Needs Plans)?
3. Why these options serve as potential revenue diversification strategies for you?
4. What are the benefits and risks of the Medicare Advantage?
5. How do I assess if this is the right opportunity for my organization?

What is Medicare Advantage?

What is its significance and growth trajectory?

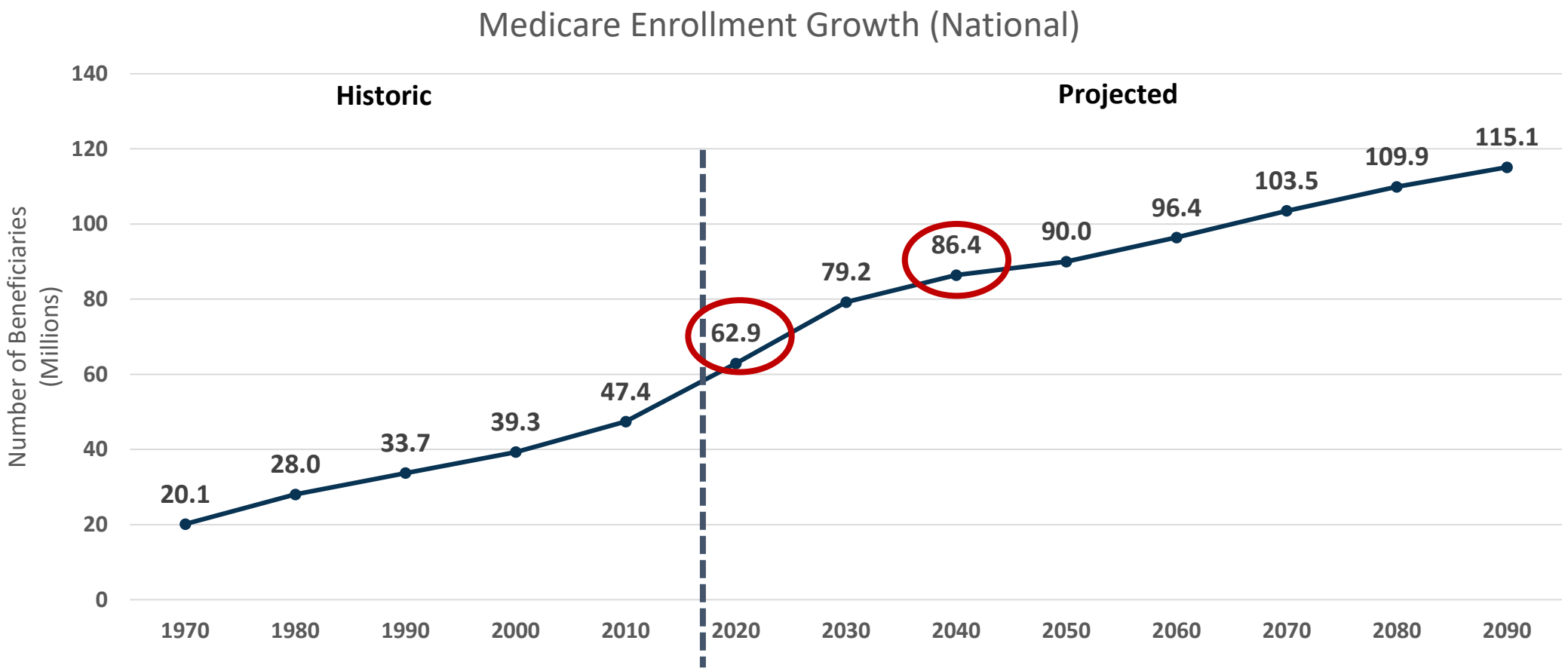
The Medicare population is growing; adults age 65+ will exceed number of children by 2035

The US population will grow more slowly, age considerably and become more racially and ethnically diverse



Source: US Census Bureau, *"Older People Projected to Outnumber Children for First Time in U.S. History,"* March 13, 2018; accessed at https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html.; US Census Bureau, *"2017 National Population Projections Tables,"* Revised, September 2018; accessed at https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.

Medicare enrollment is expected to grow rapidly through 2030

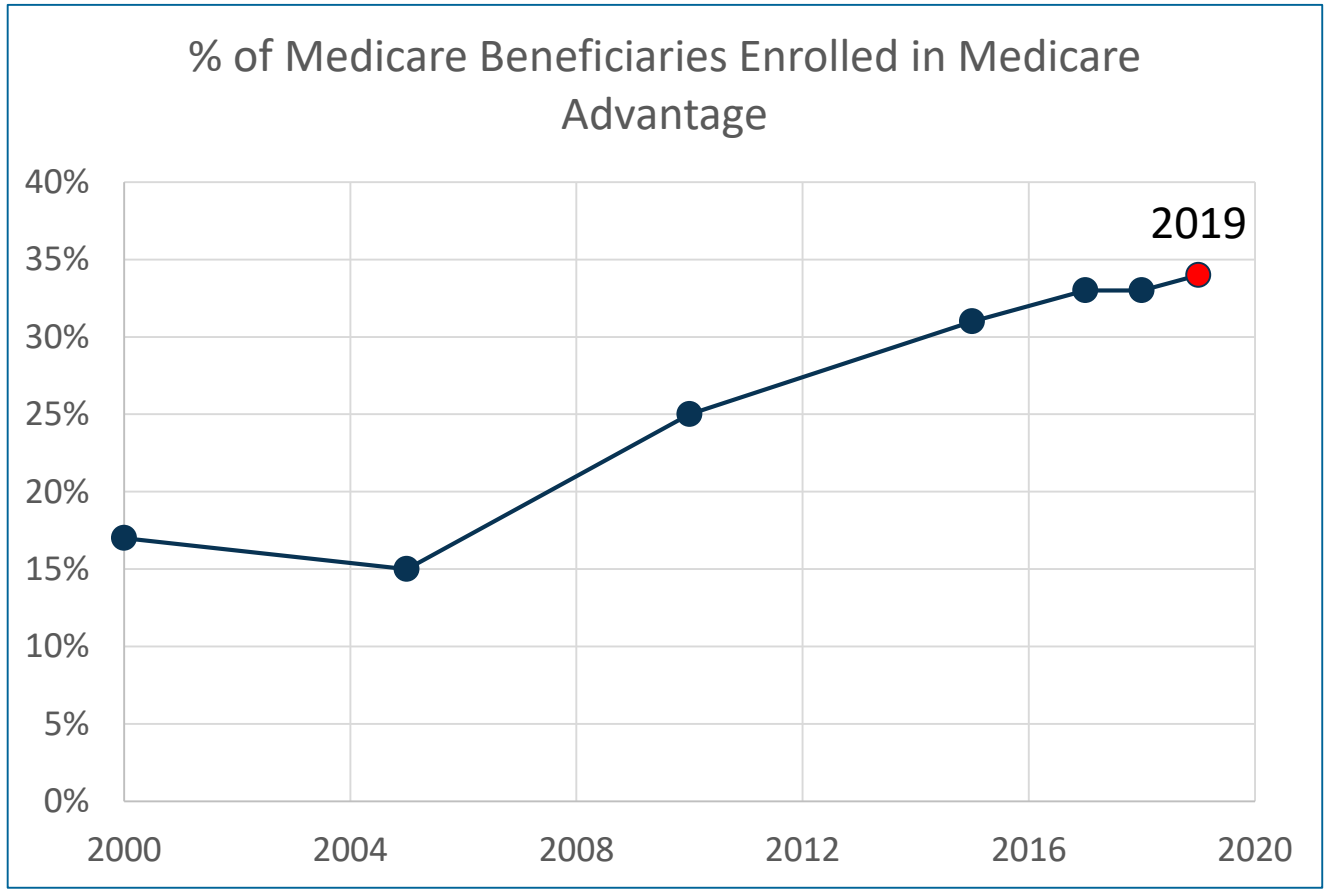


Source: Medicare Payment Advisory Commission (MedPAC) June Data Book. *A Data Book: Health care spending and the Medicare program*, June 2019
Kaiser Family Foundation State Health Facts, KFF, accessed July 29, 2019, https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries

What is Medicare Advantage

1. Members opt-in to Medicare Advantage
2. A type of private health plan that contracts with CMS to provide Part A and Part B benefits
3. Revenues come primarily from CMS in the form of capitated payment for each member
4. Members may pay a premium
5. Plans at risk for managing the member's health care cost

MA enrollment has more than doubled over the past 10 years (absolute and share of total)

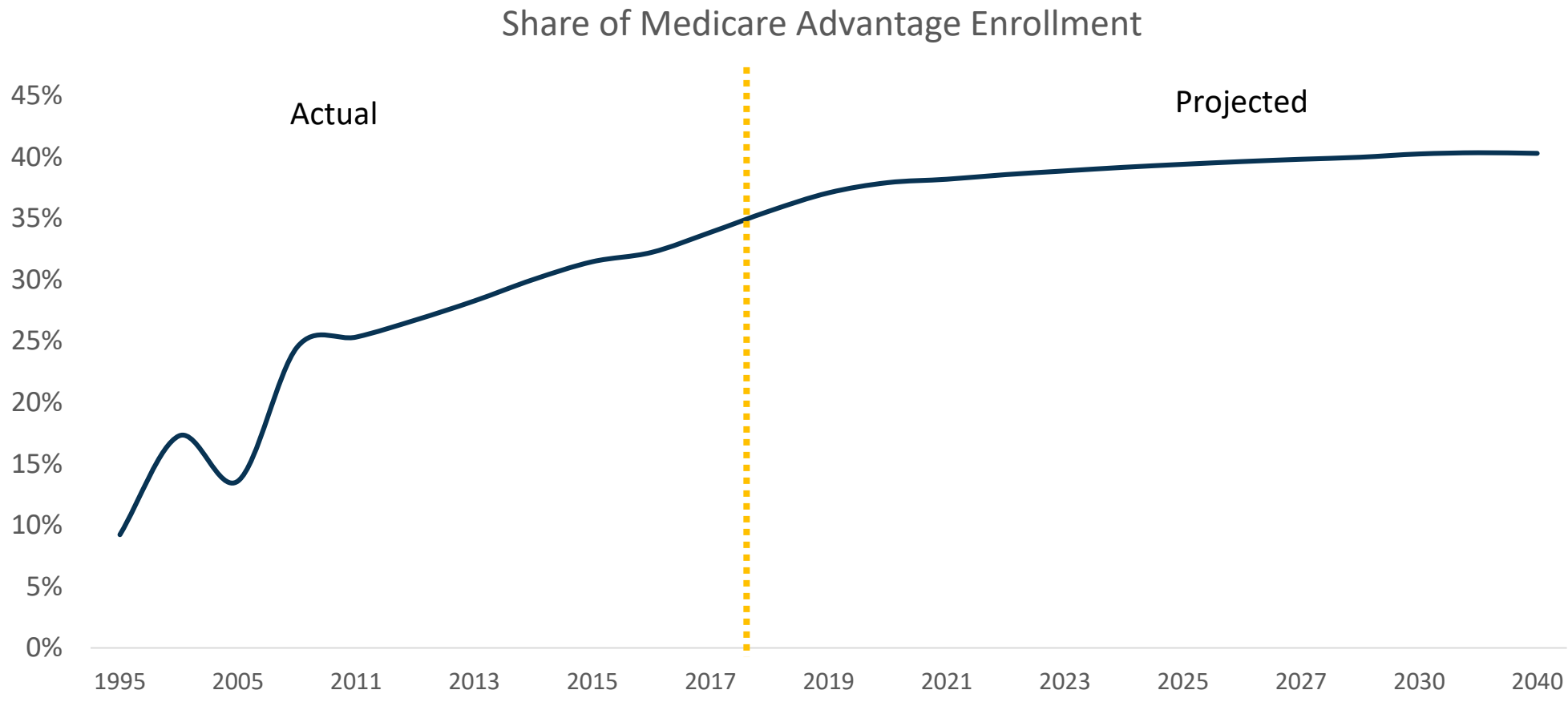


Source: HMA Analysis of CMS Enrollment Files, 2019

Five companies account for 65% of MA enrollment in 2019:

- United Health – 25%
- Humana – 17%
- Aetna (CVS Health) – 10%
- Kaiser – 8%
- Anthem – 5%

Federal policy and market dynamics are driving rapid enrollment into Medicare Advantage plans

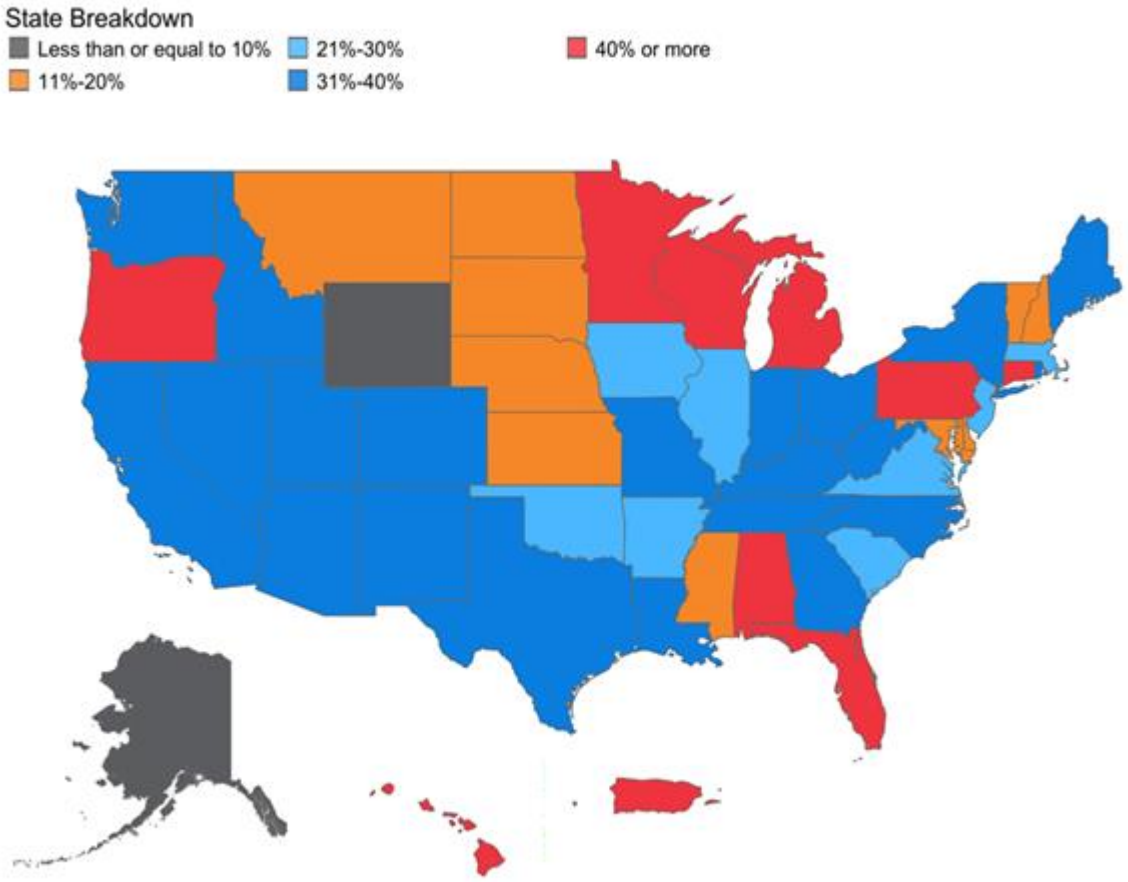


Source: 2020 Medicare Trustees Report

2020 penetration has grown to 40.5% from 37.5%

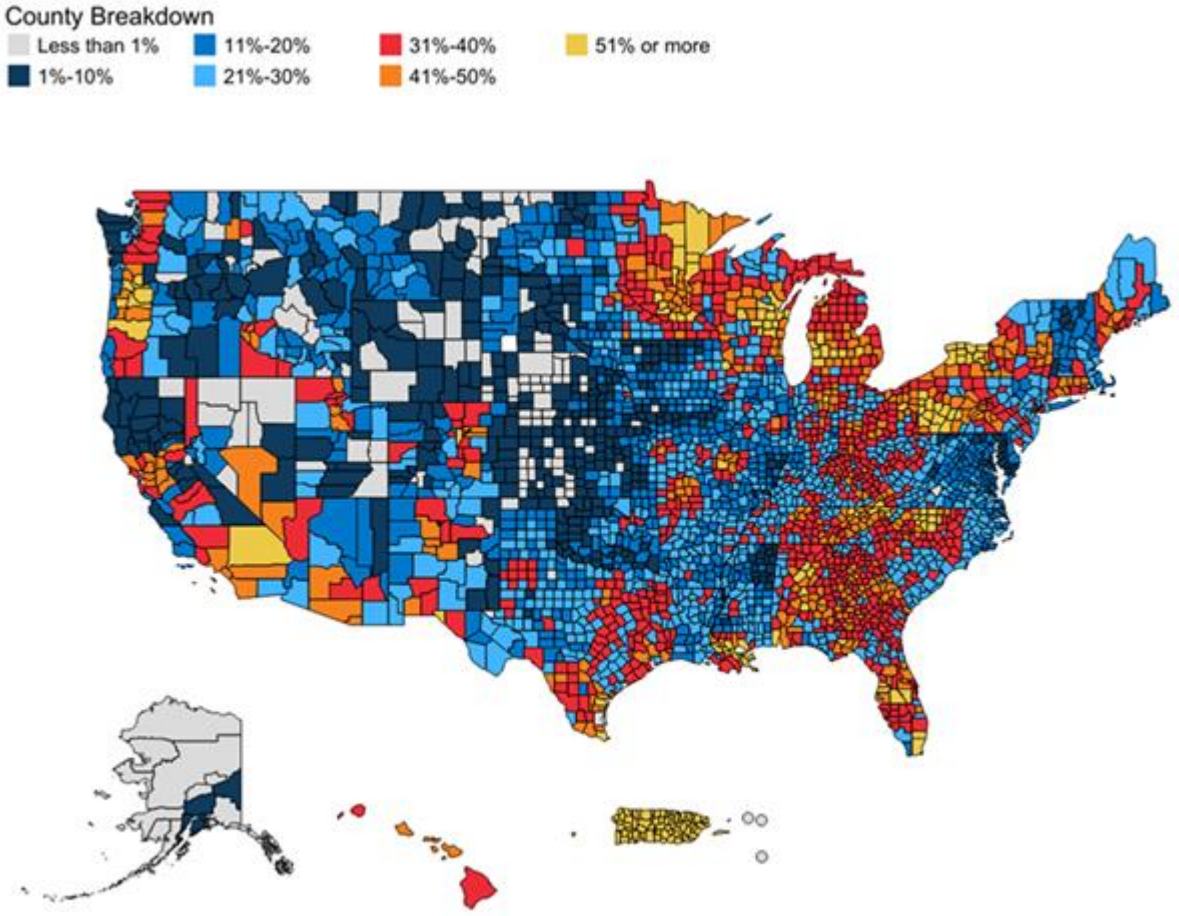
(Data from May 2020 vs. May 2019)

Medicare Advantage Penetration, by State, 2020



NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: KFF analysis of CMS State/County Market Penetration Files, 2020.

Medicare Advantage Penetration, by County, 2020



NOTE: Includes cost plans, as well as Medicare Advantage plans. Excludes territories and beneficiaries with unknown county addresses
SOURCE: KFF analysis of CMS State/County Market Penetration Files, 2020

Factors are fueling the growth of Medicare Advantage

1. Favorable federal reimbursement
2. Overall Medicare population growth
3. Erosion of employer-sponsored retiree insurance; shift to Medicare Advantage products
4. “Relative ease” of entering into Medicare Advantage business
5. Growth of Special Needs Plans (SNP)

What are the types of Medicare Advantage options for residents and community-based beneficiaries?

Why do these options serve as potential revenue diversification strategies for you?

Types of Special Needs Plans (SNPs)

Institutional and Institutional-Equivalent Special Needs Plans (I-SNP and IE-SNP)

- Need level of services provided in LTC, SNF, NF for 90 days or longer
- Individuals living in the community but requiring institutional level of care
- I-SNPs serving LTC residents must own, operate or have contracts with LTC facility

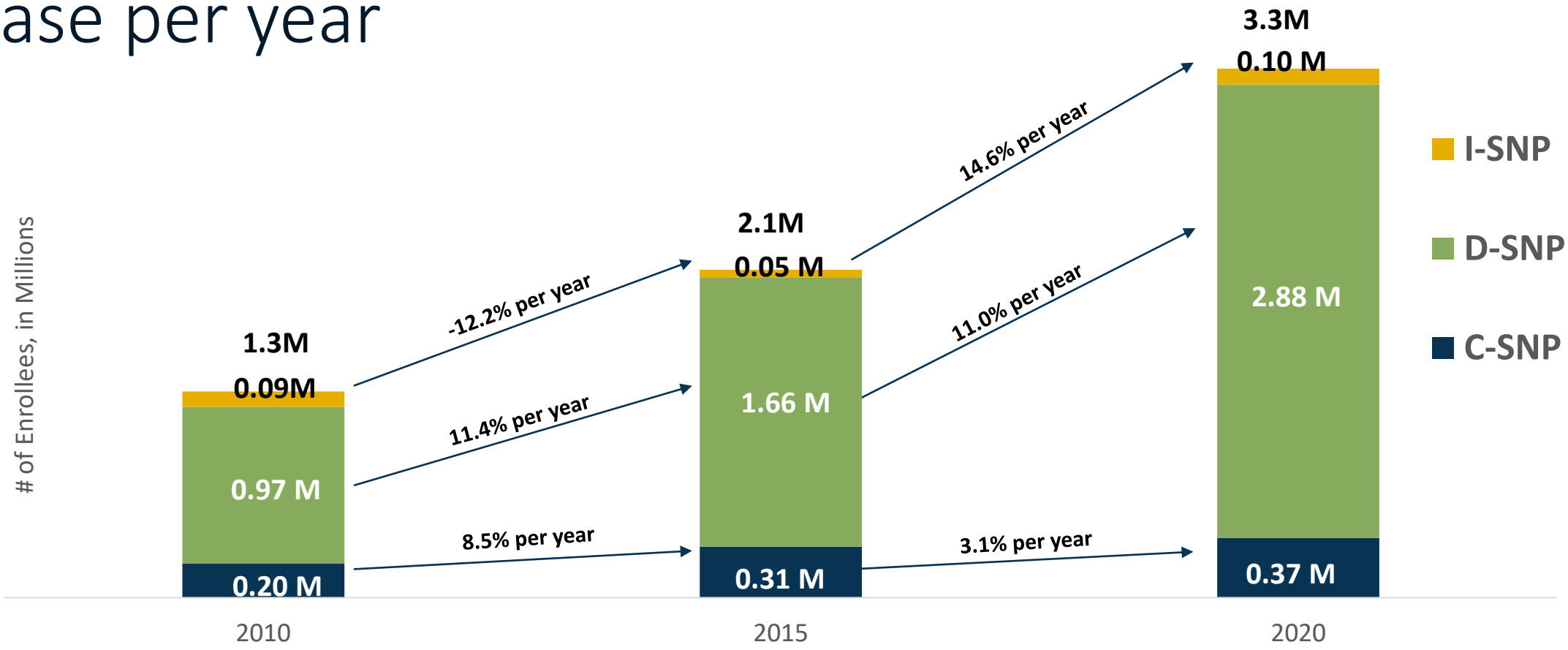
Dual Eligible Special Needs Plan (D-SNP)

- Must qualify for both Medicare and Medicaid (can be partial Medicaid)
- State Medicaid Agency Contracts (SMAC) contract required to operate D-SNP
- Requires tighter integration between Medicare and Medicaid beginning in 2021

Chronic Care Special Needs Plan (C-SNP)

- Specific severe or disabling chronic conditions
- 15 specific SNP chronic conditions approved by CMS
- Many plans will focus on a single condition or groupings of conditions

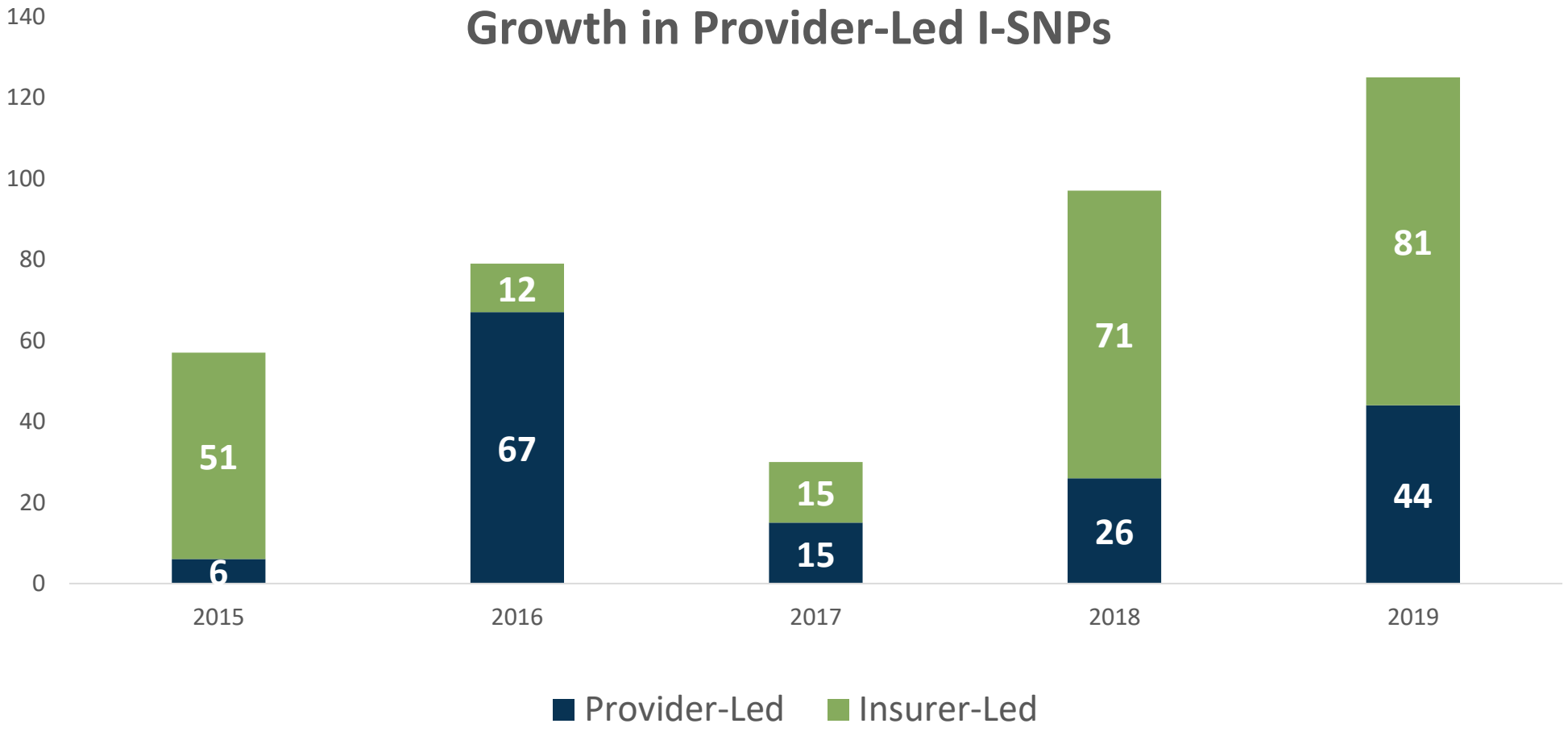
SNP enrollment is up 250% in the past 10 years. Since 2015, I-SNP enrollment has experienced a nearly 15% increase per year



I-SNP: Institutional Special Needs Plan; D-SNP: Dual Eligible Special Needs Plan; C-SNP: Chronic Special Needs Plan
Source: HMA Analysis of CMS Enrollment Files, 2010, 2015, and 2020

14

Trends in post-acute care and LTSS: Provider-led I-SNPs



The average provider-led plan has an average of 584 enrollees, with a single plan of nearly 4,500 participants skewing the number upwards

15

Source: Anne Tumlinson Innovations analysis of CMS SNF Comprehensive Reports

I-SNP contract requirements

I-SNPs that serve residents of LTC facilities must own, operate, or have a contractual arrangement with the LTC facility that includes adherence to its approved Model of Care (MOC). The eight contract requirements include:

1. Facilities in a chain organization must be contracted to adhere to the MOC;
2. Facilities must provide access to clinical staff;
3. Facilities must provide protocols for the Model of Care (MOC);
4. Delineation of services provided by the I-SNP staff and the LTC facility staff must be specified;
5. Training plan for LTC facility staff to understand the MOC must be included;
6. Procedures must be developed and in place for facilities to maintain a list of credentialed ISNP clinical staff;
7. Contract year for I-SNP must be specified; and
8. Grounds for early termination and transition plan for beneficiaries enrolled in the I-SNP must be specified.

SNPs provides NF a revenue model that moves from units of service to value

Special Needs Plans have the potential to manage high risk and vulnerable population through a model of care that avoids unnecessary and costly inpatient and emergent visits

- CMS pays I-SNP a risk-adjusted capitated rate (i.e., Per Member Per Month)
- Control of health care dollar for total cost of care
- Established facilities and trust with residence
- Control of referral patterns
- Develop and execute the care management and coordination of care for improved outcomes

Competitive advantage over traditional health plans

- Existing infrastructure and services in place – beyond the number of skilled nursing beds.
- Opportunity to leverage these infrastructures and services and the population on the campus and the catchment area.
- Abundant services provided: care management, home health, hospice, nursing, and access to primary care.
- Social determinants of health: Meals on Wheels, care management, home health and independent low-income senior housing.
- Model of Care: Already contracting with health plans to deliver on Model of Care

- **What are the benefits and risks of the Medicare Advantage?**

Profiles of successful SNPs

- Care and Case Management Infrastructure
  - Ability to risk stratify among SNP population (and identify the sickest of the sick)
  - Coordination with members of the interdisciplinary team (handoffs using HRAT to develop and updated individual care plan)
- Robust oversight process
  - Training of providers
  - Evidence of Interdisciplinary Team and Individualized Care Plan
- Understand how to address social determinants of health, not just health care
  - Being able to identify partners offer benefits that can address the non-medical care needs of the members (e.g., meals, PCAs, transportation, etc.)

Medicare Star ratings

The Medicare Star Rating program is a quality measurement program implemented by CMS to assess the quality of Part C Medicare Advantage plans and Part D Prescription Drug Plans. Star ratings are updated each year based on annual data reporting by plan sponsors and other sources. The purpose of the star ratings is to:

- Inform beneficiaries about performance of available MA plans.
- Incentivize plans to improve quality and performance by offering Quality Bonus Payments (QBP).
- Provide a mechanism for CMS to award high achieving plans through marketing incentives and prominent display on the Medicare Plan Finder.

Stars Rating

★★★★★	**Superior performance/Excellent**
★★★★	Above average performance
★★★	Average performance
★★	Below average performance
★	Poor performance

Rebates used for benefits and engagement

CMS requires MA plans to use the rebate dollars to enhance benefits, which leads to a virtuous cycle with enrollees

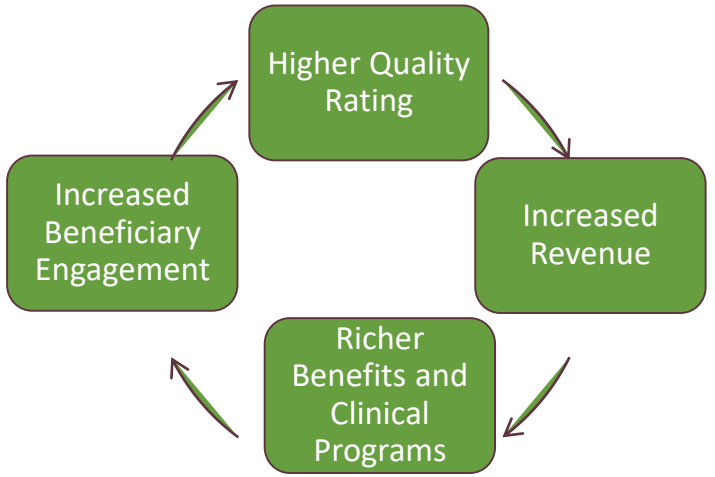
Contract A

★★★★

78% of enrollees are in 4+ Star Plans

5% Bonus

Investment of Additional Funds



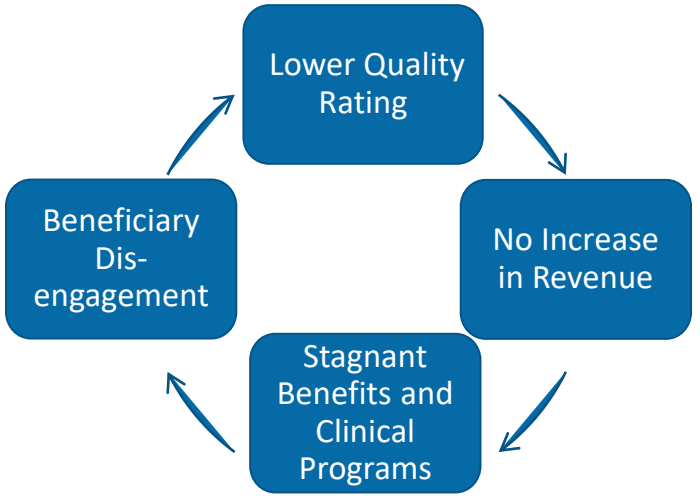
Contract B

★★★

22% of enrollees are in 3 or less Star Plans

0% Bonus

No Additional Funds to Invest

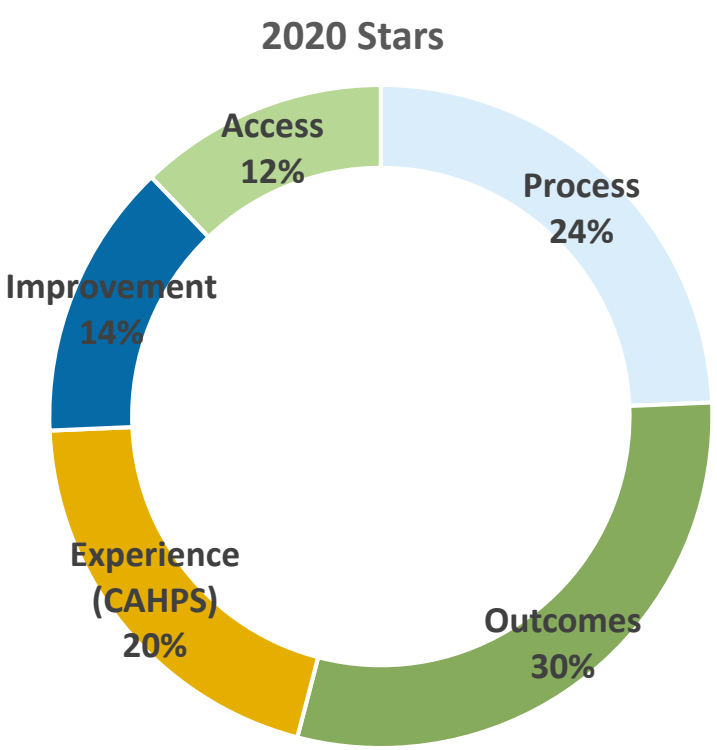


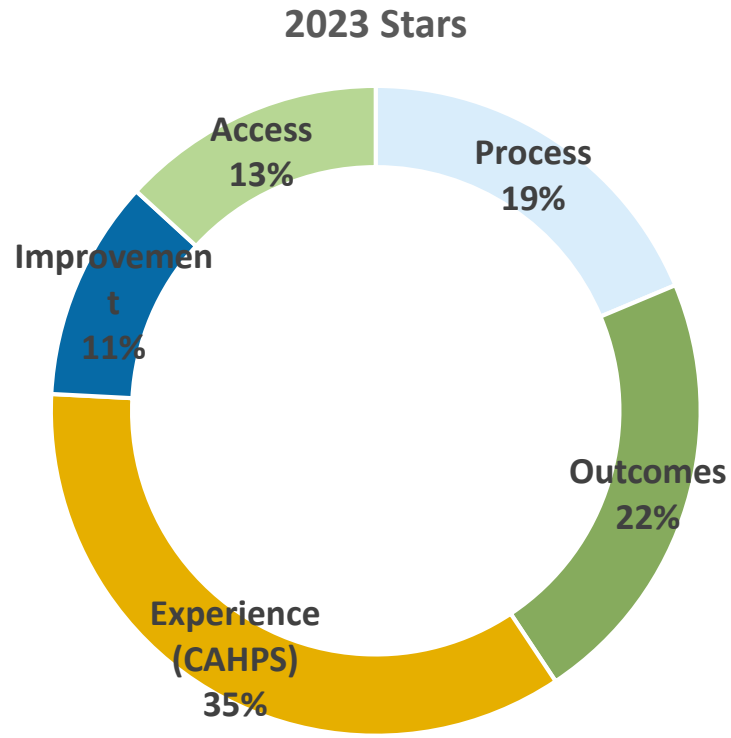
Composition of Medicare Star ratings

Member experience is playing a much bigger role in future Stars.

Star ratings are determined using measures and data from various sources, including:

- The Healthcare Effectiveness Data and Information Set (HEDIS)
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- The Health Outcomes Survey (HOS)
- Other plan data, including member satisfaction, grievances and appeals, and audit findings





Special Needs Plan Model of Care required elements

MOC1:
Description of SNP Population

MOC2:
Care Coordination

MOC3:
Provider Network

MOC4:
MOC Quality Measurement and Performance Improvement

Other Risks and Benefits

Benefits

- Move upstream to control the revenue and total cost of care
- Diversified and predictable source of revenue (PMPM)
- Already know the beneficiaries and their needs
- Ability to affect outcomes in more significant ways than many payers
- Ability to provide more direct clinical care
- Can help with occupancy rate
- As MA plan, more leverage with vendors
- Serves as a great marketing tool for entire organization

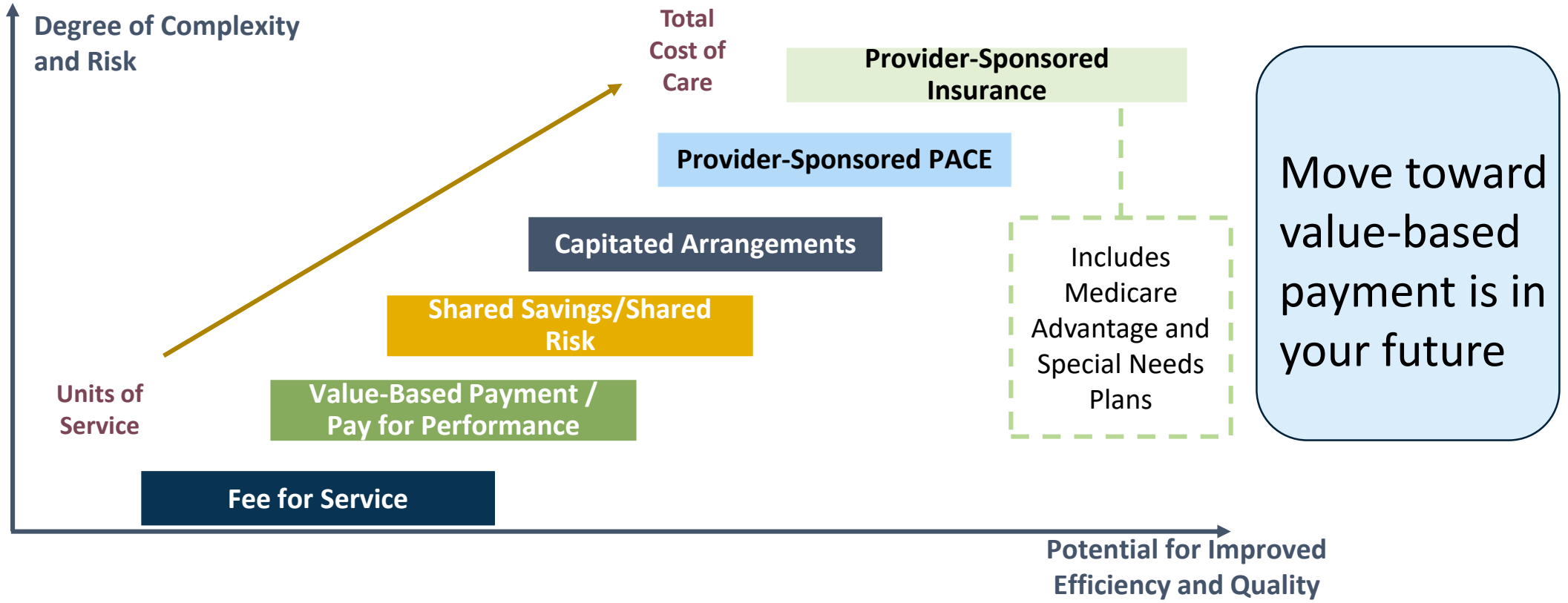
Risks

- Capital requirements
- Insurance expertise (e.g., claims payment, coordination of benefits, etc.)
- Capital requirements
- Managing risks for total cost of care
- Scale may be needed to spread investment and ongoing cost
- Managing clinical services
- Medicare Advantage is highly regulated
- Resource requirements – time, money and staff

- **How do I assess if this is the right opportunity for my organization?**

Spectrums of financial risk

Readiness for the spectrums of risks implies different strategies and internal capabilities



Medicare Advantage planning cycle is 18 months

Estimated Dates	Milestones
June - July 2020	Planning for 2022 Starts
July – August 2020	Feasibility, market assessment, Pro Forma
September 2020	Organizational decision
September 2020 – June 2021	Network development
November 2020	Notice of Intent to Apply Form
January 2021	2022 Application Posted by CMS
February 2021	2022 Applications Due to CMS
February 2021	Model of Care for Special Needs Plan Due
May – June 2021	Health Service Delivery (Network) Tables Uploaded
First Monday of June 2021	Bids Due to CMS
August – September 2021	Readiness Audit by CMS
September 2021	CMS Signs MAPD and SNP Contracts
October 15, 2021	Medicare Open Enrollment Period
January 2022	Go-Live

Medicare @ HMA

Medicare@healthmanagement.com

HMA

HEALTH MANAGEMENT ASSOCIATES

Mary Hsieh
Managing Principal
mhsieh@healthmanagement.com
(404) 834-5028

Susan Tucker
Principal
stucker@healthmanagement.com
(850) 688-6711