Mercer

Government Human Services Consulting

Medi-Cal D-SNP Feasibility Study

State of California
Department of Health Care Services
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Section 1

Executive Summary

The California Advancing and Innovating Medi-Cal (CalAIM) Medi-Cal managed care plan (MCP) Dual Eligible Special Needs Plan (D-SNP) requirement is an important component of the State's overall health care strategy for Dual Eligible enrollees. The opportunity to improve access to, and quality of care across Medicare and Medi-Cal for Dual Eligible enrollees, through better care coordination and benefit coordination, is substantial.

The Department of Health Care Services (DHCS) is collaborating with the Centers for Medicare & Medicaid Services (CMS) as well as MCPs to establish an Exclusively Aligned Enrollment (EAE) D-SNP model to replace the current financial alignment demonstration known as Cal MediConnect. MCPs in the seven Coordinated Care Initiative (CCI) counties are establishing these EAE D-SNPs effective January 1, 2023. MCPs in non-CCI counties will be required to establish EAE D-SNPs no later than contract year 2026.

EAE is a state policy that limits a D-SNP's membership to only individuals with aligned enrollment. All beneficiaries enrolled in an EAE D-SNP are also enrolled in a matching Medi- Cal plan. D-SNPs will only be allowed to enroll members who are in their aligned MCP. EAE D-SNPs are a new type of Medicare Advantage (MA) plan that will begin in California on January 1, 2023, and will provide a similar type of integrated care as Cal MediConnect. In 2023, EAE D-SNPs will be managed by the same health plans that offered Cal MediConnect. These plans will meet integrated D-SNP care coordination requirements, will have integrated member materials, and will have membership limited to dually eligible individuals who are also enrolled in the Medi-Cal managed care plan affiliated with the D-SNP. This aligned enrollment provides more integrated and coordinated care than other D-SNPs, where members may not be in a Medi-Cal plan that aligns with their Medicare plan. When dual eligible beneficiaries choose a Medicare plan that is an EAE D-SNP, they are automatically enrolled in the Medi-Cal plan that aligns with their Medicare plan, so there is one organization coordinating care across both sets of benefits.

The purpose of this study is to examine the feasibility of Medi-Cal MCPs in non-CCI counties to establish and operate EAE D-SNPs. This study gives DHCS information and data considerations for program feasibility and satisfies the requirement within Welfare and Institutions Code (WIC) § 14184.208(c)(5) to conduct a feasibility study, to be completed no later than July 1, 2022, in specific counties as determined by the Department . This will help inform DHCS' review and consideration of individual plan requests for exemption from the requirement to establish a D-SNP, thereby ensuring the Department can make an appropriate decision regarding any D-SNP exemption requests made.

A key starting point in any feasibility study is what is meant by the term "feasible", and in particular the phrase, "financially feasible". Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, adopted the following definitions after consultation with DHCS:

1. Feasible[1]
    A. Capable of being done or carried out.
2. Financially Feasible (short term)
    A. Operating a D-SNP would not be unduly burdensome from a financial perspective.
3. Financially Feasible (long[er] term)
    A. In 3–5 years, D-SNP capitation revenues and claims are projected to achieve bid gain/margin under reasonable assumptions.

Therefore, this Medi-Cal D-SNP Feasibility Study seeks to determine if the Medi-Cal contracted MCPs operating a D-SNP in non-CCI counties will be able to achieve fiscal results consistent with these definitions. On a national level, with the rapid growth in D-SNP health plans and enrollment, as well as strong profitability results, the answers to those questions appears to be a resounding yes. In California, for CCI counties effective January 1, 2023, DHCS and partner health plans are similarly confident that the transition from Cal MediConnect to D-SNP will prove feasible, and financially feasible. But what of the non-CCI counties, and their January 1, 2026 D-SNP effective date? Given that date is three and one-half years in the future, the differing county characteristics, and in several cases differing health plans with more limited or no (recent) experience in the Medicare program, answers to the feasibility questions are naturally less certain. Mercer used both qualitative and quantitative approaches to assist DHCS with prospective evaluations related to financial feasibility for non-CCI health plans/counties.

Fundamental to D-SNP feasibility is health plan financial strength. Generally each of the Medi-Cal health plans are currently in strong financial condition. Other operational and financial challenges and concerns legitimately raised by various stakeholders around D-SNP implementation are not unique to California. With the exception of a health plan having insufficient initial financial strength, Mercer believes through appropriate diligence they typically can all be overcome. However, individual plan concerns on any of these issues should be weighed carefully by DHCS in considering a D-SNP exemption request, if any.

After review and discussion, for a variety of reasons addressed later in the report, the San Francisco and Santa Barbara/San Luis Obispo regions were selected for detailed actuarial modeling. The base scenario results project a positive margin (profit) will be achieved in 2029 for each of the San Francisco and Santa Barbara/San Luis Obispo regions. Similar to other D-SNPs nationwide, the revenue in Year 1 (i.e., 2026) is projected to be insufficient to cover costs which results in a negative profit margin in a bid. Based on a variety of factors (both known and unknown) to be discussed in great detail later in this report, it is reasonable to assume there will be a path towards long-term profitability.

While it was determined to be impractical and unnecessary to actuarially model all non-CCI health plans/regions/counties at this time, there was analysis more broadly across all applicable counties through analysis of enrollment projections, and via the interview and surveys, as mentioned in detail later in the report.

[1] https://www.merriam-webster.com/dictionary/feasible

Mercer believes there is a potential path to feasibility for all regions in California. However, each region and MCP will have unique challenges to overcome as they look to achieve feasibility. We have listed some of the key factors for MCPs to be successful below. In the absence of achieving enough of these factors in a given county/region, feasibility becomes increasingly more challenging.

- D-SNP Membership Growth
- Administrative Cost per D-SNP Member
- Provider Contracting
- Star Rating
- Risk Score Coding Accuracy
- Medical Cost Management

Achieving economies of scale through membership growth, therefore spreading the fixed administrative cost over a larger membership base, is a critical element towards achieving long term feasibility. However, we believe the MCPs in California will have an opportunity to achieve these economies of scale sooner than a non-Medi-Cal affiliated Medicare Advantage start-up due to the MCPs existing Medi-Cal line of business already having a significant number of members.

We recommend DHCS encourage aligned enrollment of dual eligibles into matching MCPs and D-SNPs to promote high-levels of integrated care. DHCS has implemented this in 12 Medi-Cal Matching Plan counties, which includes CCI counties, where the Medi-Cal plan is aligned to the Medicare plan choice, if a matching plan is available. DHCS will expand this policy in counties where EAE D-SNPs will be implemented in the future.

If there are concerns about feasibility, MCPs should work with DHCS to review the specific key factors above and their corresponding feasibility impact for the MCP. This will be reviewed on a case-by-case basis which may result in potential exemption of the D-SNP requirements in specific counties for a time-limited period.

Section 2
Background and Overview

Purpose of Study

The purpose of this study is to examine the feasibility of Medi-Cal MCPs operating D-SNPs in non-CCI counties/regions throughout California.

One position on D-SNP feasibility is that Medi-Cal MCPs should strongly consider the requirement a "price of admission" or "price of continued admission" to participation in Medi-Cal. MCPs should focus on how to make the requirement feasible, rather than focusing upon how they may believe it is not feasible, since the D-SNP requirement's goal should be consistent with the MCP's own mission. Combining this thinking with the facts that nationally the number of D-SNPs has grown very rapidly (almost 48%) over just the last three years, and that nationally the average D-SNP has been quite profitable the last several years, makes a strong case for forward movement of the program requirement at an MCP level.

Another position expresses legitimate concern with regard to MCP start-up costs (among several items of concern), and the fact that even in a best-case scenario it is very likely that D-SNP line of business-specific financial losses will occur during the first one to three years of operation. This position believes there should be the possibility of a MCP exemption, or exemption(s) for some of an MCP's counties.

Both positions have merit, and Mercer does not believe them to be mutually exclusive. Much will happen between now and the January 1, 2026 MCP D-SNP requirement effective date. January 1, 2026 is over three and one-half years away. Experience, lessons learned, and best practices from the January 1, 2023 CCI/Cal-MediConnect MCPs' transition to D-SNP will have taken place. Unforeseen events impacting the many and diverse Medi-Cal stakeholders will also happen during that timeframe.

Unfortunately there is no actuarial formula that can determine if an MCP should pursue D-SNP requirement exemption, or if DHCS should grant any such request. Both are complex decisions requiring many considerations, including individual business circumstances and overall Medi-Cal program goals. But, this study gives DHCS information and data considerations for program feasibility. This information will help inform DHCS' review and consideration of individual plan requests, thereby ensuring the Department can make an informed decision regarding the potential granting of D-SNP exemptions.

The remainder of Section 2 provides further background and overview, with Section 3 delving into the feasibility analysis overview and approach.

CalAIM D-SNP Trailer Bill Language

As part of CalAIM, DHCS is requiring all Medi-Cal managed care health plans in non-CCI counties to offer a D-SNP on or before January 2026. The CalAIM trailer bill language[2] for

[2] For completeness, and any additional desired context, the entire WIC § 14184.208 is found within https://legiscan.com/CA/text/AB133/2021.

D-SNPs, Assembly Bill 133 (Ch. 143, Stats. 2021), implements this authority in WIC § 14184.208. Paragraph (5) of subdivision (c) of this section specifies:

> "The department shall conduct a feasibility study of D-SNPs, in specific non-Coordinated Care Initiative counties as determined by the department, to be completed no later than July 1, 2022. As a result of the study findings, or evidence provided by a Medi-Cal managed care plan of the potential for significant financial losses that may be incurred by a Medi-Cal managed care plan as a result of operating a D-SNP, and evidence provided by a Medi-Cal managed care plan that the plan has made a good faith effort but is not able to develop a partnership with a D-SNP for coordinated care across Medicare and Medi-Cal, the department may provide, in its sole discretion, an exemption from the requirements in paragraph (1) of this subdivision on an individual plan basis for a period of three years. The department may renew this exemption for successive three-year periods based on study findings or evidence of potential losses, and evidence of a good faith effort, as specified in this paragraph."

Mercer Government Selection; Mercer/Oliver Wyman Credentials and Qualifications

DHCS selected Mercer to prepare this feasibility study. Mercer has been a leader in Medicaid consulting since 1985. Mercer has been working with DHCS as an actuarial consultant on the Medi-Cal program for the last 17 years. Understanding that our state partners need a comprehensive view, Mercer has integrated data, clinical, financial management, and policy experts into our team to serve clients in all areas of their programs.

Mercer's sister company and consultant on the study, the Oliver Wyman Actuarial Consulting Practice, is part of Oliver Wyman Group and provides actuarial, financial, operational, and risk management services to a variety of clients including: insurance and financial service companies, health care providers, insurance regulators, governments, trusts, law firms, and corporations that retain risk. With roughly 120 members of the American Academy of Actuaries and roughly 350 total employees, Oliver Wyman Actuarial Consulting, is one of the largest actuarial firms in North America. Oliver Wyman is a leader in the Medicare Advantage (MA) consulting field, including MA, Part-D, and D-SNP bid preparation, review and audits. They have helped plans across the country develop strategy, develop tools and analyze data, and price and design MA products for over 20 years. Their experience and expertise are unique, developed from longstanding work with regulators, both at the state and federal level, as well as with market participants.

Caveats and Limitations

This feasibility study was prepared on behalf of the DHCS, and is intended to be relied upon solely by them. It should be read in its entirety and has been prepared under the direction of Mike Nordstrom, ASA, MAAA, James Lucas, FSA, FCA, MAAA, and Brooks Conway, FSA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standard for issuing the statements of actuarial opinion herein. They are available at Mike.Nordstrom@mercer.com, James.Lucas@oliverwyman.com, and Brooks.Conway@oliverwyman.com, if this audience has questions.

The results of this feasibility study are appropriate in aggregate but may not be appropriate for individual health plans. Specifically, individual health plans will need to take into account

their own circumstances and assumptions when evaluating the feasibility of initiating a D-SNP in the State of California.

To the best of Mercer's and Oliver Wyman's knowledge, there are no conflicts of interest in performing this work. The suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer and Oliver Wyman expressly disclaim responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Who Comprises California's Dual Eligibles?

The DHCS Office of Medicare Innovation and Integration[3] provides valuable facts about Medi-Cal dual eligibles: 1) There are approximately 1.6 million beneficiaries dually eligible for Medicare and Medi-Cal, and 2) Among dually eligible beneficiaries in California, approximately 25 percent are under age 65. The 1.6 million figure represents all dual eligibles, including those with full Medicare benefits, and those with partial Medicare benefits. The figure is also positively impacted somewhat by the Public Health Emergency and federal requirements related to Medicaid redetermination.

DHCS' 2023 exclusively aligned enrollment policy for D-SNPs limits enrollment in the D-SNP to only Medicare full-benefit (i.e., eligible for both Medicare Part A and Part B) dually eligible individuals.

DHCS has made a chartbook, Profile of the California Medicare Population[4], publicly available on their web-site. This work by ATI Advisory contains substantial summarized information regarding California Dual Eligible demographic data, including by geography (rural, suburban, and urban), race/ethnicity, age, and Medicare Advantage penetration rate. Geography and Medicare Advantage penetration rate play a particularly important role within this feasibility analysis. Among a multitude of interesting data and information, Mercer and Oliver Wyman calls attention to a page 21 table (replicated below):

Medicare Advantage Penetration Rate by Geography and Dual Eligibility Status

Dual Eligibility	Rural	Suburban	Urban	Statewide	Nationwide
Full Dual	1.8%	13.2%	44.3%	42.7%	52.7%
Medicare-Only	6.4%	16.6%	51.3%	49.5%	41.4%

(See page 24 for Methods: Urban, Suburban, and Rural Classification of Californian Counties)

The table shows significantly lower Medicare Advantage enrollment in Rural and Suburban counties, and aligns with the concerns expressed by health plans regarding D-SNP

[3] https://www.dhcs.ca.gov/services/Pages/OMII.aspx
[4] https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-18-2022.pdf

successful implementation in those areas. This issue is further discussed and addressed later in the study.

What are D-SNPs?

Background, Types, Significant Growth, Medicare Payment Structure

As part of its extensive stakeholder communication around CalAIM, DHCS has provided a plethora of straightforward written material, including concise definitions of common terminology.

> "Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage (MA) health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid). D-SNPs must have a State Medicaid Agency Contract (SMAC) with the Department of Health Care Services (DHCS) and DHCS can choose whether to contract with D-SNPs. The Bipartisan Budget Act (BBA) of 2018 permanently authorized D-SNPs, modified integration requirements, and established unified grievances and appeals procedures."[5]

The Federal Medicaid and CHIP Payment and Access Commission (MACPAC) adds some history with, "Originally authorized as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), D-SNPs began operating in 2006. Legal authority was extended several times and made permanent…. As of February 2022, D-SNPs were operating in 45 states and the District of Columbia." [6]

CMS indicates there are five categories[7] of D-SNPs, according to the types of beneficiaries that can enroll:

- All-Dual D-SNPs
- Full-Benefit D-SNPs
- Medicare Zero Cost Sharing
- Dual Eligible Subset
- Dual Eligible Subset — Medicare Zero Cost Sharing

From a health plan perspective there are three types of D-SNPs[8]:

1. D-SNP that is not a Highly Integrated Dual Eligible (HIDE) or Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP)
2. HIDE SNP

[5] https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Eligible-Special-Needs-Plans-in-CA.aspx

[6] https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/

[7] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Special-Need-Plans-SNP-Frequently-Asked-Questions-FAQ.pdf

[8] https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf

3. FIDE SNP

Both from a number of plans and total member enrollment perspective, D-SNPs have seen significant recent growth, with enrollment increasing even more quickly than the number of plans, therefore increasing average plan size[9]. In 2017 D-SNP enrollment nationwide was approximately two million individuals. In May, 2022 that has grown to 4.28 million D-SNP enrolled individuals, an annualized growth rate of over 16%. That growth has accelerated of late, almost 19% annualized from May, 2019, and almost 22% from May, 2021.

D-SNP Medicare payments[10]: "Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA plans. CMS makes advance monthly payments, or capitated payments, to an MA organization for each enrollee for coverage of original Medicare benefits in an MA payment area." These capitated payments are subject to CMS' proprietary HCC and RxHCC risk adjustment models that adjusts payments based on each MA Plan's member acuity. In addition, MA plans can earn a "bonus" payment if they achieve at least a 4-star (out of 5 possible) rating in the measurement year.

National D-SNP Profitability 2016–2020

Although financial results vary by individual D-SNP, on a nation-wide basis aggregate profitability experience over each of the last five years has typically been very positive. This data and information is well summarized in the annual (March) Medicare Payment Advisory Commission (MedPAC) reports; see https://www.medpac.gov/ and March, 2022 https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf

The following are some observations from those reports:

- "In **2020**, all categories of SNPs had overall positive margins. Dual eligible SNPs (D–SNPs), for beneficiaries dually eligible for Medicare and Medicaid benefits, had margins of 10.7 percent. …. The 2020 profit margin among nonprofit D–SNPs was 6.4 percent."
- "All categories of SNPs had positive margins in **2019**. Dual eligible SNPs (D–SNPs), for Medicare–Medicaid dual eligible beneficiaries, had margins of 7.8 percent … The 2019 profit margin among nonprofit D–SNPs was 2.5 percent."
- "All categories of SNPs had positive margins in **2018**. Dual eligible SNPs (D–SNPs), for Medicare–Medicaid dual eligible beneficiaries, had margins of 6.6 percent ... The 2018 profit margin among nonprofit D–SNPs was 3.0 percent."
- "All categories of SNPs had positive margins in **2017**: Dual eligible SNPs (D–SNPs) for Medicare–Medicaid dual eligible beneficiaries had an average margin of 7.4 percent (compared with 5.9 percent in 2016) … For **2016**, we reported that nonprofit D–SNPs had a margin of −2.3 percent. The comparable figure for 2017 was a margin of –1.5 percent, but that amount includes results for the outlier sponsor … with high negative margins.

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

[10] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Special-Need-Plans-SNP-Frequently-Asked-Questions-FAQ.pdf

Removing that sponsor, the 2017 profit margin among nonprofit D–SNPs was positive at 1.1 percent.

Therefore, considerable financial opportunity appears to be available for D-SNPs dedicated to serving this very vulnerable population group.

D-SNPs in California

Current Plans and Enrollment Growth

Over the last four years (month of May comparative figures[11]), California has represented 4–5% of National D-SNP enrollment. On first glance, this small, and decreasing (May, 2022 approximately 4.1%) range may be surprising given the State's focus on health care and managed care approaches. But of course these figures are prior to the CCI/Cal-MediConnect January 1, 2023 transition to D-SNPs in the seven counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. And clearly also prior to the State's non-CCI counties January 1, 2026 transition.

California D-SNPs do have a significant base, which will build dramatically beginning in 2023. The referenced CMS "Special Needs Plan Comprehensive Report" from May, 2022, with data from the CMS Health Plan Management System, provides considerable detail. From the report Mercer and Oliver Wyman sees:

California D-SNPs include total enrollment of 176,959 as of May, 2022. Several plans in California operate D-SNP plans in counties with enrollment only in the hundreds of members. However, smaller counties are grouped together for D-SNP purposes, allowing for a greater membership base.

The four largest current D-SNPs are:

1. Kaiser; multiple counties statewide; 76,014 enrollees
2. Anthem; multiple counties statewide; 36,223 enrollees
3. SCAN; Los Angeles, Riverside, San Bernardino counties; 14,749 enrollees
4. Humana; select counties; 13,013 enrollees

SCAN is the only California FIDE-SNP listed.

California D-SNPs have experienced significant growth of late, May of 2022 shows D-SNP enrollment in the State having increased at an almost 11% annualized rate from May, 2019, and over 21% from May of 2021.

Medi-Cal Managed Care 20-10029 RFP

Further evidence of the importance DHCS has placed on its CalAIM D-SNP requirement is reflected in the Medi-Cal Managed Care Plans Request for Proposal (RFP) 20-10029

[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data

(https://caleprocure.ca.gov/event/4260/20-10029). This RFP is being used to procure commercial health plans in the applicable managed care model types.

The tenth item under the RFP Qualification Requirements is as follows:

> "10. Dual Special Needs Plan (D-SNP)
>
> For each county/service area the proposer submits a proposal for evaluation, the proposer must submit the following in the Appendix section of the proposal:
>
> a. Proof that a D-SNP is currently available to dual eligible members, or
>
> b. If D-SNP is not currently available to dual eligible members,
>
> 1) And proposal is for one of the following Coordinated Care Initiative counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties, proposer must submit attestation that proposer will receive Centers for Medicare & Medicaid approval of the D-SNP for January 1, 2023 effective date.
>
> 2) And proposal is for any of the other counties, proposer must submit attestation that proposer will receive Centers for Medicare & Medicaid approval of the D-SNP for January 1, 2026 effective date."
>
> This language included in the RFP clearly identifies the requirement and expectation that health plans will have to offer a D-SNP in any and all counties in which they propose to contract with the Department to provide Medi-Cal managed care services. Even though they are not responding to the RFP, the same requirement and expectation exists for Local Initiative and County Organized Health System plans.

Medicare Advantage, Other Competitors in California

Designed to better integrate and coordinate member care, with significant beneficiary protections, *exclusively aligned enrollment* D-SNPs, which is what the MCPs in non-CCI counties will be establishing, should be well-positioned to compete in the ever-evolving healthcare marketplace. 2023 will see significant change in that marketplace, and so predictions around competition for D-SNPs in 2026, with its own significant changes, are subject to considerable uncertainty. Nonetheless, it is possible that a D-SNP in a particular county may face varying levels of competition from:

1. Other D-SNPs, including those already established with existing enrollment in a given county prior to the launch of the EAE D-SNP by the MCP
2. Regular (non-D-SNP) Medicare Advantage plans
3. Medicare Accountable Care Organizations
4. Medicare fee-for-service (FFS)
5. Program of All-Inclusive Care for the Elderly organizations
6. Institutional Special Needs Plans
7. Chronic Condition Special Needs Plans

How a EAE D-SNP prepares for and reacts to competition will be crucial to their operational and financial success. While a deep-dive on this topic is outside the scope of this study, Mathematica (https://www.mathematica.org/) provides a detailed and readable report regarding, "Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans[12]". The authors indicate, "… beneficiaries' decisions to stay or leave these plans are influenced by (1) Medicare quality ratings; (2) level of Medicaid integration; (3) other state Medicaid policies and programs; (4) local market competitive forces; or (5) other reasons, such as provider networks, cost sharing, and supplemental benefits. Because it is a diverse group, it is also important to understand how these factors affect dually eligible beneficiaries with different characteristics, including age, chronic health conditions, disability, need for LTSS, and full- versus partial-benefit dual status."

The Mathematica report also discussed *attraction* of new enrollees to a D-SNP, pointing out that many of the same retention of membership influences cited above are those that would initially attract membership to the D-SNP.

[12] https://www.mathematica.org/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans

Section 3
Analysis Overview and Approach

Overview of Feasibility Study

As mentioned in the Executive Summary section, in consultation with DHCS, Mercer and Oliver Wyman adopted the following definitions for our work in this report:

1. Feasible[13]
    A. Capable of being done or carried out.
2. Financially Feasible (short term)
    A. Operating a D-SNP would not be unduly burdensome from a financial perspective.
3. Financially Feasible (long[er] term)
    A. In 3–5 years, D-SNP capitation revenues and claims are projected to achieve bid gain/margin under reasonable assumptions.

In order to assess feasibility, Mercer and Oliver Wyman did the following:

- Developed enrollment projections for Dual eligible membership classification
- Performed a review of literature and information, including material from the Department of Managed Health Care and multiple industry comments/analyses on feasibility.
- Mercer and Oliver Wyman reviewed D-SNPs in several other select states.
- Performed targeted MCP interviews and surveyed other applicable MCPs.
- Summarized findings, including factors that contribute to feasibility and conversely the biggest hurdles to feasibility.
- Developed multi-year financial projections of membership, revenue, expenses, and profitability for San Francisco and Santa Barbara/San Luis Obispo counties/regions, along with multiple varying scenarios for each.

It was determined to be impractical and unnecessary to actuarially model out all non-CCI health plans/regions/counties. There was, however, analysis more broadly across all applicable counties through analysis of enrollment projections and via the interview and surveys, as mentioned above. San Francisco and Santa Barbara/San Luis Obispo counties/regions were selected for more detailed modeling and analysis based on the current D-SNP/Medicare Advantage penetration, competitive market landscape, and feedback from various stakeholders. These counties/regions were thought to potentially have more significant feasibility challenges. While sharing that consideration, the two regions are also

[13] https://www.merriam-webster.com/dictionary/feasible

very different. For example, San Francisco County[14] has over 18,600 people per square mile, while Santa Barbara and San Luis Obispo average 163 and 86 respectively. The age 65 and over poverty rate for San Francisco County is more than double the others, 14% versus 7% and 6%. San Francisco County has a total of nine D-SNP options currently. Santa Barbara has only one D-SNP currently and San Luis Obispo has just two.

In Section 4 Mercer and Oliver Wyman provide Findings and Recommendations, including a list of factors that support feasibility for a given health plan/region/county combination.

Dual Eligible Membership Classification and Enrollment Projections

To project potential dual eligible enrollment Mercer reviewed the most current Medi-Cal actual enrollment data available for all full-dual members in non-CCI counties by month, from January 2017 through August 2021. Full-dual members were defined as anyone with both Medicare Part A and Part B, consistent with the Medi-Cal members that are D-SNP eligible.

Mercer used the Managed Care Plan County Model Change Update memorandum provided by DHCS to account for future changes to the Medi-Cal managed care landscape prior to CY 2026 (see: https://www.dhcs.ca.gov/services/Documents/MMCD/Managed-Care-Plan-County-Plan-Model-Change-Update-12-07-2021.pdf). Additional changes were assumed based on DHCS' proposal to directly contract with Kaiser in additional counties (https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/DHCS-Kaiser-Direct-Contract-Memo-MR-Update.pdf) but no changes in MCP coverage were assumed associated with the RFP as the results are not known at this time. The reviewed eligibility was re-classified from the current view of managed care enrollment into future rating regions, consistent with CalAIM initiatives. Dual eligible FFS members were also accounted for within each county, and were allocated to health plans based on the existing membership distribution in that county. The inclusion of FFS members is consistent with the future landscape as dual eligible members will be mandatorily enrolled in Medi-Cal managed care in all counties starting January 1, 2023 (see: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf).

For enrollment projections beyond the month of August 2021, Mercer developed assumptions in the following four distinct phases (further detail provided below); prior to an assumed COVID-19 Public Health Emergency (PHE) end date, a redetermination ramp-down after the PHE, a phase after redeterminations have been completed, and a final phase to project enrollment beyond 2026.

1. A monthly growth factor of 0.25% was used to project enrollment beginning in September 2021. This growth factor was used through an assumed end date of the PHE (December 2022) for purposes of this study, including one additional month (January 2023) to account for lag. The 0.25% growth factor was determined after reviewing the average monthly growth observed during the PHE for full-dual members, and was adjusted slightly downwards to account for some leveling off towards the end of the PHE.

[14] https://censusreporter.org/

2. Once the PHE ends, members that could not previously be dis-enrolled due to redetermination would now be eligible for disenrollment. This redetermination ramp-down process is expected to happen over the course of 14 months. Mercer assumed that 35% of the membership increase during the PHE would be retained after the 14 month disenrollment. For February 2023 through March 2024, a downward linear trend was applied to reach the pre-PHE membership level (March 2020), plus 35% of the membership gained during the PHE. This assumption of a 35% PHE retention rate was partially set based on where the full-dual membership level would be at the same point in time assuming the PHE had not happened, with an additional increase due to economic factors related to the PHE.
3. Mercer then projected 0.05% monthly growth from April 2024 through the end of 2026. This assumption of 0.05% is relatively consistent with the full-dual membership growth that occurred prior to the PHE.
4. For enrollment in years beyond 2026, projections were developed using the assumptions mentioned below in the *Assumptions and Methodology* section.

Mercer developed an additional enrollment component to estimate the number of 'age-in' full-dual eligible members each health plan would get from their current Medi-Cal only populations, if state and federal policy permits auto-enrollment of these members. These are the members that are age 64 and currently enrolled in Medi-Cal managed care, who will become eligible for Medicare within the next year as they turn 65. Prior to Medicare eligibility they would be primarily grouped under the Adult, ACA Optional Expansion, or Seniors and Persons with Disabilities rating groups within each health plans' current enrollment. As a starting point, Mercer utilized health plan reported age-demographic CY 2019 enrollment information for these three category of aid groups, in particular the 55–64 (inclusive) age group. Mercer then adjusted this 10-year age band down to the age 64 group based on mortality assumptions from the Society of Actuaries, with slight modifications made to better match the population of interest, and then calculated average monthly membership (see: https://www.soa.org/globalassets/assets/files/resources/research-report/2021/population-mortality-observations.pdf).

From there, it was assumed that members would become age 65 in a linear progression over the next 12 months (i.e., one-twelfth of the members in January, etc.), which yielded an annual estimate of age-in full-dual members from these prior non-full-dual risk groups. This CY 2019 experience-based information was then trended forward to the CY 2026 time period consistent with all other modeled full-dual enrollment growth over this time period.

The following table displays the 2026 member month results from the projection methodology described above, with a column for both the age-in members as well as total full-dual enrollment by rating region and health plan (note that age-in member months are a subset of the total). The table shows that each and every county/region has a significant future full-dual eligible membership base.

CY 2026 Full-Dual Member Month Projections			
Rating Region/Counties	**Future Direct Medi-Cal HPs**	**Age-ins**	**Full-Duals**
Alameda		**20,030**	**631,057**
	Alameda Alliance for Health	18,582	600,236
	Kaiser Foundation HP	1,448	30,821
Contra Costa		**11,269**	**341,595**
	Contra Costa HP	10,070	314,922
	Kaiser Foundation HP	1,199	26,673
Fresno/Kings/Madera		**20,903**	**572,763**
	CalViva Health	14,598	413,406
	Anthem Blue Cross	6,305	159,357
Kern		**14,116**	**381,447**
	Kern Health Systems	10,251	280,273
	Health Net of California	3,621	97,391
	Kaiser Foundation HP	244	3,783
San Francisco		**13,677**	**540,698**
	San Francisco Health Plan	11,340	457,223
	Anthem Blue Cross	1,688	68,923
	Kaiser Foundation HP	649	14,552
San Joaquin/Stanislaus/Alpine/El Dorado		**21,484**	**599,542**
	HP of San Joaquin	16,589	491,604
	Health Net of California	4,463	104,554
	Kaiser Foundation HP	432	3,384
Tulare		**7,955**	**249,782**
	Anthem Blue Cross	3,370	115,150
	Health Net of California	4,585	134,632
Sacramento		**22,372**	**665,345**
	Anthem Blue Cross	9,255	215,151
	Health Net of California	6,151	132,120
	Kaiser Foundation HP	3,154	235,813
	Molina Healthcare	3,427	74,443
	Aetna Better Health	385	7,818
Imperial		**4,332**	**165,528**
	CA Health & Wellness	4,332	165,528
Santa Barbara/San Luis Obispo		**7,483**	**229,049**
	CenCal Health	7,483	229,049
Ventura		**8,703**	**278,484**
	Gold Coast HP	8,426	278,472
	Kaiser Foundation HP	277	12
Monterey/Santa Cruz/Merced/San Benito/Mariposa		**13,265**	**426,117**
	Central California Alliance	13,265	426,117
Partnership HP Counties		**41,463**	**1,333,403**
	Partnership HP of CA	39,183	1,262,561
	Kaiser Foundation HP	2,280	70,842
Rural GMC Counties		**2,041**	**67,270**
	Anthem Blue Cross	1,066	32,792
	CA Health & Wellness	974	33,011
	Kaiser Foundation HP	1	1,467

The above projections recognize Kaiser's current direct contractor relationships and their expansion in the 22 counties where Kaiser currently participates as a global subcontractor, but not the additional 10 counties where Kaiser has another line of business and would open to Medi-Cal enrollment: Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, and Yuba.

Literature/Information Gathering and Review

Department of Managed Health Care

Given their significant role and responsibilities within California health care, Mercer and Oliver Wyman reached out, through DHCS, to the Department of Managed Health Care (DMHC) with regard to any DMHC preliminary thoughts around CalAIM's D-SNP requirement and associated health plan financial feasibility.

The DMHC[15] is a regulator of full-service and specialized health plans, including most Medi-Cal managed care plans, as well as for Medicare Advantage health plans (financial solvency only). DMHC's key functions include licensing of health plans and ensuring compliance with State laws, performing financial examinations to ensure financial stability, and taking enforcement action against plans that violate the law.

One of the financial metrics DMHC monitors very closely is Tangible Net Equity (TNE) [16]. At a high level TNE is a health plan's total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of the normal course of business.

- The required TNE for a full service plan is the greater of one million dollars or a percentage of premium revenues or a percentage of healthcare expenses.
- The Department's minimum requirement for TNE reserves is 100% of required TNE. If a health plan's TNE falls below 130%, then the health plan must file monthly financial statements with the Department. If a health plan reports a TNE deficiency (TNE below 100%), then the Department may take enforcement action against the plan.[17]

For the formal requirement, definitions, and percentages of TNE, please see § 1300.76 of the Knox-Keene Health Care Service Plan Act and Regulations at https://www.dmhc.ca.gov/Portals/0/Docs/OLS/2021%20Knox-Keene%20Act%20and%20Title%2028.pdf?ver=2021-02-11-164918-577.

A review of the current TNE status for Medi-Cal MCPs shows that for the vast majority they are *multiple times* above the 130% and 100% minimums described above. This means that the Medi-Cal MCPs are generally in strong financial condition.

[15] https://www.dmhc.ca.gov/Portals/0/Docs/DO/SFPublicMeeting/SB546and17PowerPoint2022.pdf

[16] https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/p7061516.pdf

[17] https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20November%202021/AgendaItem6_FinancialSummaryofMediCalManagedCarePlansReport.pdf?ver=2021-11-16-101955-550

DMHC often splits Medi-Cal MCPs into Local Initiative (LI), County Organized Health System (COHS), and Non-Governmental Medi-Cal (NGM):

- LIs December 31, 2021 TNE: Lowest — Kern Health Systems at 491%; Highest — Health Plan of San Joaquin at 789%
- COHS December 31, 2021 TNE: Lowest — CenCal Health at 465%; Highest — CalOptima at 1,279%. (Gold Coast is the only Medi-Cal health plan not yet Knox-Keene licensed. Gold Coast will need to be Knox-Keene licensed in order to operate a Medicare D-SNP).
- NGM December 31, 2021 TNE: Lowest — California Health and Wellness (CH&W) at 177%; Highest — Blue Shield Promise Health at 834%. (Note: Kaiser, while not meeting DMHC's definition of an NGM, is at 2,012%). Also, note that CH&W is part of Centene, a Fortune 25 company https://www.centene.com/, family of companies.)

Mercer and DHCS met with DMHC on February 11, 2022. DMHC confirmed it will require Gold Coast to obtain Knox-Keene licensure to offer a D-SNP product due to CMS requirements. Furthermore, other Medi-Cal health plans would need to apply for a "material modification" in order to add the D-SNP line of business. At this point in time, DMHC does not have any initial specific issues or concerns with the DHCS D-SNP requirement. They had already received one modification request, and had turned it around quickly.

The January 1, 2023 date for CCI county MCPs to implement the D-SNP requirement is relatively soon, and it appears to essentially be a DMHC non-event for those plans that already have DMHC Knox-Keene licensure. January 1, 2026 for non-CCI county MCPs is of course considerably further away. Although the current TNE status of Medi-Cal MCPs is very strong, the TNE status of Medi-Cal contracted managed care plans will need to be considered on a case-by-case basis at the applicable future point in time.

Industry Comments/Analyses on Feasibility

After extensive planning, DHCS' CalAIM proposal, including D-SNP concepts, was formally introduced on October 29, 2019. The D-SNP policy proposal portion was revised in February of 2020. The final CalAIM proposal was completed in January of 2021. This brief timeline provides a reminder that DHCS' goal of a comprehensive D-SNP program to benefit Medi-Cal dual eligible beneficiaries has been open for comment in the public domain for quite some time.

One of the initial steps undertaken by Mercer, working with DHCS, was to gather as much of this relevant comment material from DHCS as was available, from as wide a variety of stake holders as possible. This included significant contributions from sources such as a September, 2021 comprehensive draft report on MCP needs assessment from The SCAN Foundation/Chapman Consulting (https://www.chapmanconsult.com/). The Local Health Plans of California (LHPC [https://www.lhpc.org/]) provided written comments to DHCS in June of 2021. Several different plans' draft feasibility actuarial analyses, with differing levels of detail around considerations and assumptions, were also available for review.

The SCAN Foundation/Chapman Consulting report interviewed 20 MCPs and focused primarily on operational challenges and concerns. There was relatively less emphasis on financial feasibility, although the topic clearly was not excluded within the report. Of course operational challenges and concerns also have financial implications. The report segmented

MCPs into three groups: 1) those that are National health plans, 2) those currently part of the CCI program, and 3) those with no recent Medicare experience. The report provided priority rankings on 17 topic areas for each of the three groups, and in total. Not surprisingly there was both uniformity and variation in the priority rankings provided by the three groups. The LHPC comments, in contrast, focused more on financial feasibility, and relatively less on operational challenges and concerns, although similarly, not to the exclusion of the latter. LHPC bulleted many considerations underlying an actuarial analysis. LHPC also provided suggestions for the State's feasibility study.

Several of the actuarial analyses were reviewed by Mercer. They provided varying levels of detail, but were uniformly thoughtful and professional. As the CMS Medicare Advantage (and D-SNP) Bid Pricing Tool Instructions, Worksheets, and process are standardized, it is not surprising that the analyses reviewed were logical. Actuarial judgement around assumptions and factors plays a large role in projecting results, particularly relatively far into the future such as for 2026 and beyond. Not surprisingly, in aggregate Mercer found the plan assumptions conservative, producing break-even or financial gain results at later time periods. Actuarial assumptions will clearly vary. One assumption, the Star rating (and therefore bonus amount) is of particular interest. In a couple of the plan analyses a 2029 and later years Star ratings of 3.5 were assumed. This rating provides for a 0% revenue bonus. Mercer has assumed a 4.0 Star rating for the corresponding time periods, therefore generating a 5% revenue bonus. Mercer believes a 3.5 rating to be particularly conservative. For example, the actuarial consulting firm Milliman, in a paper, indicates, "The average star rating for D-SNPs increased, with over 70% of D-SNPs achieving a 4-star rating or higher[18]." DHCS has strong expectations of the D-SNPs providing a high level of quality care for their Medi-Cal members.

Intro to D-SNPs in Select Other States

In an effort to better understand the D-SNP landscape in other Medicaid programs, Mercer researched and reviewed publically available data for the following select group of states; Arizona, Massachusetts, New Mexico, New Jersey, and Virginia. The gathered information showed no strong evidence for major profitability concerns with implementing D-SNPs. The structure and design of the D-SNP initiative in California is not exactly equal to those in other states. Though these other state designs may differ, their experience offers insights into how to maximize exclusively aligned D-SNP enrollment, thereby improving the feasibility of operating a D-SNP. The following are brief notes about some of the more impactful research results in terms of D-SNP feasibility, primarily focused on D-SNP enrollment, with further information on these other state D-SNP programs provided in the appendix of this report.

- D-SNP enrollment in Virginia and New Mexico (where D-SNPs are relatively new) revealed membership for local initiative plans was shown to increase in aggregate from July 2020 to January 2022 in step with non-local initiative plans. This shows the local initiative (i.e., non-national) plans were able to compete adequately for D-SNP membership/enrollment. In Arizona, a more established D-SNP required state, the local health plans have been able to attract and retain an adequate D-SNP membership base to achieve profitability.

[18] https://us.milliman.com/en/insight/key-insights-into-2022-medicare-advantage-d-snp-landscape#:~:text=In%202022%2C%20the%20average%20star,observed%20in%20general%20enrollment%20plans.

- The Office of the Assistant Secretary for Planning and Evaluation (ASPE) reported the following regarding ways to achieve economies of scale with D-SNPs (see https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0#exhibit6):
  - "Several of the states with the highest DSNP enrollment--Arizona, Massachusetts, Minnesota, Pennsylvania, Tennessee, and Texas--have or plan to launch MLTSS programs, and their MIPPA contracts require that DSNPs offer a companion MLTSS plan or that MLTSS plans offer a companion DSNP… In our case study interviews, DSNPs repeatedly told us that, for their MA (Medicare Advantage) organization corporate parents, the most desirable markets were in states where they had the opportunity to operate Medicaid acute care, Medicaid MLTSS contracts, general MA and DSNP contracts. These multiple contracts may allow these organizations to realize economies of scope regarding their information systems, care manager training, or other administrative functions. It may also allow them to be more responsive to changes in a state's insurance landscape."
- The following initiatives have helped promote D-SNP enrollment in Arizona:
  - Arizona recently made changes to their marketing directives to facilitate the health plans to promote/engage in education opportunities with their beneficiaries about the benefits of integrated programs. This allowed flexibility in outreach ability greatly helped increase enrollment in aligned D-SNPs.
  - Arizona now allows D-SNPs to tailor marketing efforts toward their own Medicaid plan, discourages plans from enrolling other health plans' Medicaid members in their D-SNP, and increased the number of dual eligible members enrolled in aligned D-SNPs.
- Tennessee and Arizona pioneered a 'seamless conversion' process, with CMS approval, that allows D-SNPs to automatically enroll Medicaid beneficiaries newly eligible for Medicare into their D-SNP if the member is already enrolled in the plan for Medicaid. Both states reported that seamless conversion has increased enrollment by several hundred beneficiaries a month for aligned plans.

Targeted MCP Interviews and Plan Surveys

After review and consideration of available industry comments and analyses on D-SNP feasibility, Mercer and DHCS engaged in dialogue with several individual MCPs.

Mercer and DHCS approached this portion of the information and data gathering goal via two methods: 1) Individual plan interviews of a select number of MCPs, and 2) Brief surveys e-mailed to the remaining applicable MCPs.

It was determined that individual plan interviews of all MCPs was not practical or necessary. Hence, plan selection criteria were developed to obtain varying viewpoints. Mercer targeted:

- MCPs operating in non-CCI COHS counties
- Two Local Initiative MCPs operating in non-CCI counties
- One MCP considered a national or large commercial plan

To help determine which MCPs to engage for the virtual individual interviews, DHCS solicited the recommendations of the California Association of Health Plans (CAHP) and the Local Health Plans of California (LHPC). The associations nominated the majority of the following plans.

MCPs Interviewed	
Central California Alliance for Health	San Francisco Health Plan
Health Plan of San Joaquin	Partnership Health Plan of California
Health Net Community Solutions	

In interviews, which took place between the end of March, 2022 and April, 2022, DHCS, health plan executives, and Mercer engaged in an open dialogue around questions (supplied in advance) referenced below in Figure 1A.

Figure 1A: MCP Interview Questions

1. How are you assessing the capabilities needed to offer a D-SNP in California (e.g., provider network, claims adjudication, care management, etc.)?
    A. Do you have financial concerns about establishing a D-SNP? If so, what are the most significant financial challenges you see to establishing a D-SNP?
2. Has your MCP started/completed your own D-SNP financial feasibility study with a multi-year plan and projections? If so, what were the outcomes/results? If not, why not?
    A. What are your estimates/(is your understanding) of minimum enrollment levels needed for D-SNP financial feasibility, by year (Year 1, Year 2, etc.)?
3. Does your MCP offer any type of Medicare Advantage product (i.e., Regular MA plan, D-SNP, I-SNP, or FIDE SNP) in any state today?
    A. If so, where?
    B. What are your unique financial concerns about operating a Medicare Advantage product in California versus other states?
4. Are there any policy or financial clarifications needed from CMS or DHCS to help determine the financial impact of establishing a D-SNP? If so, please list.
5. What recommendations, from a policy perspective, does your organization have for DHCS in order to make the D-SNP requirement most feasible?

Below are some high-level takeaways from the verbal responses and follow-up written responses received from the interviewed health plans.

- There were references to the D-SNP requirement being consistent with a plan's Mission. "Not whether it's feasible, but how to make it feasible."
- Most plans interviewed were not planning to begin implementation before the January 1, 2026 requirement, given ongoing efforts on other critical priorities in a rapidly changing Medi-Cal and health care landscape.

- All MCPs were working to finalize an individual financial feasibility analysis/study, or to update a previous version.
- Those studies had projected financial losses in early years of D-SNP operations.
- Some plans requested start-up cost funding and/or some type of risk mitigation such as a risk corridor for the early years.
- All plans expressed a desire for default enrollment (and passive enrollment if at all possible).
- Plans noted that their offering of Medi-Cal Community Supports benefits should help attract members.
- Plans all noted that provider network adequacy and payment levels are important factors in expanding to the D-SNP line of business.
- Some plans mentioned that geographic make-up (Metro, Rural, etc.) is a big driver in network needs. They noted significant county variation in access and Medicare payment levels.
- One plan expressed concern due to their significant use of provider subcapitation arrangements. Specifically, their concern was related to the sufficiency of encounter data submission by providers to recognize the full and proper risk of their membership for Medicare risk adjustment.
- Some plans mentioned having to commit to higher staffing levels in their compliance areas to meet Medicare requirements.
- Plans also mentioned needing State policy (such as required supplemental benefits) well in advance of their D-SNP bid preparation timeframe.

The following health plans participated in the email survey (Figure 1B) sent April 7, 2022. The MCPs were very responsive, returning individual answers within 5–10 days. Of note, over half the below MCPs currently participate in the CCI program, and therefore will be implementing D-SNPs in those counties effective January 1, 2023.

MCPs Surveyed	
Aetna	Community Health Group
Alameda Alliance for Health	Contra Costa Health Plan
Anthem Blue Cross	Gold Coast Health Plan
Blue Shield of California	Kaiser Foundation Health Plan
CenCal Health	Kern Family Health System
Molina Healthcare	

Figure 1B: MCP Survey Questions

1. What is your current status and planning with respect to establishing a D-SNP product in your county(ies) no later than January 1, 2026?

A. In the counties where you do not already have a D-SNP, in which year do you intend to establish a D-SNP, by year? Please respond by county and by year — for example: in 2023 county a; in 2024 counties b and c; in 2026 counties d, e, and f.

B. Has your plan completed a D-SNP financial feasibility study with a multi-year plan and projections? If so, what were the key results? If you have not completed a study, do you plan to in the future, or if not, why not?

2. What does your organization see as the biggest factors that will contribute to the financial feasibility of a D-SNP in your county(ies)? For example enrollment issues, provider network/rates, Medicare star rating, others. Which are most challenging to be overcome to successfully launch and operate a D-SNP in your county(ies)? Do these hurdles differ by county, and between the counties you operate in today versus counties you may be proposing to expand into?

3. OPTIONAL: Specifically, what has your organization done to date to move toward this **requirement**? Please list out key major activities.

4. OPTIONAL: What, if any, suggestions does your organization have for DHCS in terms of actions, approaches, policies that may assist in creating an environment conducive to the successful launch and operation of a D-SNP by your organization?

Several of the MCP survey responses mirrored those comments provided during the separate MCP interviews (above), or concurred with the opportunities and challenges referenced as examples within the survey questions. In general:

- There was consideration of D-SNP implementation prior to January 1, 2026. Some of this was due to already being part of a CCI county, and some due to the DHCS MCP procurement process. Others looked to determine course of action and timeframes after completion of their feasibility assessment.
- The commercial MCPs already have D-SNPs in California and/or nationally, and therefore are much more familiar with the program. Non-commercial local initiatives not in CCI counties are targeting to complete their own individual feasibility study/analysis within the next year to inform next steps.
- Approximately half the MCPs responded to each of the optional questions. Answers referenced their internal feasibility assessment/study status as well as in some cases already being (or in 2023 becoming) a current D-SNP within the State.
- Operational concerns around provider training, along with the potential use of enrollment brokers, were raised.

The MCP interviews, and separate survey responses, provided valuable additional insight into the current thinking of the Medi-Cal health plans on the upcoming D-SNP requirement. DHCS and Mercer greatly appreciate their willingness to engage in open and honest conversation as the State and health plans look to appropriately move this initiative forward.

Summary of Findings

As witness from the above sections, Mercer has performed a multi-pronged approach in pursuit of the Feasibility Study's purpose. Mercer has reviewed and analyzed available literature, information, and data, including related industry and health plan comments and

feasibility analyses. In addition, we engaged more directly with the current applicable Medi-Cal health plans through interview and survey communications. Fundamental to D-SNP feasibility is health plan financial strength. There are of course many measures of financial strength. Mercer has looked to DMHC and their percentage of TNE calculation. As previously discussed, generally each of the Medi-Cal health plans are currently in strong financial condition.

Although there are many additional considerations, some of the primary factors that can contribute to the feasibility of a successful Medi-Cal D-SNP line of business include the following:

- Strong initial and ongoing DMHC percentage of TNE, reflecting financial strength
- The ability to maximize the attraction and retention of D-SNP membership via:
  - Currently enrolled Medi-Cal managed care members who age into Medicare
  - Attraction of Medi-Cal Duals who are currently enrolled with a competing Medicare risk-based managed care plan
  - Attraction of Medi-Cal Duals who are currently enrolled in Medicare FFS
  - This enrollment maximization would be accomplished through:

    Concentrated marketing by the D-SNP around care access, benefits and Community Support, and quality as well as the potential use of enrollment brokers/agents.

    Efforts by DHCS to facilitate aligned enrollment (e.g., default enrollment for Medi-Cal only beneficiaries aging into Medi-Cal and auto-assignment algorithms to align Medi-Cal plan enrollment with Medicare plan choice), and contractually limiting competing plans and enrollment that are not part of CalAIM's D-SNP exclusively aligned enrollment goal. Some of these efforts may require requesting approval from CMS.
- Sufficient enrollment/membership such that the D-SNP administrative component compared to Medicare plan capitation revenue would be in the 8%–12% range.
- Achieving risk-based managed care model savings from Medicare FFS of 10%–15%. May be lower in early years and higher in later years.
- Ability to contract with providers, and to achieve provider contracting at or close to 100%–105% of Medicare FFS rate levels. If required to pay higher provider rates, the plan would need the ability to offset additional cost via other expense components.
- Development of a high-quality plan such that the quality Star Rating 5.0% bonus is attained. Requires a rating of 4.0 or above.
- Ability to appropriately capture members' initial and ongoing Risk Score (diagnosis) codes, as well as to continuously improve the gathering of that data and information.

Conversely, the biggest hurdles to developing a successful and feasible Medi-Cal D-SNP line of business are the exact opposite of the bullet points outlined above.

- A lack of financial strength

- A lack of sufficient membership over time
- Administrative expenses remaining high as a percent of total revenue
- Insufficient managed care model savings
- Inability to contract with providers, or contracts at high rates
- Plan quality insufficient to receive Star Rating bonus
- Relatively unsuccessful Risk Score development (through data), and lack of desirable improvement

While they can more or less easily fit into one or more of the above hurdles, a few specific areas of concern for potential D-SNPs are often referenced. The following are also issues with every state D-SNP program, but clearly apply to California as well:

- Rural areas — smaller, more spread-out populations, by definition. They also typically have relatively lower CMS payment levels. However, Plan Benefit Packages (PBPs) can operate across multiple counties which would mitigate the risk of only offering coverage in a single rural county.
- Excessive Medicare Advantage marketplace competitor saturation
- Development of operations and compliance capacity to execute any unique Medicare managed care requirements.

As mentioned, the challenges described above are not unique to California. With the exception of a health plan having insufficient initial financial strength, Mercer believes through appropriate diligence they typically can all be overcome. However, individual plan concerns on any of these issues should be weighed carefully in any D-SNP exemption request.

Multi-year Financial Projections of Membership, Revenue, Expenses, Profitability for San Francisco and Santa Barbara/San Luis Obispo Counties

Projections Range of Results, Limitations, Caveats.

Introduction

This financial feasibility analysis examines the key financial results for a hypothetical D-SNP over a period of eight years starting in 2026. The results and assumptions of this analysis are reasonable based on today's currently available information; however, readers should carefully consider the impact on healthcare trend due to the length of the projections, uncertainty in regulatory changes from CMS and/or DHCS, success of DHCS working with CMS to get new-enrollee auto enrollment for D-SNPs, and competitive market dynamics.

Results

In the tables below, Mercer and Oliver Wyman provide a summary of the key financial metrics and scenarios for San Francisco and Santa Barbara/San Luis Obispo regions.

San Francisco

Base Scenario Pricing for 2026 to 2033

Key Metrics	2026	2027	2028	2029	2030	2031	2032	2033
Member Months	18,982	38,159	45,069	52,187	59,519	67,070	74,849	82,860
Avg Members	**1,582**	**3,180**	**3,756**	**4,349**	**4,960**	**5,589**	**6,237**	**6,905**
MA Risk Score	1.203	1.214	1.226	1.238	1.247	1.253	1.259	1.264
Total Revenue PMPM	$1,428	$1,481	$1,534	$1,612	$1,667	$1,722	$1,778	$1,834
Total Incurred Benefits PMPM	1,308	1,307	1,303	1,296	1,336	1,376	1,418	1,461
Total Admin Expenses PMPM	393	265	248	236	227	220	215	211
Gain/Loss PMPM - Total	**($273)**	**($91)**	**($17)**	**$80**	**$105**	**$126**	**$144**	**$162**
Gain/Loss ($ millions)	($5.2 M)	($3.5 M)	($0.8 M)	$4.2 M	$6.2 M	$8.4 M	$10.8 M	$13.4 M
Gain/Loss % - Total	-19.1%	-6.2%	-1.1%	5.0%	6.3%	7.3%	8.1%	8.8%

Santa Barbara / San Luis Obispo

Base Scenario Pricing for 2026 to 2033

Key Metrics	2026	2027	2028	2029	2030	2031	2032	2033
Member Months	99,103	106,810	114,749	122,926	131,348	140,023	148,958	158,161
Avg Members	**8,259**	**8,901**	**9,562**	**10,244**	**10,946**	**11,669**	**12,413**	**13,180**
MA Risk Score	1.141	1.153	1.164	1.175	1.183	1.189	1.194	1.199
Total Revenue PMPM	$1,340	$1,387	$1,436	$1,499	$1,550	$1,606	$1,657	$1,709
Total Incurred Benefits PMPM	1,273	1,271	1,266	1,259	1,298	1,337	1,378	1,419
Total Admin Expenses PMPM	187	184	183	182	182	181	182	182
Gain/Loss PMPM - Total	**($119)**	**($68)**	**($13)**	**$59**	**$71**	**$87**	**$98**	**$108**
Gain/Loss ($ millions)	($11.8 M)	($7.3 M)	($1.5 M)	$7.2 M	$9.3 M	$12.2 M	$14.5 M	$17.0 M
Gain/Loss % - Total	-8.9%	-4.9%	-0.9%	3.9%	4.6%	5.4%	5.9%	6.3%

The base scenario projects a positive margin will be achieved in 2029 for the San Francisco and Santa Barbara/San Luis Obispo regions.

Similar to other D-SNPs nationwide, the revenue in Year 1 (i.e., 2026) is projected to be insufficient to cover the cost which results in a negative profit margin in the bid. Based on a variety of factors (both known and unknown), it is reasonable to assume there will be a path towards long-term profitability. The main drivers for long-term profitability will be star rating performance, covering fixed administrative costs through an adequate membership base, medical management, and risk score coding accuracy.

ASSUMPTIONS AND METHODOLOGY

Star Rating

New D-SNP plans starting in 2026 without a parent organization with an existing Medicare Advantage contract will receive the "New Plan" star rating bonus and rebate percentage.

Star Rating Impact		
Star Rating	**Rebate %**	**Bonus %**
>= 4.5	70%	5.0%
4.0	65%	5.0%
New Plan	65%	3.5%
3.5	65%	0.0%
<= 3.0	50%	0.0%

Starting in 2029, one of the key drivers of success for the new D-SNP plans will be achieving a 4.0 star rating to receive the 5.0% bonus in the table above. The work required to achieve a 4.0 star rating will have to begin immediately due to the lag in measurement and will carry an associated administrative cost. The base scenario projects a 4.0 star rating in 2029 which is then maintained in all subsequent years. Plans that are unable to achieve this star rating will see a reduction in revenue from the removal of the bonus (see scenario results below).

Fixed Administrative Costs/Membership Projections

One of the most difficult financial and operational hurdles for new D-SNP plans is achieving certain economies of scale in their administrative cost while also maintaining a high-performing organization to ascertain the results in star ratings, medical management, and coding accuracy listed above. Mercer and Oliver Wyman believe the MCPs in California will have an opportunity to achieve these economies of scale sooner than a Medicare Advantage start-up without an existing line of business as significant as Medi-Cal.

Membership projections start with the assumed 2026 dual eligible and age-in projections from above. This assumes DHCS will expand aligned enrollment of dual eligibles into matching Medi-Cal managed care plans and D-SNPs to promote more integrated care. DHCS will work with CMS to encourage this outcome. For each region, Mercer and Oliver Wyman have also assumed different percentages for the retained memberships and split of age-in members based on the number of MCPs in a region.

In discussion with DHCS, we modeled the base scenario on the following assumptions:

- In San Francisco, along with the new members that will have aged into Medicare, 5% of current 2022 Medi-Cal dual eligible members will join the D-SNP plan in 2026. In 2027, it was assumed that an additional 5% of current 2022 Medi-Cal dual eligible members will join the D-SNP plan and remain enrolled in the following years, bringing the total to 10% of current membership. Mercer and Oliver Wyman also assume the D-SNP membership will be split between two MCPs in the region.

- In Santa Barbara/San Luis Obispo, it was assumed the plans will retain 40% of their dual eligible membership in 2026 due to the low D-SNP penetration and competition in the region (both D-SNP and Medi-Cal). We assume the membership is all included in one MCP in the region.

For 2027 and future years, it was assumed that the age-in population enrollment will continue to grow at an annual rate of 3%.

We have estimated an administrative cost of $393 and $180 for San Francisco and Santa Barbara/San Luis Obispo in 2026, respectively. These estimates are based on a fixed administrative expense of $5.0 million and a variable administrative expense of $130 per member per month (PMPM) which are reasonable estimates based on what we have observed in other D-SNPs. However, we think this may be conservative for a D-SNP with a significant Medi-Cal enrollment to achieve the economies of scale discussed earlier. For projecting administrative costs beyond 2026, we applied a 1.5% annual trend.

Medical Management

We included a 3% medical cost savings due to medical management relative to Medicare FFS costs in 2026. It was also assumed plans will continue to improve medical management into 2030 by increasing the cost savings to 6% in 2027, 9% in 2028, and 12% in 2029 and will maintain at that level in all following years. The continued improvement of medical management directly correlates to the reduction of costs associated with a member, therefore contributing to the increase in profits or decrease in losses. These assumptions are based on our experience with other new market entrants and are significantly lower than average for an established successful D-SNP.

Risk Score Coding

As stated above, Oliver Wyman assumes the potential membership will come mostly from those that age into Medicare including those that age into Medicare FFS. Both of these populations typically have lower risk scores than their current Medicare Advantage counterparts. This is due to the fact that risk scores for newly enrolled members are solely based on demographic factors and the Medicare FFS population generally have less complete diagnosis coding. Consequently, lower risk scores are associated with a lower revenue.

Risk scores were developed using the 2019 CMS FFS 5% sample data filtering on the dual eligible members in San Francisco and Santa Barbara/San Luis Obispo counties. Oliver Wyman also assume members coming onto the plan will be reflective of a normal level of coding intensity seen in Medicare FFS members.

As Oliver Wyman projects the coding accuracy efforts, we have considered the reasonability of both coding improvement efforts seen nationwide and the average risk scores for D-SNP members in California. We assumed a risk score coding improvement (net of normalization) of 2.0% annually for the first three years followed by 0.5% annually thereafter.

Benchmark Rate

To develop benchmark rates for 2026, Oliver Wyman relied on the CY2023 benchmarks published by CMS as a starting point and applied a 3.0% annual trend for all the projection years.

Manual Rate

The manual rate was developed using the CMS 2019 5% sample data, limited to the dual eligible population in the specific counties for San Francisco and Santa Barbara/San Luis Obispo regions. The manual rate was then trended to 2023 using CMS FFS utilization and unit cost trends by service categories. These estimates are then adjusted further for any benefit changes and induced utilization.

Trend

To stay consistent with the trend for the benchmark rate above, Oliver Wyman assumed a trend rate of 3% annually for projections beyond 2023.

Reimbursement Rates

The base scenario assumes plans will pay providers at 105% and 100% of the Medicare allowed fee schedule for San Francisco and Santa Barbara/San Luis Obispo regions, respectively. In San Francisco, it is assumed the higher reimbursement rates will be necessary to reimburse providers to meet network adequacy requirements. For Santa Barbara/San Luis Obispo, Oliver Wyman has assumed 100% of the Medicare allowed fee schedule after discussions/responses by the Medi-Cal plan in the region and their ability to contract at Medicare reimbursement rates.

Supplemental Benefits

Supplemental benefits are assumed to be provided at a cost of $40 PMPM initially in 2026. These cost projections were developed using current CMS landscape data limited to Medicare Advantage D-SNP plans in California. For 2027 through 2033, it was assumed that supplemental benefits costs will increase at 3% annually. Plans that obtain higher star ratings are able to generate more rebates which allows the plans to afford additional supplemental benefits giving them a competitive advantage.

Part D Assumptions

Part D net claims are projected to be $65 PMPM in 2026 based on an analysis of anonymized internal Oliver Wyman D-SNP data, as well as publicly available information on D-SNP plans. Net claims are defined as the plan's liability on a claim after considering all offsets to gross drug cost including member cost sharing, Low Income Subsidy, reinsurance, and rebates.

- Net claims are projected to stay flat at $65 PMPM across all years under the assumption that rebates, primarily, as well as reinsurance and member cost sharing, will increase across time to offset the increases in gross drug cost.

Part D administration and gain loss were set equal to Part C as a percentage of revenue.

CMS nationwide direct subsidy was assumed to be ($9) PMPM in 2026 and was assumed to decline by $3 a year.

Part D risk scores were set equal to Part C risk scores based on an internal analysis of the differential between C and D for anonymized internal D-SNP clients.

A Low-Income Premium subsidy of $33 is assumed based on an historical analysis of the California Market.

This analysis assumes no structural changes to the Part D program, such as the elimination of DIR, Part D benefit redesign, inflation caps, or government price negotiations.

Scenarios

Oliver Wyman has projected several alternate scenarios to demonstrate the impact of key assumptions on these future projections.

- **Expected Membership**: Several alternate scenarios were developed using the membership assumptions in the table below. Note Mercer and Oliver Wyman have not displayed more favorable (than base) scenarios as the base scenarios already have the plans achieving profitability within a reasonable timeframe.

  In San Francisco, the impact of lowering membership by assuming no retention of current Medi-Cal dual eligible members delays the ability of plans to reach profitability to 2031. Additionally, in the lowest membership scenario, where there is no retention of current Medi-Cal dual eligible membership and it is expected dual eligible age-in membership will not be evenly split between the two MCPs resulting in an MCP with only 25% of the dual eligible age-ins, the plans are not able to reach a profitable level by 2033. We believe these assumptions are overly conservative and not in line with administrative (marketing) assumptions.

  In Santa Barbara/San Luis Obispo, we continued to assume the Medi-Cal dual eligible membership is entirely included in one MCP in the region, but have lowered the membership by assuming that there will be only 20% retention of Medi-Cal dual eligible members, half the base scenario assumption. In this scenario plans are able to make small profit starting in 2033. Additionally, in the lowest membership scenario, where there is no retention of current Medi-Cal dual eligible members, plans are unable to reach a profitable level by 2033.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
Low Membership, Equal MCO Split								
Membership - Total	**543**	**1,102**	**1,678**	**2,271**	**2,882**	**3,511**	**4,159**	**4,827**
Gain/Loss PMPM - Change	**($510)**	**($263)**	**($154)**	**($104)**	**($77)**	**($60)**	**($49)**	**($41)**
Gain/Loss PMPM - Total	($801)	($363)	($174)	($24)	$29	$68	$98	$124
Gain/Loss ($ millions)	($5.2 M)	($4.8 M)	($3.5 M)	($0.7 M)	$1.0 M	$2.9 M	$4.9 M	$7.2 M
Low Membership, Unequal MCO Split								
Membership - Total	**271**	**551**	**839**	**1,136**	**1,441**	**1,756**	**2,080**	**2,414**
Gain/Loss PMPM - Change	**($809)**	**($580)**	**($340)**	**($221)**	**($151)**	**($105)**	**($72)**	**($46)**
Gain/Loss PMPM - Total	(1,100)	(680)	(361)	(141)	(46)	23	75	118
Gain/Loss ($ millions)	(4)	(4)	(4)	(2)	(1)	0	2	3
Santa Barbara / San Luis Obispo								
Lower Membership, 20% Retention of MA Membership								
Membership - Total	**4,441**	**5,083**	**5,745**	**6,426**	**7,128**	**7,851**	**8,596**	**9,363**
Gain/Loss PMPM - Change	**($45)**	**($37)**	**($31)**	**($26)**	**($22)**	**($19)**	**($17)**	**($15)**
Gain/Loss PMPM - Total	($164)	($105)	($43)	$33	$49	$68	$81	$93
Gain/Loss ($ millions)	($8.7 M)	($6.4 M)	($3.0 M)	$2.5 M	$4.2 M	$6.4 M	$8.4 M	$10.5 M
Lowest Membership, No Rentention of MA membership								
Membership - Total	**624**	**1,266**	**1,927**	**2,609**	**3,311**	**4,034**	**4,778**	**5,545**
Gain/Loss PMPM - Change	**($623)**	**($292)**	**($181)**	**($127)**	**($95)**	**($74)**	**($60)**	**($49)**
Gain/Loss PMPM - Total	($742)	($360)	($194)	($68)	($24)	$13	$38	$59
Gain/Loss ($ millions)	($5.6 M)	($5.5 M)	($4.5 M)	($2.1 M)	($0.9 M)	$0.7 M	$2.2 M	$3.9 M

- **Star Rating**: In this scenario, it is assumed that plans will achieve a 3.5 star rating from 2026 to 2033 which results in a reduction in margin in 2029 of $3.5 million and $4.1 million for San Francisco and Santa Barbara/San Luis Obispo, respectively. This is a significant financial decline from the base scenario due to the loss of additional revenue that is provided to 4-star plans.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
3.5 Star Rating for 2029-33								
Gain/Loss PMPM - Change	**$0**	**$0**	**$0**	**($66)**	**($70)**	**($74)**	**($77)**	**($80)**
Gain/Loss PMPM - Total	($290)	($101)	($21)	$14	$36	$54	$70	$84
Gain/Loss ($ millions)	($5.4 M)	($3.7 M)	($0.9 M)	$0.7 M	$2.1 M	$3.6 M	$5.2 M	$7.0 M
Santa Barbara / San Luis Obispo								
3.5 Star Rating for 2029-33								
Gain/Loss PMPM - Change	**$0**	**$0**	**$0**	**($34)**	**($35)**	**($36)**	**($38)**	**($39)**
Gain/Loss PMPM - Total	($119)	($68)	($13)	$25	$36	$51	$60	$69
Gain/Loss ($ millions)	($11.8 M)	($7.3 M)	($1.5 M)	$3.1 M	$4.7 M	$7.1 M	$8.9 M	$10.8 M

- **Medical Management**: The base scenario assumes that plans will achieve 3% savings due to medical management relative to FFS Medicare costs in 2026 and continue to improve until 2029 when a stable amount of savings is reached.
  - In the first alternate scenario it is assumed that plans will be able to achieve a higher level of savings due to medical management by 5%, 8%, 12%, and 15% in 2026, 2027, 2028, and 2029 respectively. An increase in savings directly correlates to the increase of revenue. This increased savings allows for plans to reach a profitable level earlier than in the base scenario, 2028 and 2029 in San Francisco and Santa Barbara/San Luis Obispo respectively.
  - In the second alternate scenario it is assumed that plans will only be able to achieve a lower level of savings due to medical management at 0%, 3%, 6%, and 6% in 2026, 2027, 2028, and 2029, respectively. This reduction in savings does not impact the ability for plans in San Francisco to reach profitability in 2029, but it does reduce the projected revenue obtained by $3.6 million. On the other hand, this reduction in savings does not allow for the Santa Barbara/San Luis Obispo plans to reach a profitable level by 2033.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
Medical Management Improvement								
Gain/Loss PMPM - Change	**$37**	**$33**	**$45**	**$44**	**$44**	**$45**	**$46**	**$48**
Gain/Loss PMPM - Total	($254)	($67)	$25	$124	$150	$173	$193	$212
Gain/Loss ($ millions)	($4.8 M)	($2.6 M)	$1.1 M	$6.5 M	$8.9 M	$11.6 M	$14.4 M	$17.6 M
Medical Management Reduction								
Gain/Loss PMPM - Change	**($34)**	**($40)**	**($45)**	**($50)**	**($52)**	**($55)**	**($56)**	**($58)**
Gain/Loss PMPM - Total	($325)	($140)	($66)	$30	$53	$73	$90	$106
Gain/Loss ($ millions)	($6.2 M)	($5.4 M)	($3.0 M)	$1.6 M	$3.2 M	$4.9 M	$6.8 M	$8.8 M
Santa Barbara / San Luis Obispo								
Medical Management Improvement								
Gain/Loss PMPM - Change	**$28**	**$29**	**$45**	**$46**	**$47**	**$49**	**$51**	**$52**
Gain/Loss PMPM - Total	($91)	($39)	$32	$105	$119	$136	$148	$160
Gain/Loss ($ millions)	($9.0 M)	($4.2 M)	$3.7 M	$12.9 M	$15.6 M	$19.1 M	$22.1 M	$25.3 M
Medical Management Reduction								
Gain/Loss PMPM - Change	**($42)**	**($43)**	**($45)**	**($46)**	**($48)**	**($49)**	**($51)**	**($52)**
Gain/Loss PMPM - Total	($161)	($111)	($57)	$13	$24	$38	$47	$56
Gain/Loss ($ millions)	($15.9 M)	($11.9 M)	($6.6 M)	$1.5 M	$3.1 M	$5.4 M	$7.0 M	$8.8 M

- **Risk Score Coding**: Similar to the base scenario, the alternate scenarios assume that plans will improve risk score coding for a new member at a higher rate during the first three years, before maintaining a steady level of improvement annually.
  - The first alternate scenario assumes that plans will achieve a 1.0% risk score coding improvement (net of normalization) for the first three years of a newly enrolled member, a 1% reduction from the base scenario, before maintaining a 0.5% improvement in the following years. Revenue fluctuates proportionally with risk

scores, so a 1.0% reduction solely in risk score coding from the base scenario, not a reduction in morbidity, will also reduce the profit.

- The second alternate scenario assumes that plans will achieve a 3.0% risk score coding improvement for the first three years of a newly enrolled member, a 1% increase from the base scenario, before maintaining a 0.5% improvement in the following years. Revenue fluctuates proportionally with risk scores, so a 1.0% increase solely in risk score coding from the base scenario will also increase the profit.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
1% Coding Improvement Reduction								
Gain/Loss PMPM - Change	**$8**	**($2)**	**($13)**	**($24)**	**($30)**	**($35)**	**($39)**	**($42)**
Gain/Loss PMPM - Total	($282)	($103)	($34)	$56	$75	$93	$108	$123
Gain/Loss ($ millions)	($5.4 M)	($3.9 M)	($1.5 M)	$2.9 M	$4.5 M	$6.2 M	$8.1 M	$10.2 M
1% Coding Improvement Increase								
Gain/Loss PMPM - Change	**$8**	**$10**	**$13**	**$18**	**$23**	**$26**	**$29**	**$32**
Gain/Loss PMPM - Total	($282)	($90)	($7)	$98	$128	$154	$176	$197
Gain/Loss ($ millions)	($5.4 M)	($3.4 M)	($0.3 M)	$5.1 M	$7.6 M	$10.3 M	$13.2 M	$16.3 M
Santa Barbara / San Luis Obispo								
1% Coding Improvement Reduction								
Gain/Loss PMPM - Change	**$0**	**($6)**	**($13)**	**($20)**	**($25)**	**($29)**	**($32)**	**($35)**
Gain/Loss PMPM - Total	($119)	($74)	($25)	$38	$46	$58	$66	$73
Gain/Loss ($ millions)	($11.8 M)	($7.9 M)	($2.9 M)	$4.7 M	$6.0 M	$8.2 M	$9.8 M	$11.6 M
1% Coding Improvement Increase								
Gain/Loss PMPM - Change	**$0**	**$6**	**$13**	**$20**	**$25**	**$29**	**$32**	**$35**
Gain/Loss PMPM - Total	($119)	($62)	$0	$79	$97	$117	$130	$143
Gain/Loss ($ millions)	($11.8 M)	($6.6 M)	$0.0 M	$9.7 M	$12.7 M	$16.3 M	$19.4 M	$22.6 M

- **Medical Trends**: The base scenario assumes an annual 3% trend through the projection years across all service categories.
  - The first alternate scenario assumes that this annual medical trend will be 4% through the projection years, which is slightly higher than the CMS benchmark trend rate. The increase to medical trends increases the medical costs which translates to a reduction in profits.
  - The second alternate scenario assumes that this annual medical trend will be 2% through the projection years, which is slightly lower than the CMS benchmark trend rate. The reduction to medical trends decreases the medical costs which translates to an increase in profits.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
Medical Trend Above Benchmark								
Gain/Loss PMPM - Change	**($21)**	**($42)**	**($61)**	**($81)**	**($98)**	**($117)**	**($136)**	**($156)**
Gain/Loss PMPM - Total	($311)	($142)	($81)	($1)	$7	$10	$10	$8
Gain/Loss ($ millions)	($5.4 M)	($5.4 M)	($3.7 M)	($0.0 M)	$0.4 M	$0.7 M	$0.8 M	$0.7 M
Medical Trend Below Benchmark								
Gain/Loss PMPM - Change	**$38**	**$51**	**$63**	**$79**	**$96**	**$116**	**$137**	**$160**
Gain/Loss PMPM - Total	($252)	($49)	$42	$159	$202	$244	$284	$324
Gain/Loss ($ millions)	($4.8 M)	($1.9 M)	$1.9 M	$8.3 M	$12.0 M	$16.3 M	$21.2 M	$26.9 M
Santa Barbara / San Luis Obispo								
Medical Trend Above Benchmark								
Gain/Loss PMPM - Change	**($33)**	**($46)**	**($59)**	**($75)**	**($90)**	**($107)**	**($124)**	**($143)**
Gain/Loss PMPM - Total	($152)	($114)	($72)	($16)	($19)	($20)	($27)	($35)
Gain/Loss ($ millions)	($15.1 M)	($12.1 M)	($8.3 M)	($2.0 M)	($2.5 M)	($2.7 M)	($4.0 M)	($5.5 M)
Medical Trend Below Benchmark								
Gain/Loss PMPM - Change	**$34**	**$47**	**$62**	**$78**	**$96**	**$114**	**$134**	**$156**
Gain/Loss PMPM - Total	($86)	($21)	$49	$137	$167	$202	$232	$263
Gain/Loss ($ millions)	($8.5 M)	($2.2 M)	$5.6 M	$16.8 M	$21.9 M	$28.3 M	$34.6 M	$41.7 M

- **Provider Reimbursement Rates**: Alternate scenarios were developed to demonstrate the impact of provider reimbursement rates.
  - Most Medicare Advantage organizations reimburse providers at rates similar to 100% of traditional Medicare reimbursement. Therefore, Oliver Wyman has provided an alternate scenario assuming that plans will reimburse providers at 100% of the Medicare allowed fee schedule. The reduction to provider reimbursement lowers the medical costs which translates to an increase in profitability.
  - A second alternate scenario assumes that plans will reimburse providers at a higher rate of 110% of the Medicare allowed fee schedule to meet network adequacy requirements. The increase to provider reimbursement increases the medical costs which in turn creates a reduction in profitability.

Scenario Results	2026	2027	2028	2029	2030	2031	2032	2033
San Francisco								
100% Medicare FFS Provider Reimbursement								
Gain/Loss PMPM - Change	**$79**	**$77**	**$75**	**$75**	**$76**	**$78**	**$81**	**$83**
Gain/Loss PMPM - Total	($211)	($23)	$55	$155	$182	$206	$227	$247
Gain/Loss ($ millions)	($5.4 M)	($0.9 M)	$2.5 M	$8.1 M	$10.8 M	$13.8 M	$17.0 M	$20.5 M
110% Medicare FFS Provider Reimbursement								
Gain/Loss PMPM - Change	**($63)**	**($69)**	**($76)**	**($81)**	**($84)**	**($88)**	**($91)**	**($93)**
Gain/Loss PMPM - Total	($353)	($170)	($96)	($1)	$21	$40	$56	$71
Gain/Loss ($ millions)	($6.7 M)	($6.5 M)	($4.3 M)	($0.0 M)	$1.3 M	$2.7 M	$4.2 M	$5.9 M
Santa Barbara / San Luis Obispo								
105% Medicare FFS Provider Reimbursement								
Gain/Loss PMPM - Change	**($82)**	**($80)**	**($79)**	**($78)**	**($80)**	**($81)**	**($84)**	**($86)**
Gain/Loss PMPM - Total	($201)	($148)	($91)	($19)	($9)	$6	$14	$22
Gain/Loss ($ millions)	($19.9 M)	($15.8 M)	($10.5 M)	($2.4 M)	($1.1 M)	$0.9 M	$2.1 M	$3.4 M
110% Medicare FFS Provider Reimbursement								
Gain/Loss PMPM - Change	**($139)**	**($144)**	**($149)**	**($154)**	**($159)**	**($164)**	**($169)**	**($174)**
Gain/Loss PMPM - Total	($258)	($212)	($162)	($95)	($88)	($77)	($71)	($67)
Gain/Loss ($ millions)	($25.6 M)	($22.7 M)	($18.5 M)	($11.7 M)	($11.5 M)	($10.7 M)	($10.6 M)	($10.5 M)

Section 4
Findings and Recommendations

List of Factors that Support Feasibility for a Given Plan/Region/County Combination.

As we have discussed throughout this feasibility study, we believe there is a potential path to feasibility for all regions in California. However, each region and MCP will have unique challenges to overcome as they look to achieve feasibility. We have listed some of the key factors for MCPs to be successful below. In the absence of achieving enough of these factors in a given county/region, feasibility becomes increasingly more challenging.

- Membership Growth
  - MCPs must achieve the required level of membership to obtain the appropriate economies of scale to reduce fixed administrative costs to achieve profitability.
  - Regions with a high number of dual eligible beneficiaries are more likely to allow for multiple D-SNPs to achieve the membership growth needed to be successful.
  - Regions with a lower penetration of D-SNP members and/or only one Medi-Cal plan today, will also have ample opportunities to achieve the membership growth required for the MCP to be successful.
  - Offering competitive supplemental benefits will also help MCPs achieve the membership growth needed to be successful.
- Administrative Cost per D-SNP Member
  - As the MCP grows membership, the fixed cost of the D-SNP will be spread across more members which will reduce the percentage of revenue used on administrative services therefore increasing profitability and competitiveness of the D-SNP.
  - Competitive and reasonable third-party administrative contracts should be established based on benchmarks of similar cost for those services so to not overpay for any specific administrative function.
- Provider Contracting
  - Provider contracting will vary based on the leverage of providers in specific regions to negotiate better rates as a percentage of Medicare FFS.
  - MCPs may need to think of creative value-based care (VBC) contracts with these providers to achieve both network adequacy and a reasonable provider reimbursement for financial success.
- Star Rating
  - MCPs without an existing Medicare contract will receive the “New Plan” star rating for the first three years of operation.

  - MCPs will need to understand and focus significant efforts on achieving high quality ratings on Day One of operations to achieve at least the 4.0 star rating which results in a 5% bonus to the benchmark and 65% rebate for savings generated to spend on improved supplemental benefits and/or profit.

- Risk Score Coding Accuracy
  - MCPs will want to maximize their coding accuracy so they can receive the appropriate revenue from CMS to cover the acuity of their members.
  - MCPs should set up operational processes to reconcile and improve risk adjustment from a physician coding accuracy in-office with patients to submissions of encounters to Model Output Reports to final CMS payment received.
  - Provider VBC contracts may be beneficial for the plan to successfully encourage physicians to accurately code members.
- Medical Cost Management
  - MCPs will need to set up utilization management (UM) and care management (CM) programs to achieve the levels of savings needed to achieve financial feasibility.
  - The level of sophistication and outcomes driven by these UM and CM programs will vary by MCP and region based on their prior experience and physician/member engagement.

These key factors will need to be considered for each MCP as they look to determine their own path to feasibility. Additionally, they must maximize the performance of each of these key factors to be successful as a D-SNP in California.

If there are concerns about feasibility, MCPs should work with DHCS to review the specific key factors above and their corresponding feasibility impact for the MCP. This will be reviewed on a case-by-case basis which may result in potential waivers of the D-SNP requirements in specific counties.

Appendix A

Additional Information Regarding D-SNPs in Select Other States

D-SNP enrollment in Virginia and New Mexico (where D-SNPs are relatively new) revealed membership for local initiative plans increased in aggregate from July 2020 to January 2022 in step with non-local initiative plans. In Virginia, non-local (i.e., national) initiatives experienced larger growth than Virginia Premier, the local plan with greater D-SNP penetration. Optima Medicare, another local plan in Virginia with lower penetration, was able to more than double enrollment from July 2020 to July 2021, and then grow 44% annualized from July 2021 to January 2022. Within New Mexico, the large increases in D-SNP membership for the local plan, and large decreases for national plans, are largely influenced by shifts in Medicaid managed care enrollment as a result of plans entering/exiting the Medicaid landscape.

Local/National	State	Organization Name	Star Rating 2020	Star Rating 2021	Star Rating 2022	July 2020 Membership	July 2021 Membership	January 2022 Membership
Local	Virginia	Optima Medicare	-	-	4.0	1,017	2,763	3,319
Local	Virginia	Virginia Premier	3.0	2.5	3.5	6,452	7,233	6,721
National	Virginia*	All National Plans**	4.4	3.8	3.9	65,490	89,981	106,142
Local	New Mexico	Presbyterian Health Plan	3.5	3.5	3.5	4,068	12,140	13,311
National	New Mexico	All National Plans**	3.9	3.5	3.6	25,034	4,644	5,954
Local	Arizona	Banner - University Care Advantage	3.0	3.5	3.5	15,557	15,390	15,181
Local	Arizona	Mercy Care Advantage	3.5	3.0	3.5	16,218	16,265	15,791
National	Arizona	All National Plans**	3.8	3.4	3.9	69,108	79,492	82,840

*The data on National plans in Virginia includes one contract Plan Benefit Package that exists across both Virginia and North Carolina. Therefore the star rating and listed membership includes enrollment across both states, rather than only Virginia.

**The aggregate star ratings for the national plans are computed based on all national plans within that region that had both star ratings and membership reported for the applicable time period. The membership information provided is across all plans, regardless of star rating availability.

Sources:
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Plan

D-SNP enrollment in Arizona's local plans actually shrank slightly over the time period examined. However, D-SNPs in Arizona are more established and have stronger market penetration already, as shown by their higher membership counts. The growth of non-local initiatives is partially skewed here due to the fact local initiatives cannot grow outside of their operating region, while non-local health plans can expand throughout more areas of the State.

Other states also revealed helpful ideas as to how to promote enrollment when developing a new D-SNP program. In a study conducted by the ASPE, it was reported (see https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0#exhibit6):

> "Several of the states with the highest DSNP enrollment--Arizona, Massachusetts, Minnesota, Pennsylvania, Tennessee, and Texas--have or plan to launch MLTSS programs, and their MIPPA contracts require that DSNPs offer a companion MLTSS plan or that MLTSS plans offer a companion DSNP… In our case study interviews, DSNPs repeatedly told us that, for their MA (Medicare Advantage) organization corporate parents, the most desirable markets were in states where they had the opportunity operate Medicaid acute care, Medicaid MLTSS contracts, general MA and DSNP contracts. These multiple contracts may allow these organizations to realize economies

> of scope regarding their information systems, care manager training, or other administrative functions. It may also allow them to be more responsive to changes in a state's insurance landscape."

D-SNPs reported their MA organizations preferred markets that allowed them to operate multiple contracts. The coordination allowed for a more efficient administrative burden, and greater flexibility in the event of state insurance program change. Similar information was found relative to D-SNPs in New Jersey.

ASPE also detailed how Arizona recently modified its marketing directives for D-SNP products to allow plans to educate beneficiaries about the benefits of integrated products, which Arizona reported to cause "significant" increases in enrollment. Further, Arizona now allows D-SNPs to tailor marketing efforts toward their own Medicaid MLTSS members and reported that this marketing promoted aligned enrollment, discouraged plans from enrolling other plan's Medicaid members in their D-SNP, and increased the number of dual eligible members enrolled in aligned D-SNPs. Tennessee and Arizona also pioneered a 'seamless conversion' process with CMS approval, that allows D-SNPs to passively enroll Medicaid beneficiaries newly eligible for Medicare into their D-SNP if the member is already enrolled in the plan's Medicaid program. Both states reported seamless conversion has increased enrollment by several hundred beneficiaries a month for aligned plans. Massachusetts similarly reported that utilizing a passive enrollment process, which automatically assigned members to a plan with an opt-out option, helped to improve enrollment within their duals demonstration. (https://www.mass.gov/doc/draft-concept-paper-duals-demonstration-20-06-13-18/download).

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