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Our Presentation:

Reviewing Medicare Advantage Regulatory Changes for 2020 – MA & Part D Rate Announcement, Call Letter and Final Rule

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Dial in to our operator assisted call, **877.629.4729**

NOTES

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QUESTIONS

Use the "Questions and Answers"

RECORDING

This webinar is being recorded. We will notify you via email once the recording is posted and available for viewing.

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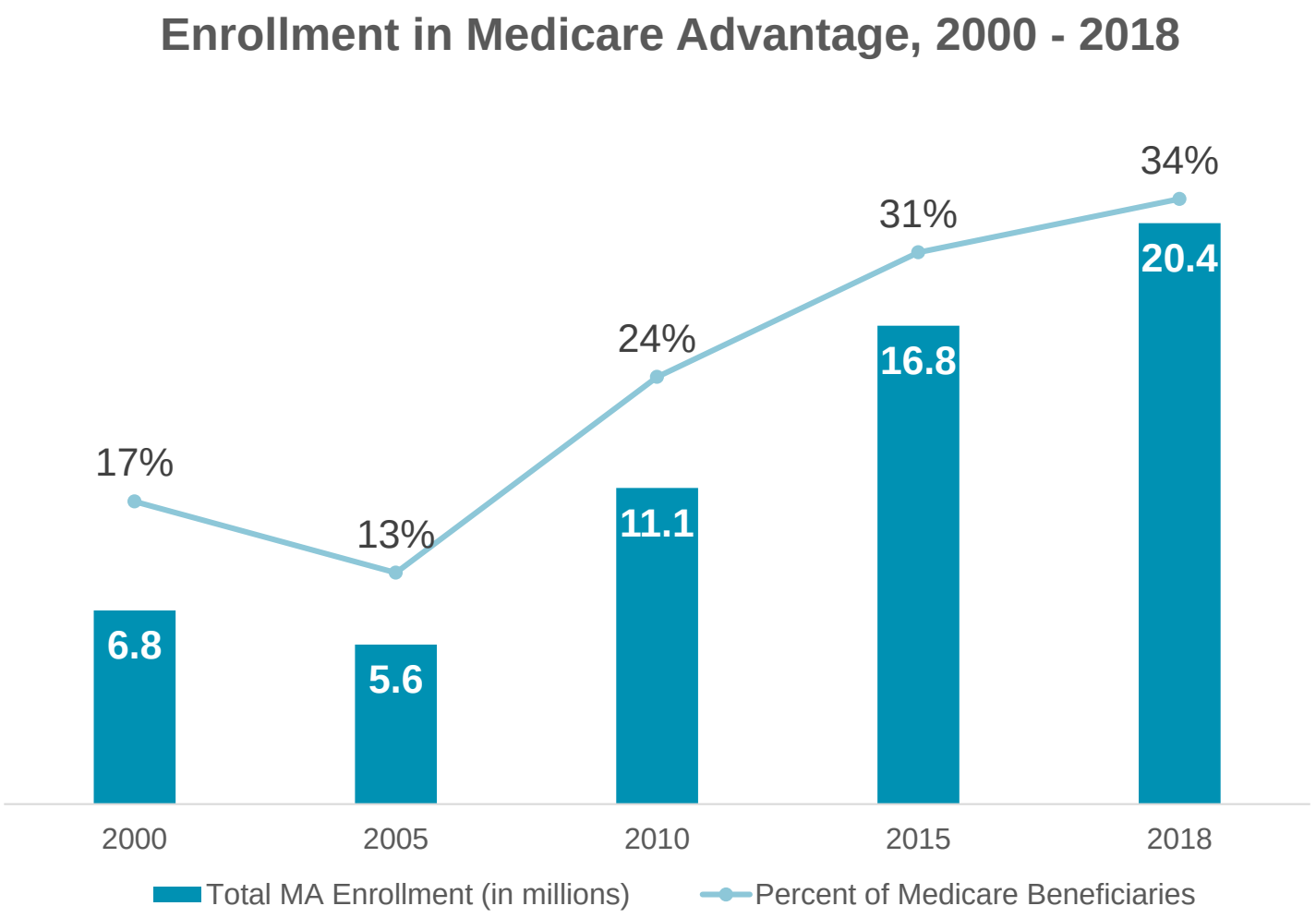
Agenda

- **Rate Announcement**
  - Changes in Rates for 2020
  - Modifications to Risk-adjustment Methodology
- **Call Letter**
  - Oversight Mechanisms for Opioid Utilization
  - Supplemental Benefits for Chronically-ill Enrollees
- **Final Rule**
  - Expansion of Telehealth Benefits
  - Integration of SNP Benefits for Dual-Eligibles
  - Changes to Star Rating Program
  - Expanded Program Preclusion Criteria
- **Strategic Considerations for Providers**

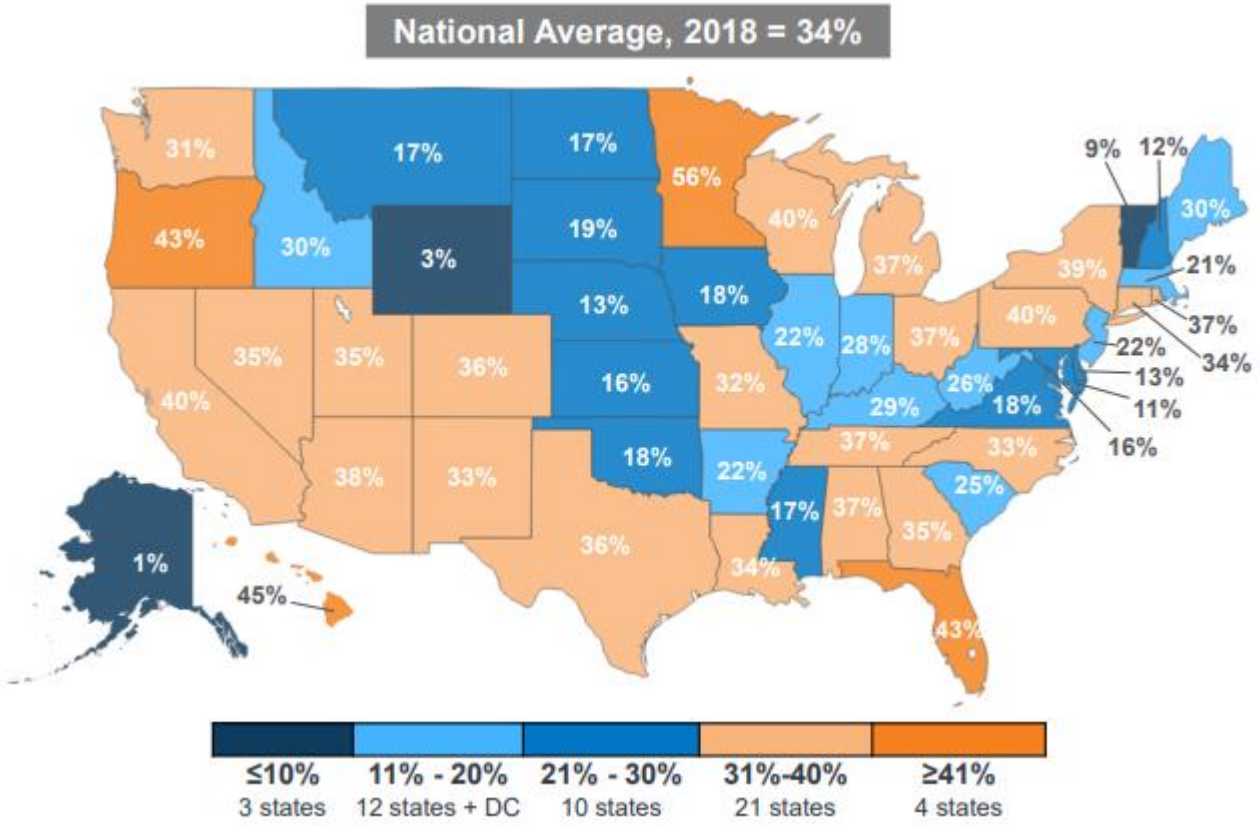
Enrollment in Medicare Advantage Continues to Grow



NOTE: Includes cost plans as well as Medicare Advantage plans. About 61 million people are enrolled in Medicare in 2018.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

MA Penetration Varies by State

Medicare Advantage Enrollment Penetration Rates, 2000 - 2018



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

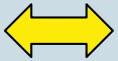
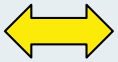
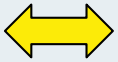
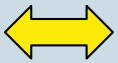
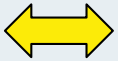
MA Rate Announcement, Call Letter, and Final Rule Summary

- MA Rate Announcement and Call Letter published on April 1 on CMS website
  - The rate announcement and call letter are released annually to update methodologies and establish parameters for MA plan's bids for the following payment year
  - The advance notice was released in two parts with separate comment periods. Part I was released on December 29, 2018, and Part II on January 30, 2019
  - Increases payments to MA plans by 2.5 percent in payment year (PY) 2020
  - Finalizes changes to 2020 MA Star Ratings
  - Provides guidance for plans wishing to offer additional benefits to chronically ill enrollees beyond what is available to all MA beneficiaries as permitted by the Balanced Budget Act of 2018 (BBA 2018).
- MA, MA PDP Final Rule (CMS-4185-F) posted online for inspection on April 5, published on April 16 in *Federal Register*
  - Rulemaking in the form of proposed and final rules for Medicare Advantage is sporadic
  - Proposed rule was released on November 1, 2018
  - Rule prompted by need to implement provisions related to MA and Part D in the Balanced Budget Act of 2018
  - Defines "Additional Telehealth Benefits" that may be permitted, under BBA 2018, to be part of the basic benefit
  - Enhances coordination of benefits in dual eligible special needs plans (D-SNPs)

MA Rate Announcement for PY 2020

Rate Announcement

- MA rates will increase by 2.53 percent in PY 2020

Impact	2020 Advance Notice	2020 Rate Announcement	Change from Advanced Notice
Effective Growth Rate	4.59%	5.62%	
Rebasing/Re-pricing	TBD	-0.02%	
Change in Star Ratings	-0.14%	-0.14%	
Medicare Advantage coding intensity adjustment	0.0%	0.0%	
Risk Model Revision	0.28%	0.21%	
Encounter Data Transition	-0.06%	-0.06%	
Employer Group Waiver Plan Payment Policy	0.0%	0.0%	
Normalization	-3.08%	-3.08%	
Expected Average Change in Revenue	1.59%	**2.53%**	

Changes to Risk Adjustment Methodology

- The 21st Century Cures Act mandated adjustments to the MA risk adjustment model to account for the number of conditions

- For PY 2020, CMS finalized implementation of alternative payment condition count (PCC) model that includes:
  - A variable incorporating the count of the number of conditions a patient has
  - Condition categories for pressure ulcers and dementia
  - In PY 2019, CMS added condition categories for substance use disorder, mental health, and chronic kidney disease.

- The alternative PCC model will replace the HCC model and be phased-in over a three-year period, starting in PY 2020.
  - For PY 2020, 50% of the risk score will derive from the PCC model, and 50% will be calculated from the HCC model

Changes to Risk Adjustment Methodology

- Risk scores are calculated based on diagnosis data
  - Patient diagnoses have historically been collected from MA plans in CMS's Risk Adjustment Processing System (RAPS) or FFS data

- CMS is incorporating diagnosis data collected through patient encounter (PE) data collected from MA plans
  - CMS began blending RAPs, FFS and PE data in PY 2016. CMS is committed to increasing the use of encounter data over time.
  - In PY 2020, 50 percent of the data used to calculate risk scores will be derived from RAPS+FFS, 50 percent from RAPS+FFS+patient encounter data

	2016	2017	2018	2019	2020
RAPS+FFS	90%	75%	85%	75%	**50%**
RAPS+FFS+PE	10%	25%	15%	25%	**50%**

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MA Final Call Letter for PY 2020

Drug Utilization Review Controls for Opioids

- New for PY 2020
  - Pain management and complementary/integrative treatments
    - Offer targeted benefits and cost sharing reductions for patients with chronic pain or undergoing addiction treatment
  - Access to opioid reversal agents
    - Encourage plans to lower patient cost sharing for opioid-reversal agents
- Star ratings
  - Updated specifications for the following Part D opioid-related measures and adds them to the display page (precursor to formal adoption of a measure):
    - Use of Opioids at High Dosage and/or from Multiple Providers
    - Concurrent Use of Opioids and Benzodiazepines
- In 2019, MA plans were required to:
  - Strengthen the monitoring of Part D drug management programs for high risk opioid users
  - Impose enhanced safety alerts, such as a 7-day supply limit for patients starting use of opioids

Changes to MA Star Ratings

- Call Letter finalizes policy to adjust 2020 Star Ratings for contracts affected by extreme and uncontrollable circumstances, such as major hurricanes and other federal disasters, during the performance period. The policy is similar to the policy CMS implemented for 2019 Star Ratings.
  - Star Ratings are adjusted if over 25% of a plan's enrollees reside in a FEMA-designated Individual Assistance area:
  - Contracts will receive the higher of the 2019 or the 2020 measure-level Star Rating for each CAHPS, Health Outcomes Survey (HOS), and HEDIS-HOS measures.
  - Adjustments are made to a contract's Star Ratings for one year only. Contracts with over 60% of enrollees impacted are excluded from calculation of Reward Factor thresholds (but still eligible for the Reward Factor).
  - Similar policy for PY 2022 and later years was codified separately in MA final rule for uncontrollable circumstances occurring on January 1, 2020 or later.

- Temporary removal of Controlling High Blood Pressure (Part C) measure from 2020 and 2021 Star Ratings due to measure specification changes

- Removal of three measures in 2022 Star Ratings due to low reliability
  - Adult BMI Assessment (Part C)
  - Appeals Auto-forward (Part D)
  - Appeals Upheld (Part D)

Supplemental Benefits for Chronically-ill Enrollees

- The Balanced Budget Act of 2018 authorized the expansion of ***supplemental*** benefits that may be targeted by MA plans to chronically-ill enrollees. These benefits:
  - May include non-health related benefits
  - Do not have to be offered to all chronically-ill enrollees
  - Must be **reasonably expected to improve or maintain health or overall function** of an enrollee in relation to their chronic condition or illness

- MA plans are required to develop objective criteria and maintain detailed documentation for determining when a chronically-ill person is eligible for a particular item or service

- These supplemental benefits can be designed to address *social determinants of health*. CMS indicated the following examples of expanded benefits a MA plan could offer to a chronically-ill enrollee:
  - Meal delivery beyond a limited basis
  - Transportation for non-medical needs such as grocery shopping
  - Indoor air quality improvement services
  - Capital or structural improvements to living quarters *(were previously excluded in advance call letter)*

Supplemental Benefits for Chronically-ill Enrollees

- Chronically-ill is defined as having one of the following 15 conditions:

Chronically-ill conditions[1]	
Chronic alcohol and other drug dependence	ESRD
Autoimmune disorders, including rheumatoid arthritis	Severe hematologic disorders
Cancer, excluding pre-cancer	HIV/AIDS
Cardiovascular disorders	Chronic lung disorders
Chronic heart failure	Chronic and disabling mental health conditions
Dementia	Neurologic disorders
Diabetes mellitus	Stroke
End-stage liver disease	

[1]Medicare Managed Care Manual, Chapter 16B, Section 20.1.2.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf

MA and Part D Flexibility Final Rule

Expansion of Telehealth Benefits

- BBA 2018 permits plans, beginning in 2020, to provide “Additional Telehealth Benefits” as part of their basic bids.
  - Basic bids represent the MA plans’ per patient per month (PMPM) offer to provide all services covered by traditional Medicare to enrollees
  - Most telehealth was previously categorized as a supplemental benefit whose costs could not be included in their PMPM bid because Part B limited payment for telehealth services; plans are now able to include expanded telehealth services in their bids

- CMS expanded the definition of “Additional Telehealth Benefits” to include:
  - Part B services that can be provided via telehealth – but for which Part B does not permit payment if provided electronically
  - Services that have been identified by the MA plan as clinical appropriate to provide electronically
  - Do not include capital and infrastructure costs and investments

- MA plans may only furnish additional telehealth benefits through in-network providers. Telehealth services through out-of-network providers are classified as supplemental benefits.

Enhanced Integration of D-SNP Benefits

- D-SNP plans are required to coordinate Medicare and Medicaid benefits for dually-eligible enrollees.

- BBA 2018 required that dual-eligible special needs plans (D-SNPs) better integrate Medicare and Medicaid benefits by either:
  - Covering Medicaid long-term care services and supports and/or behavioral health services through a capitated benefit from a state Medicaid agency
  - Notifying the state Medicaid agency of hospital and skilled nursing facility admissions for at least one group of high-risk dual eligible beneficiaries
  - Requirements go into effect in contract year 2021

- CMS also finalized a unification of the Medicare and Medicaid grievance and appeals processes for fully-integrated (FIDE) and highly-integrated (HIDE) D-SNPs and affiliated Medicaid managed care plans.
  - These D-SNP provisions will start in contract year 2021

Preclusion Criteria

- The preclusion list was first announced in April 2018 as a means for prohibiting payment for Part D drugs and MA items or services furnished or prescribed by demonstrably problematic providers and prescribers.

- CMS finalized several changes to the preclusion list policies to clarify criteria, including:
  - Establishes that a felony conviction under state or federal law is a new, separate basis for placement on the preclusion list, and prescribes the length of time on the preclusion list for providers or prescribers with a felony conviction
  - Consolidation of the appeals process (concurrent rather than sequential appeals for revocation of billing rights and placement on preclusion list)
  - Timeframe for additions to the preclusion list

- The rule finalized a provision that a beneficiary has no appeal rights with respect to a claim detail on the basis of a prescriber/provider's presence on the preclusion list.
  - If a prescriber/provider is added to the preclusion list, a MA plan must provide notice to beneficiaries within 30 days
  - Plans must deny claims for a precluded provider/prescriber 60 days after notice is sent to beneficiaries

Annual Key Dates for MA Plans

Key Date	Event
February	Advance Notice and Proposed Call Letter released. (Release required to be at least 60 days before the first Monday in April and allow for at least a 30-day comment period.)
April 1	Final Rate Announcement of MA Capitation Rates and MA and Part D Payment Policies, including the Call Letter released
No later than 1st Monday in June	Deadline for submission of bids and formularies for the coming year
June to August	CMS review and approval of bids
Late July 2019	Final Regional PPO base premiums and Part D base premiums are published by CMS. Bids are finalized based on these amounts
Mid-September	All contracts for the coming CY fully executed
Early October	Plan star ratings go live

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Strategic Considerations for Providers

Key Implications

Regulations support the continued growth of Medicare Advantage

- MA plans will want to shift risk to providers

Coding accuracy and specificity is even more important due to the enhanced utilization of encounter data

- Payment Condition Count (PCC) to fully replace HCC by 2022

Provider organizations must work with and influence payer partners to optimize VBID and supplemental benefit options

- Opportunity to shape chronic conditions and SODH benefits

Working with payers to ensure that you maximize the use of and reimbursement for telehealth

- Additional telehealth benefits only through in-network providers

Outlook: Bipartisan View on Value Based Care & Risk

$13K+

Medicare

Spending per beneficiary

$5K+

Medicaid

Spending per beneficiary

Providers

Insurers

- Innovative care delivery processes
- Use data from across the continuum
- Multiple care access points
- Continued clinical integration
- Organize community resources
- Become an Insurer
- Eliminate variation & increase efficiency

Shift Risk to Providers

- Become a provider
- Negotiate lower prices
- Delay or challenge bill payment
- Incent retail provider (CVS) use
- Reduce expensive settings of care
- Use data to create preferred network
- Micromanage providers (UR, PPO…)
- Organize physicians

How do you select your strategic path forward?

	Plan Type	Success Factors			
		Coding Accuracy	Star Score	Care Management	Sales and Marketing
	Traditional FFS				
	Upside only shared savings	✓✓	✓✓	✓	✓
	Down-side risk	✓✓✓	✓✓✓	✓✓	✓✓
	Health plan joint venture	✓✓✓	✓✓✓	✓✓✓	✓✓
	Health plan ownership with a TPA	✓✓✓✓	✓✓✓✓	✓✓✓✓	✓✓✓✓
	Health plan ownership and management	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓

MA strategy process considerations

Premier Medicare Advantage Advisory Support

Assess

- **Medicare Market Assessment, Implications, & Strategy**
- **MA Strategy Development**
- **MA provider-sponsored health plan market assessment and feasibility**

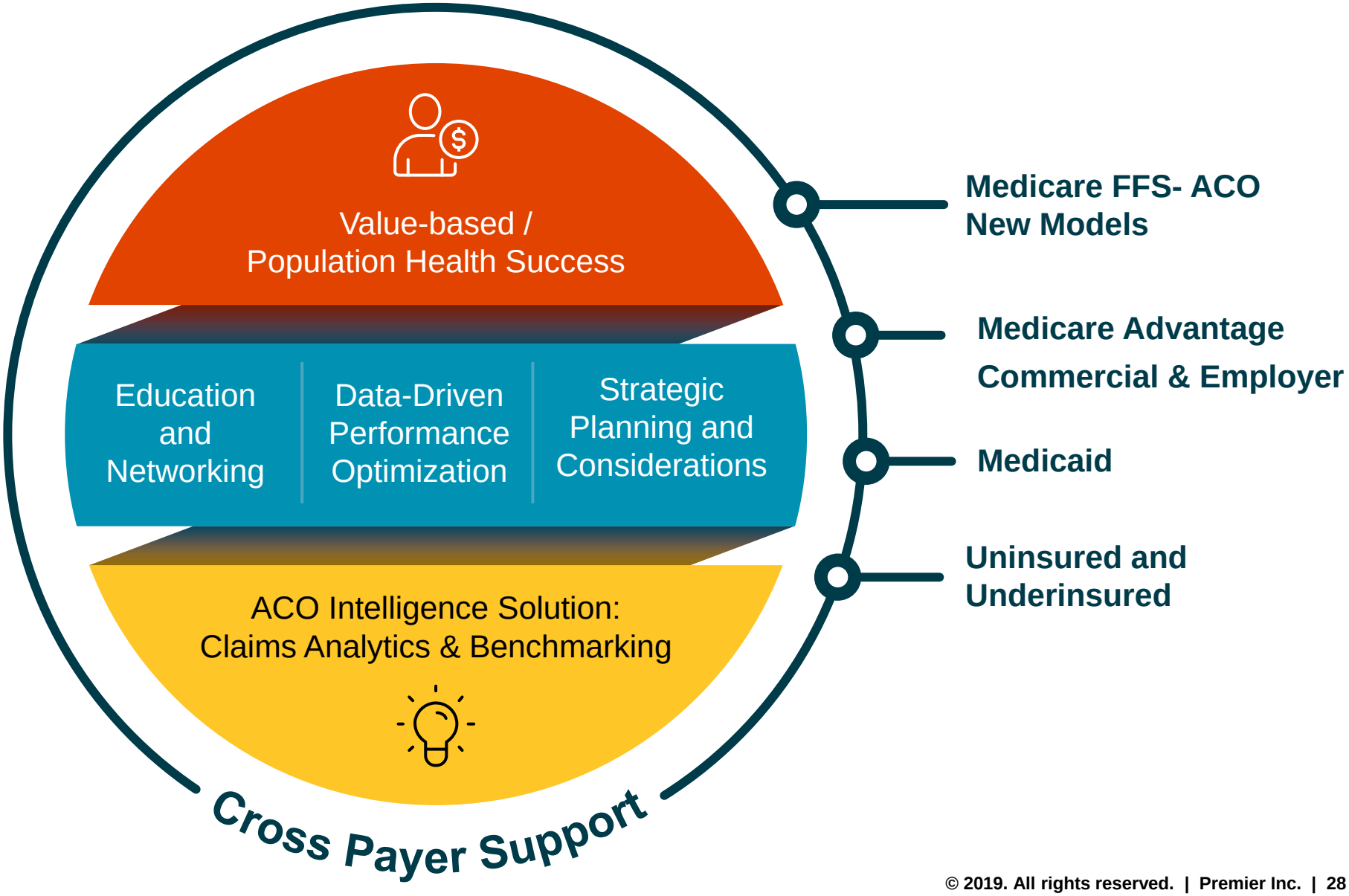
Design & Build

- **MA payer partner scorecard**
- **MA contract optimization**
- **MA payer partner, and contracting negotiations guidelines and strategy**

Execute & Operate

- **Claims analytics & reporting**
- **Coding and documentation improvement to drive accurate risk scores**
- **HEDIS and patient experience to drive Star bonus performance**
- **Sales and marketing**

Population Health Management Collaborative



Medicare Advantage (MA) Cohort

Purpose: Provide a learning and performance improvement network focused on sharing lessons learned and strategies for developing best practices for driving performance improvement in MA metrics for MA VBP success. The aim of the Cohort is to ensure that PHMC members are armed with the knowledge needed to capitalize on the ever growing Medicare Advantage market.

Structure: Monthly calls/webinars, facilitated small group and 1:1 discussions, and aggregated survey and market summaries.

Content Examples

2018

- January-April: Coding Accuracy for Risk Scores Sprint
- April-December: Keys to MA success
  - Star Scores
  - Sales and Marketing
  - Care Management

2019

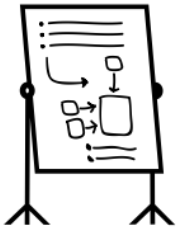
- January-June
  - Care Management (continued)
  - Contacting, enhancing payer partnerships
  - Policy updates / Call letter impact
  - Market indicators that inform your MA strategy
  - Introduction of PCC risk score program
  - Member case studies

4.0 enhancements for Medicare Advantage

Annual MA guidance reports – The MA strategy selected by a provider organization is heavily dependent on individual market dynamics. Therefore, using publicly available sources and information collected from MA Cohort members, individualized reports including macro and micro level market considerations and call letter implications will be developed and presented to Advanced members on an annual basis.

MA policy updates, summaries, and notifications – Advanced members will begin receiving more frequent and thorough MA policy updates, starting in April with a thorough summary and webinar reviewing key implications of the 2019 MA call letter and rate adjustment.

MA assessments – As one of the annual assessment options available through PHMC, members may now select an MA strategy or capabilities assessment.



MA strategy and education sessions – Similar to PHMC led Medicare ACO strategy sessions, members may now select to utilize Premier SMEs to facilitate and lead in-person MA educational or strategy sessions

Important Links

Rate Announcement and Call Letter:

Rate Announcement and Final Call Letter

CMS Fact Sheet

CMS Press Release

Final Rule:

Medicare Advantage and Part D Flexibility Final Rule

CMS Fact Sheet

CMS Press Release

Questions

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