HEALTH MANAGEMENT ASSOCIATES

Analysis of the 2021 CMS Advance Notice and Part C/Part D Proposed Rule

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AGENDA

- Key Themes and Priorities
- Part C Policies
- Part D Policies
- Risk Adjustment and Other Payment Changes
- Star Ratings
- Key Timelines

MULTIPLE SOURCES OF GUIDANCE FOR PLANS AS THEY PREPARE TO SUBMIT 2021 BIDS

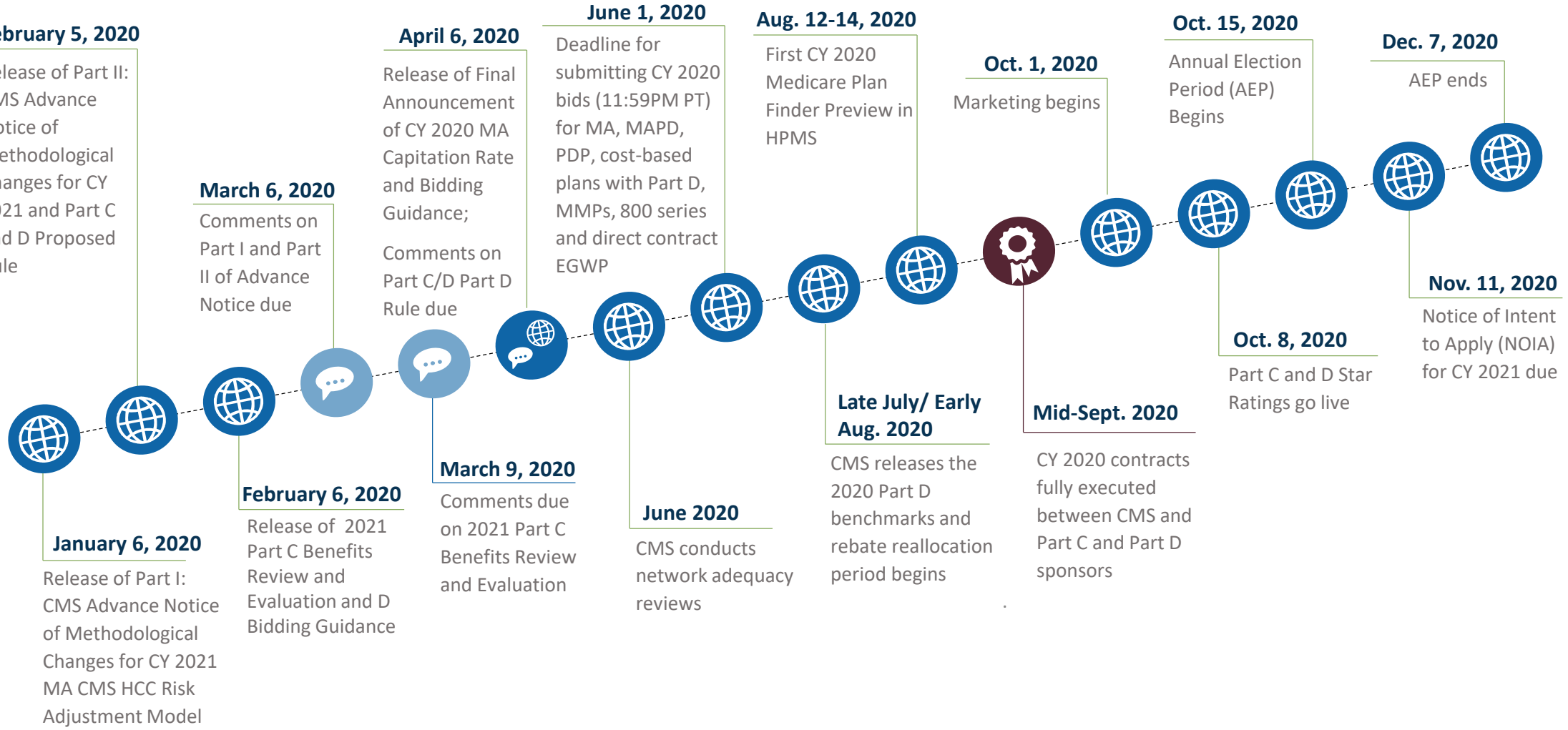
- This webinar summarizes proposed payment updates and policy changes from the following:
  - Part I and Part II Advance Notice
  - Proposed Rule on Policy and Technical Changes to Medicare Advantage (MA) and Part D for CY 2021 and CY 2022 (Proposed Rule)
  - Part D Bidding Instructions Guidance
  - Part C Benefits Review and Evaluation
  - Part C and Part D Annual Calendar
- CMS stated it will not publish a Call Letter for 2021; much of the guidance previously included in the 2020 Call Letter is proposed to be codified in the CY 2021 and CY 2022 Proposed Rule

KEY THEMES OF THIS YEAR'S ADVANCE NOTICE AND PROPOSED RULE

- Proposed payment update for CY 2021 is more modest than CY 2020
- Most significant proposed policy changes to:
  1. Integrate individuals with End Stage Renal Disease (ESRD)
  2. Update network adequacy requirements and further promote of telehealth
  3. Revise Star Rating calculations to further emphasize patient experience measures
  4. Promote lower-cost Part D prescription drugs

KEY DATES FOR CY 2021 MEDICARE ADVANTAGE PLANS

Comments on the Advance Notice Part I and Part II are due March 6. Comments on the Part C/D Proposed Rule are due April 6



PROPOSED NET PAYMENT IMPACTS FOR 2021

Preliminary estimate of expected average change in revenue, excluding coding trend, is 0.93%. Actual revenue change will vary by plan and by geography

Year-to-Year Percentage Change in Payment		
Impact Area	**2021 Advance Notice***	**2020 Final***
Effective Growth Rate	**2.99%**	**5.62%**
Rebasing/Repricing	TBD	-0.02%
Change in Star Ratings	+0.23%	-0.14%
MA Coding Intensity Adjustment	0.0%	0.0%
Risk Model Revision	+0.25%	+0.21%
Encounter Data Transition	0.0%	-0.06%
Normalization	-2.54%	-3.08%
Expected Average Change in Revenue	**0.93%**	**2.53%**
Coding Trend	**3.56%**	**3.30%**

* Average values provided by CMS

PART C POLICIES

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CY 2021 BENEFIT DESIGN AND BID REVIEW HIGHLIGHTS

Total Beneficiary Cost (TBC)	• $37 per-member-per-month, up from $36 in 2020
Maximum Out of Pocket Spending (MOOP)	• Change in MOOP to account for ESRD; 40% differential factor • $7,550 (Mandatory) and $3,450 (Voluntary)
Cost Sharing Requirements	• Increases to all categories of inpatient hospital and skilled nursing facility (days 21-100) cost sharing

Comment Opportunity

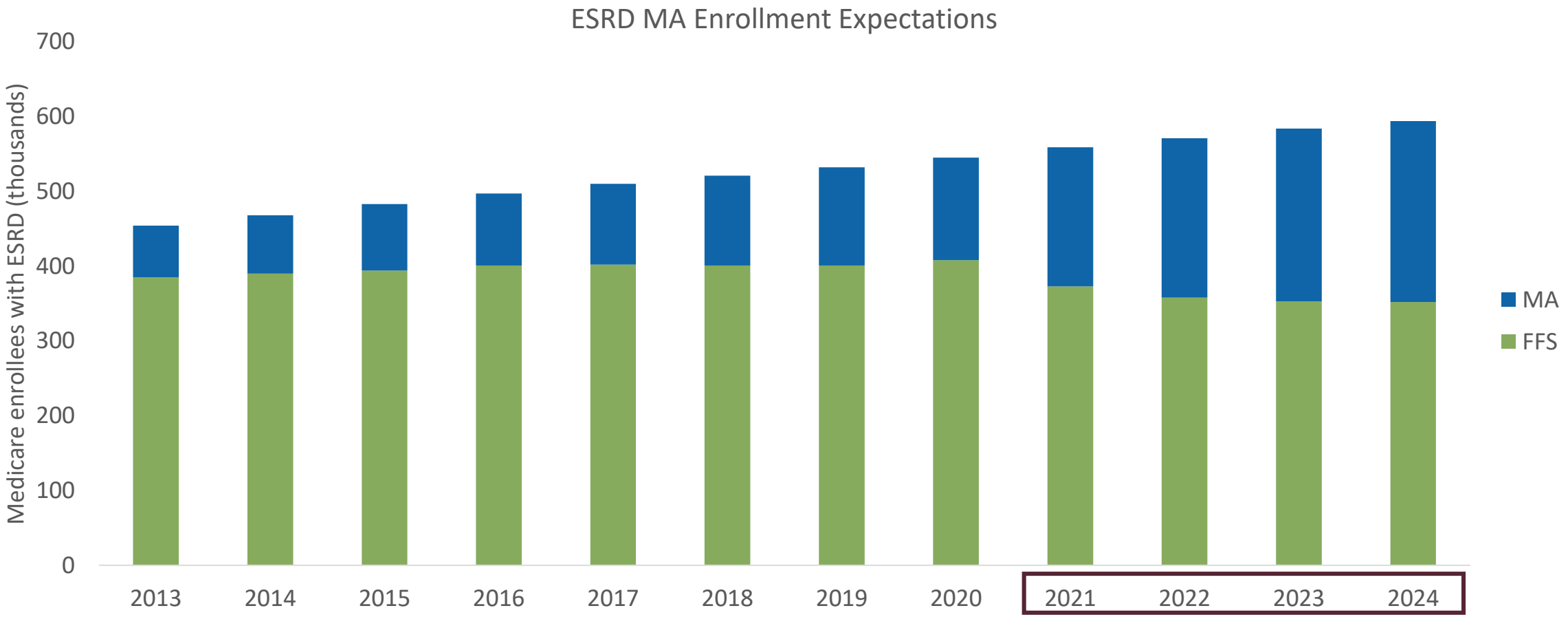
REQUIREMENTS PERMITTING BENEFICIARIES WITH ESRD TO ENROLL IN MA

Comment Opportunity

Medicare beneficiaries already diagnosed with ESRD may enroll in a Medicare Advantage plan beginning in 2021

- Original Medicare will cover kidney acquisition costs for MA beneficiaries; costs will be excluded from MA benchmarks
- To assist with the expected added costs and network access issues, CMS proposed:
  - Potential changes to network adequacy requirements in 2022 to promote greater use of home dialysis:
    - Removing outpatient dialysis from list of facility types subject to time and distance standards
    - Allowing plans to attest to providing dialysis services in lieu of requiring plans to meet time and distance standards
    - Allowing exceptions to time and distance standards if a plan is instead covering home dialysis
    - Customizing time and distance standards for all dialysis facilities
  - Modifications to cost-sharing limits (i.e., MOOP) for all enrollees to account for anticipated increased ESRD costs

PROPORTION OF INDIVIDUALS WITH ESRD ENROLLING IN MA IS EXPECTED TO GROW



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PROPOSED CHANGES TO NETWORK ADEQUACY AND INCREASED USE OF TELEHEALTH

Comment Opportunity

CMS proposed to codify the existing network adequacy methodology and promote MA plans in rural areas and encourage use of telehealth

CMS proposed:

- Promoting out-of-network telehealth to be covered as basic benefit
- Easing maximum time and distance standards in rural areas
- Providing a 10 percentage point "credit" toward percentage of beneficiaries residing within the applicable time and distance standards in select cases:
  - Plan contracts with telehealth providers in select specialties (dermatology, psychiatry, neurology, otolaryngology and cardiology)
  - Plans in states with certificate of need (CON) laws
- Exclusion of Opioid Treatment Programs (OTPs) from provider types subject to network adequacy standards due to newness of benefit

With all proposals, plans would still be required to meet minimum provider number requirements

PHASE-OUT OF D-SNP "LOOKALIKES"

Comment Opportunity

CMS proposed to no longer approve D-SNP "lookalike" plans by 2022 to encourage greater enrollment in plans that integrate/coordinate Medicare and Medicaid services

No New Approvals or Renewals

- Policy would apply in states with D-SNPs or MMPs
- CMS would not approve new lookalike plans or renew existing lookalike plans

Criteria for Identifying D-SNP Lookalikes

- 80% enrollment threshold
- Evaluated using 2021 enrollment and/or projected 2022 enrollment (bid)

Enrollee Transition

- Existing D-SNP lookalike MAOs can transition enrollees to another MA plan or D-SNP
- For MAOs that do not have this option, enrollees can elect another plan or chose Original Medicare

ADDITIONAL PART C POLICY PROPOSALS

Comment Opportunity

- **Increased Flexibility for Plans to Define "Chronically-ill" Enrollees for Special Supplemental Benefits for the Chronically Ill (SSBCI)**
- **Treatment of Supplemental Benefits in Medical Loss Ratio (MLR)**

PART D POLICIES

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CHANGES FOR 2021 – PART D BENEFITS AND PAYMENT HIGHLIGHTS

Annual Percentage Increase (API)	• Proposed API of 2.85%--sum of annual projected trend of 3.16% and prior year revision of -0.30%. • Out-of-pocket thresholds increase by $200 for non-LIS beneficiaries and $275 for LIS beneficiaries
Plan Liability for Gap Coverage	• **Generic**: Plan liability maintained at 75%; Beneficiary co-insurance maintained at 25% • **Brands**: Plan liability maintained at 5%; Beneficiary co-insurance maintained at 25%

Other Benefit Design Changes	• **Standalone PDP Meaningful Differences.** Remains at $22 in OOPC between Enhanced Alternative vs. Basic Plan
	• **Specialty Tier Threshold.** Proposed to increase from $670 in 2020 to $780 in 2021 CMS seeks feedback on methodology used to evaluate threshold changes
	• **Maximum Copays.** No change
	  • Preferred Generic: <$20
	  • Generic: $20
	  • Preferred Brand: $47
	  • Non-preferred Drug $100

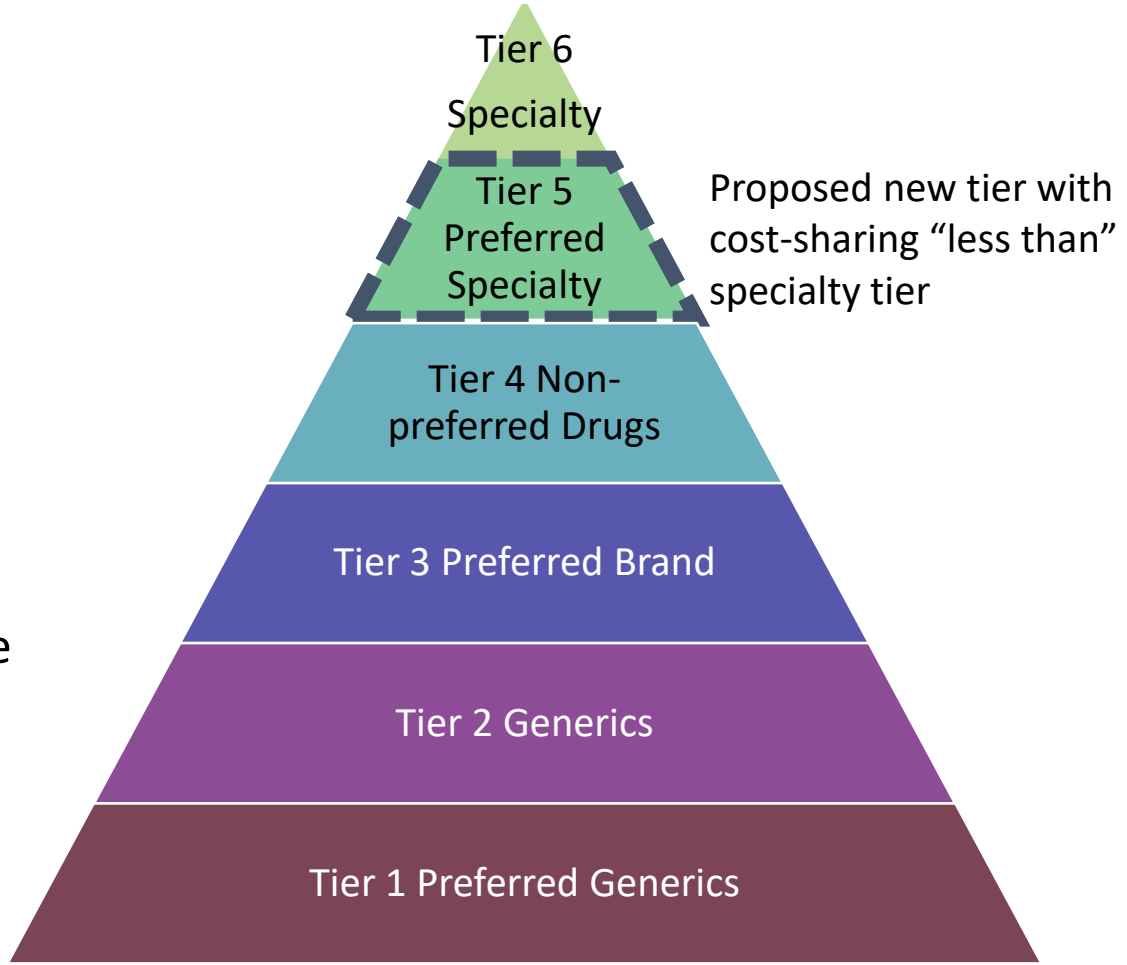
Comment Opportunity

"PREFERRED" SPECIALTY TIER INTENDED TO PROMOTE LOWER COST SHARING

Comment Opportunity

CMS proposed to:

- Permit Part D plans to have up to 2 specialty tiers
- Require plans to permit exception requests for drugs on the higher cost-sharing specialty tier to the lower cost-sharing "preferred" specialty tier
- Permit plans to make drugs on the specialty tier(s) ineligible for exception requests to non-specialty tiers
- Maintain a specialty-tier cost threshold that includes the top 1% of drug ingredient costs



REAL TIME BENEFIT TOOL (RTBT) TO IMPROVE PRICE TRANSPARENCY FOR ENROLLEES

Comment Opportunity

RTBTs are electronic tools that enable users to view accurate, timely, and patient-specific real-time formulary and benefit information, including cost sharing and any utilization management requirements for drugs and their alternatives

- In the May 2019 final rule, CMS required Part D plans to support a RTBT capable of integrating with at least one e-prescribing or EHR system **beginning January 1, 2021 for prescribers**
- CMS proposes to require Part D plans to implement a RTBT **beginning January 1, 2022 for all Part D enrollees**
- Part D plans will need to develop applications to allow enrollees to view RTBT information
- Part D plans will also be required to make this information available through their customer service call centers

PROPOSALS TO IMPLEMENT OPIOID PROVISIONS IN THE SUPPORT ACT

Comment Opportunity

- **REQUIRE PART D PLANS TO ESTABLISH DRUG MANAGEMENT PROGRAMS (DMPs) (CY 2022)**
- **REQUIRE PART D PLANS TO DISCLOSE OPIOID INFORMATION TO ENROLLEES (CY 2021)**
- **MODIFIES REQUIREMENTS FOR MEDICATION THERAPY MANAGEMENT (MTM) (CY 2021)**

ESTABLISHING PHARMACY PERFORMANCE MEASURE REPORTING REQUIREMENTS

Comment Opportunity

Part D plans currently do not have to disclose to CMS the measures they use to evaluate pharmacy performance in their network agreements. CMS proposed to require Part D plans to disclose to CMS their pharmacy performance measures

Data elements may include:

- Name of the performance measure
- Performance calculation methodology
- Success/failure thresholds
- Financial implications of success/failure to achieve thresholds
- Pharmacy appeal requirements
- Method of payment of collection

CMS proposed to publish the list of pharmacy performance measures used

RISK ADJUSTMENT AND OTHER PAYMENT CHANGES

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CMS CONTUINES TO IMPLEMENT NEW RISK ADJUSTMENT MODEL

Comment Opportunity

The 21st Century Cures Act required CMS to update the risk adjustment model to take into account the count of chronic conditions for each enrollee

CMS-HCC 2017	CMS-HCC 2020
• 79 Diagnostic Condition Categories • 16 Condition Interaction Effects • 6 Disability – Condition Interaction Effects	• 86 Diagnostic Condition Categories • 16 Condition Interaction Effects • 6 Disability – Condition Interaction Effects • 10 Condition Count Categories

Phase-in Schedule for 2020 Model, as Required by 21st Century Cures Act

2020	2021	2022
50% CMS-HCC 2020 50% CMS-HCC 2017	75% CMS-HCC 2020 25% CMS-HCC 2017	100% CMS-HCC 2020 0% CMS-HCC 2017

CMS INTENDS TO INCREASE RELIANCE ON ENCOUNTER DATA FOR RISK ADJUSTMENT IN 2021

CMS proposed to increase the use of encounter data in 2021

Proposed use of encounter data in Part C, Part D, and ESRD Risk Adjustment models:

50% (2020) → 75% (2021)

CODING ADJUSTMENT AND NORMALIZATION FACTORS

MA Coding Pattern Adjustment	**5.90% -** This amount is mandated by statute, and is the minimum required (same in 2020).

NORMALIZATION FACTORS

CMS-HCC Model Normalization Factors:

- 2017 CMS-HCC Model – From 1.075 to 1.106
- 2020 CMS-HCC Model – From 1.069 to 1.097

PACE Normalization Factor: 1.106

ESRD-Dialysis Normalization Factor: From 1.059 to 1.079

ESRD-Functioning Graft Normalization Factor: From 1.084 to 1.118

RxHCC Normalization Factor: From 1.019 to 1.063

STAR RATINGS

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KEY PROPOSED UPDATES TO THE 2021 STAR RATINGS PROGRAM

Comment Opportunity

Patient Experience Measure Weights and Cut Points and Outliers	• Proposed to increase the weight of patient experience/complaints and access measures from 2.0 to 4.0 beginning in 2023 • Proposed to increase the stability of cut points by modifying the cut point methodology for non-CAHPS measures through direct removal of outliers
Generic Utilization Part D Measurement Concept	• Proposed development of measures to assess generic and biosimilar utilization in Medicare Part D; potential measure concepts include: (1) Generic Substitution Rate, (2) Generic Therapeutic-Alternative Opportunity Rate, (3) Biosimilar Utilization Rate
Contract Consolidation	• Proposed to add a rule to account for instances when the measure score is missing from the consumed/surviving contracts due to a data integrity issue • A score of zero would be assigned for the missing measure score in calculating enrollment-weighted measure score

CHANGES TO 2021 STAR MEASURES

Updated Star Measures

- Care for Older Adults – Functional Status Assessment Indicator (Part C)
  - *Removing a numerator requirement on assessments*
  - *Move to display for 2022/2023*
- Reviewing Appeals Decisions (Part C)
  - *Technical change*
- HEDIS: Patient-Used Device Data (Part C)
  - *Wider use of technologies that incorporate patient data into clinical data repositories*
- HEDIS: Digital Specifications (Part C)
  - *CMS encourages MA contracts to begin using and referencing NCQA digital specifications for HEDIS Effectiveness of Care measures*
- HEDIS: Cross-Cutting Exclusions (Part C)*
  - *Methods and exclusions for individuals receiving palliative care or who require nursing home level of care*

Removal of Measures

- None for 2021

Display Measures

NEW

- Physical Functioning Activities of Daily Living (Part C)
- Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D)

UPDATED

- HEDIS Follow-up after Emergency Dept Visit for Patients with Multiple Chronic Conditions (Part C)
  - *CMS is proposing to add to 2023 Star Ratings*
- HEDIS Transitions of Care (Part C)
  - *CMS is proposing to add to 2023 Star Ratings*
- Controlling High Blood Pressure (Part C)
  - *Will return to Star Ratings for 2022*
- Hospitalization for Potentially Preventable Complications (Part C)*
- Antipsychotic Use in Persons with Dementia Overall, for Community-only Residents, and in Persons with Dementia, for Long-term Nursing Home Residents (Part D)
- Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment (Part C)*

RETIRED

- Osteoporosis Testing in Older Women (Part C) – beginning in 2023

*Comment opportunity

POTENTIAL CHANGES AND ADDITIONS TO STAR RATINGS FOR 2022 AND BEYOND

New Measure Concepts

- End-Stage Renal Disease (ESRD) Measures (Part C)*
- Prior Authorizations (Part C)*
- Physical Functional Activities of Daily Living (HOS) (Part C)*
- Osteoporosis Screening (Part C)
- Cardiac Rehabilitation (Part C)*
- Diabetes Overtreatment (Part C)*
- Home Health Services (Part C)*
- Generic Utilization (Part D)*
- Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D)*
  - *Will be added to display for 2023/2024*
- Initial Opioid Prescribing at High Dosage (IOP-HD) (Part D)*
- Initial Opioid Prescribing for Long-Acting or Extended Release Opioids (IOP-LA) (Part D)*
- Net Promoter Score (NPS)*

Changes to Measures

- HOS Measure: Improving or Maintaining Physical Health (Part C)*
  - *Change case-mix adjustment and increase minimum required denominator*
  - *Expansion to under 65 pop*
- HOS Measure: Improving or Maintaining Mental Health (Part C)*
  - *Change case-mix adjustment and increase minimum required denominator*
  - *Expansion to under 65 pop*
- Statin Use in Persons with Diabetes (Part D)*
  - *Reclassify as a process measure*
- Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D)
  - *Consider risk adjustment and stratification for sociodemographic status*

Removal of Measures

- Rheumatoid Arthritis Management (Part C)*
  - *For 2021 measurement year/2023 Star Ratings*

*Comment opportunity

IMPLICATIONS

QUESTIONS? CONTACT ONE OF THE FOLLOWING HMA MEDICARE PRACTICE EXPERTS

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