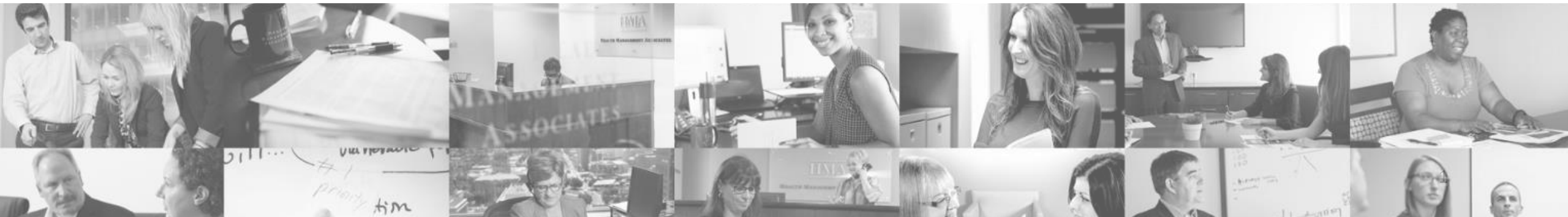
HEALTH MANAGEMENT ASSOCIATES

Analysis of the 2020 CMS Advance Notice Parts I and II and Draft Call Letter

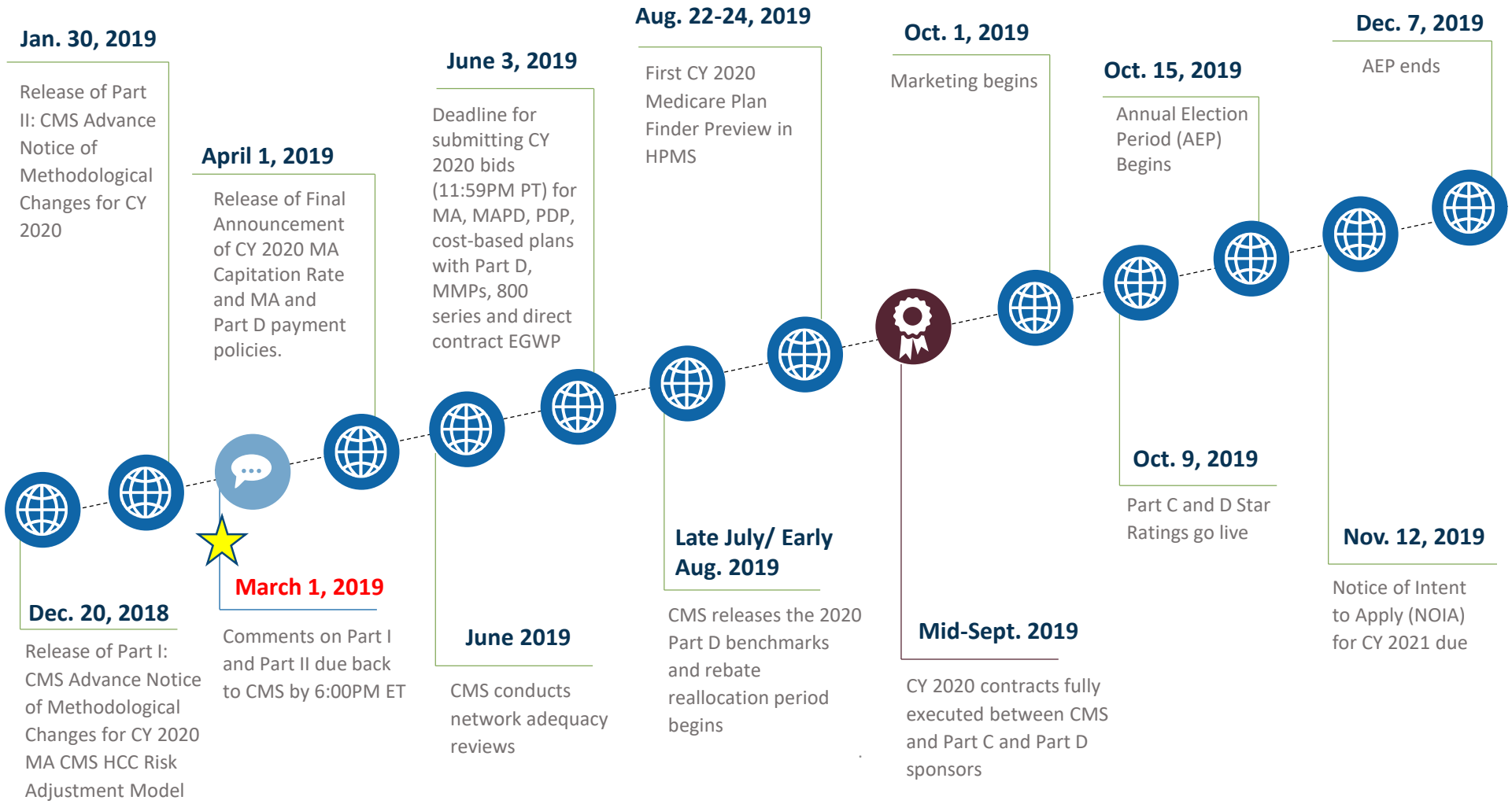


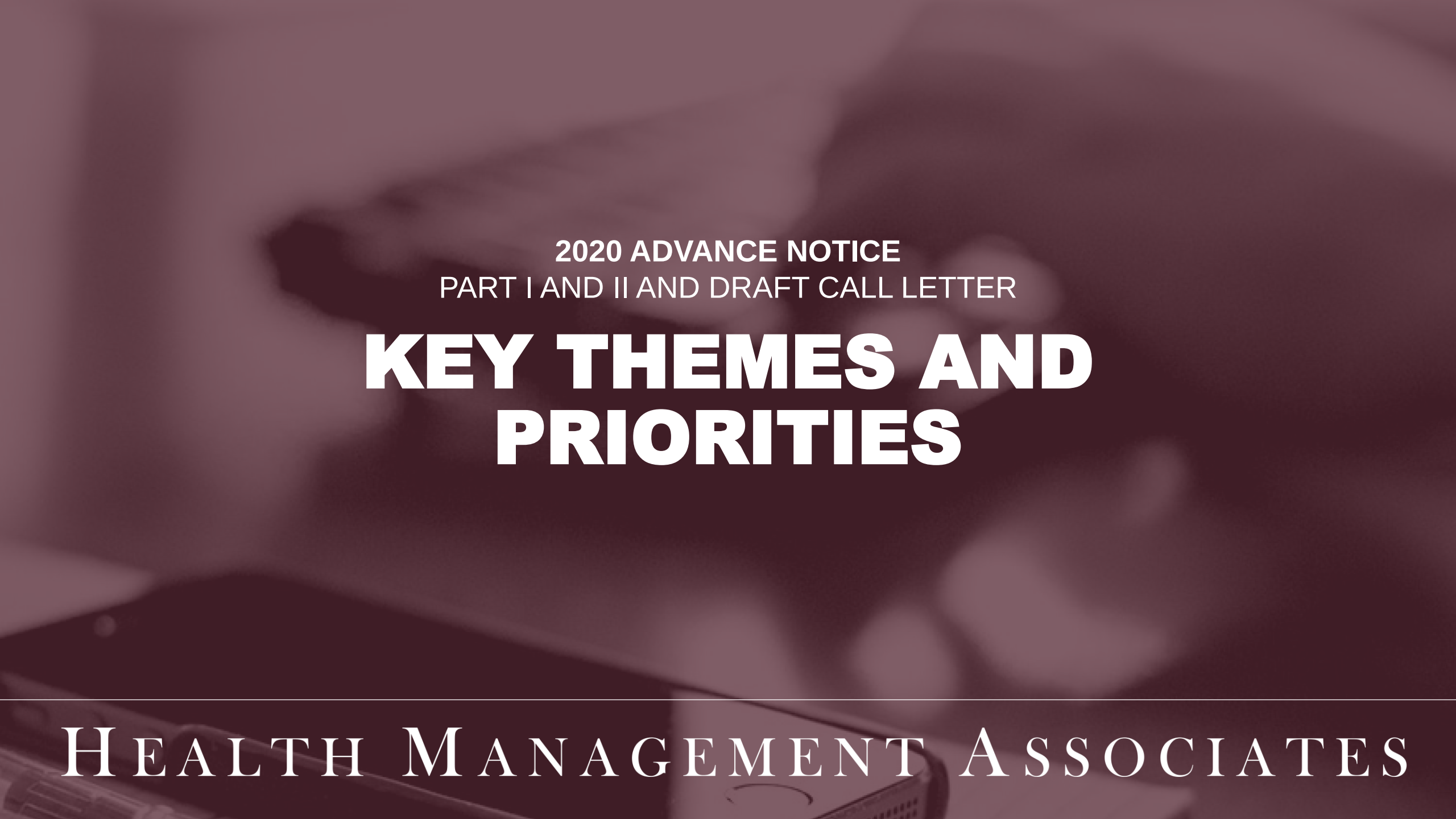
AGENDA

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

KEY DATES FOR CY 2020 MEDICARE ADVANTAGE PLANS

Comments on the Advance Notice Part I and Part II and Draft Call Letter are due March 1





2020 ADVANCE NOTICE

PART I AND II AND DRAFT CALL LETTER

KEY THEMES AND PRIORITIES

HEALTH MANAGEMENT ASSOCIATES

- Proposed Payment Updates
- Dual Eligible Integration
- Continued Focus on the Opioid Epidemic & Improved Access to Treatment
- New Risk Adjustment Methodologies
- Updates to Star Ratings
- Criteria for Non-Medical Supplemental Benefits
- Promoting Greater Generic Drug Dispensing and Vaccines

NET PAYMENT IMPACTS FOR 2020

Preliminary estimate of expected average change in revenue, excluding coding trend adjustments, is 1.59%. Actual revenue change will vary by plan and by geography.

Year-to-Year Percentage Change in Payment		
Impact Area	**2020 Advance Notice***	**2019 Final***
Effective Growth Rate	4.59%	5.28%
Rebasing/Repricing	TBD	0.49%
Change in Star Ratings	-0.14%	-0.26%
MA Coding Intensity Adjustment	0.0%	0.01%
Risk Model Revision	0.28%	0.28%
Encounter Data Transition	-0.06%	-0.04%
EGWP Payment Policy	0.0%	-0.1%
Normalization	-3.08%	-2.26%
Expected Average Change in Revenue	**1.59%**	**3.4%**
Coding Trend	**3.3%**	**3.1%**

* Average values provided by CMS

PART D: SUBSTANTIAL INCREASE IN OUT-OF-POCKET SPENDING DUE TO "PART D CLIFF"

Absent Congressional action, Affordable Care Act (ACA) provision which slowed the growth of the catastrophic coverage threshold level will expire in 2020. This will result in a significant increase in out-of-pocket spending needed to reach catastrophic coverage.

Standard Benefit	2018	2019	2020
Deductible	$405	$415	$435
Initial Coverage Limit (ICL)	$3,750	$3,820	$4,020
Out of Pocket Threshold	$5,000	$5,100	$6,350
Total Covered Part D Spend for LIS (including the coverage gap)	$7,508.75	$7,653.75	$9,038.75
Estimated Total Covered Part D Spend for non LIS	$8,417.60	$8,906.55	$9,719.38
Minimum Cost Sharing			
Generic/Preferred Multi-Source Drug	$3.35	$3.40	$3.60
Other	$8.35	$8.50	$8.95

PART C POLICIES

HEALTH MANAGEMENT ASSOCIATES

Key Updates to Part C Benefit Design	
Total Beneficiary Cost (TBC)	• $36 per-member-per-month
Maximum Out of Pocket Spending (MOOP)	• "Intermediate MOOP" • CMS is also considering additional flexibilities for select service category cost sharing standards for plans that use the voluntary or intermediate MOOP
Cost Sharing Requirements	• Increases to all categories of inpatient hospital and skilled nursing facility (days 21-100) cost sharing
New Opioid Treatment Program (OTP)	• New covered benefit including certain medications, substance use counseling, individual and group therapy, and toxicology testing • OTPs must be enrolled in Medicare, certified by SAMHSA, and accredited by a SAMHSA-approved entity • Access must be consistent with existing community patterns of care in the areas where the network is being offered

Comment Opportunity

Comment Opportunity

The Bipartisan Budget Act of 2018 (BBA 2018) permits MA plans to offer non-primarily health-related supplemental benefits to chronically ill enrollees in 2020

- **Items or Benefits that are Not Primarily Health Related or Offered Non-Uniformly**
  - Must have a reasonable expectation of improving or maintaining health or overall function
    - E.g., transportation for non-medical needs, home-delivered meals, food and produce
    - May not include capital or structural improvements that would increase home value
  - Plans can vary which eligible enrollees are offered SSBCI, but must offer objective criteria for determination
  - Coverage requests for supplemental benefits should be treated similar to requests for other plan benefits

- **CMS seeks feedback on whether other factors (e.g., financial need) should be considered in determining permissible SSBCI**

CMS'S PROPOSAL OUTLINES INITIAL CRITERIA FOR SSBCI ELIGIBILITY

Comment Opportunity

- **Definition of Chronically-Ill Enrollee**
  - Must meet all three of the following criteria:
    - Have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit the overall health or function of the enrollee
    - Have a high risk of hospitalization or other adverse health outcomes, and
    - Require intensive care coordination
  - For CY 2020, CMS will consider any enrollee with one of 15 SNP-specific chronic conditions to meet the statutory criteria of a chronically ill enrollee
  - MA plans do not need to specify the process they use to determine enrollee eligibility

- **CMS solicits comment on whether plans should have flexibility to determine if a chronic condition meets the statutory standard and if CMS should consider alternative approaches**

SEVERAL PROVISIONS ADDRESS D-SNP POLICIES AND MEDICARE/MEDICAID ALIGNMENT

D-SNP LOOK-ALIKES — Comment Opportunity

D-SNP ADMINISTRATIVE ALIGNMENT OPPORTUNITIES — Comment Opportunity

CROSSOVER CLAIMS — Comment Opportunity

ADDITIONAL CY 2020 SUPPLEMENTAL BENEFIT OPPORTUNITIES ARE AVAILABLE

- **NON-OPIOID PAIN MANAGEMENT**
- **PHYSICAL EXAM SUPPLEMENTAL BENEFIT FOR SNPS**

2020 DRAFT CALL LETTER – OTHER HIGHLIGHTS

- **EMPLOYER GROUP WAIVER PLANS (EGWPs)** — Comment Opportunity
- **PROVIDER DIRECTORIES**
- **RISK BASED PHARMACY BENEFIT ARRANGEMENTS RFI** — Comment Opportunity

PART C AND D DEMONSTRATIONS

VBID TEST MODEL

- ✓ Opens VBID demonstration model to eligible plans in all 50 states starting in CY 2020
- ✓ Expands model to include RPPOs and SNPs
- ✓ Ability to test: non-uniform benefit design (cost-sharing or supplemental benefits) targeted based on condition and/or socioeconomic status; expanded rewards and incentives programs; and telehealth networks to expand access
- ✓ Participating plans must offer wellness and health care plan (WHP), including advance care planning
- ✓ Applications due March 1, 2019
- ✓ CMS indicates it plans to test the inclusion of the Medicare hospice benefit in Medicare Advantage starting in CY 2021

Part D Payment Modernization Model

- ✓ Tests risk sharing model for Part D—plans take two-sided risk for the federal reinsurance subsidy
- ✓ Provides new flexibilities including Part D Rewards and Incentives programs
- ✓ Open to PDPs and MA-PDs
- ✓ Applications due March 1, 2019

PART D POLICIES

HEALTH MANAGEMENT ASSOCIATES

2020 DRAFT CALL LETTER – CY 2020 PART D BENEFITS AND PAYMENT HIGHLIGHTS

Key Part D Payment Updates

Annual Percentage Increase (API)	• Proposed API of 5.21%--sum of annual projected trend of 5.25% and prior year revision of -0.04%. Increases in out-of-pocket thresholds substantially higher due to "Part D Cliff."
Plan Liability for Gap Coverage	• **Generic**: Plan liability increased from 63% to 75%; Beneficiary co-insurance decreased from 37% to 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.** Remains at $670. 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

SEVERAL PROVISIONS ENCOURAGE SPONSORS TO PREVENT AND ADDRESS OPIOID OVERUTILIZATION

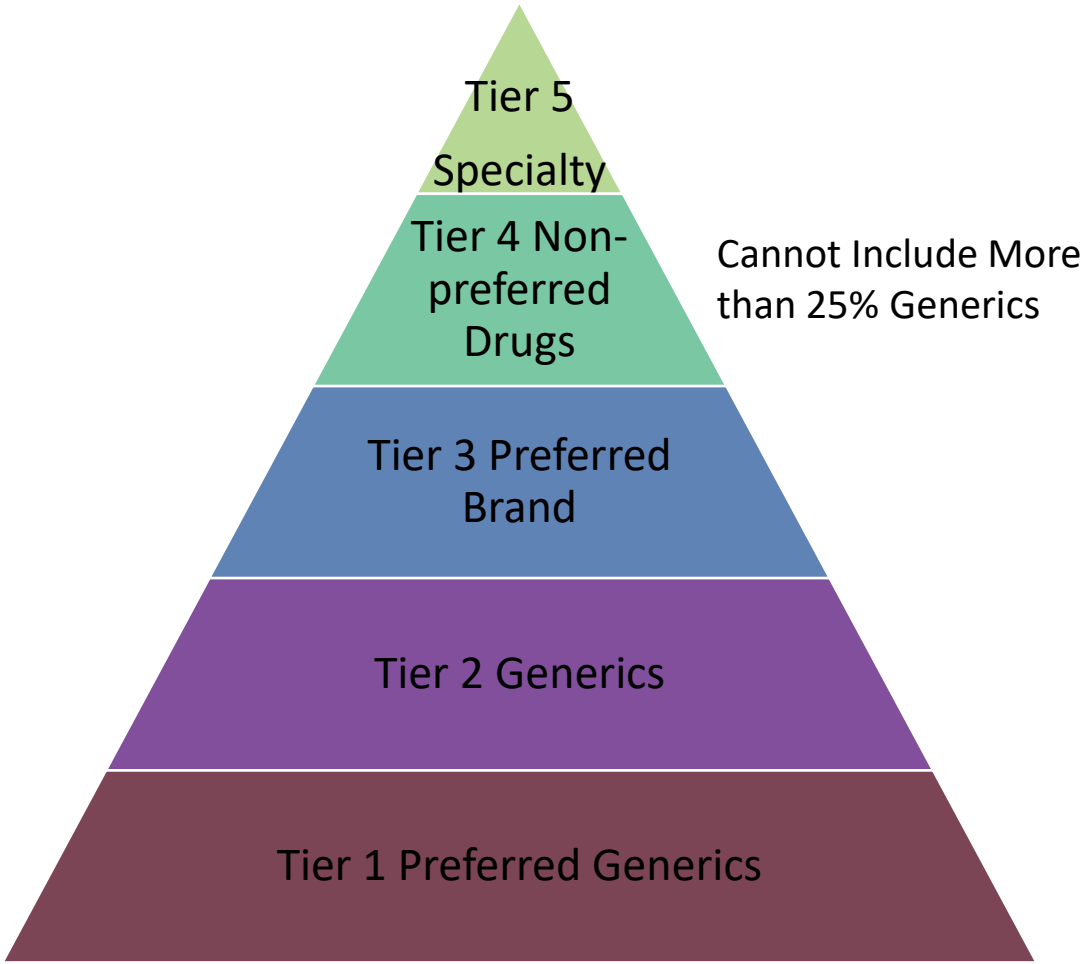
- **ACCESS TO OPIOID REVERSAL AGENTS (NALOXONE) & MEDICATION-ASSISTED TREATMENT**
- **CHANGES TO THE OVERUTILIZATION MONITORING SYSTEM (OMS)**
- **UPDATES TO OPIOID OVERUSE MEASURES**

Comment Opportunity

CMS PROPOSED DRUG TIER CHANGES TO ENCOURAGE GREATER USE OF GENERICS

Comment Opportunity

- **Constrains number of generics placed in non-preferred drug tier (Tier 4)**
- **Discourages placement of generics on brand tiers (and brands on generic tiers)**
- **Encourages Part D sponsors to either offer no cost-sharing for vaccines or place them on a low-cost-sharing tier**
- **Solicits feedback about placement of biosimilars: generic vs. specialty tier?**

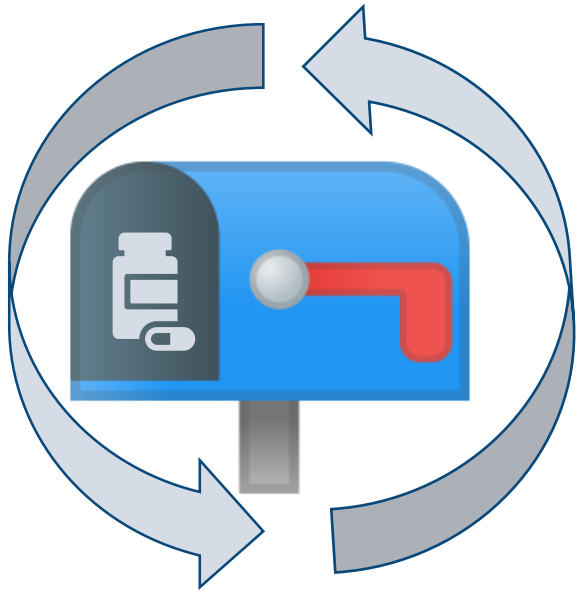


CMS PROPOSES TO ALLOW OPT-IN VOLUNTARY AUTO-SHIP REFILL PROGRAM

Comment Opportunity

Proposal would replace current policy requiring affirmative consent for sending refills prior to each delivery

- Only applicable to drugs that a beneficiary has been using for at least **four consecutive months**
- Beneficiaries must be given opportunity to select auto-ship on a **drug-by-drug** basis
- Part D sponsors should provide no less than **two reminders** prior to sending
  - CMS does not specify method of outreach for reminders
  - Reminder should provide instructions for beneficiary to cancel shipment
- Pharmacies or Part D sponsors must confirm beneficiary participation **at least annually**



REMOVAL OF ANTI-KICKBACK PROTECTION FOR PRESCRIPTION DRUG REBATES	
Published: 2/6/19 | **Status:** Proposed | **Comment Period:** Open (4/8/19) | **Effective Date:** Varies	
Drug Rebates and the Anti-Kickback Statue	Aims to increase transparency, reduce incentives to raise drug prices, and lower out-of-pocket cost by excluding from safe harbor protection certain reductions in price and other remuneration from a drug manufacturer paid to PBMs, Part D plans, and Medicaid MCOs. **Effective Date:** January 1, 2020 (but CMS is asking for feedback on whether this gives entities a sufficient transition period)
New Safe Harbors	Proposes two new safe harbors for: 1) discounts reflected at the point-of-sale (if certain requirements are met); and 2) certain fixed fee service arrangements between drug manufacturers and PBMs. **Effective Date:** 60 days following publication of final rule

RISK ADJUSTMENT AND OTHER PAYMENT CHANGES

HEALTH MANAGEMENT ASSOCIATES

CMS IS REQUIRED TO IMPLEMENT NEW RISK ADJUSTMENT MODEL

Comment Opportunity

The 21st Century Cures Act requires CMS to update the risk adjustment model to take into account the number of conditions. CMS is proposing two versions of the Payment Condition Count (PCC) model

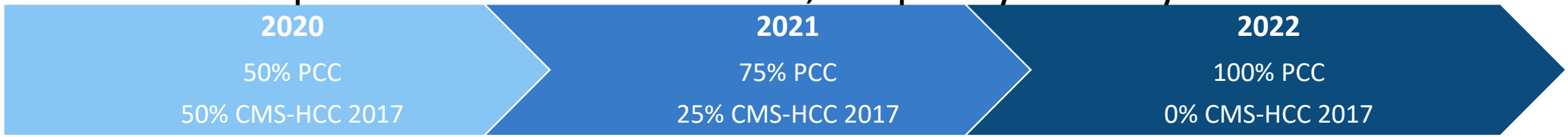
PCC Version One

- Unlike current CMS-HCC model, PCC also takes into the account the **number of conditions** a beneficiary has
- Number of conditions counted would be capped at **ten**
- Includes more severe/chronic conditions and improves accuracy

PCC Version Two

- Identical to PCC version one, but with **three** additional HCC condition categories
- Additional HCC categories include pressure ulcers, dementia with complications, and dementia without complications

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



CMS INTENDS TO INCREASE RELIANCE ON ENCOUNTER DATA FOR RISK ADJUSTMENT IN 2020

CMS is proposing to increase the use of encounter data in 2020

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

25% (2019) → 50% (2020)

SEVERAL PROPOSED UPDATES TO NORMALIZATION FACTORS

NORMALIZATION FACTORS

MA Coding Pattern Adjustment	**5.90% -** This amount is mandated by statute, and is the minimum required (same in 2019).

CMS-HCC Model Normalization Factors:
Consistent with Part I Advance Notice proposal to blend risk scores calculated with 1) 2017 CMS-HCC payment model and 2) proposed Payment Condition Count model, CMS calculated two factors

- 2017 CMS-HCC Model – From 1.041 to 1.075
- Payment Condition Count Model – From 1.38 to 1.069

PACE Normalization Factor: 1.159 (same as 2019)

ESRD-Dialysis Normalization Factor: From 1.033 to 1.059

ESRD-Functioning Graft Normalization Factor: From 1.048 to 1.084

RxHCC Normalization Factor: From 1.019 to 1.043 **OR** 1.035

Comment Opportunity

STAR RATINGS

HEALTH MANAGEMENT ASSOCIATES

CMS PROPOSES SEVERAL CHANGES TO STAR RATINGS

Key Updates to Star Ratings	
Removal of Part D Appeals Measures	• CMS proposes to remove two Part D appeals measures in the 2020 measurement year due to low statistical reliability • Measures seek to evaluate timeliness of processing appeals and the rates at which appeals are upheld • CMS is considering maintaining measures on Display Page
Updates to Extreme and Uncontrollable Circumstances Policy	• CMS again proposes to adjust the Star Ratings to take into account the effects of extreme and uncontrollable circumstances • Methodology similar to that which was adopted for the 2019 Star Ratings, but two proposed changes for 2020 – Eliminating the difference-in-differences adjustment for survey data – Clarifying the rules around measures with missing or biased data in the prior or current year

Comment Opportunity

CHANGES TO 2020 STAR MEASURES

Updated Star Measures

- Medication Adherence for Cholesterol (Statins) (Part D)
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D)
- Medication Adherence for Hypertension (RAS Antagonists), Diabetes Medications, and Cholesterol (Statins) (Part D)
- Statin Use in Persons with Diabetes (SUPD) (Part D)
- Members Choosing to Leave the Plan (Part C & D)

Removal of Measures

- Controlling High Blood Pressure (Part C) (to return to Star Measures in 2022)

Display Measures

NEW

- Transitions of Care (Part C)
- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C)
- MPF Price Accuracy (Part D)

UPDATED

- Use of Opioids at High Dosage and from Multiple Providers (OHDMP) and Antipsychotic Use in Persons with Dementia (APD) (Part D)
- Problems Getting Information and Help from the Plan and Problems with Prescription Drug Benefits and Coverage Disenrollment Reasons Survey composite measures (Part D)

RETIRED

- Transition Monitoring Program Analysis (TMPA) and Formulary Administration Analysis (FAA) (Part D)

POTENTIAL CHANGES AND ADDITIONS TO STAR RATINGS FOR 2021 AND BEYOND

New Measure Concepts

- Cross-Cutting Topic – Measure Digitalization (Part C)
- Cross-Cutting Topic – Exclusions for Advanced Illness (Part C)
- Physician/Plan Interactions (Part C & D) — Comment Opportunity
- Pain Management (Part C)
- Patient-Reported Outcome Measures (Part C) — Comment Opportunity
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Part C)
- Antibiotic Utilization Measures (Part C)
- Diabetes Overtreatment (Part C)
- Interoperability Measures (Part C) — Comment Opportunity

Changes to Measures

- Plan All-Cause Readmissions (Part C)
- Medication Reconciliation (Part C)
- Osteoporosis Measures (Part C)
- Care for Older Adults – Functional Status Assessment Indicator (Part C)
- Hospitalization for Potentially Preventable Complications (Part C)
- Medication Adherence (ADH) for Hypertension, Diabetes, and Cholesterol (Statins) (Part D) — Comment Opportunity
- Antipsychotic Use in Persons with Dementia (APD) and Statin Use in Persons with Diabetes (SUPD) (Part D)
- Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH), and Polypharmacy Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Part D)
- Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D)
- High Risk Medication and Diabetes Medication Dosing (DMD) (Part D)

Removal of Measures

- Adult BMI Assessment (Part C)
- Appeals Auto-Forward (Part D)
- Appeals Upheld (Part D)

Comment Opportunity

KEY TIMELINES

HEALTH MANAGEMENT ASSOCIATES

KEY DATES FOR CY 2020 MEDICARE ADVANTAGE PLANS

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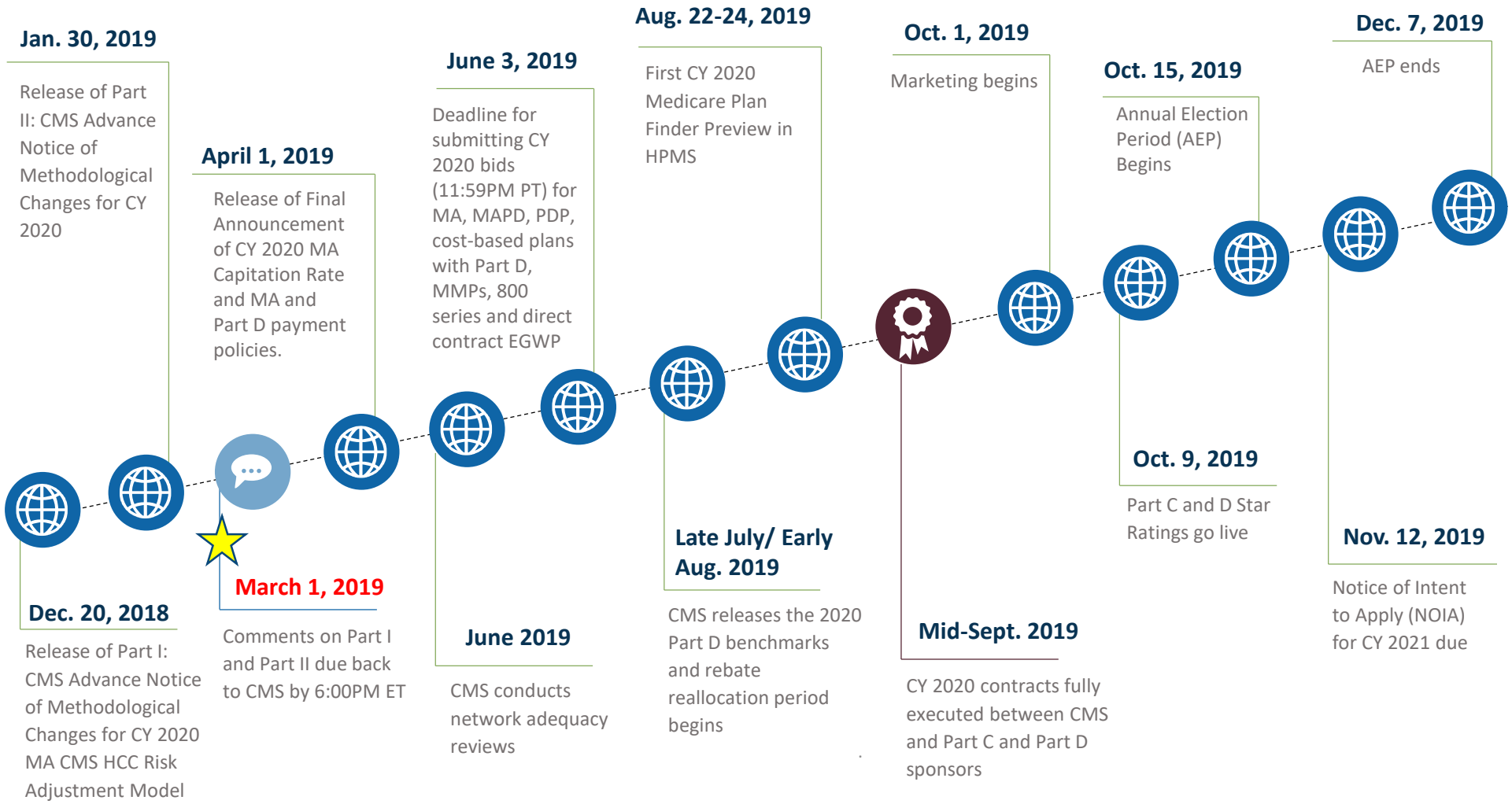

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