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Medicare Advantage 2019 Advance Notice

Summary of the Announced Methodology Changes

February 2018

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes and updates for Payment Year 2019 as detailed in both Parts 1 and 2 of the Advance Notice. For a more detailed analysis of the Cures Act changes, please see our posted brief: Medicare Advantage 2019 Advance Notice – Part 1

Key Risk Adjustment Methodology Changes & Updates of the 2019 Advance Notice

Advance Notice Part 1, 21st Century Cures Act Changes:

- **Cures Act Directive:** Consider using two years of diagnosis data for calculation of Payment Year 2019 risk scores.

  CMS Response: The Advance Notice omitted any mention of this directive, however, Pulse8 confirmed on an industry conference call with CMS administrators that there is no change to the risk adjustment methodology time period parameter. For Payment Year 2019, dates of service from only 2018 will be used for risk score calculation.

- **Cures Act Directive:** Consider the total number conditions of a beneficiary for complete risk score calculation.

  CMS Response: Advent of an HCC-count-per-member variable as part of member risk score calculation methodology: The risk score adjustment amount increases as the number of conditions per individual increases.

  Impact: While highly dependent on a plan's ability to recognize and document comorbid conditions, preliminary analysis by Pulse8 shows the proposal to be a favorable adjustment to plan risk scores, with the financial impact in the range of $3 to $8 PMPM.

- **Cures Act Directive:** Evaluate impact of additional diagnoses within both behavioral health and chronic kidney disease groups.

  CMS Response:

  - Behavioral Health HCC Updates: Both mental health and substance abuse HCCs have been augmented to account for trends in behavioral health treatment.

- Chronic Kidney Disease: Addition of HCC 138 – CKD Stage 3 added to model, limited to the moderate diagnosis only, mild Stage 3 CKD is not included in the CMS-HCC model.

Impact: Based on historical prevalence, we are expecting the impact of the additional diagnoses to be $3 to $5. The documentation of mental health and substance abuse conditions can be highly variable dependent on the availability of mental health professionals. With more focus on these conditions in the future, the impact is likely to become more favorable.

- **Cures Act Directive:** Risk adjustment model changes must be phased-in over a 3-year period starting in 2019, with 100% adoption for 2022.

  CMS Response: The 2019 Advance Notice proposes to blend risk score calculation using a progressive blending of the 2017 and 2019 risk adjustment models. See Figure 1 below.

  Figure 1: Phase-In Schedule for Blending the Proposed 2019 Model with the Current 2017 Model

Payment Year	Proposed 2019 Model	Current 2017 Model
2019	25%	75%
2020	50%	50%
2021	75%	25%
2022	100%	NA

  Legend:
  Proposed 2019 Model: "2019 Part C, Version 23, CMS-HCC Model," AKA "Payment Condition Count Model"
  Current 2017 Model: "2017 Part C, Version 22, CMS-HCC Model," used for Payment Years 2018 and 2017

  - Part 1 of the Advance Notice announces that CMS will merge 2019/2017 model blending methodology with the existing process of EDPS/RAPS risk score blending calculation. Currently, for Payment Year 2018, EDPS data risk scores are weighted at 15% with RAPS data risk scores weighted at 85%. The Advance Notice sets the blend rate for Payment Year 2019 at 25% EDPS, 75% RAPS – the same ratio used for 2019/2017 model blending. Per the Advance Notice:
    - EDPS risk scores will be calculated using the proposed 2019 Model at 25%
    - RAPS risk scores will be calculated using the current 2017 Model at 75%
    - Total risk scores will be calculated by weighting EDPS/2019 Model risk score at 25% and adding this product to 75% of the RAPS/2017 Model risk score.
  - Part 1 of the Advance Notice puts-forth an additional change to EDPS/RAPS risk score calculation methodology. To wit: "CMS observes that Encounter Data inpatient submissions are low compared to corresponding RAPS inpatient submissions. Amending

inpatient diagnoses from Encounter Data with inpatient diagnoses from RAPS will improve the completeness of the data for payment in 2019."

Advance Notice Part 2, Proposed Payment Adjustment Rates & Other Updates

- Part C Coding Intensity Adjustment: 5.90%
- Part C Normalization Factors:
  - Payment Year 2019 Model: 1.038
  - Payment Year 2017 Model: 1.041
- Figure 2, below, displays the variables impacting plan payments over the past three years plus the values proposed for 2019. Bulleted here are some key observations of Figure 2:
  - CMS estimates an expected increase of 1.84% to plan payments for 2019.
  - The estimated, net impact to revenue of the Cures Act 2019 risk adjustment model is positive 0.28%.
  - The estimated impact due to Change in Star Ratings is 50% less than in 2018, dropping to negative 0.20% from negative 0.40%.
  - The estimated impact of the MA Coding Intensity Adjustment will break a 3-year adverse trend of 0.25% year-over-year. For 2019, the adjustment is slated to be 5.90%, which is actually 0.01% better (less) than 2018's 5.91%.

Figure 2: Medicare Advantage, Part C Payment Adjustments Payment Year 2016 to 2019

Factors & Adjustment Variable	2016 Final Announcement	2017 Final Announcement	2018 Final Announcement	2019 Advance Notice
Effective Growth Rate	4.20%	3.10%	2.70%	4.35%
Transition to ACA Rules	-0.80%	-0.80%	N/A	N/A
Rebasing/Re-pricing	-0.30%	0.00%	0.30%	TBD*
Change in Star Ratings	0.50%	0.10%	-0.40%	-0.20%
Risk Model Revision	-1.70%	-0.60%	0.00%	0.28%
MA Coding Intensity Adjustment	-0.25%	-0.25%	-0.25%	0.01%
Encounter Data Transition Impact	N/A	N/A	N/A	-0.04%
EGWP Payment Policy Update	N/A	N/A	N/A	-0.30%
Normalization Factor	-0.40%	-0.60%	-1.90%	-2.26%
Plan Payment Impact Estimate	***1.25%***	***0.85%*****	***0.45%***	***1.84%***

**Rebasing/re-pricing impact is dependent on finalization of average geographic adjustment index and will be available with the publication of the 2018 Rate Announcement. **Totals may not add due to rounding.*

- Updated ESRD Risk Adjustment Model for Payment Year 2019
    - Cures Act allows all Medicare beneficiaries with ESRD to enroll in MA plans beginning in 2021; CMS preparing for increase in MA ESRD population by recalibrating model on data that are more recent. 2019 model based on 2014 service diagnoses for 2015 expenditures.
    - Medicaid designation based on payment year status, not service year status as before.

Key 5-Star Quality Methodology Changes & Updates from the 2019 Advance Notice

New Measures:

- Statin Use in Persons with Diabetes (SUPD; Part D)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)

Removed Measures:

- Beneficiary Access and Performance Problems (BAPP)
- Reducing the Risk of Falling (Part C)

New Display Measure:

- Plan Makes Timely Decisions about Appeals (Part C)

Noteworthy Proposed Changes for 2019 and Beyond:

- Star Ratings and Quality Bonus Payments (QBPs) for surviving plans when two or more contracts are consolidated will be addressed in pending rulemaking for Contract Year 2019
- Increase in the maximum possible Categorical Adjustment Index (CAI) from 0.09 to 0.14
- Proposed Changes to MPF Price Accuracy (Part D) and moving measure to the Display Page for the 2020 and 2021
- PQA is recommending the Medication Adherence measures be risk-adjusted for various sociodemographic characteristics beginning with the 2018 calculations and CMS will determine how to implement within the Star Ratings by early 2019
- CMS is developing a Technical Expert Panel (TEP) of representatives across stakeholder groups to obtain feedback on the Star Ratings framework, topic areas, methodology, and operational measures
- Proposed Scaled Reductions for Appeals IRE Data Completeness Issues
- Several proposed changes to existing measures, including adding telehealth and remote access technologies for some measures

New measures proposed for 2020 to address care coordination, multiple chronic conditions, and opioid use.

Key Quality Payment Program Changes & Updates from the 2019 Advance Notice

CMS will begin implementing an additional way for eligible clinicians to become QPs that considers their participation not only in Advanced APMs, but also in innovative alternative payment arrangements through other payers such as Medicaid, Medicare Advantage, and commercial payers.

- Aligns the standards that apply to Medicare and other Payer-Advanced APMs
- This year's rule includes provisions to make it easier for eligible clinicians to participate in select APMs (known as Advanced APMs), which may allow them to qualify for incentive payments
- Clinicians who do not meet the thresholds to become QPs will have the opportunity to qualify as QPs through the All-Payer Combination Option
- **Medicare Advantage plans can count as a MACRA APM** (e.g. if you already have an APM in place, this can reduce some of your reporting burden)