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Medicare Advantage 2019 Announcement

Summary of the Announced Methodology Changes

April 2018

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes and updates for Payment Year 2019 as detailed in the "Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2018. This document uses an event narrative format establishing a record of proposed changes through to final policy.

Key 2019 Risk Adjustment Methodology Changes & Updates

21st Century Cures Act Directives

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

  CMS 2019 Advance Notice: CMS 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 parameter. For Payment Year 2019, only dates of service from 2018 will be used for risk score calculation.

  CMS 2019 Announcement: There is not a specific, declarative statement on the use of two years of diagnosis data for risk score calculation; however, the topic is mentioned within the "Responses to Public Comments" section of the artifact. On page 42, "While we did not propose to implement a model based on ICD-10 diagnoses or two years of diagnosis data for payment year 2019, we will consider these changes to the model in future payment years."

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

  CMS 2019 Advance Notice: 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.

  CMS 2019 Announcement: CMS has decided NOT to implement, for 2019, the HCC-count-per-member methodology proposed in the Advance Notice. In explaining the decision, CMS referenced the implementation of other Cures Act initiatives for 2019 and acknowledged that the added complexity of also integrating the "Payment Condition Count" methodology would tax

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plans to an extreme. While the "Payment Condition Count" methodology will not be adopted for 2019, CMS did commit to integrating these changes for 2020, with 100% phase-in for 2022.

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

  CMS 2019 Advance Notice: Behavioral Health: Both mental health and substance abuse HCCs have been augmented to account for trends in behavioral health treatment. Chronic Kidney Disease HCC Updates: Addition of CKD Stage 3 model, limited to the moderate diagnosis only; mild Stage 3 CKD is not included in the CMS-HCC model.

  CMS 2019 Announcement: The changes to the HCC clinical model were approved for both the behavioral health and kidney disease categories. CMS did announce changes to the proposed labels for the new behavioral health HCCs. Below are the official HCC values and labels:

  - Behavioral Health
    - HCC 54 – Substance Use with Psychotic Complications
    - HCC 55 – Substance Use Disorder, Moderate/Severe, or Substance Use with Complications
    - HCC 56 – Substance Use Disorder, Mild, Except Alcohol and Cannabis

    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.

  - Chronic Kidney Disease
    - HCC 138 – Chronic Kidney Disease, Moderate (Stage 3)

- **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 2019 Advance Notice: The 2019 Advance Notice proposes to blend risk score calculation using a progressive blending of the Current 2017, Version 22 Model (used for 2017 and 2018 payment) and the Proposed 2019, Version 23 Model.
  - 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 the EDPS/2019 Model risk score at 25% and adding this product to 75% of the RAPS/2017 Model risk score.

  CMS 2019 Announcement: Adopted as issued in the Advance Notice.

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2019 Payment Rate Factor Changes & Adjustment Variables Updates

- Part C Coding Intensity Adjustment
  CMS 2019 Advance Notice: 5.90%
  CMS 2019 Announcement: Adopted as issued in the Advance Notice.

- Part C Normalization Factors
  CMS 2019 Advance Notice
  Payment Year 2019/Version 23 Model: 1.038
  Payment Year 2017/Version 22 Model: 1.041
  CMS 2019 Announcement: Adopted as issued in the Advance Notice for both models.

- All Payment Rate Factor Changes & Adjustment Variable Updates
  Figure 1, below, compares the initial Advance Notice payment factors and variables to the finalized Announcement payment factors and variables**.**

Figure 1: Plan Payment Rate Changes - 2019 Advance Notice to 2019 Announcement

Factors & Adjustment Variable	2019 Advance Notice	2019 Announcement	2019 Announcement less Advance Notice
Effective Growth Rate	4.35%	5.28%	0.93%
Rebasing/Re-pricing*	0.30%	0.49%	0.19%
Change in Star Ratings	-0.20%	-0.26%	-0.06%
MA Coding Intensity Adjustment	0.01%	0.01%	0.00%
Risk Model Revision	0.28%	0.28%	0.00%
Encounter Data Transition Impact	-0.04%	-0.04%	0.00%
EGWP Payment Policy Update	-0.30%	-0.10%	0.20%
Normalization Factor	-2.26%	-2.26%	0.00%
Plan Payment Impact Estimate	***2.14%***	***3.40%***	***1.26%***

**At the time of the 2019 Advance Notice, the Rebasing/Re-Pricing adjustment was TBD, the 2018 rate is used as a benchmark.*

Key 5-Star Quality Methodology Changes & Updates from the 2019 Final Call Letter

- New Measures:
  - Statin Use in Persons with Diabetes (SUPD; Part D)
  - Statin Therapy for Patients with Cardiovascular Disease (Part C)
- Removed Measure:
  - Beneficiary Access and Performance Problems (BAPP)
- New Display Measure:
  - Plan Makes Timely Decisions about Appeals (Part C)
- Removed Display Measures:
  - Enrollment Timeliness (Part C and D)
  - Appropriate Monitoring of Patients Taking Long-term Medications and Asthma Medication Ratio (Part C)

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Noteworthy 5-Star Changes for 2019 and Beyond:

- The Reducing the Risk of Falling measure will not be retired, but instead moved to an improvement measure for 2019 and 2020 Star Ratings calculations.
- Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications (Part D). Beneficiaries with ESRD are excluded from the measure per the PQA measure specifications. CMS will expand its data sources for identifying all Part D enrollees with ESRD for exclusion from the measures to include ICD-10-CM codes found in both Part A & B claims and Risk Adjustment Processing System (RAPS) RxHCCs for 2019 and beyond.
- Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). The Proportion of Days Covered (PDC) will be adjusted for inpatient (IP) stays and hospice enrollment for MA-PDs and PDPs, and skilled nursing facility (SNF) stays for PDPs for 2019.
- Members Choosing to Leave the Plan (Part C & D). CMS will expand the exclusions for this existing measure to include plan benefit package (PBP) service area reductions (SARs) that result in the unavailability of PBPs that the enrollee is eligible to move to within the contract.
- Changes to the Categorical Adjustment Index (CAI) values and tables for 2019.
- 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.
- 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.
- Scaled Reductions for Appeals IRE Data Completeness Issues.
- Several proposed changes to existing measures starting in 2020, 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.

Impact: As expected, CMS made few changes from the Advance Notice, including the change for surviving plans when two or more contracts are consolidated. Plans should start now to address new measures being added, specifically the Part D Statin and Opioid measures. Understanding denominators, which could be large for these measures; and the overlap to existing measures, including HEDIS® and Part D medication adherence measures; as well as making sure your Risk Adjustment, HEDIS®, 5-Star, and Pharmacy teams are working together, will be critical.

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