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Medicare Advantage

Payment Year 2020 Advance Notice – Part 2

Review of Key Proposals with Expert Insight

February 2019

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes and updates for Payment Year 2020, as detailed in Part 2 of the Advance Notice. To access Pulse8 insights from the Part 1 notice, **click here**.

Proposed Adjustments for PY2020 Risk Payment Calculus

- **Coding Pattern Adjustment**
  - All Models: 5.90%
- **Part C Normalization Factors**
  - 2020 CMS-HCC PCC Model: 1.069
  - 2017 CMS-HCC Version 22 Model: 1.075

  CMS noted that the significant increase in the Normalization Factor was due to Original Medicare risk scores increasing at a faster rate. CMS theorized that changes in demographics, the continuing implementation of ICD-10, and the increasing penetration of alternative payment models with incentives to report diagnosis codes more completely are the drivers of upward pressure on FFS risk score averages.
- **PY18 to PY19 to PY20 Percentage Change in Payment Adjustment Variables**

  Figure 1, below, juxtaposes the just-released PY2020 Advance Notice variable estimates against same for PY2019 Announcement and PY2018 Announcement.

  Figure 1

Factors & Adjustment Variable	2018 Announcement	2019 Announcement	2020 Advance Notice
Effective Growth Rate	2.70%	5.28%	4.59%
Rebasing/Re-pricing	0.30%	0.49%	TBD
Change in Star Ratings	-0.40%	-0.26%	-0.14%
MA Coding Intensity Adjustment	-0.25%	0.01%	0.00%
Risk Model Revision	0.00%	0.28%	0.28%
Encounter Data Transition Impact	N/A	-0.04%	-0.06%
EGWP Payment Policy Update	N/A	-0.10%	0.00%
Normalization Factor	-1.90%	-2.26%	-3.08%
Plan Payment Impact Estimate	***0.45%***	***3.40%***	***1.59%***

Special Supplemental Benefits for the Chronically Ill (SSBCI)

In the PY2019 Call Letter from February of 2018, CMS announced its re-interpretation of the Social Security Act statute which sets the parameters defining supplemental health care benefits. Following suit, the Bipartisan Budget Act of 2018 amended the same Social Security Act statute specifically for Medicare Advantage plans. And thus, the Special Supplemental Benefits for the Chronically Ill (SSBCI) program was established.

From the Call Letter section of the PY2020 Part 2 Advance Notice: "We believe the intended purpose of the new category of supplemental benefits is to enable MA plans to better tailor benefit offerings for the chronically ill population, address gaps in care, and improve specific health outcomes."

The Call Letter goes on to define 'Chronically Ill' as a member who:

1) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
2) has a high risk of hospitalization or other adverse health outcomes; and
3) requires intensive care coordination.

For number 1 above, the Call Letter references the same 15 chronic conditions established for Special Needs Plans (SNPs), as defined in Chapter 16b of the Medicare Managed Care Manual. (Note that the SSBCI is not limited to SNPs; the SSBCI is available for all Part C MA plans.) The 15 chronic conditions are:

- Chronic Alcohol / Drug Dependence
- Specified Autoimmune Disorders
- Cancer
- Specified Cardiovascular Disorders
- Chronic Heart Failure
- Dementia
- Diabetes
- End-Stage Liver Disease
- ESRD (requiring dialysis)
- Specified Severe Hematological Disorders
- HIV/AIDS
- Specified Mental Health Conditions
- Specified Neurological Disorders
- Stroke

CMS is not requiring MA plans to have their process for identifying qualifying SSBCI members submitted for approval; however, MA plans are expected to develop and document their SSBCI member-identification mechanisms.

The Call Letter further distinguishes SSBCI from traditional benefits, in that SSBCI are not required to be primarily health related: "In general, MA organizations have broad discretion in developing items and services they may propose as SSBCI so long as the item or service has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease."

Lastly, the Part 2 Advance Notice Call Letter section on SSBCI stresses that MA plans will have to develop benefit-qualifying criteria, backed with detailed documentation, to explain why, "… one chronically ill enrollee is eligible for a particular item or service and another is not."

Pulse8 Insight: *SSBCI dovetails with the PY2020 implementation of the Payment Count Condition risk score device: Both initiatives are designed to incentivize plans to consider the medical complexity and severity of their membership. A member Health Risk Assessment program for determination of SSBCI "chronically ill" status would have a natural intersection with 5+ PCC position members.*

8 Key MA 5-Star Quality Measures Program Takeaways

1. **Plan Notification of Measure and Star Rating Methodology Changes**

   Historically, the Part C and D Star Ratings methodology changes proposed in the annual Call Letter have NOT been fully documented within said Call Letter. There has always remained additional guidance on changes that have been issued in technical notes released after the Call Letter, overlapping with the impacted measurement period.

   To increase transparency and provide true, "advance notice" regarding enhancements and changes to the Part C and D Star Ratings program, CMS has made PY2020 the last year in which all specifications and requirements are NOT fully detailed in the annual Call Letter. Starting in PY2021, all new regulations will be announced, in total, through the Call Letter process prior to the measurement period.

   Pulse8 Insight: *The enhanced process for notification of methodology changes should assist plans with preparing for future changes to Part C and Part D Star Ratings.*

2. **Addressing the Opioid Epidemic**

   CMS is proposing several policies for 2020 to address the opioid epidemic, including additions of the updated PQA opioid measures. PQA finalized changes to the three opioid measures for the 2019 measurement year to better align with the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain:

   I. Use of Opioids at High Dosage and from Multiple Providers (OHDMP) (current display measure)

   II. Use of Opioids at High Dosage (OHD) and Use of Opioids from Multiple Providers (OMP) (proposed display measure)

   III. Concurrent Use of Opioids and Benzodiazepines (COB) (proposed display measure)

CMS will implement these revisions in the Patient Safety reports for the 2019 measurement year and propose to include all three revised measures on the 2021 display page; to be considered for the 2023 Star Ratings (2021 data), which would be proposed through rulemaking.

Pulse8 Insight: *Plans should already have programs in place that provide measure performance oversight and interventions to address the opioid measure set. Pulse8 products, Qualit8 and Formul8, can assist plans with these critical measures.*

3. Several Measure Updates

- Medication Adherence (ADH) for Cholesterol (Statins) (Part D) - PQA updated this measure for the 2018 measurement year to exclude beneficiaries with end-stage renal disease (ESRD).
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D) - PQA updated this measure for 2018 to include a new denominator rule to accurately account for all CMRs received.
- Medication Adherence Measures: Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D) - In line with PQA measure updates for the 2018 measurement year, CMS is proposing to exclude beneficiaries who elected to receive hospice care at any time in the measurement period and apply this change to the 2020 Star Ratings (instead of applying a Proportion of Days [PDC] adjustment for hospice enrollment as is currently done). This change narrows the population covered by the measure with no other changes. These changes would begin with the 2019 measurement year for the 2021 Star Ratings.
- Statin Use in Persons with Diabetes (SUPD) (Part D) - PQA clarified the specifications for eligible population received ≥ 2 prescription claims on different dates of service. CMS proposes to apply this non-substantive change to the 2021 measures. In addition, CMS is proposing a change from a weight of 1 to 3 as is standard practice for an intermediate outcome measure.
- Improvement measures (Part C & D) - Updated proposed list of measures to be used to calculate the 2020 Star Ratings. What? Missing Words…
- Members Choosing to Leave the Plan (Part C & D) - CMS is proposing to exclude from the numerator disenrolls for which the new contract service area does not overlap with the old contract service area.
- New or Updated 2020 Display Measures:
  - Transitions of Care (Part C) - Proposing NCQA measure be added to the 2020 display page with the intent to propose this measure for inclusion in future Star Ratings.
  - Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C) - CMS is proposing to add this NCQA measure to the 2020 display page.

- MPF Price Accuracy (Part D) - As stated in the 2019 Call Letter, CMS propose enhancements to the MPF Price Accuracy measure to be first published as a display measure in 2020, and then to be applied to the Star Rating measure for 2022.
- Problems Getting Information and Help from the Plan and Problems with Prescription Drug Benefits and Coverage Disenrollment Reasons Survey composite measures (Part D) - CMS is proposing changes to this measure.

Pulse8 Insight: *Most measure changes are slight and to keep in alignment with NCQA and PQA technical updates. Plans should be aware of specification changes and the impact of those changes on their measure performance. Pulse8's Qualit8 prospective tool can assist plans with managing a prospective 5-Star approach.*

4. Retired or Removed of Measures

- 3 measures from the 2022 Star Ratings - CMS is proposing to remove the following program due to the measures showing low statistical reliability:
  - Adult BMI Assessment (Part C)
  - Appeals Auto-Forward (Part D)
  - Appeals Upheld (Part D)
- 1 Retired Display Measure for 2020:
  - Transition Monitoring Program Analysis (TMPA) and Formulary Administration Analysis (FAA) (Part D)
- Temporary Removal of Controlling High Blood Pressure - CMS is proposing to temporarily remove the CBP (Part C) measure from the 2020 and 2021 Star Ratings due to changes in the NCQA measure specification change to align with the release of new hypertension treatment guidelines from the American College of Cardiology and American Heart Association.
- High Risk Medication (HRM) and Diabetes Medication Dosing (DMD) (Part D) - CMS will retire these two display measures for 2021 and no longer report these measures in the Patient Safety reports for the 2019 measurement year
- Medication Reconciliation (Part C) - NCQA proposes to retire the standalone Medication Reconciliation Post-Discharge measure for HEDIS 2020, which covers the 2019 measurement year.

Pulse8 Insight: *Removal of the Adult BMI and temporary removal of CBP could have negative impact on plans who have been performing well in those measures. Pulse8's Qualit8 prospective tool can assist plans with understanding and planning for 5-Star changes and the impact it will on have a plan's overall 5-Star performance.*

5. Adjustments to Star Ratings for Extreme and Uncontrollable Circumstances

CMS is proposing a similar policy to adjust the 2020 Star Ratings in the event of extreme and uncontrollable circumstances, such as major hurricane weather events. In addition to Star Rating adjustments, the proposal excludes those contracts from the clustering algorithm for non-CAHPS® measures to better eliminate the effect of outliers for plans who have at least 60% or more of their enrollees impacted by these circumstances.

Pulse8 Insight: *These changes will help stabilize the thresholds and cut points from year to year; however, plans need to be prepared that future cut points will likely increase with the removal of these low-performing plans. Pulse8's Qualit8 product can provide plans with the tools that allow plans to prepare for cut point changes and foresee impacts on overall performance, which is critical to managing 5-Star success.*

6. Potential Changes to Existing Star Ratings and Display Measures

- Plan All-Cause Readmissions (Part C) - NCQA is modifying the Plan All-Cause Readmissions measure for HEDIS 2020 (measurement year 2019). CMS is proposing to return this measure with the substantive updates by the measure to the 2023 Star Ratings using data from the 2021 measurement year with a weight of 1 for the first year and a weight of 3 thereafter.
- Osteoporosis Measures (Part C) - For HEDIS 2020, NCQA is reevaluating Osteoporosis Testing in Older Women (HOS) and Osteoporosis Management in Women Who Had a Fracture measure (Part C). Starting with the 2021 Star Ratings, CMS would use the Medicare Reconciliation Post-Discharge measure that is collected under the Transitions of Care measure from HEDIS 2020 covering the 2019 measurement year. CMS is also interested in the data being collected through the Electronic Clinical Data Sources (ECDS) reporting method. If developed and approved, the new measure would likely be included for Medicare reporting in HEDIS 2021.
- Care for Older Adults – Functional Status Assessment Indicator (Part C) - NCQA is considering refining the hybrid specification for the Functional Status Assessment indicator in the Care for Older Adults measure. If approved, these measure changes would be implemented in HEDIS 2020 or HEDIS 2021.
- Hospitalization for Potentially Preventable Complications (Part C) - For HEDIS 2020, NCQA is recommending updating the small denominator limit to < 150 for all risk-adjusted utilization measures, including Hospitalization for Potentially Preventable Complications, which is a current display measure.
- Antipsychotic Use in Persons with Dementia (APD) - PQA clarified the specifications to state that the eligible population received ≥ 2 prescription claims on different dates of service. CMS proposes to apply this non-substantive change to the 2021 measures (based on 2019 data).

Pulse8 Insight: *These changes will help stabilize the thresholds and cut points from year to year; however, plans need to be prepared that future cut points will likely increase with the removal of these low-performing plans. Pulse8's Qualit8 product can provide plans with the tools that allow plans to prepare for cut point changes and foresee impacts on overall performance, which is critical to managing 5-Star success.*

7. Potential New Measure Concepts

- Cross-Cutting Topics
  - Measure Digitalization (Part C) - CMS is aligning with NCQA's ECDS digital specifications for up to 20 existing HEDIS Effectiveness of Care measures for HEDIS 2020.
  - Exclusions for Advanced Illness (Part C) - NCQA is continuing work on the advanced illness and long-term care cross-cutting exclusions that were implemented in HEDIS 2019. CMS will review the updates at that time to determine whether it will permit incorporation of the updates into the Star Ratings without rulemaking.
- Physician/Plan Interactions (Part C & D) - CMS has indicated they would like feedback on the feasibility of developing and implementing a measure specifically related to plan coverage and payment decisions, claims processing issues, and other common administrative processes that plans have in place.
- Interoperability Measures (Part C) - CMS states that interoperability, the ability of health systems to effortlessly exchange and use electronic health information, is critical to improving care and reducing costs for Medicare beneficiaries. CMS is requesting feedback for measures that identify achievements in interoperability and patient access to health data.
- Patient-Reported Outcome Measures (Part C) - CMS states patient engagement is key to achieving high quality care. Currently, Part C includes 2 global PRO measures—improving or maintaining physical health and improving or maintaining mental health. CMS is interested in feedback from stakeholders about priorities, challenges, and successes plans have had using similar metrics internally, any synchronicities and/or efficiencies that could be gained from the MA program, focusing on particular PROs, and suggestions for future measure development related to PROs.
- Pain Management (Part C) - NCQA is exploring the development of new measures assessing the use of non-opioid therapies (pharmacologic and non-pharmacologic) for pain and PROs (e.g., functional status, quality of life) to manage care for patients with chronic pain. NCQA will hold discussions with plans and practices in the winter/spring of 2019 to assess the use of PROs in pain management. If approved, these new measures would likely be included in HEDIS 2021. CMS will consider whether to engage in rulemaking to incorporate such new measures into the Star Ratings.

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Part C) - For HEDIS 2020, NCQA is considering expanding the existing HEDIS measure, Adherence to Antipsychotic Medications for Individuals with Schizophrenia, to include reporting for the Medicare health plans. If approved, the measure would potentially be reported by MA and cost plans for HEDIS 2020 with possible future reporting on the CMS display page.
- Antibiotic Utilization Measures (Part C) - For HEDIS 2020, NCQA is considering expanding three of its existing HEDIS measures to include reporting for the Medicare plans that focus on antibiotic prescribing practices. If approved, the expanded measures would be reported by MA and cost plans for HEDIS 2020 with possible future reporting on the CMS display page.
- Diabetes Overtreatment (Part C) - QA is exploring the development of a new measure assessing overtreatment in clinically complex, older patients with type 2 diabetes. NCQA plans to begin testing this measure in 2019. If approved, this new measure would likely be included in HEDIS 2021. CMS will consider whether to engage in rulemaking to incorporate such new measures into the Star Ratings.

Pulse8 Insight: *Many of the proposed changes and concepts from CMS focus on data interoperability, Patient Report Outcomes (PRO) measures, and management of chronically ill/complex members. This aligns CMS with the NCQA movement to ECDS measure reporting over the next 3-5 years and the increase in value-based care being driven by CMS. Successful organizations should be shifting to keep with the demands by using a Member-Centered approach that taps into electronic health information with the long-term goal of improving care and reducing cost. Pulse8 products, Qualit8 and Integr8, can assist plans with ECDS submission and deploying member-centered interventions that will drive 5-Star success.*

8. Special Supplemental Benefits for the Chronically Ill

Beginning with the 2019 plan year, CMS determined that plans can provide certain enrollees with access to different benefits and services. The Bipartisan Budget Act of 2018 allows MA plans to offer non-primarily health-related supplemental benefits to chronically ill enrollees. Special supplemental benefits may include, but are not limited to, transportation for non-medical needs, home-delivered meals, food, and produce.

Pulse8 Insight: *Plans can use this new flexibility in supplemental benefits and additional services to chronically ill patients to remove barriers and improve health outcomes, which can positively impact a plan's overall 5-Star rating. We expect to see plans who use this approach with strategic focus to be increasing thresholds for many heavily weighted measures.*