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Medicare Advantage

Payment Year 2020 Final Call Letter Review

Impact Summary of Risk Adjustment & Five Star Ratings Program Changes

April 2019

PULSE8 is privileged to bring you a summary of key Medicare Advantage program changes and updates for Payment Year 2020 as detailed in the "Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 1, 2019. This review includes bottom-line impact assessments of the finalized changes. Please refer to the previously released Advance Notice Pulse8 Briefs, Part 1 and Part 2, for a deeper dive into the 2020 methodology.

Alternative Payment Condition Count (APCC) Risk Score Model

CMS will implement the APCC model for 2020. The APCC model introduces additive risk score values for members with multiple (4 or more) HCCs. The APCC model also includes recalibrated risk score coefficients for both the HCC and demographic schedules. Lastly, the APCC model includes the addition of three new payment HCCs:

- HCC 51 – Dementia with Complications
- HCC 52 – Dementia without Complications
- HCC 159 – Pressure Ulcer of Skin with Partial Thickness Skin Loss

Impact: The advent of APCC risk score methodology and the added payment HCCs are additive to member risk score payment for all plans. The recalibrated risk score coefficients for the existing 83 HCCs are a net reduction for all plans. The demographic recalibration net impact to risk score payment is divergent: some plans will see a net reduction, others will experience an increase. Figure 1, below, estimates percent impact ranges to risk payment for the two methodology additions and the two risk score coefficient recalibrations.

Figure 1: Risk Score Payment % Impact Estimates - APCC Model Alterations

APCC Risk Model Alteration	Minimum	Maximum
Addition of Payment Condition Count	0.40%	0.95%
Addition of HCCs 51, 52, 159	0.30%	0.75%
Recalibration of existing 83 HCC Risk Scores	-0.85%	-1.70%
Recalibration of Demographic Risk Scores	-0.10%	0.40%
Net Impact All Risk Score Payment Changes	-0.05%	0.35%

Note: The estimates above are ranges from separate analyses, not averages from a single analysis. As such, each of the line entries are independent of each other, the values are not additive.

Bullet-Point Key 2020 Risk Adjustment Changes & Updates

- RAPS/EDPS blend rate for risk score calculation:
  - **50% all provider types RAPS data using the 2017 Version 22 risk adjustment model**
  - **50% EDPS and inpatient RAPS data using the 2020 APCC model**
- Part C Coding Intensity Adjustment: **5.90%**
- Part C Normalization Factors
  - **2020 Alternative PCC Model: 1.069**
  - **2017 Version 22 Model: 1.075**

Figure 2: Year-to-Year Percentage Impact of All Risk Adjustment Payment Changes

Plan Payment Variables	Payment % Impact Estimates 2020 Final Call Letter
Effective Growth Rate	5.62%
Rebasing/Re-pricing	-0.02%
Change in Star Ratings	-0.14%
MA Coding Intensity Adjustment	0.00%
Risk Model Revision	0.21%
Encounter Data Transition Impact	-0.06%
EGWP Payment Policy Update	0.00%
Normalization Factor	-3.08%
Plan Payment Impact Estimate	***2.53%***

Impact: *Figure 2, above, is copied from the CMS newsroom website. It indicates the expected impact of the proposed 2020 policy changes on plan payments relative to 2019. The 'Risk Model Revision' line entry of 0.21% is CMS' calculated all plan average of the APCC risk score methodology changes detailed in Figure 1. Using Pulse8's estimated low impact for Risk Model Revision changes (-0.05%), the all changes estimate drops to 2.27%. Pulse8's high impact estimate (0.35%) pushes the all changes estimate up to 2.88%.*

Health Plan Ramifications of the Alternative Payment Condition Count Risk Model for 2020

Pulse8's analyses estimate that the Dementia HCCs 51 and HCC 52 combine to between 3.5% and 5.5% in Community Non-Dual populations, with a minimum average risk score of 0.340. Health plans should begin to analyze their clinical data warehouses for immediate dementia condition gap closure in 2019. Additionally, plans need to capitalize on the additive risk score by closing open HCC counts 4 through 10

to accurately value a member's disease burden as currently defined with the advent of the payment condition count methodology.

Impact Summary for 2020 MA 5 Star Ratings

CMS released the final call letter earlier this month and, as anticipated, most of the proposed changes were included in the final letter. Some of those noteworthy changes to MA 5-Star Ratings include the new plan notification of methodology changes, anticipated new measures to address opioids, several measures updates, three new retired measures, expanding the CAI measure set, and the new supplemental benefits offerings, which could be a game changer for plans.

There are a few areas worth noting that changed from the draft call letter in February including, Medication reconciliation will not be retired (at this time), Statin Use in Persons with Diabetes (SUPD) will remain a 1 weighted measure, and CMS also provided additional clarifications for the new supplemental benefits that allow plans more flexibility.

Below are some of the highlights and potential impact to a Plan's 5-Star Performance:

Plan Notification of Measure and Star Rating Methodology Changes

As CMS previously announced, PY 2020 will be the last year in which all specifications and requirements are not fully detailed in the annual Call Letter. Starting in PY 2021, all new regulations will be announced, in total, through the Call Letter process prior to the measurement period.

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

Addressing the Opioid Epidemic

CMS received feedback that there is overlap between the two Poly measures and the soon to be retired High Risk Medication measure, and between the Poly-CNS and COB measures. CMS indicated it will continue to asses this overlap and, based on the analysis, it will consider adding all or some of these measures to the 2023 Star Ratings (2021 data). These measures will be added to the display page for 2021 (2019 data) and 2022 (2020 data).

Impact: *Despite ongoing changes to technical specifications by NCQA and CMS, Plans should have programs in place that provide measure performance oversight and interventions to address the opioid measure set to prepare for future Star Rating measures.*

Several Measure Updates

- CMS continues to include several measure changes which are slight and to keep in alignment with NCQA and PQA technical updates.

- 3 Measures will Retire from 2022 Star Ratings
    - Adult BMI Assessment (Part C)
    - Appeals Auto-Forward (Part D)
    - Appeals Upheld (Part D)
- Temporary Removal of Controlling High Blood Pressure: CMS will move this measure to the display page for the 2020- and 2021-Star Ratings to align with the release of new hypertension treatment guidelines from the American College of Cardiology and American Heart Association. Plans should continue to focus on improvements, as this will move back into future star ratings.
- 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): Based upon comments from the draft Call Letter, NCQA will reevaluate the requirements for where the numerator information must be located in the Transitions of Care measure. CMS will continue to use the standalone Medication Reconciliation Post-Discharge measure at this time.

***Impact**: Plans should be aware of specification changes and the impact of those changes on their measure performance. Pulse8's Qualit8 solution can assist plans with managing a prospective 5-Star approach.*

Extreme and Uncontrollable Circumstances Policy

CMS will be using a similar policy to adjust the 2020 Star Ratings with two considerable changes that include eliminating the difference-in-differences adjustment for survey measures, and clarifying the rules around measures with missing or biased data in the prior or current year.

***Impact**: CMS continues to evaluate and update methodology to help stabilize the thresholds and cut points from year to year; however, plans need to be prepared that future cut points will be difficult to anticipate and likely increase with the removal of these low-performing plans. Pulse8's Qualit8 product can provide plans with tools that are critical to increasing overall performance and managing 5-Star success.*

Special Supplemental Benefits for the Chronically Ill

CMS provided additional clarification on the new Supplemental Benefits for the Chronically Ill (SSBCI), giving more detailed guidance on the definition of chronically ill as well as stating MA Plans may offer additional items and services, including capital or structural improvements if those items and services have a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic condition or illness.

***Impact:** This additional guidance gives plans more even more flexibility in supplemental benefits and additional services to chronically ill patients. We expect to see plans who apply strategic focus to this area to raise the bar considerably on many heavily-weighted measures.*