Deep Dive Into the CMS Advance Notice

February 28, 2023

RISE

Today's Speakers

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Who is Healthmine?

Member Engagement

Conduct outreach to engage members in self-managing health risk and conditions using omnichannel communications including in-app enablement, texts, email, phone calls and mailers.

Member Experience

Keep up with member satisfaction through digital surveys, such as Pulse Surveys, mock CAHPS, mock HOS and NPS©.

Digital HRA

Uncover new or unidentified risk in your population from self-reported data in an NCQA-certified digital HRA supporting race, ethnicity and language data gathering.

Smart Rewards & Incentives

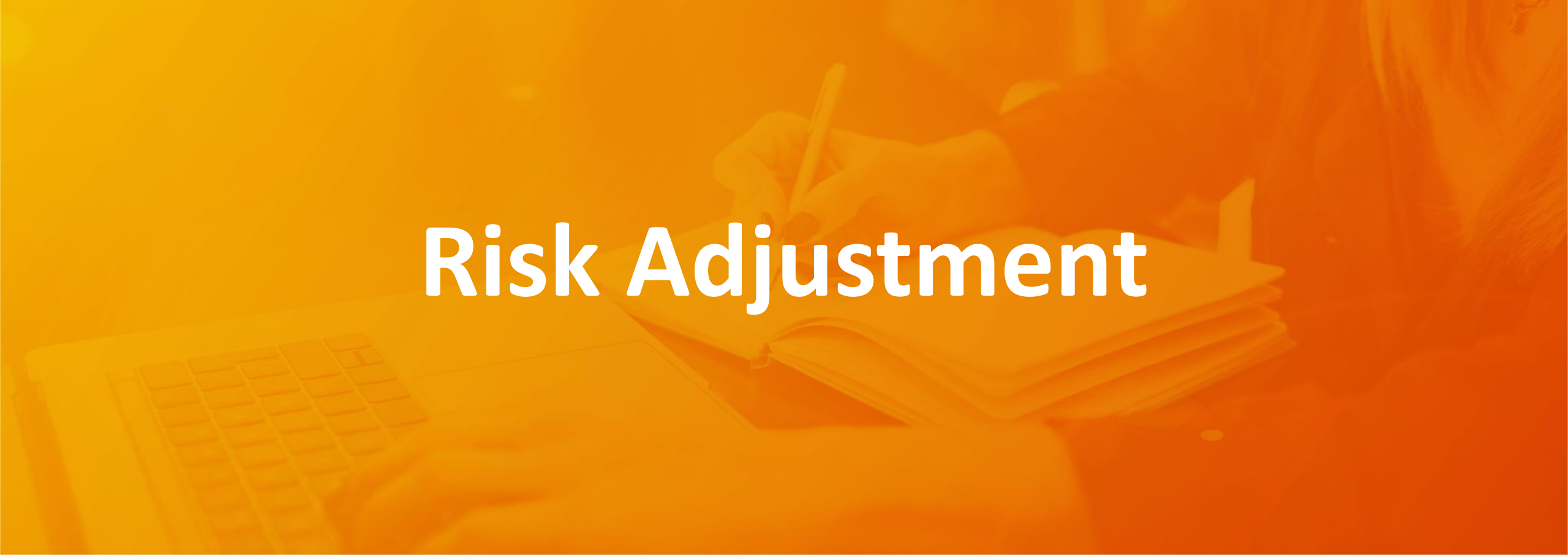
Motivate members with the right rewards to encourage the right actions that enable continuous health improvement and better clinical outcomes.

Medicare Insights

Effectively measure, monitor, and manage your Star Rating performance across all measures, with real-time identification of the measure- and member-level improvements needed to impact your Star score.

Expert Advisory

Leverage our team of industry experts to guide strategy and implement our technology tools in ways that best meet your unique needs.



Risk Adjustment

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RADV Rule History

2010

Extrapolation

2012

- Extrapolation
- FFS Adjuster

2018

- Extrapolation starting PY2011
- No FFS Adjuster
- Sub-cohort audits

2023

Final rule which blends components of previous proposals

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Final RADV Rule

THE FINAL RADV RULE HAS POTENTIAL IMPLICATIONS FOR HEALTH PLANS, PROVIDERS AND VENDORS.

Key Components

- No FFS adjuster
- Extrapolation begins PY2018
- No specific audit or extrapolation methodology
- Applies to CMS and OIG audits

Potential Implications

- Return of $s to CMS
- MA bids
- Managing CMS and OIG audits

Actions to Improve RADV Outcomes

- Review provider and vendor contracts.
- Identify and review high risk codes. Delete unsupported codes.
- Implement a robust compliance program.
- Integrate risk adjustment across your organization.
- Align with your partners.

Effect of Rate Changes on Medicare Advantage Payments

YEAR TO YEAR PERCENTAGE CHANGE TO PAYMENTS

	2022 Final Rate Announcement	2023 Final Rate Announcement	2024 Advance Notice	
Effective Growth Rate	5.59%	4.88%	2.09%	Change in benchmarks, which represent the maximum amount CMS will pay for Medicare covered claims. Largely driven by growth in FFS costs
Rebasing/Re-pricing	0.16%	0.39%	TBD	Change to payments by updating benchmark rates to reflect CMS's latest estimates of county level spending for FFS Medicare. Ensures the most recent set of data is used to predict FFS costs
Change in Stars	-0.28%	0.54%	-1.24%	Impact to payments attributed to Star rating changes
MA Coding Adjustment	0%	0%	0%	Risk score reductions beyond the 5.9% statutory minimum. This is a reduction in MA risk scores based on higher level of coding seen in MA. This has not changed in several years
Risk Model Revisions + Normalization	0.25%	0%	-3.12%	Changes to the risk model impacting payments to plans
Normalization	-1.64%	3.5%		Normalizing risk scores to an average of 1.0
MA Risk Score Trend	N/A	3.50%	3.30%	Expected difference in MA versus FFS coding
Expected Average Change in Revenue	**4.08%**	**8.50%**	**1.03%**	

CMS is Proposing Several Changes to the Risk Adjustment Model that Will Impact HCCs

RECALIBRATING THE MODEL TO MORE CURRENT YEARS	2014 diagnoses (Dx) and 2015 expenditures	→	**2018 Dx and 2019 expenditures**
UPDATING THE DENOMINATOR YEAR USED TO DETERMINE RISK SCORE FACTORS	2015 denominator year	→	**2020 denominator year**
RECLASSIFICATION OF HCCS	ICD-9	→	**ICD-10**

Reclassifying HCCs Using ICD-10

THE HCC MODEL CHANGE, PLUS NORMALIZATION, WILL RESULT IN A 3.12% DECLINE (CMS ESTIMATE) TO PLAN PAYMENTS IN 2024. ACTUAL IMPACT WILL VARY BY CONTRACT.

+29 payment HCCs

- 115 payment HCCs up from 86

2k+ fewer Dx codes

- Removal of over 2,000 diagnosis codes from the HCC model

CMS Proposes Removing Diagnosis Codes and Constraining Some Coefficients

Notable Dx codes no longer in the HCC model include	• Atherosclerosis of extremities • Angina pectoris • Protein calorie malnutrition
Several HCCs will experience a decline in the number of Dx codes mapped to the HCC. Examples include	• Major depression **(51% dropped)** • Vascular disease **(44% dropped)** • RA & inflammatory disease **(11% dropped)**
All levels of Diabetes assigned the same coefficient (0.166)	• In the current HCC model, Diabetes ranged from 0.105 to 0.302 (aged, community member)
All levels of Congestive Health Failure assigned the same coefficient (0.360)	• In the current HCC model, Congestive Heart Failure is 0.331 (aged, community member)

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Stars & Quality

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Key 2024 Stars Proposals: Proposed Rule & Advance Notice

MY2022/ SY2024

- Codify Tukey Cutpoint Calculations[PR]
- Remove CDC-Nephropathy[PR]

MY2023/ SY2025

- Add web-based surveying to CAHPS[AN]
- Remove 15-minute wait time CAHPS question[AN]
- Change optional exclusions to required for CBP, COL, KED and member deaths for HEDIS[AN]

MY2024/ SY2026

- Reduce CAHPS & Administrative measure weights to 2x[PR]

- Remove Med Rec Post-Discharge as Stand-alone Measure[PR]

- Apply Improvement measure Hold Harmless solely to 5-star plans[PR]
- Remove cutpoint guardrails[PR]

Add to Stars:

- Kidney Health for Pts w/Diabetes[PR]
- COA Functional Status Assessment[PR]
- Concurrent Use Opioids & Benzos[PR]
- PolyRx Mult Anticholinergics[PR]
- PolyRx Mult CNS Meds[PR]

- Add ages 45-49 to Colorectal Cancer Screening[PR]
- Expand required MTM eligibility criteria[PR]
- Add transgender and gender diverse members to Breast Cancer Screening[AN]

- Change CDC-Eye, CDC-A1c Control to ECDS[AN]
- Add glucose management indicator to CDC-A1c Control[AN]

- Use Continuous Enrollment for Medication Adherence/SUPD denominator inclusion[PR, AN]

Add to Display:

- Adult Immunization Status[AN]
- Screening for Depression & FollowUp[AN]
- Timely Follow-up After Acute Exacerbations of Chronic Conditions[AN]

- Provide materials on standing basis in non-English/alternate format for languages >5% of pbp service area on request or after learning of enrollee preference
- Develop/maintain procedures identify members w/low digital health literacy & offer digital health education to help access telehealth
- Notify members annually of ability to opt out of phone calls for plan business
- Provide full LIS subsidy for members currently only qualifying for partial LIS subsidy

MY2025/ SY2027

- Replace Reward Factor with Health Equity Index Factor[PR]
- Explore retiring COA Pain Assessment[AN]
- Explore replacing current Controlling Blood Pressure with new longitudinal measure[AN]
- Explore replacing COA Functional Status Assessment & Med. Review with new measures[AN]
- Explore adding Unfair Treatment CAHPS measure[AN]
- Explore adding Initiation & Engagement of Substance Use Disorder Treatment[AN]
- Explore adding new Kidney Health & Chronic Pain Assessment and FollowUp measures[AN]

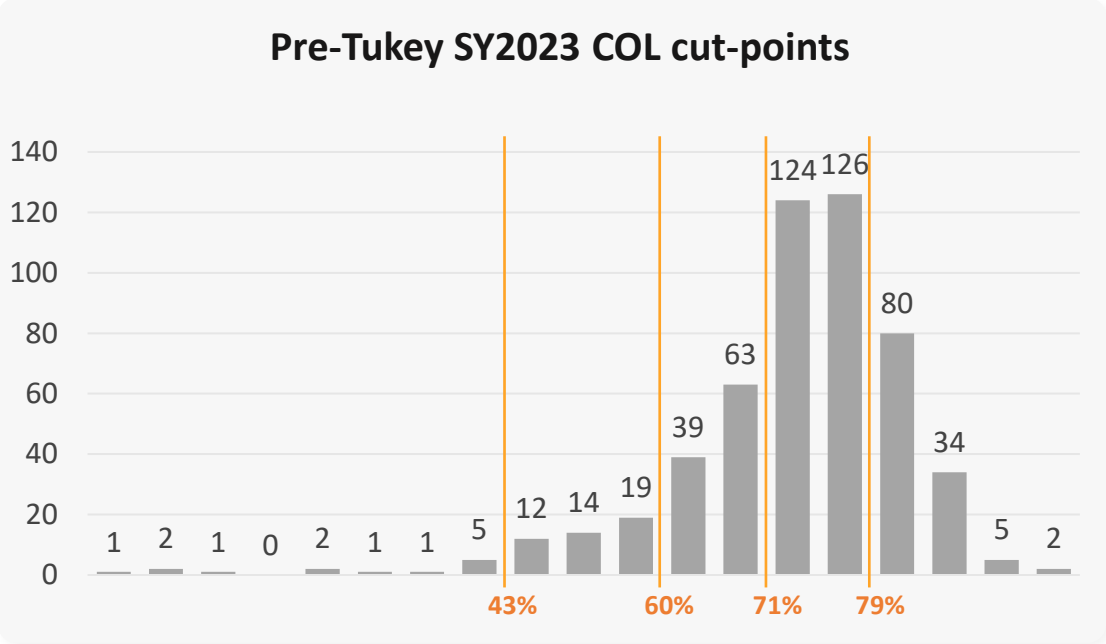
MY2026/ SY2028

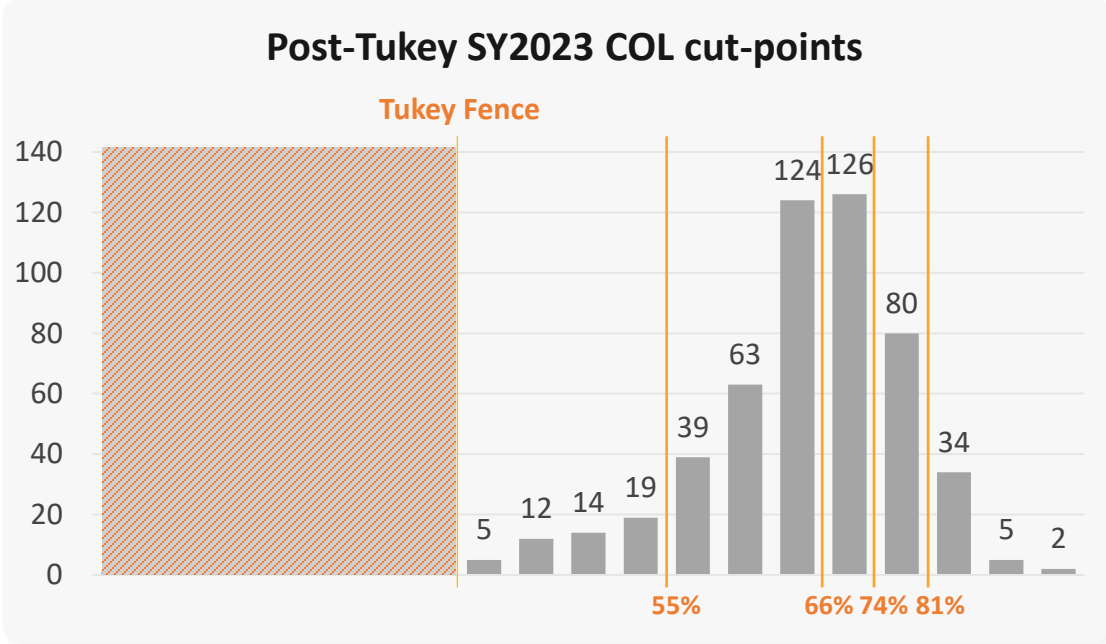
- Risk-adjust Med Adherence measures[PR]
- Remove IP/SNF Med Adherence adjustments [PR]
- Explore adding Adult Immunization Status[AN]
- Explore adding Screening for Depression and Follow-up Plan[AN]
- Explore adding Timely Follow-up After Acute Exacerbations of Chronic Conditions[AN]

Tukey Outlier Deletion Will Suppress Star Ratings

CMS has selected a validated statistical model (the Tukey outlier deletion methodology) to eliminate the impact of outliers on cut points.

- CMS will identify and remove outliers prior to clustering contract scores to determine measure cut points.
- CMS' goal is to stabilize cut points and prevent large year-to-year fluctuations it caused by outlier scores of a few contracts.





For Year 1 (MY2022/SY2024), CMS will rerun the prior year's thresholds, using mean resampling and Tukey outlier fence deletion so that the guardrails will be applied such that there is consistency between the years.

Cut-point Rebasing: Tukey Impact At-A-Glance

	Simulated Cut-point Increases	Simulated Cut-point Decreases	No Change in Simulated Cut-points
1-to-2 stars	19	8	1
2-to-3 stars	16	10	2
3-to-4 stars	14	7	7
4-to-5 stars	14	6	8

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2023 Star Measure ID	Measure	Tukey Cut-point Impact: 2 stars	3 stars	4 stars	5 stars
C01	Breast Cancer Screening	5	0	0	-2
C02	Colorectal Cancer Screening	17	8	3	3
C04	Monitoring Physical Activity	-2	-2	-1	0
C05	Special Needs Plan Care Management	-1	-3	-2	2
C06	Care for Older Adults – Medication Review	35	13	11	5
C07	Care for Older Adults – Pain Assessment	28	17	6	3
C08	Osteoporosis Management in Women who had a Fracture	-5	-5	-5	-5
C09	Diabetes Care – Eye Exam	6	1	0	0
C10	Diabetes Care – Kidney Disease Monitoring	7	-3	1	2
C11	Diabetes Care – Blood Sugar Controlled	25	8	2	1
C12	Controlling Blood Pressure	NA	NA	NA	NA
C13	Reducing the Risk of Falling	2	2	4	3
C14	Improving Bladder Control	3	2	1	0
C15	Medication Reconciliation Post-Discharge	-4	-1	0	0
C16	Statin Therapy for Patients with Cardiovascular Disease	5	3	0	0
C23	Complaints about the Health Plan	-1	-1	0	0
C24	Members Choosing to Leave the Plan	3	5	1	2
C26	Plan Makes Timely Decisions about Appeals	35	23	17	3
C27	Reviewing Appeals Decisions	13	8	4	0
C28	Call Center – Foreign Language Interpreter and TTY Availability	35	18	1	1
D01	Call Center – Foreign Language Interpreter and TTY Availability	33	12	15	9
D02	Complaints about the Drug Plan	-1	-1	0	0
D03	Members Choosing to Leave the Plan	3	5	1	2
D07	MPF Price Accuracy	16	2	0	1
D08	Medication Adherence for Diabetes Medications	3	0	-1	-1
D09	Medication Adherence for Hypertension	0	-4	-2	-1
D10	Medication Adherence for Cholesterol	-3	-2	-1	-1
D11	MTM Program Completion Rate for CMR	26	16	2	2
D12	Statin Use in Persons with Diabetes	-4	-4	-2	-2

Proposed MY2024 Improvement Measure Hold Harmless Change

CMS PROPOSES APPLYING THE IMPROVEMENT MEASURE HOLD HARMLESS ONLY TO DETERMINE 5-STAR RATINGS.

- CMS currently computes overall ratings with and without the Improvement measures. If Improvement measure ratings cause the contract to fall <4 stars overall, CMS holds the contract harmless and ignores the Improvement measures to determine the final overall rating.
- CMS proposes application of this Hold Harmless provision only to determine 5-star overall ratings beginning in 2024.
- If codified, CMS will no longer apply the Hold Harmless provision to contracts earning 4 or 4.5 stars.

THIS IS THE SINGLE MOST IMPACTFUL CHANGE IN THE PROPOSED RULE AND ADVANCE NOTICE. AND THE LEAST DISCUSSED

- *Improvement measures will be used in the computation of overall ratings even if these measures cause plans to earn a lower rating.*
- *Consistently highly-rated measures can negatively impact Improvement measures if numerator improvements stagnate or decline.*
- *This proposal is projected to reduce CMS' QBP spending by $19 billion over 10 years. All other 2024 proposals combined reduce QBPs by only $5 billion more.*

THINKING POSITIVELY

- This change helps plans who are truly committed to continuous quality improvement.
- This change may help plans who naturally perform well and improve year-over-year in measures. These plans may not need to use scarce resources to keep improving.
- New measures generally experience more consistent improvement in the early years of inclusion in Stars. The large number of new measures offers strong measure Math Path lever to earn compounded value from measure-level investments.
- Continued improvement on measures such as Colorectal Cancer Screening or Breast Cancer Screening where 5-star cut-points have hit a ceiling can continue to be leveraged in Improvement measure calculations to maintain 5-star overall ratings.
- Measures are designed to help new contracts earn 4+ stars in early years of operation.

PREPARING FOR A RISKY REALITY

- This change will cause many plans to lose their 4th star.
- Success requires a new Math Path with real-time attention to measure, numerator and Improvement measure math for the full population and by HEI cohorts.
- Since measure weighting applies to Improvement measure calculations, unplanned performance on even a very few measures can impact rating.
- The Health Equity Index will simultaneously require additive cohort-level math. If Reward Factor remains in place in MY2024, the expanded Improvement measure math must be done with both Reward Factor and Health Equity Index as the goal for MY2024.
- Plans who are too new or small to earn ratings on all measures will experience unusual mathematical impact based on the unique measures they earn ratings for.

Health Equity Accountability in MA Begins with MY2024 Performance

DECEMBER 2022 PROPOSED RULE PROPOSES REPLACING THE "REWARD FACTOR" WITH AN INCENTIVE TO REDUCE DISPARITIES WITHIN EACH H-CONTRACT.

Timing

HEI will start with the **2027** Star Ratings

- Data used for the **2026** and **2027** Star Ratings
  - **MY2024** and **MY2025**

To Do Now:

- Conduct Health Equity Improvement projects based on risk stratified data
- Update reporting and dashboards at contract, summary, measure, member and provider level
- Model out scenarios and communicate impact to overall Star Rating

HEI is calculated for members who are Dual Eligible, Low-Income Subsidy, or disabled

- *Top third of contracts receive 1 point*
- *Middle third receive 0 points*
- *Bottom third receive -1 point*

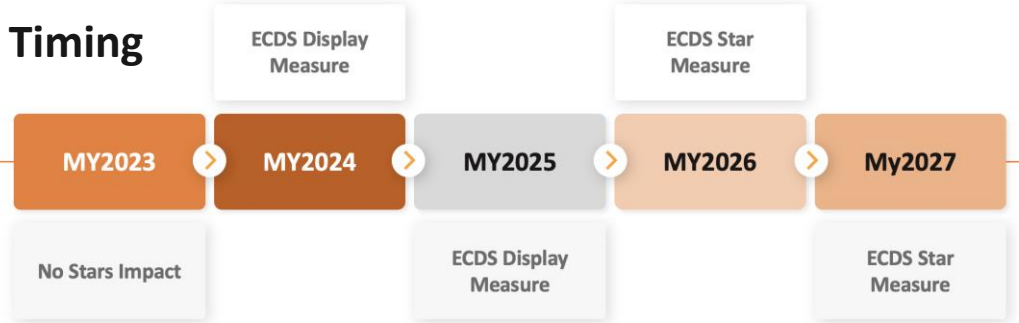
The index will then be calculated as:

$$\frac{\text{weighted sum of points across all measures included in the index}}{\text{weighted sum of the number of eligible measures}}$$

- The index factor will range from 0 to 0.4.
- Includes HEDIS, CAHPS, HOS and Part D Measures.
- The Health Equity Index will be calculated for Overall and Summary Ratings.
- Contracts will need to have a minimum of 500 members.

Continue Health Equity Focus on HEDIS SNS-E Measure

Timing



To Do Now:

- Review HRA and screenings to ensure they are a NCQA-Approved Screening Instrument
- Work with your HEDIS auditor to approve all survey templates
- Map out workflows with internal teams, vendors, and providers to obtain LOINC and SNOMED Codes for screenings and interventions
- Start conversations with providers and VBC contracting team

Screening Measure Definition: % Members screened, with a NCQA approved instrument, at least once from January 1 to December 1 for unmet food, housing and transportation needs

Intervention Measure Definition: % Members who screened positive for an unmet needs received an intervention within 30 days of the positive screen

Data Sources:

- Administrative
- Claims
- Case Management
- Electronic Medical Record
- Health Information Exchange

Closed- Looped Referrals and a Social Connection Measure are on the horizon

2024 Bid Enhancements Must Support Different Goals & Needs

MY2024/SY2026

- *Reduce CAHPS & Admin weights to 2x*
- ***Return Improving or Maintaining Physical Health & Improving or Maintaining Mental Health***
- Add *KED, COA-FSA, Concurrent Use of Opioids & Benzos, PolyRx Mult Anticholinergics, PolyRx Mult CNS Meds* to Stars
- ***Remove hybrid reporting from Colorectal Cancer Screening & transition to ECDS***
- Remove hybrid reporting from *Diabetes Care-Eye Screening and Diabetes Care-A1C Control* & transition to ECDS
- ***Allow States to require separate H-contract with only that state's D-SNP members***
- Retire *Med Rec Post-Discharge* as stand-alone measure
- Add ages 45-49 to *Colorectal Cancer Screening*
- Expand required MTM eligibility criteria
- Add glucose management indicator to *Diabetes Care-A1c Control*
- Expand *Breast Cancer Screening* criteria to include others at risk (transgender, gender diverse)
- Use Continuous Enrollment for *Med Adherence* & *SUPD* denominator inclusion
- Apply *Improvement* measure Hold Harmless solely to 5-star plans
- Remove cutpoint guardrails
- Use MY2024 results in Health Equity Index
- Add *Adult Immunization Status, Screening & Follow-up for Depression, Timely Follow-up After Acute Exacerbations of Chronic Conditions* to Display
- ***Part D Price Concessions applied at point of sale***

Are your 2024 enhancements strong enough to support new measures, new rate goals post-Tukey, and every "new need" in 2024?

Are your 2024 enhancements targeted enough to achieve relative excellence among younger, disabled members measured by Health Equity Index?

Is MLR-eligible infrastructure adequate to support capture of race, ethnicity, language and social risk factors from all members??

Are your 2024 enhancements targeted to the right subsets of members to drive meaningful improvements?

- Do enhancements reduce MLR or improve Star measures for members with Math Path risk?
- Do enhancements support collection of race, ethnicity and languages to help focus member engagement?
- Do enhancements support the cultures and communities where we need to improve?

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THANK YOU