spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

2020 Advance Notice & Draft Call Letter

OVERVIEW

On January 30th, the Centers for Medicare and Medicaid Services (CMS) released Part II of the Advance Notice and the Draft Call Letter, which propose policy and payment updates for Medicare Advantage (MA) and Part D plans, and Programs of All-Inclusive Care for the Elderly (PACE) for calendar year (CY) 2020. Part I of the Advance Notice was released at the end of 2018. The Advance Notice is released in two parts to allow for a 60-day comment period for the MA risk adjustment changes proposed in Part I.

The proposed policy changes in the 2020 Advance Notice and draft Call Letter are expected to increase revenue to participating plans by 1.59%, though the re-pricing impacts have yet to be determined and the estimate does not include an adjustment for the underlying coding trend. CMS anticipates that the underlying coding trend would increase risk scores, on average, by 3.3% in 2020.

This document summarizes key provisions of Part I and II of the Advance Notice and Draft Call letter. CMS will accept comments on Part I and II through March 1, 2019 and policies will be finalized in the 2019 Rate Announcement and final Call Letter by April 1, 2019. The full proposals are available here.

NEW MA RISK ADJUSTMENT MODEL

The 21st Century Cures Act requires that CMS update the CMS- Hierarchical Condition Categories (HCC) risk adjustment model so that it accounts for the number of conditions that a beneficiary has.

In the 2019 Final Notice, CMS outlined a plan to implement the Payment Condition Count (PCC) Model, which considers up to 10 conditions that a beneficiary has. The 2020 Advance Notice proposes to implement the PCC Model. As an alternative, CMS also presents for comment a model that is very similar to PCC, except it includes additional HCCs for Dementia and Pressure Ulcers.

CMS will begin to phase-in implementation of a new model in 2020, starting with blend of 50% CMS-HCC risk adjustment model from 2017 and 50% of the proposed PCC Model. The PCC Model will be fully phased in by 2022, as required by the 21st Century Cures Act.

Encounter Data

In 2016, CMS began incrementally supplementing inpatient Risk Adjustment Processing System (RAPS) data with encounter data to calculate risk scores. For 2019, CMS is calculating risk scores with: 75% RAPS and FFS data; and 25% RAPS inpatient records, FFS, and encounter data. In 2020, CMS proposes to increase the weight of encounter data by calculating risk scores with: 50% RAPS inpatient, FFS, and encounter data; and 50% RAPS and FFS data.

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PART D RISK ADJUSTMENT MODEL

Part II of the Advance Notice proposes technical changes to the Part D risk adjustment model, RxHCC, to reflect the 2020 benefit structure and rates. Similar to CMS-HCC, encounter data is being phased-in to the RxHCC. In 2019, risk scores were calculated using 25% encounter data and FFS diagnoses and 85% RAPS data and FFS diagnoses. For 2020, the weight of the encounter data will increase to 50%, while the weight of RAPS data and FFS diagnoses will decrease to 50%.

PACE RISK ADJUSTMENT MODEL

The CMS-HCC risk adjustment model that CMS currently uses for PACE is calibrated with 2006 diagnoses and 2007 costs, with a 2009 denominator. The Advance Notice proposes to update the risk adjustment model for 2020 by calculating risk scores with the 2017 CMS-HCC model. The model accounts for whether enrollees who reside in the community are:

- Non-dual aged;
- Non-dual disabled;
- Partial benefit dual aged;
- Partial benefit dual disabled;
- Full benefit dual aged; and
- Full benefit dual disabled.

CODING PATTERN ADJUSTMENT

CMS proposes a coding pattern adjustment of 5.90% to plan payments to reflect differences in diagnosis coding between MA and FFS providers. This is identical to the coding pattern adjustment for 2019 and is the minimum allowed by law.

EMPLOYER GROUP WAIVER PLANS (EGWPS)

Employers and union-only groups may offer retirees supplemental coverage in Medicare in the form of an EGWP. CMS is proposing to continue the payment policy that was finalized for 2019, which includes waiving the Bid Pricing Tool bidding requirements for all MA EGWPs and setting EGWP payments using only individual market plan bids to calculate the bid-to-benchmark ratios.

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SUPPLEMENTAL BENEFITS

For the 2019 benefit year, CMS expanded the scope of supplemental benefits by allowing additional services and equipment to fall under the definition of "primarily health related" and by rescinding uniformity requirements. The draft Call Letter proposes further expanding these benefits by allowing MA plans to offer special supplemental benefits for the chronically ill (SSBCI), including new "non-primarily health related" supplemental benefits, beginning 2020.

MA plans would have broad discretion in developing items and services they propose to offer as "non-primarily health related" supplemental benefits to chronically ill enrollees, so long as the SSBCIs can be reasonably expected to improve or maintain the enrollee's health and/or overall function relating to the chronic disease. This will give MA plans additional flexibility to address social determinants of health.

SSBCIs may include:

- Transportation for non-medical needs;
- Home-delivered meals (beyond current allowable limited basis); and/or
- Food and produce.

CMS notes that SSBCIs cannot include:

- Capital or structural improvements to a home that could potentially increase property value (i.e., permanent ramps, widening doors and hallways);
- Items/services to induce enrollment; or
- Benefits covered by original Medicare.

MA plans would still be required to incur a "non-zero direct medical cost" for supplemental benefits. For SSBCIs, plans may incur "non-administrative" costs for providing these benefits.

CMS is requesting comment on the limits of supplemental benefits and whether or not consideration of other factors should be included in determining benefits for chronically ill enrollees.

CONTINUED OPIOID RESPONSE

The draft Call Letter proposes continuing 2019 policies, such as Part D drug management programs for high-risk opioid users and seven-day supply limits for opioid naïve patients for 2020. CMS also proposes additional strategies to address the opioid crisis, including: Opioid Treatment Programs (OTPs), non-opioid pain management supplemental benefits, opioid reversal agents, and updating opioid measures for Star Ratings.

Medicare-covered OTP Services

The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act requires that opioid use disorder treatment services furnished by Opioid Treatment

Programs (OTPs) be included as a Medicare Part B service by 2020. Opioid use disorder treatment services include: dispensing and administering FDA-approved opioid agonist and antagonist treatment medications, substance use counseling, individual and group therapy, and toxicology testing. As a Medicare-covered benefit, all MA plan types, Section 1876 and 1833 cost-based plans, and PACE organizations will be required to provide OTP services.

Non-Opioid Pain Management Supplemental Benefits

CMS is encouraging MA organizations to include medically-approved non-opioid pain management and other complementary and integrative treatment into Part C plan benefit packages, including non-Medicare covered services like chiropractic services, acupuncture, and therapeutic massage if advised by a physician. The non-opioid pain management benefit must directly treat or ameliorate the impact of an injury or illness.

In the next few months, CMS's National Committee for Quality Assurance will discuss non-opioid chronic pain options with plans and providers for 2021 and look into new measures for the therapies.

Improving Access to Opioid-Reversal Agents

CMS is encouraging Part D sponsors to include opioid-reversal agents like naloxone in their formulary and benefit designs, and to lower cost-sharing for these drugs. In addition, CMS proposes to allow co-prescribing naloxone with opioids to patients that are deemed high-risk. CMS is requesting comments on how to feasibly implement co-prescribing.

Star Ratings

CMS is proposing to update the Star Rating methodology to revise the language on potential opioid misuse. In addition to Opioids at High Dosage and Multiple Providers as one measure, ratings will include two additional separate measures: Opioids at High Dosage and Use of Opioids from Multiple Providers. CMS also proposes to add a measure for Concurrent Use of Both Opioids and Benzodiazepines.

CMS STAR RATINGS

For 2020, the draft Call Letter proposes technical changes to a number of MA and Part D Star Rating measures and would remove the following measures:

- Adult BMI assessment (MA)
- Appeals Auto-forward (Part D)
- Appeals Upheld (Part D)

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In addition, CMS proposes to temporarily remove the Controlling High Blood Pressure (MA) measure to revise and align with the new hypertension treatment guidelines from the American College of Cardiology and American Heart Association. The measure would be moved back into the Star Ratings in 2022.

CMS proposes to add the following measures for 2020:

- Measure digitalization (MA)
- Exclusions for Advanced Illness (MA)
- Physician/Plan Interactions (MA & Part D)
- Interoperability Measures (MA)
- Patient-Reported Outcome Measures (MA)
- Pain Management (MA)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (MA)
- Antibiotic Utilization Measures (MA)
- Diabetes Overtreatment (MA)

Lastly, CMS is proposing adjustments to 2020 Star Ratings in the event of extreme and uncontrollable circumstances, like major weather events such as hurricanes.