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

2020 Rate Announcement & Call Letter

OVERVIEW

On April 1st, the Centers for Medicare and Medicaid Services (CMS) issued a final Rate Announcement and Call Letter for CY 2020. These documents establish various policy and payment updates for Medicare Advantage (MA) plans, Prescription Drug Benefit (Part D) plans, and Programs of All-Inclusive Care for the Elderly (PACE) programs. The finalized policy changes are expected to increase revenue to participating plans by 2.53%, up from the 1.59% projected in the draft call letter. In addition, CMS expects the underlying coding trend will increase risk scores by an average of 3.3% in 2020.

This document summarizes key provisions of the Rate Announcement and Call Letter. The press release and fact sheet may be viewed here. The text of the regulation is available here.

MA RISK ADJUSTMENT MODEL

The Rate Announcement will implement several changes to the CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model for MA plans.

Alternative Payment Condition Count Model

The 21st Century Cures Act requires that CMS update the HCC model so that it accounts for the number of conditions that a beneficiary has.

CMS will implement the Alternative Payment Condition Count (APCC) risk adjustment model for a blended risk score calculation, which is similar to the originally proposed Payment Condition Count (PCC) model but also includes:

- Additional HCCs for dementia and pressure ulcers; and
- Additional variables to adjust risk scoring based on the number of conditions.

CMS will begin to phase in implementation of the APCC model in 2020. Initially, risk scores will be a blended score, with 50% based on the CMS-HCC risk adjustment model from 2017 and 50% based on the new APCC risk adjustment model. The APCC model will be fully phased in by 2022.

Encounter Data

In 2016, CMS began incrementally supplementing inpatient Risk Adjustment Processing System (RAPS) data with encounter data to calculate risk scores. In 2020, the CMS-HCC portion of the blended risk score will be calculated using RAPS and FFS data for diagnoses, while the APCC portion of the risk score will be calculated using RAPS inpatient, FFS, and encounter data. The CMS-HCC and APCC portions will comprise 50% each of the total risk score.

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

Coding Pattern Adjustment

CMS finalized 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 the minimum required by law.

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. CMS will update the risk adjustment model for 2020 by calculating risk scores with the 2017 CMS-HCC model. As a result, PACE risk adjustment will now be split into the six CMS-HCC community segments:

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

Since most PACE enrollees are full benefit duals, this segmentation will increase the predicted cost.

Encounter Data

CMS will continue to calculate Part C and Part D risk scores for PACE organizations by pooling risk adjustment-eligible diagnoses from encounter data, RAPS and FFS claims (with no weighting) to calculate a single score.

FRAILTY FACTOR ADJUSTMENT

CMS will update frailty factors for PACE plans and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) so that they are consistent with changes to the CMS-HCC for 2020. CMS will continue the practice of comparing a blended frailty score for FIDE SNPs to the PACE level of frailty to assess whether the FIDE SNP and PACE program are serving similarly frail members.

PART D RISK ADJUSTMENT MODEL

The Prescription Drug HCC (RxHCC) model used in 2019 was calibrated with 2014 diagnoses and 2015 expenditure data from Prescription Drug Event (PDE) records. In 2020, CMS will continue to use 2014/2015 data for RxHCC calculations, instead of updating to 2015/2016 data.

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

SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

For the 2019 benefit year, CMS expanded the scope of supplemental benefits by allowing additional services and equipment to be "primarily health related" and by rescinding uniformity requirements. In 2020, CMS is further expanding these benefits by allowing MA plans to offer special supplemental benefits for the chronically ill (SSBCI), including "non-primarily health related" supplemental benefits.

MA plans will have broad discretion to offer items and services 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 their chronic disease(s). This gives MA plans additional flexibility to address social determinants of health.

The final Call Letter removes the originally proposed restriction on offering capital improvements that add value to an enrollee's home. As such, beginning CY 2020, MA plans may offer as SSBCIs:

- Capital or structural improvements to a home (i.e., permanent ramps, widening doors and hallways);
- Transportation for non-medical needs;
- Pest control or indoor air quality equipment and services;
- Home-delivered meals (beyond current limits); and/or
- Food and produce.

SSBCIs may not include:

- Items/services to induce enrollment; or
- Benefits covered by original Medicare.

MA plans are still required to incur a non-zero direct medical cost for supplemental benefits. Specifically, for SSBCIs, plans should incur costs that are counted as "non-administrative", even if they are paid to a non-medical provider. As such, CMS notes that plans may contract with community-based organizations (e.g., food banks) to support the provision of SSBCIs and other supplemental benefits.

EMPLOYER GROUP WAIVER PLANS (EGWPS)

Employers and union-only groups may offer retirees supplemental coverage in Medicare in the form of an EGWP. CMS will continue the payment policy that was finalized from 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. CMS will also allow EGWPS to buy-down Part B premiums in a manner similar to individual market MA plans.

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

CONTINUED OPIOID RESPONSE

CMS will continue its 2019 policies addressing the opioid epidemic, such as Part D drug management programs for high-risk opioid users and seven-day supply limits for opioid naïve patients. CMS is implementing 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 SUPPORT for Patients and Communities Act of 2018 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.

Accordingly, 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. However, these would be considered supplemental benefits rather than basic benefits for plan bid and premium purposes. The non-opioid pain management benefit must directly treat or ameliorate the impact of an injury or illness.

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 will allow co-prescribing naloxone with opioids to patients that are deemed high-risk.

Opioid Use Star Ratings

CMS is updating the Star Rating methodology 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. All measures have exceptions for individuals with cancer. CMS is also adding a measure for Concurrent Use of Both Opioids and Benzodiazepines.

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

CMS STAR RATINGS

CMs is implementing technical changes to a number of MA and Part D Star Rating measures and removing the following measures from the 2022 Star Ratings:

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

In addition, CMS is temporarily removing 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 will be moved back into the Star Ratings in 2022. CMS will also consider making further adjustments based on changes to HEDIS or other considerations.

Lastly, CMS finalized its proposal to make adjustments to the Star Ratings in the event of extreme and uncontrollable circumstances (such as major hurricanes), using a similar methodology to the one adopted for 2019.