CY 2019 MEDICARE ADVANTAGE RULE AND CALL LETTER

A Presentation to The Second National Medicare Advantage Summit
May 16, 2018

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TODAY'S AGENDA

- Medicare Advantage/Part D Rule Overview
- 2019 Final Call Letter
  - Major Highlights
  - Benchmark and Rates
  - Risk Adjustment
  - Supplemental Benefits and Flexibility
  - Opioid Policy
  - Other Key Updates
- Deep Dive on Addressing Social Determinants

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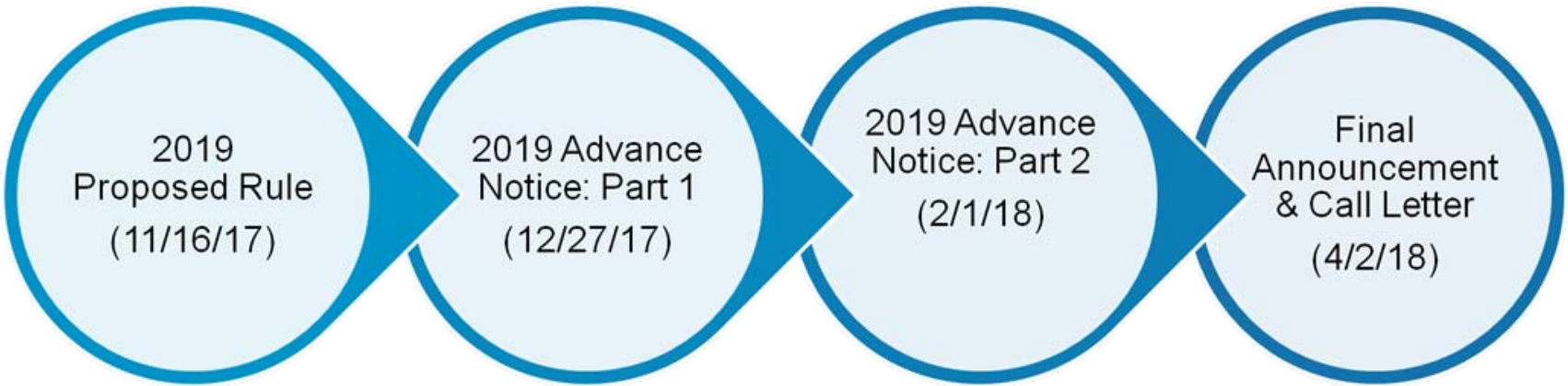
MEDICARE ADVANTAGE IN 2019



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KEY THEMES

- CMS confirms once again that Medicare Advantage (MA) is the most stable of all insurance product lines
- This is the biggest Call Letter in years:
  - Flexibility is the rule – without endangering beneficiaries
  - Rates are up
  - Risk adjustment changes as expected
  - New tools and regulations for addressing opioid abuse
  - Implementation of Obama-era EGWP policy
  - Star Ratings changes modest, but competition never greater
  - “Scarlet Letter” for poor performers will not be implemented
  - New compliance challenges, especially provider directory accuracy
  - Supplemental benefits flexibility is a game changer

MEDICARE ADVANTAGE/PART D FINAL RULE

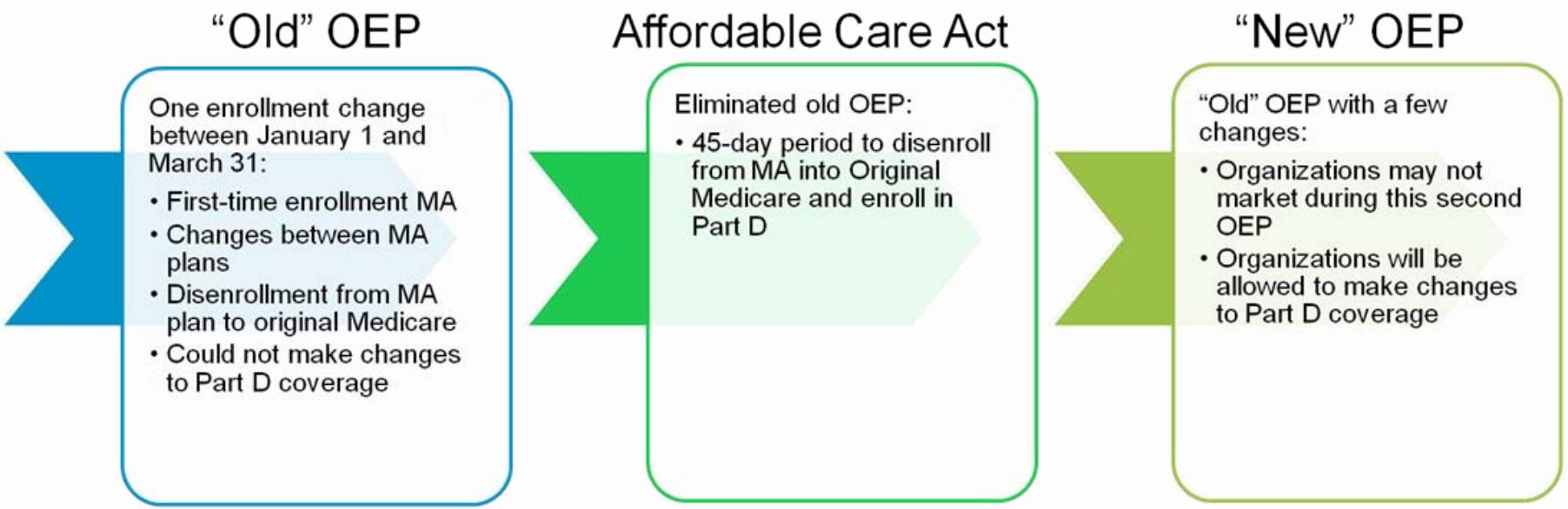
NEW MEDICARE ADVANTAGE RULE

NEW PART D RULE

- Implementation of Comprehensive Addiction and Recovery Act
- Expedited Substitutions of Generics
- RFI on Point of Service Rebates and Price Concessions
- Any Willing Pharmacy Standards
- Part D Tiering Exceptions
- Other Part D Proposals

MARKETING & ENROLLMENT CHANGES

New Open Enrollment Period (OEP)



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MARKETING & ENROLLMENT CHANGES

Default Enrollment Changes

- CMS adopted a “simplified election process” for those converting coverage from other non-MA plans to an MA plan
  - MAOs can accept enrollment requests throughout an individual’s Initial Coverage Election Period (ICEP).
  - CMS limits this enrollment mechanism to beneficiaries enrolled in a Medicaid managed care plan offered by the same organization.
- Previously, CMS allowed MA plans to enroll by default a newly MA-eligible individual enrolled in either a commercial or Medicaid plan.

EXPEDITED SUBSTITUTIONS OF GENERICS

- Plans may immediately add a newly approved generic to a formulary without advance CMS approval.
- Proposal changes notice to a general statement of potential changes, followed by specific notice; and
- Reduces direct notice for removal of drug or change in cost sharing from 60 to 30 days.

ANY WILLING PHARMACY (AWP) STANDARDS

- CMS seeks to update AWP requirements by:
  - Clarifying that policy applies to all pharmacies no matter how they are organized
  - Revising the definition of “retail pharmacy” and adding definition for “mail order”
  - Establishes a deadline of September 15 for providing standard terms and conditions

PART D TIERING EXCEPTIONS

- CMS is proposing to eliminate allowing plans to exclude a dedicated generic tier from the tiering exceptions process, and
- Establish a framework based on the type of drug (brand, generic, biological product) requested and the cost-sharing of applicable alternative drugs, and
- Clarify cost sharing is based on lowest cost tier when alternatives are available

OTHER PART D CHANGES

- *Change to Days' Supply Required by Part D Transition Process:* CMS proposes to shorten the required transition supply in the Long Term Care (LTC) setting from 90 to 30 days.
- *Electronic Transaction Standard Used by Part D Plans:* Update to the current electronic prescribing standard for the Part D e-Prescribing Program to the latest version, Version 2017071.
- *Treatment of Biological Products:* CMS proposes to amend the definition of generic drug to include follow-on biological products for LIS cost sharing and non-LIS catastrophic cost sharing.
- *Preclusion List:* CMS would remove the current prescriber and provider enrollment requirements and instead provide sponsors with a preclusion list

2019 FINAL CALL LETTER

MAJOR HIGHLIGHTS

CMS finalized as proposed:

- New codes adopted for Hierarchical Condition Category (HCC) model, 25% phased in for 2019
- EGWP methodology
- Supplemental benefit expanded definition
- Flexibility and simplification in benefit design and bid process
- First-tier, downstream, and related entity (FDR) training

CMS made changes to:

- Will not implement either of the two proposed condition count methodologies in risk adjustment
- EGWP bid-to-benchmark ratios adjusted for HMO/PPO mix

CMS RATE METHODOLOGY IMPACT

Year-to-Year Aggregate Change in Part C Payment

Methodology & Trend	2019 Advance Notice	2019 Final	
Effective Growth Rate (Cost Trend)	4.35%	**5.28%**	Aggregate Part C trend is nearly 100 basis points better than anticipated
Rebasing/Re-pricing	TBD	**0.49%**	Consistent with previous years
Change in Star Ratings	-0.20%	**-0.26%**	CMS estimate of impact of 2018 Star Ratings on 2019 rates
Risk Model Revision	0.28%	**0.28%**	All proposals adopted
MA Coding Intensity Adjustment	0.01%	**0.01%**	No change
Encounter Data Transition	-0.04%	**-0.04%**	Proposed EDS/RAPS blend (25%/75%) adopted proportions
EGWP Payment Policy	-0.30%	**-0.10%**	Fully implementing as proposed but with alternative adjustment for HMO/PPO mix
Normalization	-2.26%	**-2.26%**	No change in estimate
Expected Average Change in Revenue	1.84%	**3.40%**	

Source: CMS Fact Sheets

ACA BENCHMARK CEILING

- Under the Affordable Care Act (ACA), the benchmark (including bonus) in any given county can never exceed what it would have been under the old law.
- The old rate will never die and will hover over the ACA benchmarks as a ceiling – unless Congress acts.
- CMS has acknowledged this trend is counter to the goal of providing incentives for quality, but change can only be made through legislation.

	5% Bonus Rate Capped	0% Bonus Rate Capped
2019 # Counties	1,560	953
% of Enrollees	31.1%	13.4%
2018 # Counties	1,603	1,000
% of Enrollees	30.0%	10.0%

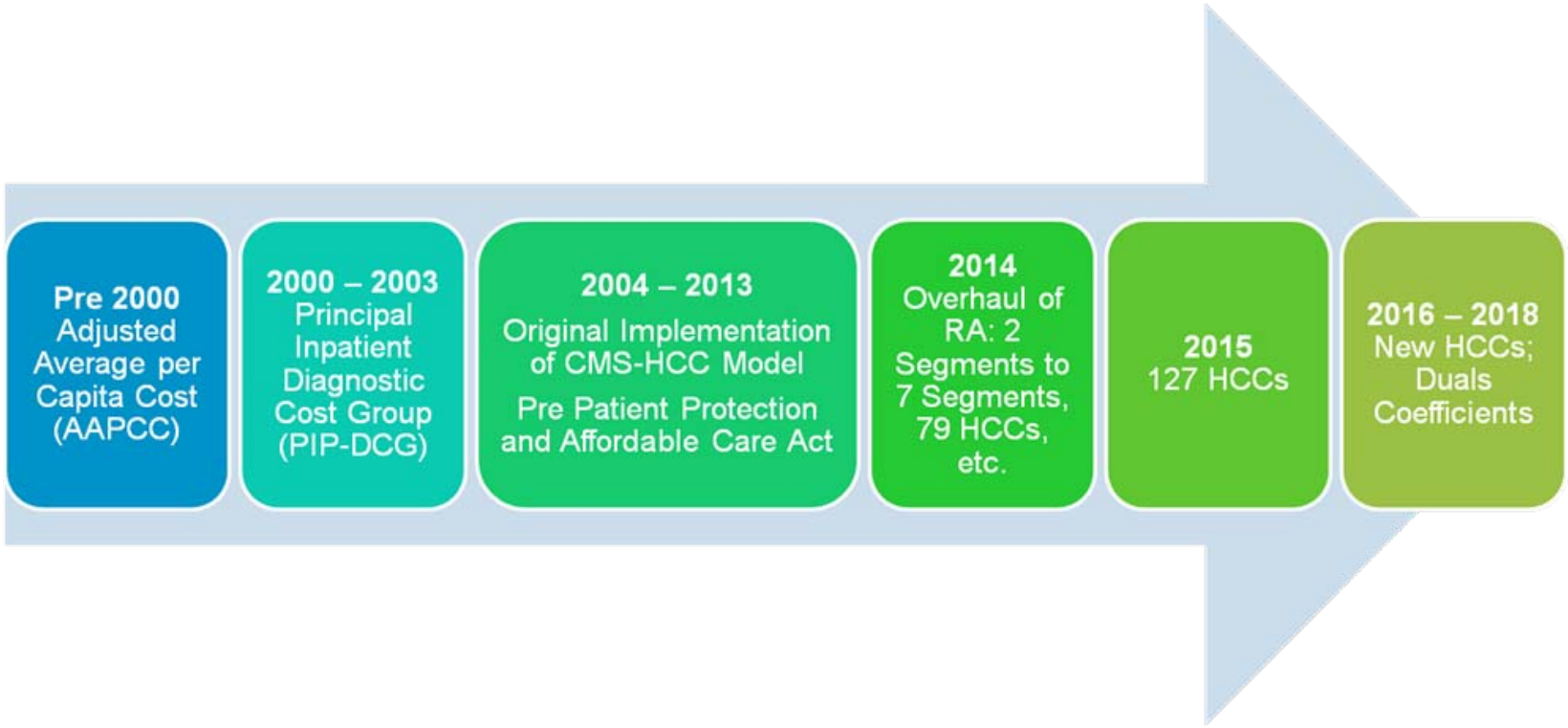
BENEFIT & BID CHANGES

- Seeks comment on whether CMS should change their **Maximum Out-of-Pocket** (MOOP) limits in the future and allow for more “flexible benefit designs that would provide beneficiaries with valuable plan options.”
- D-SNPs and I-SNPs may offer **Enhanced Disease Management** (EDM) supplemental benefit that is currently available to non-SNP MA plans.
- CMS is eliminating the **meaningful difference requirement** beginning in 2019. Sponsors will no longer need to submit actuarial certification that substantiates differences between the plan options they offer.
- Plans may reduce cost-sharing for certain benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees who meet **specific medical criteria**.

SUPPLEMENTAL BENEFITS: INNOVATION ABOUNDS

- CMS expanded its definition of supplemental benefits to include those which compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable utilization – including "daily maintenance" benefits.
- To be "primarily health related," the benefit or service must "*diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization*."
  - Must be medically appropriate and recommended by a licensed provider as part of a care plan if not directly provided by one
  - Do not include items or services solely to induce enrollment
- The Bipartisan Budget Act (BBA 2018) codified the policy, expanding supplemental benefits for chronically ill members beginning in 2020.

A BRIEF HISTORY OF MEDICARE RISK ADJUSTMENT



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RISK MODEL HIGHLIGHTS

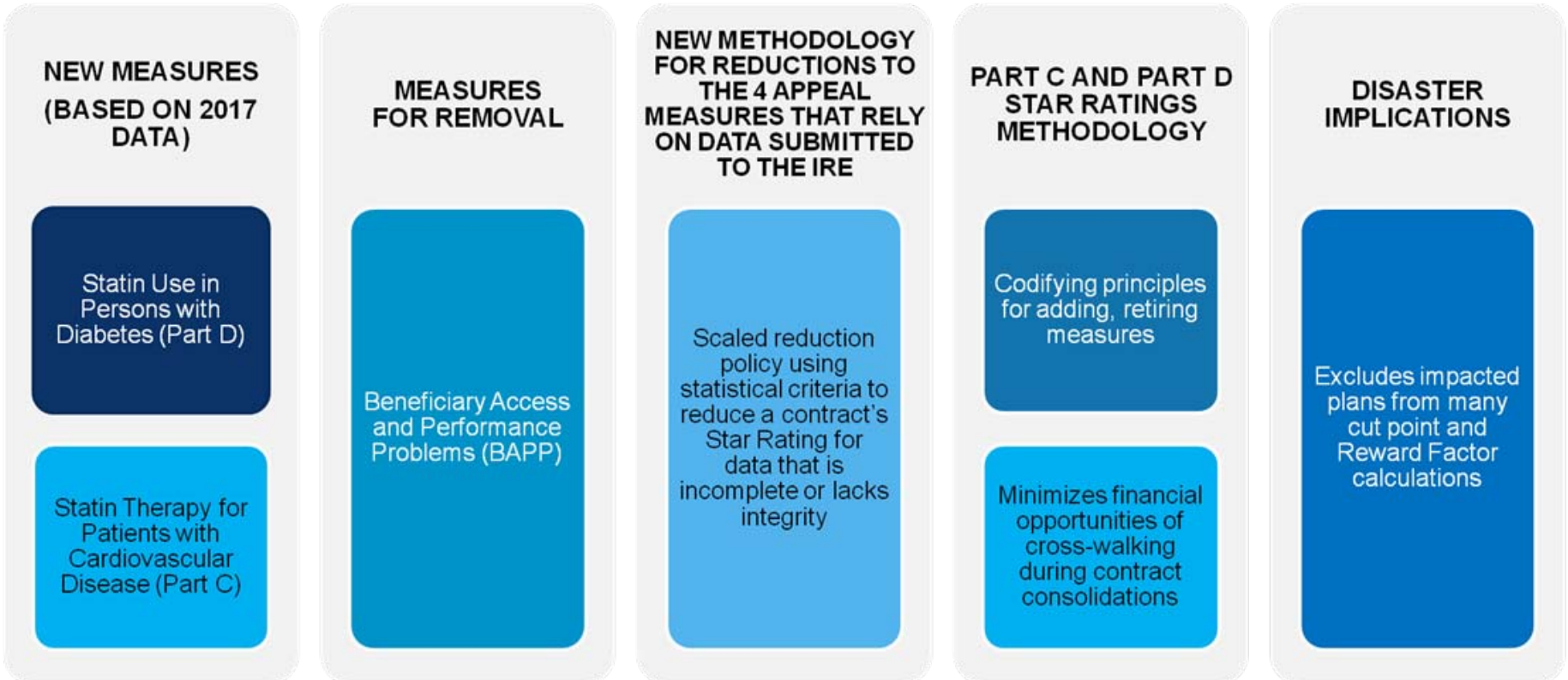
- Payment Condition Count Model not implemented for 2019
- Requested implementation delay
  - Evaluate impact
  - Validate results
  - Provider feedback
- Cure's Act interpretation difference
- Plan to implement in 2020

- Proposed conditions finalized
  - Chronic Kidney Disease
  - Mental Health
  - Substance Use Disorder
- Conditions are clinically meaningful
- Predict significant cost
- Improve prediction for members

2019 HCC MODEL FINAL RULES

- 2018 RxHCC Model will be used in 2019
- Updated ESRD dialysis and ESRD functioning graft model
- Coding Pattern Adjustment proposed and finalized at 5.90%
- Updated frailty factors to determine scores for FIDE-SNPs

2019 STAR RATINGS PROPOSALS



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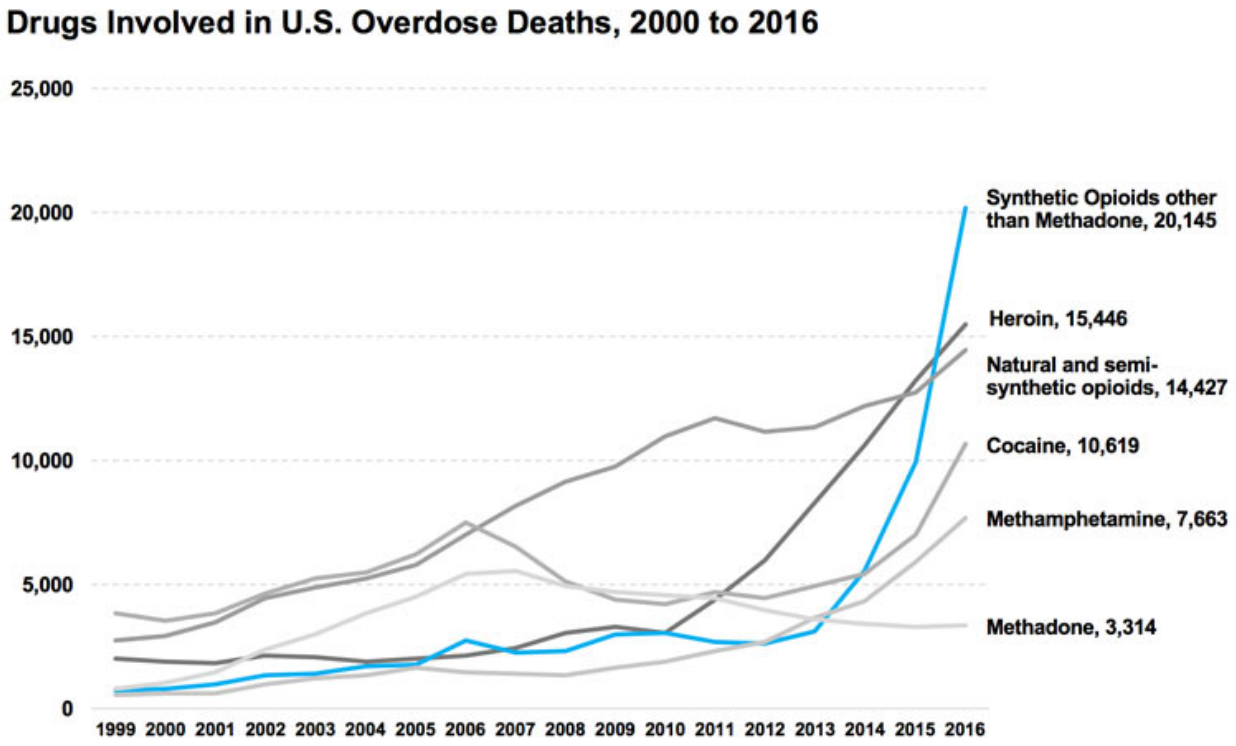
STAR RATINGS 2020 & BEYOND

- New hypertension treatment guidelines are being evaluated by NCQA; *Controlling Blood Pressure* may be temporarily retired to the display page for the 2020 Ratings.
- HEDIS® measures may not be clinically appropriate for all members, which could be incorporated into HEDIS® 2019.
- Medication Adherence measures may be risk adjusted for various socio-demographic characteristics beginning with the 2018 calculations; once complete (expected in early 2019), CMS will determine how to implement within the Star Ratings program.
- Medicare Plan Finder (MPF) Price Accuracy measure will be implemented through the display page for the 2020 and 2021 ratings; CMS seeks feedback on leaving the current MPF Price Accuracy measure "as is" until the new modified measure takes effect in the 2022 ratings.

PROMOTING USE OF OVERDOSE-REVERSING DRUGS



Source: CDC WONDER

Surgeon General proclamation April 5, 2018: "I am emphasizing the importance of the overdose-reversing drug naloxone…**knowing how to use naloxone and keeping it within reach can save a life.** The unpredictability in illegal drug products is dramatically increasing the risk of a fatal overdose."

EVOLUTION OF OPIOID LAW AND RULES

Congress – July, 2016: Comprehensive Addiction and Recovery Act

- Nalaxone availability expanded
- Improve prescription drug monitoring
- Resource shift from punishment to treatment for incarcerated persons
- Questions about illegal drug convictions barred form FAFSA financial aid form

CMS 2017 Call Letter

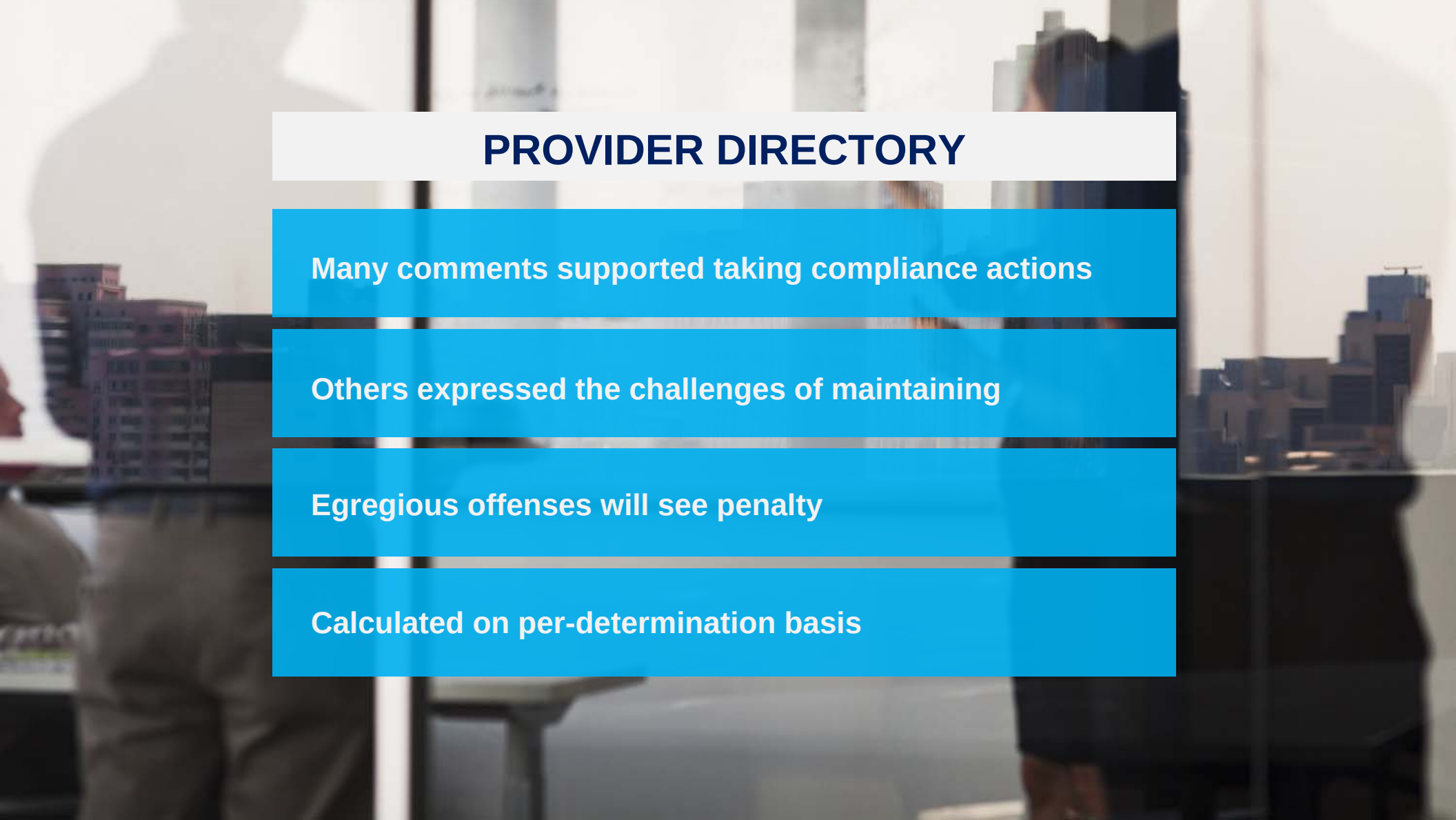
- Soft edit at point of sale (POS), minimum 90 mg Morphine Equivalent Dose (MED)
- Hard edit at POS, minimum 200 mg MED
- Known exceptions (hospice, certain cancer, medically necessary, etc.)

CMS 2019 Call Letter

- Hard safety edit to limit initial opioid prescription to maximum 7-day supply
- Identification and lock-in of high-risk opioid users
- Real-time safety edits for chronic opioid users
- Risk/benefit analysis of maintaining or decreasing opioid dosage carefully considered

COST PLAN TRANSITION UNDER MACRA

- Beginning with 2019, CMS will non-renew any portion of a Cost plan's service area if there are at least 2 competing MA local or 2 MA regional coordinated care plans with minimum enrollment for the entire year prior to the non-renewal.
- **Cost plans must complete transition to MA by contract year 2019.**

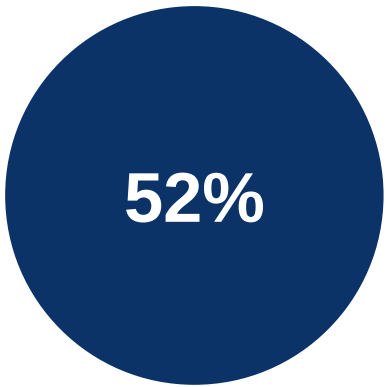


PROVIDER DIRECTORY

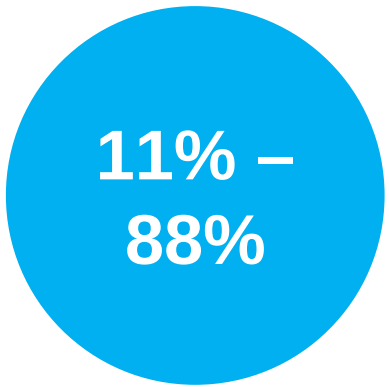
- Many comments supported taking compliance actions
- Others expressed the challenges of maintaining
- Egregious offenses will see penalty
- Calculated on per-determination basis

ROUND 2 RESULTS

There is work to be done here!



52% OF THE TIME, DIRECTORY INFORMATION WAS INCORRECT



THE RANGE OF INACCURACIES = 11% TO 88%

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NEW MACRA SUPPORT FOR PROVIDERS

CMS will begin accepting “Other Payer Advanced Alternative Payment Model (APM) arrangements” in 2019

CMS will need to obtain information on payment arrangements prior to 2019

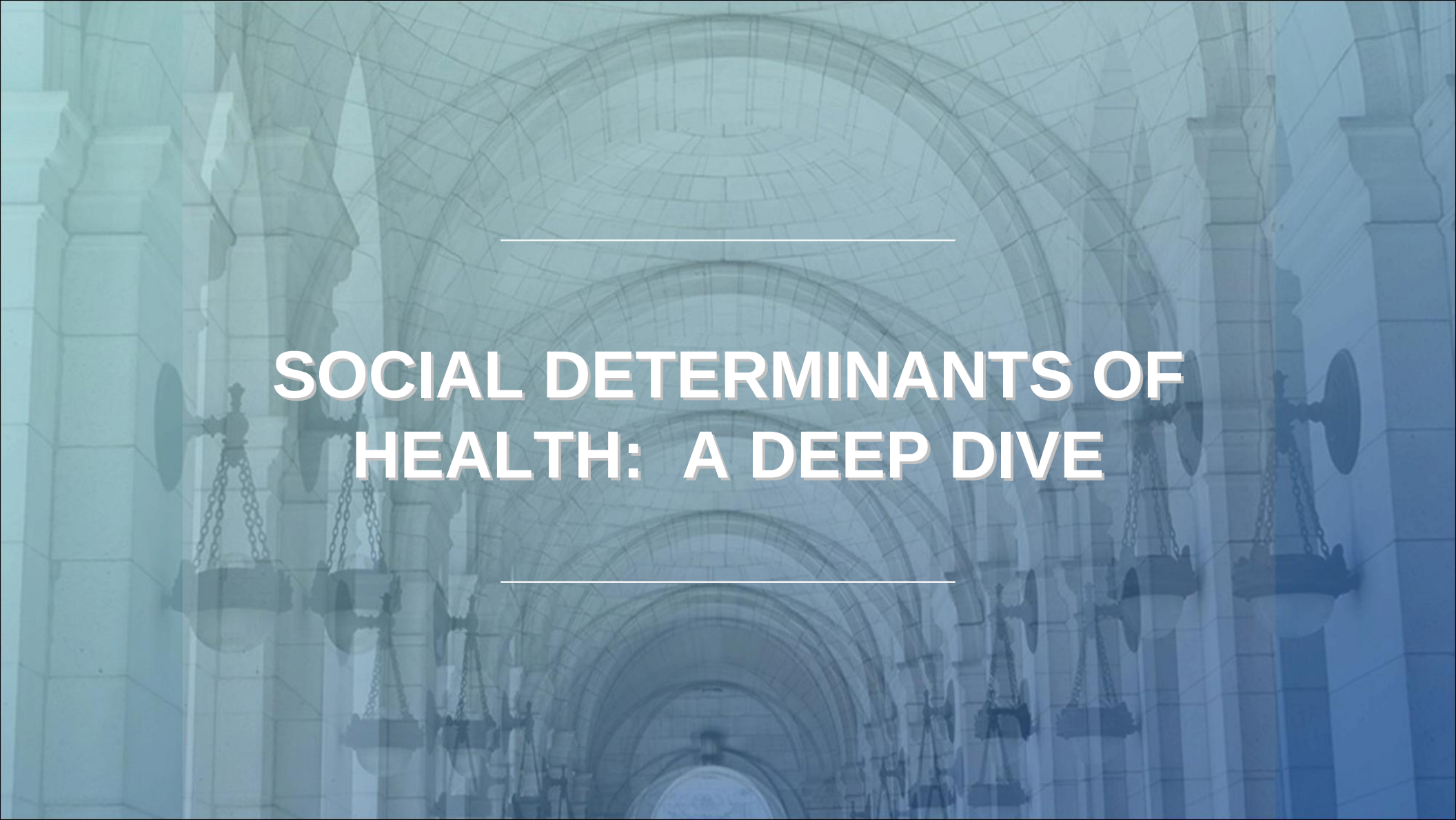
Plans can submit info as part of 2019 bid submission

EGWPs

- Part C entities offering employer/union-only group waiver plans are not required to submit Part C bid pricing information.
- CMS will fully transition in 2019 to using only individual market plan bids to calculate the bid-to-benchmark (B2B) ratios to set EGWP payments.
- Since the Advance Notice, CMS slightly revised the methodology to adjust the B2B for HMO/PPO mix difference between EGWP and individual MA.

What's Next?

- Consider your supplemental benefits
- Assess your readiness for revenue impacting risk adjustment changes
- Evaluate and minimize risks associated with industry M&A
- Ensure your provider directory is accurate
- Formulate a plan to help your members with opioid addiction



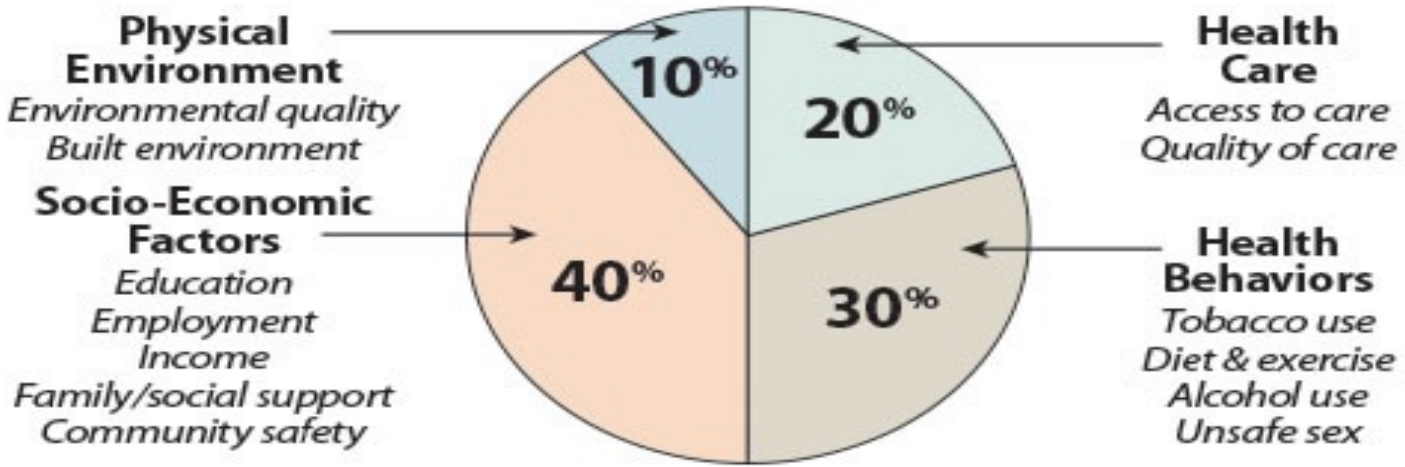
SOCIAL DETERMINANTS OF HEALTH: A DEEP DIVE

SUPPLEMENTAL BENEFITS: INNOVATION ABOUNDS

- CMS expanded its definition of supplemental benefits to include those which compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable utilization – including “daily maintenance” benefits.

Social Determinants of Health

Population Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, http://www.countyhealthrankings.org/about-project/background

THE IMPORTANCE OF SOCIAL DETERMINANTS

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Some studies attribute as much as 50% of healthcare outcomes to social determinants of health.

THE HENRY J. KAISER FAMILY FOUNDATION

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GETTING A SHARPER PICTURE OF THE POPULATIONS YOU SERVE

- Obtaining available information on membership's income, race, ethnicity, home ownership rate, language
- Best practices for data collection, tracking, and reporting
- Strategies for effectively conducting your own research
- Understanding the factors that motivate healthcare decision-making for your primary member groups

INFORMATION ALREADY AVAILABLE

- Claims and encounter data
- Hierarchical Condition Categories (HCC)
- Health Risk Assessments (HRAs)
- Other clinical assessments
- Pharmacy data
- Lab encounters and results
- Data required to meet federal and state requirements:
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Health Outcomes Survey (HOS)
  - Medical Management System

- Audit data
- Plan surveys
- Welcome call
- Call systems: customer service, medical management, pharmacy
- Home visit observations

COMMISSION A STUDY

- CMS Model of Care requirements for Special Needs Plans offer rigor to capture and address the non-clinical characteristics of your membership
- Publicly available data abounds! CDC, RWJF, KFF, Healthy People 2020, U.S. Census Bureau, state & local CHNAs….
  - Disease prevalence
  - Neighborhood and lifestyle conditions (including property and mortgage data, types of homes, distance to public transportation)
  - Racial and cultural diversity
  - Income levels, credit attributes and bankruptcy history
  - Education and literacy levels
  - Presence of children in the home
  - Criminal convictions and incarceration history
  - Purchasing habits
- Flexible, customized health risk assessments offer high-ROI opportunity to identify each member's needs
- Vendors are beginning to capitalize on technology to enable efficient use of member-specific information

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UNDERSTANDING THE FACTORS THAT MOTIVATE YOUR MEMBERSHIP

- By Lines of Business
  - Commercial (e.g infertility program)
  - Government Programs (e.g. Community Health Fairs, asthma program)
- Understanding social impacts and community
  - Food and nutrition
  - Safe and stable housing
  - Health literacy and disease understanding
  - Self-care capacity
- Focus groups by age, generation
  - Personal Responsibility to stay healthy. Where is it in the priority list for current state (e.g. food, children, safety, home)?
  - Incentives: Financial, Debit Cards, Education, jobs, transportation
  - What role can the plan take in these identified motivators or does it extend to community partners and drive social impact.

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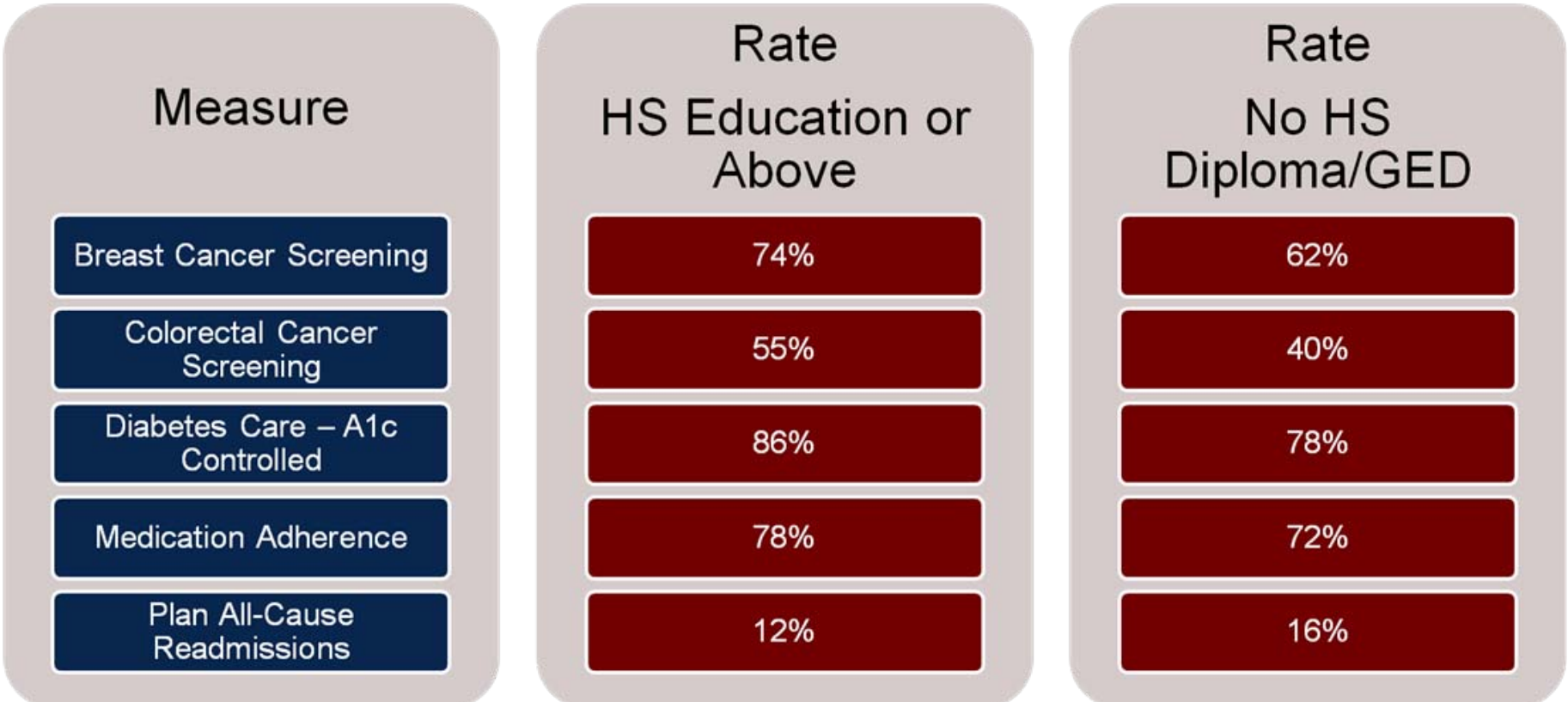
OBTAINING AND USING INFORMATION

- Does your data warehouse and technology tools/systems integrate data obtained from inside and outside the organization?
- Do your staff know how to identify a member's SDOH and personalize interventions accordingly? Do they have the time to make a meaningful impact and to influence member behavior?
- Is your QI staffing level adequate to allow robust collection and analysis of the data?
- Do your reports and dashboards allow segmented tracking and monitoring of groups sharing similar characteristics?
- Do you have P&Ps or program evaluations that reinforce at least annual evaluations that are reported to committees and BOD?

DATA COLLECTION, TRACKING AND REPORTING: BEST PRACTICES

- Creativity & innovation
  - Meet with members where they live to allow first-hand assessment and optimal member comfort
  - Store data and electronic, query-able location where it can be integrated with medical and medication data
  - Hardwire processes that integrate non-clinical data into care planning, quality strategies, etc
- Review stake holders and formal process
  - Internal: business partners, units, committees, alliances
  - External: vendors (e.g. data, survey, auditors), providers, community partners, social impact partners
- Converting barriers and challenges into opportunities
  - Timely & Accurate
  - Integration with flexibility
    - Sustainability
    - Scalability
  - Usefulness

EXAMPLE: USING DATA TO FORMULATE STRATEGY



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THE SCIENCE OF MOTIVATING MEMBERS TO IMPROVE HEALTH

HIGHLY ENGAGED

- I follow my doctor's orders religiously.
- I take my medications as prescribed.
- I seek ways to improve my health.
- I have resources to meet my needs.

ENGAGED

- I know how to improve my health.
- I generally follow my doctor's orders.
- I appreciate reminders from my MA plan.
- I use good judgment regarding my health.

ALMOST ENGAGED

- I know I should improve my health.
- Sometimes I don't make good choices.
- I know how to improve my health.
- I give up when it gets hard.

NOT ENGAGED

- I'm not willing to change my behavior.
- I don't know how to manage my health.
- Sometimes I need help from others.

DISENGAGED

- I don't have resources to meet my needs.
- I rely on others for many daily activities.
- I do not want to change.

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STORIES FROM THE FIELD: SETTING STRATEGIES THAT MOTIVATE MEMBERS

40% of the members in a D-SNP are illiterate (sign their name with an "X")

Vast majority of the members of a D-SNP reside in multi-story, aging, inner-city apartment buildings with unreliable elevators

Almost 50% of a D-SNP plan's members rely on public transportation and live in neighborhoods where gang/gun violence is at an all-time high

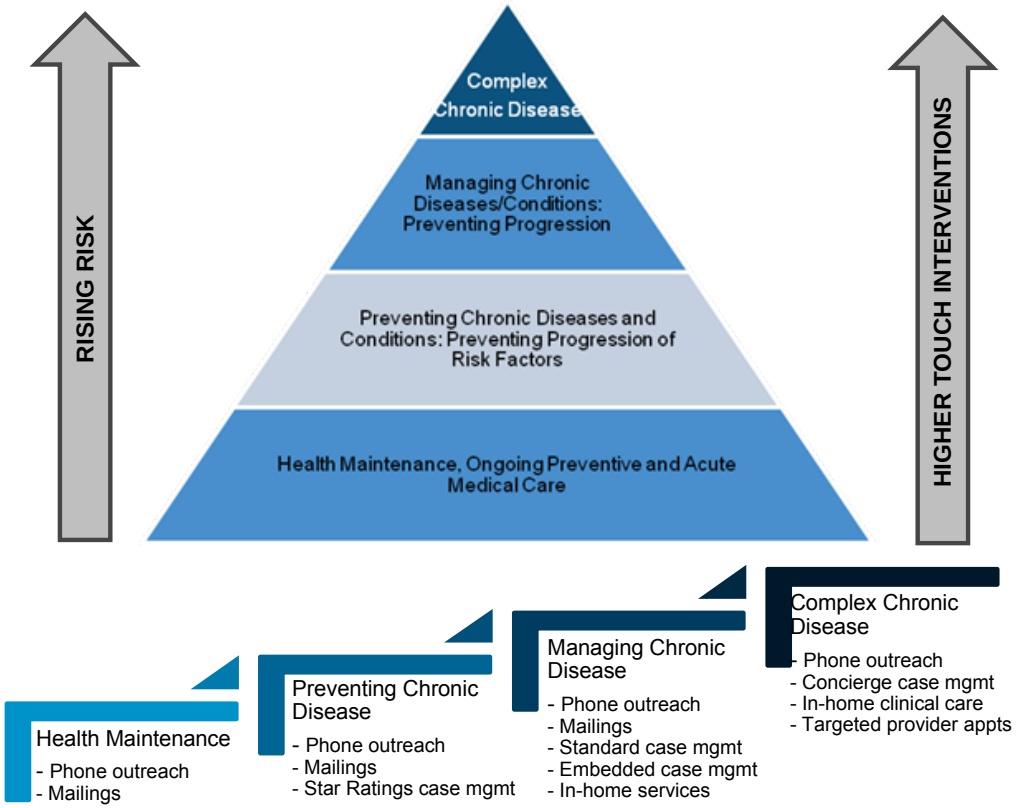
60% of a Medicaid plan's members struggle to find providers with appointments available after 4pm

10% of an MA-PD plan's members use a church-based clinic staffed by locums tenens physicians

Almost 50% of an MA-PD plan's members report being uncertain of having access to enough food.

68% of an MA-PD report not being able to afford the medications prescribed by their doctor using their plan's formulary structure

PERSONALIZING CARE TO IMPROVE OUTCOMES



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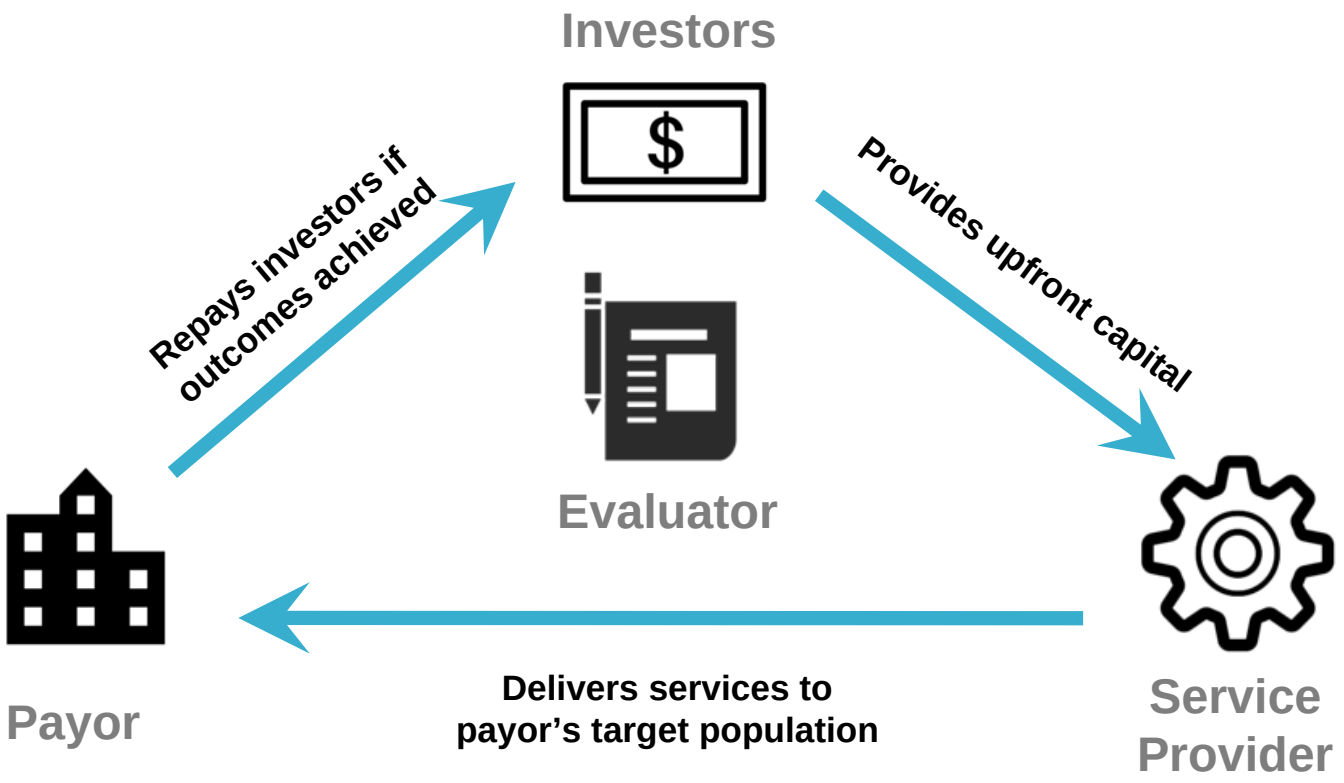
MEDICARE ADVANTAGE IS FERTILE SOIL FOR SOCIAL IMPACT INVESTING



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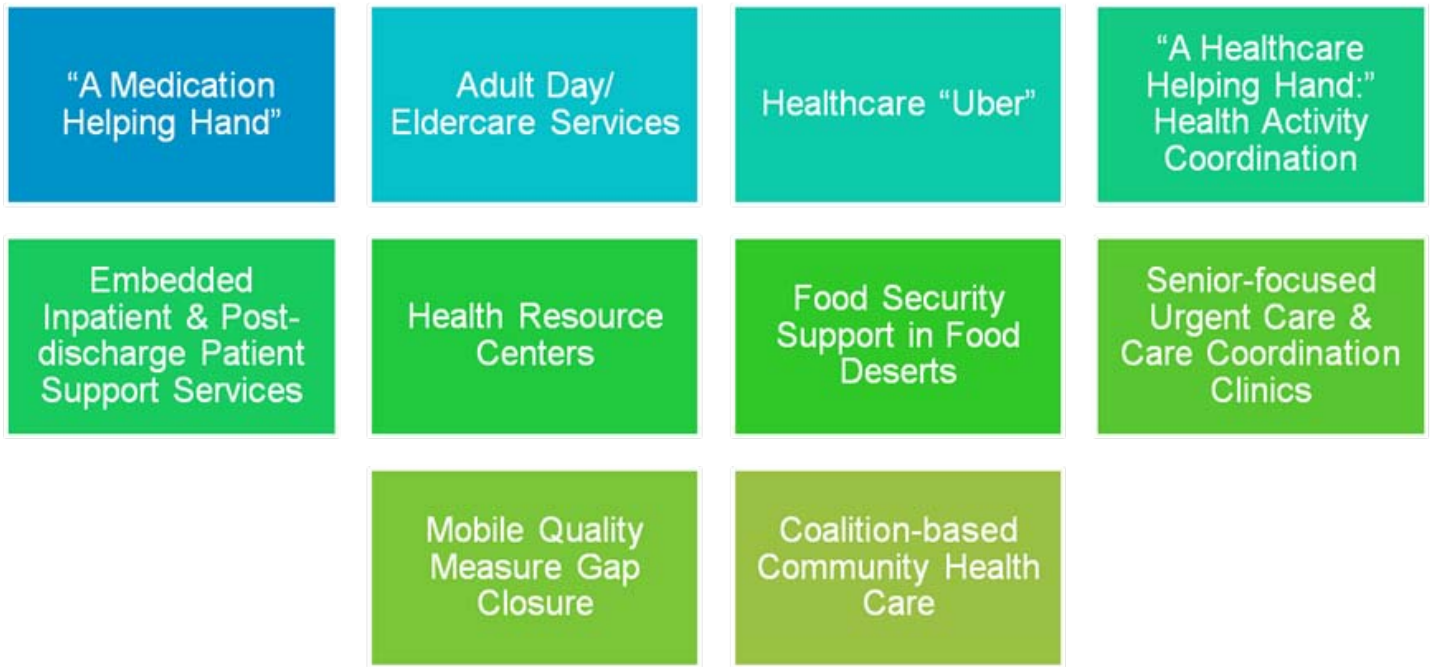
USING SOCIAL IMPACT INVESTING TO SUPPORT MA

MA Plan Pain Points	How SIBs Address Pain Points
• Increasing market competition	• Demonstrate a commitment to innovation and outcomes, providing a competitive advantage
• Expanding care to more and higher-cost patients	• Address upstream determinants of health that remediate downstream costs
• Improving value of care	• Enhance focus on interventions that improve health outcomes and reduce costs
• Focusing on measuring outcomes of population health initiatives	• Systematize rigorous evaluation to demonstrate causal impact of certain interventions

POTENTIAL SOCIAL IMPACT INVESTMENTS IMPACTING STAR RATINGS & HEALTH OUTCOMES



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