Medicare Advantage- Trends and Impacts

October 25, 2023

AMERICA'S PHYSICIAN GROUPS

Hosts

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Speakers

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Director

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Who We Are

- **Healthsperien, LLC** is a boutique health care policy consulting firm operating at the intersection of business strategy, in-depth policy analysis, and lobbying.
- Critically, we focus on the most vulnerable populations in America and only do business with entities aligned with our mission.

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Agenda

Welcome (5 min)

Overview of MA Landscape (10 min)

MA Key Issues

- Risk Adjustment (10 min)
- Star Ratings (15 min)
- Prior Authorization (5 min)

Impact to MA Physician Organizations (10 min)

Advocacy Initiatives (5 min)

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Overview of Medicare Advantage Landscape

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Medicare Advantage Landscape At-a-Glance

HEADWINDS

- Continued Congressional and Administration scrutiny on Medicare Advantage program with the propensity for policy changes that may tighten margins and increase monitoring efforts.
- Increased skepticism on the value of supplemental benefits to drive health outcomes versus as a marketing tool
- 2024 Final Rate Notice risk adjustment changes negatively impacting MA revenue.
- Star Ratings changes reducing quality bonus program payments.
- Implementation of RADV audits with potential for negative financial impacts.
- IRA implementation and Part D redesign.

TAILWINDS

- Shifting demographics expanding eligible MA population.
- Increasing penetration of MA, comprising over 50% of total Medicare population.
- Continued focus on improving care delivery models for dually eligible beneficiaries.
- Heightened importance of addressing health equity and disparities in underserved populations.
- Shifting member preferences that value a customer-centric experience
- Continued vendor innovations in care management approaches and remote care.

Key Point: Increasing financial pressure and scrutiny will incent plans to pull business levers with downstream impacts to providers.

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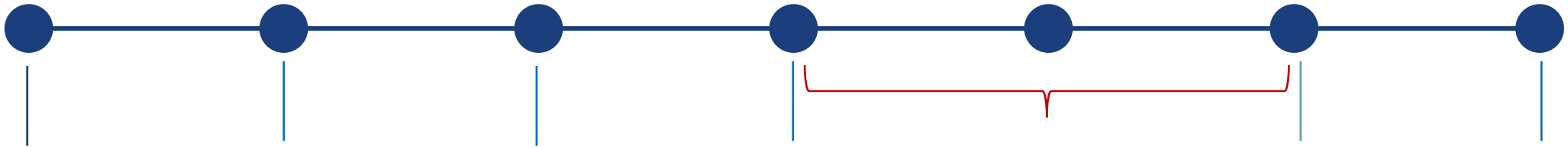
Recent and Future MA Policy Developments Timeline

Key:
Star Ratings Changes
Risk Adjustment
Inflation Reduction Act



2021 Star Ratings: COVID-19 flexibilities in effect, including data collection freeze

2022 Star Ratings: COVID-19 flexibilities in effect, including hold harmless policy and disaster policy

2023: RADV Final Rule takes effect, starting with PY 2018

2023 Star Ratings: Most COVID-19 flexibilities expired; implementation of 5% cut point guardrails

2024 Star Ratings: Tukey outlier methodology applied

IRA implementation; Eliminates 5% coinsurance for catastrophic coverage in Medicare Part D in **2024**, adds a $2,000 cap on Part D out-of-pocket spending in **2025**, and limits annual increases in Part D premiums for **2024-2030**

2024 – 2026: Phase in of V28 Risk Adjustment changes

2026: First Medicare negotiated drug prices take effect

2027 Star Ratings: Health Equity Index implemented, using 2024/25 measurement data

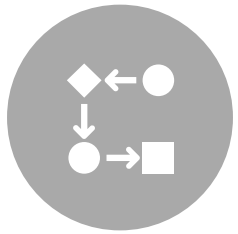
Options for Plans in Response?

MA plans have a number of potential policy and financial levers to pull in responding to financial pressures.

Reduction in scope and quantity of supplemental benefit offerings

Changes to premiums, deductibles, and cost-sharing

Changes to provider network contracts (e.g., reimbursement, narrower networks)



Stricter utilization management policies (and influenced by recent PA changes)

Increased focus on VBP arrangements

Medicare Advantage Key Issues: Risk Adjustment

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2024 Final Rate Announcement: Overview

- On March 31st, CMS released the Announcement of 2024 Final Rate Announcement – which establishes MA payment and coverage policies for the upcoming plan year.
- CMS finalized removal of certain diagnoses from the HCC model, based on conditions that are coded with higher frequency in MA compared to FFS.
- The updates to the model phase in over the next three years:
  - CY 2024: Risk scores calculated as a blend of **33%** using the updated 2024 model, and 67% from the current model (2020 model)
  - CY 2025: **67%** calculated under 2024 model and 33% under 2020 model
  - CY 2026: **100%** calculated under updated 2024 model

Change	2023	2024 (Proposed)	2024 (Final)
Effective Growth Rate	4.88%	2.09%	**2.28%**
Rebasing/Repricing	.39%	TBD	**0%**
Change in Star Ratings	.54%	-1.24%	**-1.24%**
MA Coding Intensity Adjustment	0%	0%	**0%**
Risk Model Revision and Normalization	-.81%	-3.12%	**-2.16%**
MA Risk Score Trend	*3.50%*	*3.30%*	***4.44%***
Expected Average Change in Revenue	8.50%	1.03%	**3.32%**

MA Plan Financial Impacts

- Operates as a coding intensity adjustment; 2024 RA Model changes result in the removal of ~2000 unique diagnoses codes
- CMS also "constrained" certain HCCs, where some HCCs (diabetes and CHF) are given the same coefficients and contributions to the risk score
- MA plans serving members with these removed diagnoses codes and constrained HCCs may see corresponding decreases in risk scores and thus payment
- **Contributes to an overall reduction in revenue of -2.16%**

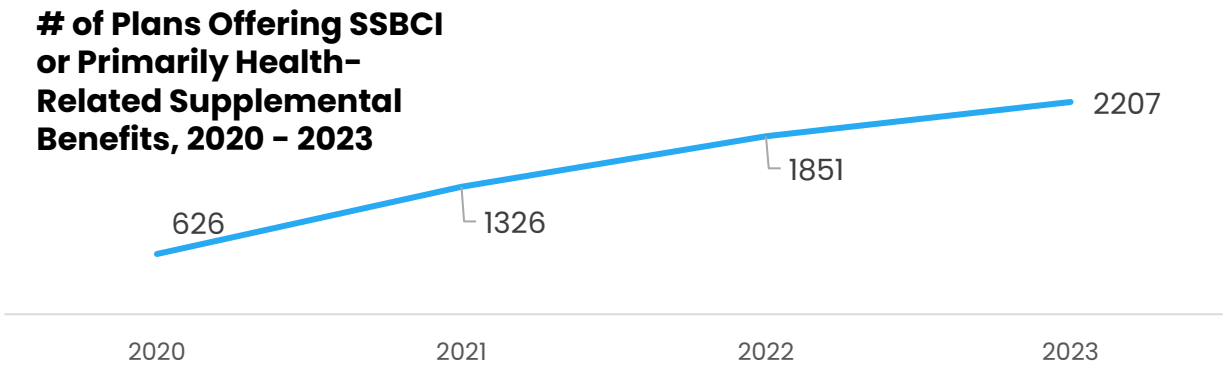
D-SNP Impacts

- *In response to CMS' proposal, several plans highlighted the disproportionate impact to D-SNPs, given the high acuity populations these plans serve.*
- *Estimated D-SNP revenue reduction from -6% to -15%*

2020 HCC Labels	Dropped Diagnoses
Major Depressive, Bipolar, and Paranoid Disorders	425
Complications of Specified Implanted Device or Graft	325
Major Head Injury	496
Amputation Status, Lower Limb/Amputation Complications	291
Other Significant Endocrine and Metabolic Disorders	229
Vascular Disease	330
Spinal Cord Disorders/Injuries	352
Diabetes with Chronic Complications	400
Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	648
Dialysis Status	50

Supplemental Benefits

- **Constraint of supplemental benefit offerings not appearing to play out**; CMS notes that supplemental benefit offerings will "increase slightly" in 2024.
- Differing incentives between plans to offer supplemental benefits:
  - **Regular MA plans can offer both supplemental benefits and reduced cost-sharing** to attract members.
  - D-SNPs are **generally unable to impose cost sharing for Medicare benefits** for certain Medicaid-eligible individuals. Consequently, supplemental benefits are a **critical marketing tool** for D-SNPs. Individuals enrolled in D-SNPs are **typically of higher acuity with health-related social needs**, which further informs D-SNP supplemental benefit development.



Three types of Supplemental Benefits:

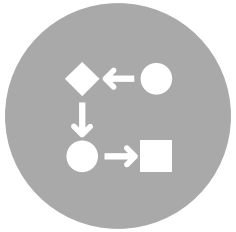
- **Standard**: Must be primarily health related, offered to all enrollees (e.g., vision, hearing, dental, etc.)
- **Targeted**: Benefits offered to qualifying enrollees by health status or disease state. CMS has also expanded the interpretation of what items and services can be covered as "primarily health-related."
- **SSBCI**: Expanded supplemental benefits to plan enrollees deemed to be chronically ill. Includes benefits that are not primarily health related and can be offered non-uniformly to enrollees.

Options for Plans in Response?

Reduction in scope and quantity of supplemental benefit offerings

Changes to premiums, deductibles, and cost-sharing (premiums increase 3.6% in 2024)

Changes to provider network contracts (e.g., Reimbursement, narrower networks)



Stricter utilization management policies (and influenced by recent PA changes)

Increased focus on VBP arrangements

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Medicare Advantage Key Issues: Star Ratings

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Star Ratings Changes

Expiration COVID-19 Flexibilities

- During the COVID-19 pandemic, CMS allowed MA plans to pick the "better of" current or historical performance.
- This enabled MA contracts to benefit from performance improvements without factoring performance deterioration.
- Rating increases from 2021 to 2022 were 30 to 40% higher than the average seen in the previous 5 years.
- **This flexibility expired in 2023 Star Ratings, impacting Star Ratings negatively.**

Reduction in CAHPS Weights

- Starting with 2026 Star Ratings, reduces CAHPS measure weights from 4 to 2.
- Previous estimates have shown that these customer experience measures would decrease from comprising ~60% of total Star Ratings to ~30%.
- **Plans will correspondingly shift from an overemphasis on CAHPS to other health outcomes and process metrics.**

Select CAHPS patient experience and complaints measures:

- Measure: C17 - Getting Needed Care (CAHPS)
- Measure: C18 - Getting Appointments and Care Quickly (CAHPS)
- Measure: C19 - Customer Service (CAHPS)
- Measure: C20 - Rating of Health Care Quality (CAHPS)
- Measure: C21 - Rating of Health Plan (CAHPS)
- Measure: C22 - Care Coordination (CAHPS)

Tukey Outlier Deletion

What is it?

- Implemented for **2024 Star Ratings**
- Star Ratings "cut points" define the threshold needed to assign a specific 1 – 5 rating for a specific measure. Cut points are calculated based on collective performance data from all Medicare contracts.
- The Tukey method identifies certain outliers (e.g., extremely high and low readmission rates) from the performance data and **removes these outliers prior to developing the cut points.**
- Plans most impacted are those that were already closest to 3.5/4 star cut points. Plans below 4 stars do not get 5% benchmark benefit.
- CMS also implemented **cut point guardrails in 2023 Star Ratings**, limiting year-over-year changes in cut points to **5%**.

Implications

- Outliers are **more commonly found at the low end of performance** among poorly performing contracts. Consequently, deleting these outliers will likely make it **more difficult to achieve high Star Ratings performance.**

McKinsey estimates implementation of the methodology in 2024 will cost insurers $800 million in Star Ratings bonuses.

ACAP anticipates disproportionate impacts to D-SNPs: 14% of D-SNP contracts would lose bonus payments and 27% would lose rebate dollars, compared to 7% and 20% of non-D-SNP contracts.

Star Ratings: Health Equity Index

What is it?

- Beginning with 2027 Star Ratings and using 2024/25 measurement year data, the HEI will replace the current MA Star Ratings reward factor, and assess contract performance among beneficiaries with certain social risk factors (SRFs), across almost all Star Ratings measures.
- SRFs initially will include 1) receipt of Low-Income Subsidies (LIS), 2) being a full or partial benefit dually eligible individual, or 3) having a disability, based on the original reason for entitlement to the Medicare program

Data collection starts now – and will influence care management approaches and VBC arrangements with providers caring for underserved groups, including dually eligible individuals.

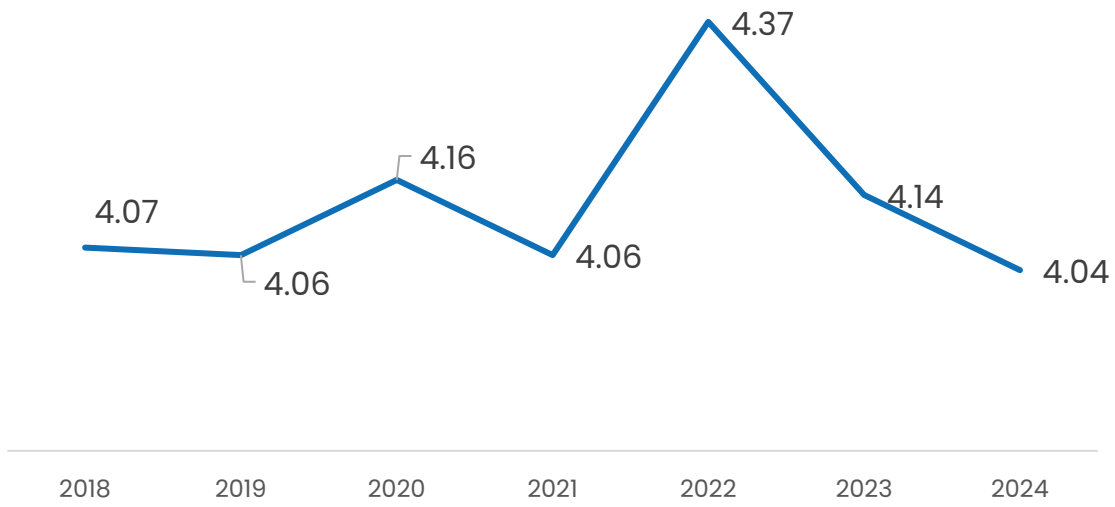
Methodology

1. To calculate the HEI reward, MA plans are ranked into thirds based on their relative performance for each measure, and awarded 1, 0, or -1 points for each measure.
2. Points are added up across measures, and contracts with a positive overall score and a certain percentage of members with SRFs will receive a 0 to .4 point bump to their overall summary rating.

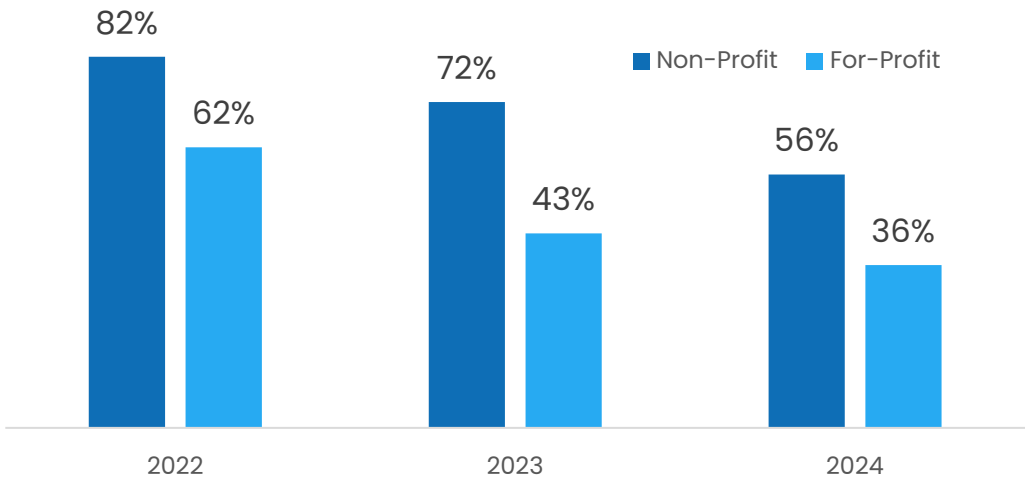
What Does it All Mean?

- Star Ratings continue to decline in 2024, wake of ending COVID-19 flexibilities and Tukey outlier implementation.
- Non-profit insurers continue to significantly outpace for-profit insurers on Star Ratings performance
- Reduced revenue will **increase pressure on MA plans** to pull policy levers previously discussed, including **potential reductions to supplemental benefits** given the direct impact on rebate dollars.
- Star Ratings performance will **influence metrics MA plans use with providers in VBC arrangements**.
- It will also **shape care management strategies** by the MA plan, impacting provider care delivery approaches.

Average MAPD Star Ratings, 2018 - 2024



Percentage of Plans 4+ Stars, Non-Profit vs. For-profit



Performance by Organization

While non-profit status elucidates an overarching differentiating factor in Star Ratings performance, downstream impacts ultimately require a plan and region-specific assessment

Supplemental Benefits

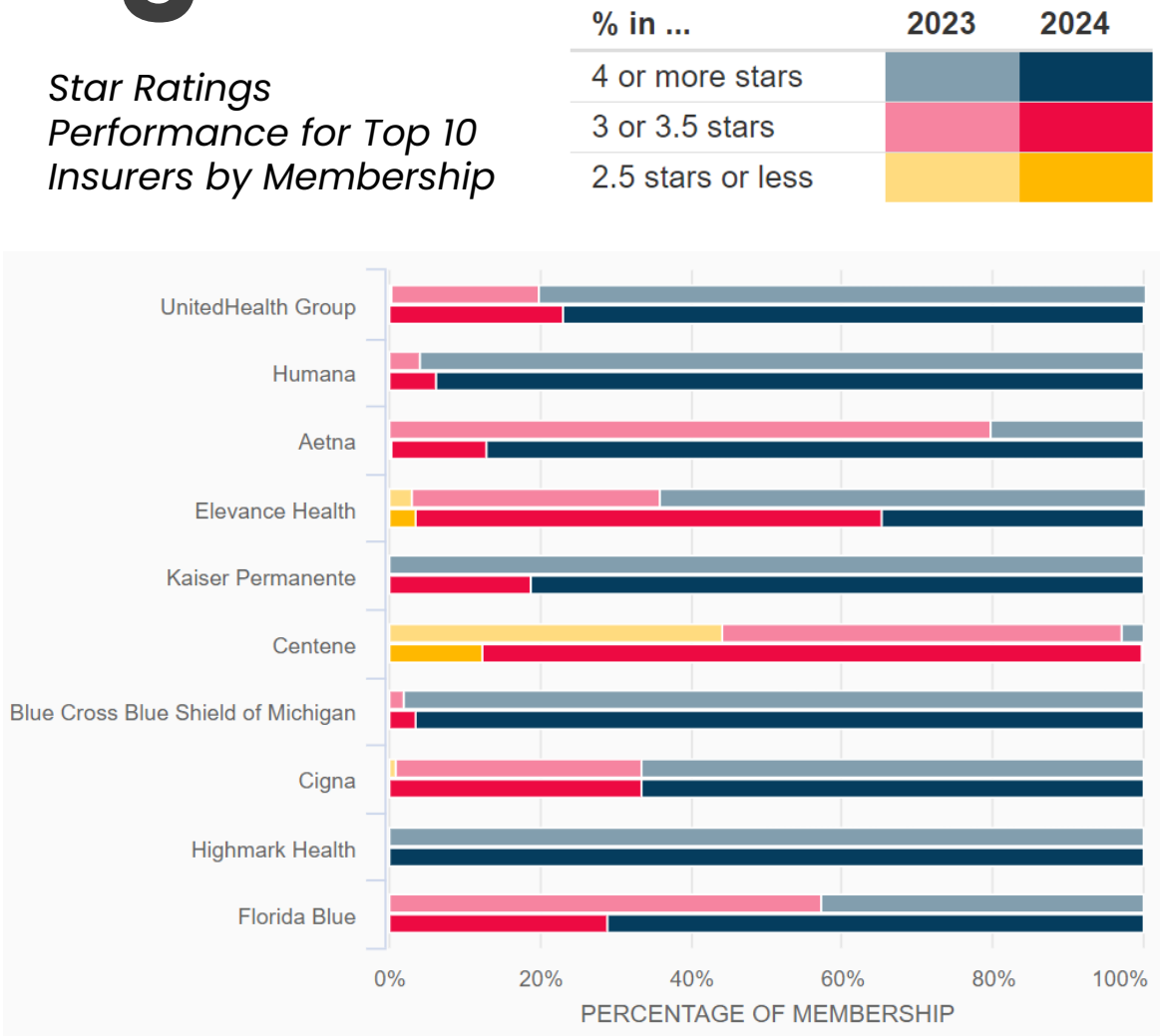
Premiums, Cost-Sharing, Deductibles

Provider Networks

Utilization Management

VBC

Star Ratings Performance for Top 10 Insurers by Membership



Source: Modern Healthcare

Medicare Advantage Key Issues: Prior Authorization

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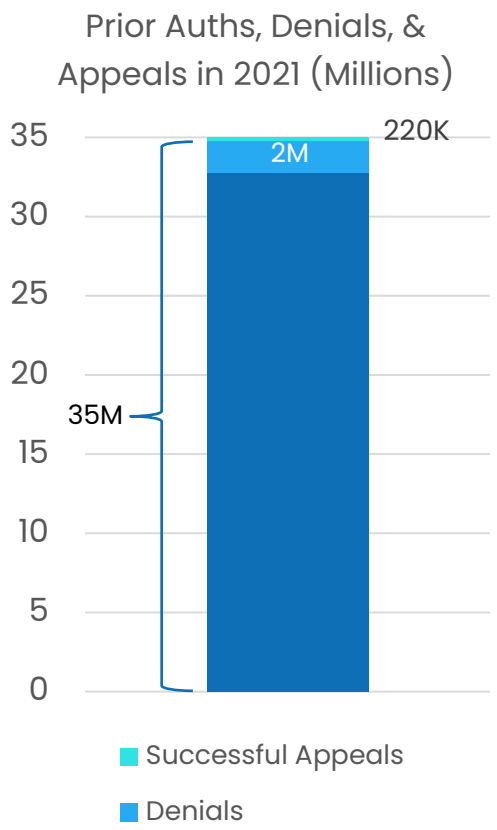
Prior Authorization Landscape

PAs are Near Universal

- According to a KFF analysis, **almost all (99%) current MA enrollees are in plans requiring prior authorization** for at least some services.
- While prior authorizations are more likely to be required for higher-cost services such as chemotherapy, **6% of MA enrollees were in plans requiring prior authorizations for preventative services during inpatient hospital stays.**

Significant Burden Posed by PAs

- 35 million prior authorization requests were submitted to MA insurers on behalf of enrollees in 2021
- The volume of PA determinations varied across MA insurers, ranging from 0.3 requests per enrollee to 2.9 per enrollee.
- Over 2 million PA requests were fully or partially denied by MA insurers. 11% of PA denials were appealed.
- **82% of appeals resulted in fully or partially overturning the initial prior authorization denial.**



OIG Report Sheds Light on Burdens Posed by PA to Lawmakers

In July of 2023, The Office of the Inspector General (OIG) published a study expressing concern that the capitated payment structure under which MA plans are paid a fixed PMPM—regardless of the amount of care rendered per enrollee—may incentivize plans to limit beneficiary access to care to maximize profits.

The OIG findings indicate:

- Prior Authorizations are used by MA plans to delay or deny access to medically necessary care.
- This leads to financial burdens incurred by MA enrollees who opt to pay for care out-of-pocket. This is a significant issue, given that most Medicare beneficiaries live on fixed incomes and have limited savings.
- Significant administrative burdens are imposed upon those patients and providers who chose to appeal denials.

Lawmakers at the State and Federal Levels are Active on this Issue

CMS

- 2024 Medicare Advantage and Part D Rule
- 2022 Proposed Prior Auth Rule
  - Does not give real time or near-real time authority
  - Does not have the same transparency requirements

Congress

- H.R. 3173 - **Improving Seniors' Timely Access to Care Act of 2021**
- Passed in the House in 2022
- Received a CBO score in 2022 indicating a $16 billion cost increase, but with options to significantly offset these costs

States

- 30 states are considering legislation regarding the practice of Prior Authorizations.
- Nearly 90 reform bills have been considered during 2022-2023.

How the 2024 Medicare Advantage & Part D Rule Changed Prior Authorizations

1. Requires Prior Authorization Approvals to be valid as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.
2. Requires all MA plans to establish utilization management committees to ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines(NCDs and LCDs).
3. Prohibits MA plans from requiring prior authorization for an active course of treatment for at least 90 days when a patient switches MA plans.
4. Limits the use of MA plans' prior authorization policies to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.

What do These Changes Mean?

Decreased practice administration costs due to a reduction in denials and appeals, which take away from patient care and operations.

Fewer delays of necessary medical care for patients—AMA data shows that **33% of physicians report that prior authorization has led to a serious adverse event for a patient in their care.**

Improved patient outcomes from a reduction in care denials, allowing for continuous delivery of needed treatment to patients.

Improvements in Patient and Provider Experience—reduced frustration with PA driven administrative burden.

Future MA Prior Authorization changes will impose additional pressure on MA plans and limit this key "lever" to manage costs.

Impact to MA-POs (Physician Organizations)

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Key Takeaways from Healthsperien

- V28 will require:
  - Estimate of impact on your contracted health plans
  - Close assessment on continued ability to serve beneficiaries in value-based contracting – particularly as plans lean on provider contracting more
- MA plans – particularly D-SNPs – are unlikely to make significant modifications to supplemental benefits in 2024. (May be different in 2025)
- Trend of 2024 star ratings is generally downward – but true impact depends heavily on plan type.
- Additional Prior Authorization changes on the horizon at the state and federal levels resulting in continued reduced administrative burden and stricter MA requirements.

Key Takeaways from APG

1. Increasing government scrutiny on MA as enrollment has crossed 50% (additional audits and revenue compression)
2. Growing beneficiary voice on dissatisfaction with marketing and prior authorization
3. Dwindling FFS enrollment underscores need to shift methodology on benchmarks, risk adjustment, etc.
4. MA-POs need to continue to innovate in addressing SDoH
5. Federal Advocacy is key to success

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APG Upcoming Advocacy Activities

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Q&A

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