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Viewpoints on the 2021 CMS Rate Announcement and other regulatory changes for MA and Part D plans

Like you, we at Optum are concerned about the impact of COVID-19 on the health and well-being of clients, care providers, patients and the safety of our team members. We are devoting significant effort and resources to responding to this serious situation.

We are committed to being supportive of keeping you informed of new guidance from the Centers for Medicare & Medicaid Services (CMS).

CMS has released the 2021 Rate Announcement and other regulatory changes as related to COVID-19, 2021 and 2022 final rules and additional important information for Medicare Advantage (MA) and Part D plan sponsors ("Plans"). Collectively, the information presented in this document is referred to as regulatory changes regardless of source. As always, these changes contain both a mix of opportunities and challenges that plans will need to assess and develop strategies to address. Most importantly, commentary about general impact can vary greatly based on specific plan circumstances.

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7 KEY FINAL CHANGES FOR 2021

1 **Estimated MA and fee-for-service (FFS) growth rate of about 3.72%,** which results in a net 1.66% change in national average plan payments after considering changes, in risk score normalization factor, risk model changes and changes in Star Ratings. Actual results, will vary significantly by county and plan.

SEE PLAN PAYMENT

2 Estimated end-stage renal disease (ESRD) **growth percentage of 4.04%.**

SEE PLAN PAYMENT

3 **MA risk scores will be based on 75%** Encounter Data System (EDS) data for payment year 2021.

SEE RISK ADJUSTMENT

4 MA normalization factors continue to show **large increases for Hierarchical Condition Category (HCC) models** due to recent trends in FFS population.

SEE RISK ADJUSTMENT

5 **Star Ratings program** makes adjustment for the current public health emergency, meanwhile still planning to increase focus on the voice of the patient by increasing weight to CAHPS and complaints/access measures.

SEE STAR RATINGS PROGRAM

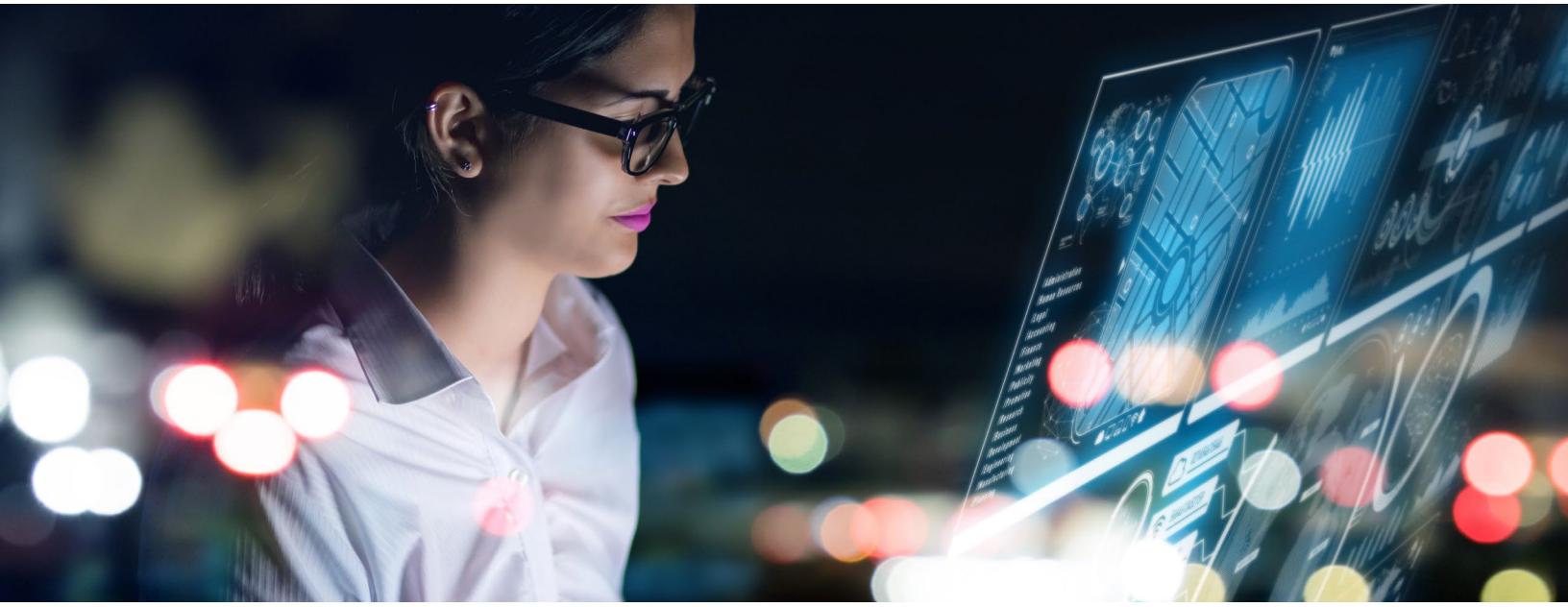
6 Mandatory MOOP **increasing from $6,700 to $7,550.**

SEE MEDICARE PART C

IN 2021

7 ESRD members will now have the ability to enroll in MA plans, **placing greater emphasis on managing this high-cost population.**

SEE MEDICARE PART C



Plan payment

Highlights of final changes

- 1.66% plan payment increase is a national average and does not account for all variables that affect plan payments. It reflects a 3.72% increase due to growth rate and a large decrease due to normalization factor updates. The national average plan payment increase reflects a minimal impact due to Stars and Risk model revisions, but this does not include CMS estimates of coding trend.

- Plans may want to consider how the following may vary from the national averages:
  - Impact of FFS rate rebasing addition of kidney acquisition cost (KAC) adjustment, continued revisions to AGA repricing for FFS payment revision, Disproportionate Share Hospital (DSH) program changes, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) changes, and Center for Medicare and Medicaid Innovation (CMMI) program impact
  - Impact of revisions to risk model 0.25%
  - Variances from average 0.23% Star Ratings change impact
  - Contract-specific HCC coding trend, not reflected in 1.66% revenue change (CMS estimate = 3.56% for 2021)

- CMS' national estimates for FFS and risk score projections do not reflect the impact of COVID-19

- 2021 applicable ("quartile") percentages have been updated based on 2020 FFS per-capita rates.

- The national average 2021 ESRD growth rate is estimated to be 4.04%

1.66% plan payment increase is a national average.

Risk adjustment

Highlights of final changes

CMS will continue the phase-in of Encounter Data Submissions (EDS) as a diagnosis source for payment year 2021 with EDS driving 75% of an MA plan's risk score using the 2020 CMS-HCC model. RAPS data submissions will drive 25% of the MA plan's remaining risk score using the 2017 CMS-HCC model.

- CMS will continue implementation of the 21st Century Cures Act's risk adjustment requirements:
  - Factors for substance use disorder, mental health, and chronic kidney disease (CKD) diagnoses
  - Adjustment as the number of diseases or conditions an individual has increases (APCC)
- APCC CMS-HCC risk adjustment model that was implemented for calendar year 2020 is now known as the 2020 CMS-HCC model
- The 2017 CMS-HCC model normalization factor is increasing from 1.075 to 1.106
- The 2020 CMS-HCC model normalization factor is increasing from 1.069 to 1.097
- On April 10th, CMS provided guidance that telehealth would be allowed for risk adjustment under certain circumstances:
  - Face-to-face (utilizing audio and visual)
  - Still requires other risk adjustment criteria (e.g., IP, OP or professional service, with appropriate provider type)
  - Guidance to bill utilizing POS "02" or any POS with modifier "95"

MA risk scores will be based on **75% Encounter Data System (EDS) data** for payment year 2021.

Star Ratings program

Highlights of upcoming changes

- 2021 Star Ratings updates
  - 2020 Star Ratings HEDIS and CAHPS measures scores to be used for 2021 Star Ratings*
  - If CMS is unable to process 2021 Star Ratings due to limited functions or systemic data issues, 2021 Star Ratings will be replaced with 2020 Star Ratings*
  - Measure-level assignment of 2020 Star measures (Medication Therapy Management (MTM), Special Needs Plan (SNP) Care Management) if data quality issues arise*
  - Patients' experience, complaints, access measures move to 2x weight
  - Reviewing appeals decisions (allow re-openings through June 30)
  - Plan all-Cause Readmission (PCR) and Controlling High Blood Pressure (CBP) on display
- 2022 Star Ratings changes to monitor
  - Delay of planned guardrails policy for Star 2022 only*
  - Expansion of "hold harmless rule" for improvement measure*
  - HEDIS and CAHPS submission expected; if HOS not able to be performed in 2020, will use prior year's HOS measure scores*
  - To retire: Adult BMI Assessment, Part D Appeals measures
  - Controlling High Blood Pressure (CBP) return to Star Ratings (1x)
  - New cross-cutting exclusions: palliative care and individuals who require nursing home-level care but reside in the community
  - Temporary measure removal for Plan all-Cause Readmission (PCR) and Care for Older Adults (COA): Functional Status Assessment
  - Medication Adherence measures (risk-adjustment)

New measure concepts

1. End-Stage Renal Disease (ESRD) measures
2. Prior Authorizations
3. HOS measures
4. Osteoporosis Screening
5. Cardiac Rehabilitation
6. Diabetes Overtreatment
7. Home Health Services
8. Generic Utilization
9. Initial Opioid Prescribing (IOP) Measures
10. Net Promotor Score (NPS)**

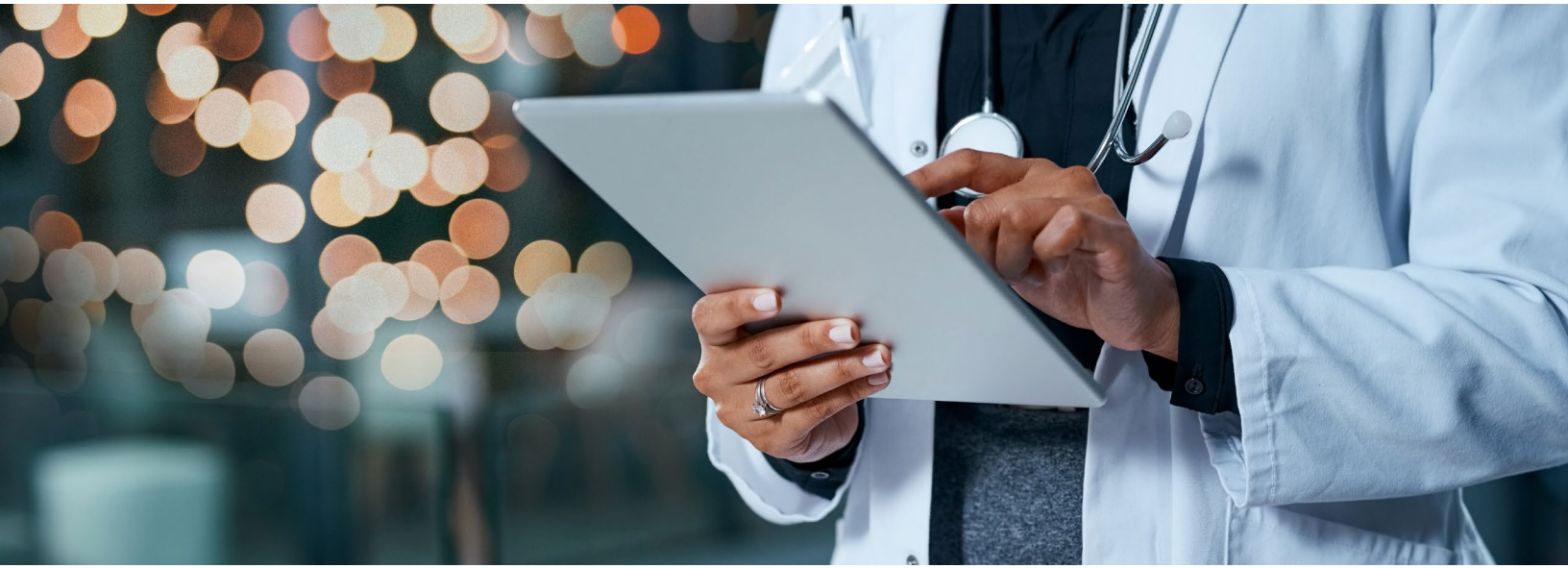
*Interim Final Rule with COVID-19 related adjusts

**Net Promoter, Net Promoter System, Net Promoter Score, and NPS are registered trademarks of Bain & Company, Inc., Fred Reichheld and Satmetrix Systems, Inc.

Star Ratings program

Highlights of upcoming changes

- 2023 Star Ratings and beyond
  - Patients' experience (CAHPS), complaints, and access measures move to 4x weight
  - New measures: Transitions of care (TRC) and Follow-up after ED visit for patients with multiple chronic conditions (FMC)
  - Controlling high blood pressure (CBP) weight increase (3x) and return of plan all-cause readmission (PCR) (1x for one year)
  - HOS: improving or maintaining physical health (PCS) improving or maintain mental health (MCS) to display temporarily
  - To retire: Rheumatoid Arthritis measure
  - Outlier deletion incorporated in cut point determination



Medicare Part C

Highlights of changes

- CMS is codifying their definition of supplemental health benefits to offer Medicare Advantage Organizations (MAOs) greater flexibility in benefit offerings to enhance quality of life and improve health outcomes.
  - MA plans may offer "non-primarily health related" supplemental benefits such as meals and non-medical transportation to chronically ill under certain conditions.
  - CMS is expanding the allowable chronic conditions eligible under Special Supplemental Benefits for the Chronically Ill (SSBCI).
- ESRD members will be eligible to enroll in MA plans starting in 2021
  - Blend will be 75% EDS (2020 ESRD Model) plus 25% RAPS (2019 ESRD Model)
- Total benefit cost (TBC)
  - Increasing by $3 from $36 PMPM to $39 PMPM
  - Dual Eligible Special Need Plans (D-SNP) and Value-Based Insurance Design (VBID) (benefit enhancements) continue to be excluded from test.
- Discriminatory Cost-Sharing Requirements updated for inpatient and skilled nursing facility (SNF)
- Maximum out of pocket (MOOP)
  - Cost limits increased from 2020 as a result of ESRD members' eligibility. Increase in MOOP is expected to further increase in 2021.
    - Voluntary MOOP increasing from $3,400 to $3,450
    - Mandatory MOOP increasing from $6,700 to $7,500

ESRD members will now have the ability to enroll in MA plans, placing greater emphasis on managing this high-cost population.

Medicare Part D

Highlights of changes

- Part D benefit parameter increases consistent with changes in the annual percentage increase in Part D expenditures
  - 2.85% API increase for 2021 reflects a 3.16% for 2020 trend and -0.30% for prior periods
- Meaningful difference limit remains $22 PMPM between basic and enhanced alternative (EA) PDP plans.
- Normalization factor increased by approximately 1.9%
- 2021 Coordination of Benefits (COB) user fee remains at $1.05 per member per year (PMPY) and will be collected for the first nine months of the coverage year at $0.1166 PMPM consistent with prior years.
- CMS is requiring Part D plans to disclose quality measures they use to evaluate pharmacy performance in their network agreements
- On Wednesday, March 11, 2020, CMS announced the Part D Senior Savings Model
  - Voluntary model requiring participating plans to provide coverage to Model insulins at a maximum $35 copay throughout the Part D coverage phases
  - Model insulins include all drugs classified as insulins in the American Hospital Formulary Service (AHFS) or DRUGDEX® information system for participating manufacturers
  - Participating providers include Eli Lily and Company, Novo Nordisk, Inc., Novo Nordisk Pharma, Inc. and Sanofi-Aventis U.S. LLC
  - Participating plans will have the ability to offer rewards and incentives in connection with promoting improved health, medication adherence and efficient use of healthcare resources

Minimal changes anticipated within Part D for 2021.

Other announcements

Highlights of changes

- Starting in 2022, CMS will non-renew non-SNP plans targeting full dual-eligible enrollment
  - Non-renew plans if 80% or more of the plan's total enrollment is entitled to medical assistance under a state plan under Title XIX
- CMS is codifying special election periods (SEPs) for exceptional conditions

4 KEY TAKEAWAYS OF THE CHANGES

Financial impact may vary from plan to plan based on a combination of:

- Benchmark changes
- Risk adjustment changes
- Cost sharing and benefit design requirements
- Star Ratings
- Morbidity of enrolled population
- Service-area mix

COVID-19-related impacts accelerating telehealth within the national landscape

Stars/quality will see on-going **impacts from COVID-19 for the next few years**

The largest change from the Advance notice was **the growth rate**

Plans encouraged not to lose sight of changes to ESRD and plan now for 2021

Optum is here to help

Now more than ever, it is imperative that Medicare Advantage plans continue to execute effectively. They need to leverage quality, risk adjustment and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits, member premiums and margins. Integrating initiatives across each of these functions may improve results, improve the member and provider experience, and reduce program costs.

Optum is unique in its alignment and delivery of the critical combination of actuarial, care management and operational consulting expertise. In an environment where there are often more and more issues to address, we have helped our clients achieve the balanced approach they need to manage the challenges of the Medicare Advantage market.

Optum is unique in its combination of:

ACTUARIAL

CARE MANAGEMENT

OPERATIONS

TECHNOLOGY

Actuarial services and performance reporting: We have the experience and tools to assist in developing strategic bid pricing to help align with a plan sponsor's operational and strategic goals. We also offer both Parts C and D reporting tools to help plan sponsors monitor their performance during the plan year.

Risk score accuracy: We offer clinical and operational insight and delivery support to improve the accuracy and completeness of risk scores, combined with the analytics to illustrate the revenue impacts and critical path for such initiatives.

Star Ratings performance management: We offer projections, assessments, processes, dashboards and other critical components to improve Star Ratings outcomes.

Foundational analytics and advanced modeling: We have data, experience and analytic models to support your strategic decision-making, risk management and resource prioritization. This includes guidance on how to assess and address emerging opioid challenges and social determinants of health.

Population health management: We offer deep experience in care management and network management to minimize risk, including kidney programs aligned with these final rules.

Enabling risk-based reimbursement: We bring hands-on experience in creating transformational provider risk-sharing arrangements.

MEET OUR EXPERTS

Alex Balmes

Senior Director, Optum Actuarial Services

Alex Balmes has 20 years of experience in health care, including 16 years providing actuarial services within Optum Advisory Service. His current focus is on Medicare Advantage, Medicaid and the ACA lines of business. His experience includes MA and Part D bid development, reserving, provider contracting, RA valuation, M&A management, actuarial recruiting and analytical systems development.

Randall Fitzpatrick, FSA, MAAA

Vice President, Optum Actuarial Services

Randall Fitzpatrick provides consulting services to health insurers, Medicare Advantage organizations, MCOs and health care providers. His expertise includes pricing and filing of Medicare Advantage Part C and Part D bids, reserving, provider contract analytics and strategic market analyses for MA. He also provided actuarial services to CMS for the review and audit of its bid pricing tools.

Helen Kurre

Practice Lead, Star Ratings, Optum Advisory Services

In her role as practice lead, Helen Kurre is responsible for assessing, designing and implementing improvement solutions to support Star Ratings improvements for health plans and providers. She has 30 years of health care experience, including health plan and provider quality improvement leadership, HEDIS, and CAHPS/HOS.

Rose Bernards

Consultant, Risk Adjustment, Optum Advisory Services

Rose Bernards brings over 25 years of health care experience to her role as part of Optum Advisory Services. Rose's career spans a combination of ambulatory clinic, hospital, insurance and vendor roles providing unique, integrated perspectives across the health care landscape. She currently helps support both payers and providers seeking to improve accurate and complete documentation and coding for their risk adjusted contracts across Medicare, Medicaid and commercial lines of business.

Contact Optum to discuss how we can help you assess and address 2021 rule changes.

1-800-765-6807 | empower@optum.com

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Learn more at optum.com.

This document includes guidelines within our definition of the 2021 CMS Rate Announcement and other regulatory changes.

All information contained herein is provided solely as commentary and should not be misunderstood as constituting legal or compliance advice. Plans should consult their own legal and/or compliance advisors as to recommended next steps.

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11000 Optum Circle, Eden Prairie, MN 55344