

# Ohio Health Care Association SNF Winter Conference

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Westerville, Ohio  
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**Ohio Health Care Association  
SNF Winter Conference**

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## Medicare Advantage Advocacy What do Operators Need to be Aware of?

- The Association continues to advocate for MA beneficiary access to timely and medically necessary care and provider sustainability via comments on MA proposed rules, requests for information, CMS meetings.
- [AHCA/NCAL, as part of a coalition](#) of other long term and PAC associations and the Centers for Medicare Advocacy, met with leadership from the Centers for Medicare and Medicaid Services (CMS) on January 3 at the coalition's request to advocate for clarity on plan compliance with the [CY 2024 Medicare Advantage Final Rule](#).
- Leaders from CMS indicated they will be strongly enforcing compliance with the new regulations through routine and focused audits of plans serving approximately 90 percent of people with MA in year one. This is an enhancement from their typical three-year audit cycle. CMS also referenced the [memos](#) sent to plans regarding their oversight activities.
- CMS staff invited further communication from coalition members on instances of plan non-compliance with these regulations.



## Current Requirements of MA Plans Highlights of the 2024 Medicare Advantage Final Rule

- Concurrence with CMS coverage criteria.
- Prior Authorization may be used only to confirm the presence of diagnoses and other medical criteria.
- Prohibition on diversion of care to lower level of care.
- Denials based on medical necessity must be reviewed by healthcare professionals with relevant expertise.





## Current Requirements of MA Plans Provider Resources

- AHCA released a checklist on the new MA regulations governing prior authorizations and utilization management strategies.
- AHCA will host a [webinar](#) on February 27<sup>th</sup> at 1:00pm on the new regulatory limits on MA plan behavior and provider resources:  
[What to Know About New Medicare Advantage Rules \(ahcancal.org\)](https://ahcancal.org)



## Medicare Advantage What do Providers Want to Know?

- All Provider Types are advocating for change and accountability:
  - Rate Adequacy - FFS vs Medicare Advantage/Contractual Relationships.
  - Beneficiary and Provider Protections.
- All Provider Types are concerned about Utilization Management:
  - FFS Guidelines vs. MA Published Criteria.
  - AI generated & proscribed lengths of stay.
  - Jimmo Settlement.
  - Concurrent reviews and continued coverage of Part A services.
- What can we do when a plan is side-stepping these rules?





## Medicare Advantage **Proposed** Requirements CY 2025 MA Proposed Rule

- On November 6, 2023, CMS released the [CY2025 MA and Part D Proposed rule](#)
- Notable provisions
  - New exception request from network adequacy requirements for facility-based I-SNP plans operating on a single contract ID from general MA network adequacy standards.
  - Require QIOs instead of MA plans to review untimely fast track appeals of MA plan coverage denials for SNFs, HH and CORFs.
- AHCA|NCAL submitted comments on the proposed rule which was due on January 5, 2024



## CY2025 MA and Part D Proposed Rule I-SNP Network Adequacy Exception Provision

- Two proposed basis for facility-based I-SNP network adequacy exception requests include:
  - Demonstrated inability to successfully negotiate and secure a contract with individual providers and/or facilities;
  - Documented access to basic benefits through the “additional telehealth benefits” process outlined in § 422.135 and also covers in-person, out-of-network services at in-network cost sharing when approved by plan.
- AHCA|NCAL strongly advocated for CMS’ recognition of the unique care utilization patterns of I-SNP beneficiaries and thus the need for modifications to general network adequacy requirements.
- AHCA strongly supports this proposal with requests for CMS to broaden to include all additional SNPs located on a “campus”.





## CY2025 MA and Part D Proposed Rule Untimely Fast Track Appeals Provision

- Currently, Medicare beneficiaries in a Medicare Advantage Plan do not have the same access to Quality Improvement Organization (QIO) review of a fast-track appeal as Traditional Medicare beneficiaries. CMS is proposing to
  1. Require the QIO, instead of the Medicare Advantage Plan, to review untimely fast-track appeals of a Medicare Advantage Plan's decision to terminate services in a skilled nursing facility; and
  2. Fully eliminate the provision requiring forfeiture of an enrollee's right to appeal a termination of services decision when they leave the facility.
- These proposals would bring MA regulations in line with what is available to beneficiaries in Traditional Medicare and expand the rights of Medicare Advantage Plan beneficiaries to access the fast-track appeals process.
- AHCA strongly supports this proposal.



## CY2025 MA and Part D Proposed Rule Duals Provisions

- CMS put forth several proposals to increase the percentage of dually eligible enrollees who receive Medicare and Medicaid services from the same MA organization including:
  - Revision of the current quarterly special enrollment period ("SEP") for dually eligible and low-income subsidy ("LIS") program individuals to elect a standalone prescription drug plan (PDP)/Traditional Medicare on a monthly basis.
  - Create a new SEP to allow dually eligible individuals to elect an integrated D-SNP monthly.
  - Limit enrollment in certain D-SNPs to individuals who are also enrolled in an affiliated Medicaid managed care plan.
  - Limit the number of D-SNP plan benefit packages an MA organization, its parent organization, or entity that shares a parent organization with the MA organization, can offer in the same service area as an affiliated Medicaid MCO.
- Protect dual eligibles by limiting out-of-network cost sharing for D-SNP preferred provider organizations for specific services.
- Expand prohibitions on D-SNP look-alikes by gradually lowering the enrollment threshold for MA plans that enroll dual-eligible individuals.
- Update the Medicare Plan Finder website, so that MA plans integrated with Medicaid Managed Care plans will show the additional benefits available through Medicaid.





## CY2025 MA and Part D Proposed Rule Additional Provisions

- New guardrails for plan compensation to agents and brokers to stop anti-competitive steering.
- Improve access to behavioral health by adding certain behavioral health provider specialties to MA network adequacy standards.
- New standards for supplemental benefits for chronically ill beneficiaries.
- Annual health equity analysis of utilization management policies and procedures.



## CMS RFI on MA Data Comments due by May 29, 2024

- CMS is seeking feedback on format and type of data that will provide better transparency into MA operations.
- Goal is to make MA data commensurate with traditional Medicare for transparency and comparison to other programs such as ACOs.
- Topics of interest:
  - Beneficiary access to care including provider directories and networks.
  - Prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms.
  - Cost and utilization of supplemental benefits.
  - MA marketing and consumer decision-making.
  - Care quality and outcomes, including value-based care arrangements and health equity
  - Healthy competition in the market, including the impact of mergers and acquisitions, high levels of enrollment concentration, and the effects of vertical integration.
  - Special populations such as individuals dually eligible for Medicare and Medicaid, end stage renal disease (ESRD), and other enrollees with complex conditions.





## CY 2025 MA Advance Notice Comments due by March 1, 2024

- On January 31, CMS released the updated 2025 payment policies for the MA program known as the Advance Notice.
- MA payments are expected to increase 3.7% (>\$16 billion) from 2024 to 2025
  - However, the increase includes an MA risk score trend of 3.86%.
  - Also includes the three-year phase-in of several technical and clinical updates to the MA risk adjustment model and medical education costs.
- CMS is also proposing improvements to Part D drug benefit for CY 2025 that will result in lower costs for beneficiaries.
- Rate Announcement and Part D Redesign Program Instructions must be released by April 1, 2024.
- AHCA analyzing the rule from the provider-led SNP perspective and will be offering comments.



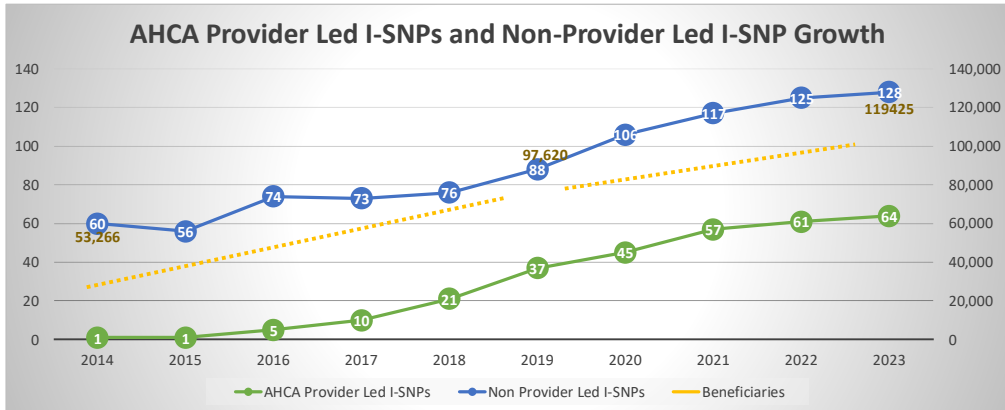
## AHCA Population Health Management (PHM) Initiatives

- Advocating for protections in Medicare Advantage (MA).
- Building coalitions to create MA plan accountability and new models applicable to LTC.
- Lobbying CMS to expand growth of provider led I-SNPs
  - Advocating for “Aligned I-SNP” proposal to demonstrate the equal effectiveness of I-SNPs in achieving duals integration for LTC beneficiaries as D-SNPs are for community dwelling duals.
- Providing member support on PHM models.





## LTC Provider Led I-SNPs Continue to Grow as Providers Seek Meaningful Opportunities to Engage in PHM



[December SNP Comprehensive Reports](#)



## ACOs and ISNPs

**Marty Grabijas**

Sr. Director, National Contracting



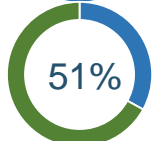


## CMS Wants out of the Risk Business



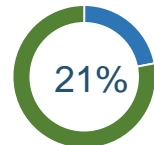
28%

Medicare beneficiaries still in traditional fee-for-service



51%

30.7 Million Medicare Advantage Enrollees



21%

Medicare FFS beneficiaries in population-based models – Accountable Care Organizations, Bundles

CMS Goal:  
By 2030, all Medicare FFS in accountable care model



## Medicare ACOs Growing Including Privately Sponsored ACOs

MSSP

456 ACOs with 10.9 million beneficiaries attributed (permanent CMS ACO)

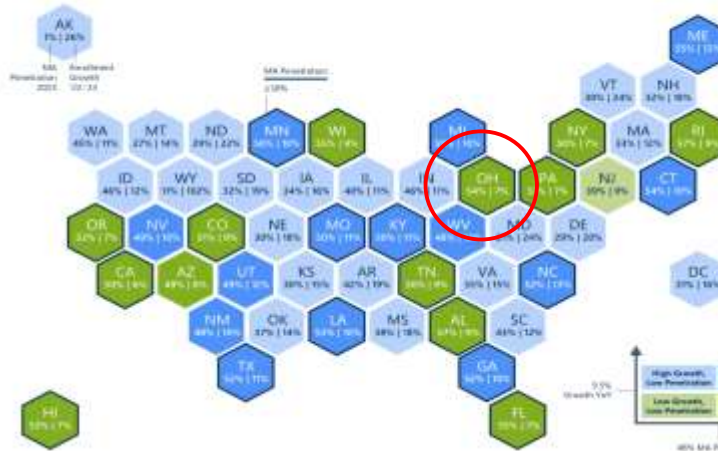
ACO  
REACH

132 REACH ACOs with 2.1 million beneficiaries





# Medicare Advantage Volume Surpassing Fee For Service



Source: Chartis, Medicare Advantage and Growth Rates by State

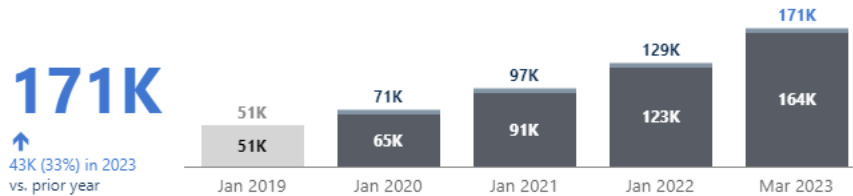


# Ohio ISNP Growth

How fast are Special Need Plans growing in my state?

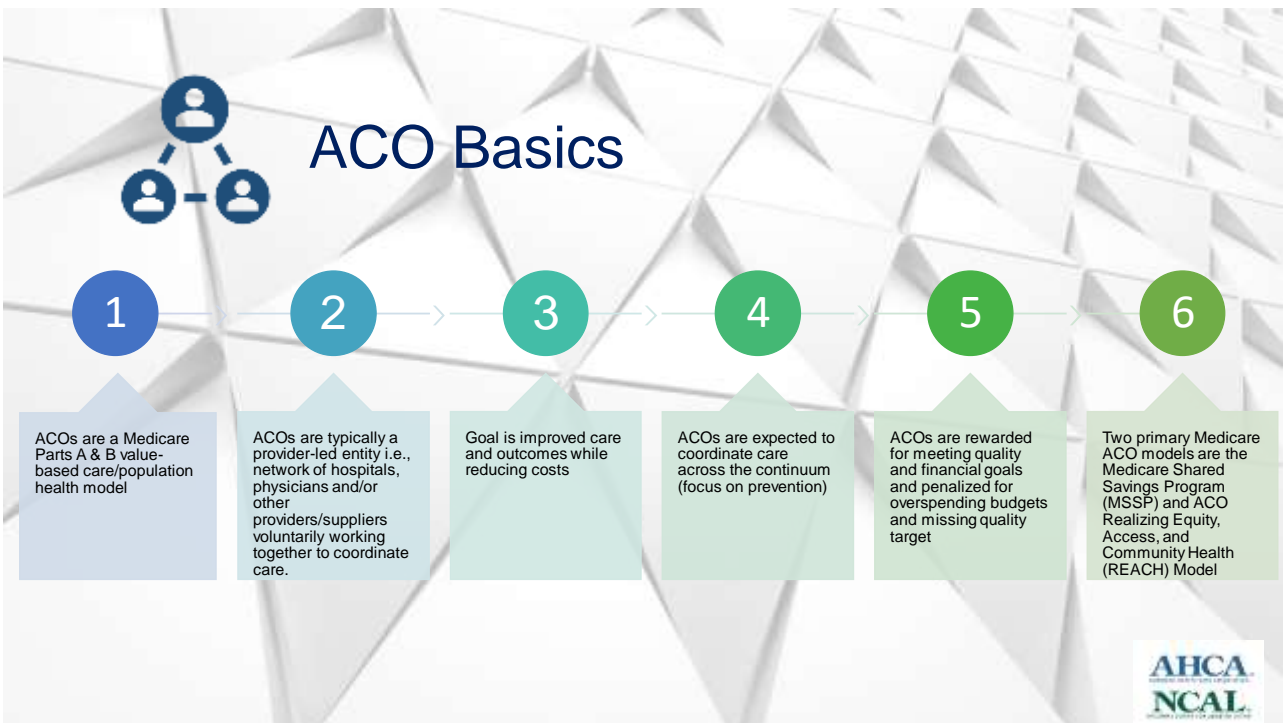
Special Need Plans (SNP) offer more comprehensive coverage. In 2023, SNP enrollees reached over 5.0M (29% increase) in the U.S. Your state grew to 171K (33% increase).

• C/D Condition • Institutional • Dual Eligible





# ACOs vs ISNPs



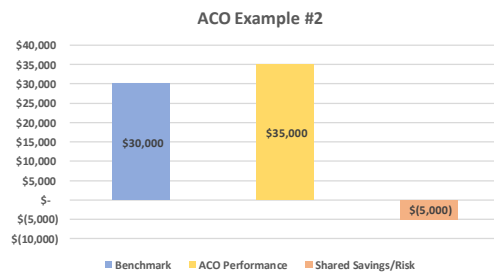
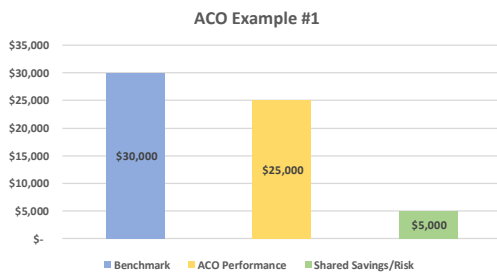


## Medicare ACO Basics

- Patient Are Assigned**
  - Patients are assigned based on the plurality of their primary care claims
- CMS Sets Benchmark**
  - Based on historical or historical and adjusted by regional spending depending on ACO type
- CMS Pays FFS Rates**
  - Providers bill Medicare using the current FFS payment systems
- CMS Assesses Savings/Losses Based on ACO Performance**
  - Annual spending is then compared to the CMS benchmark



## ACO Economics





## Two Primary ACO Models: MSSP and ACO REACH

	MSSP (Medicare Shared Savings Program)	ACO REACH (Accountable Care Organizations Realizing Equity, Access and Community Health)
<b>Description</b>	Voluntary program, permanent part of the Medicare program	CMMI ACO demonstration that replaces Direct Contracting
<b>Level of Risk</b>	Offers a glide path to risk	Highest level of risk for total cost of care of beneficiaries
<b>Payments</b>	CMS pays all providers directly	Capitated payment model that offers two types of capitation
<b>Minimum Number of Beneficiaries</b>	ACO must have 5,000 beneficiaries in order to participate	Offers three different participation tracks, one of which is High Needs Population which requires 500 beneficiaries to start
<b>Focus</b>	Provide highly coordinated care and reduce costs	Health equity and greater <b>focus on dually eligible and complex individuals</b>



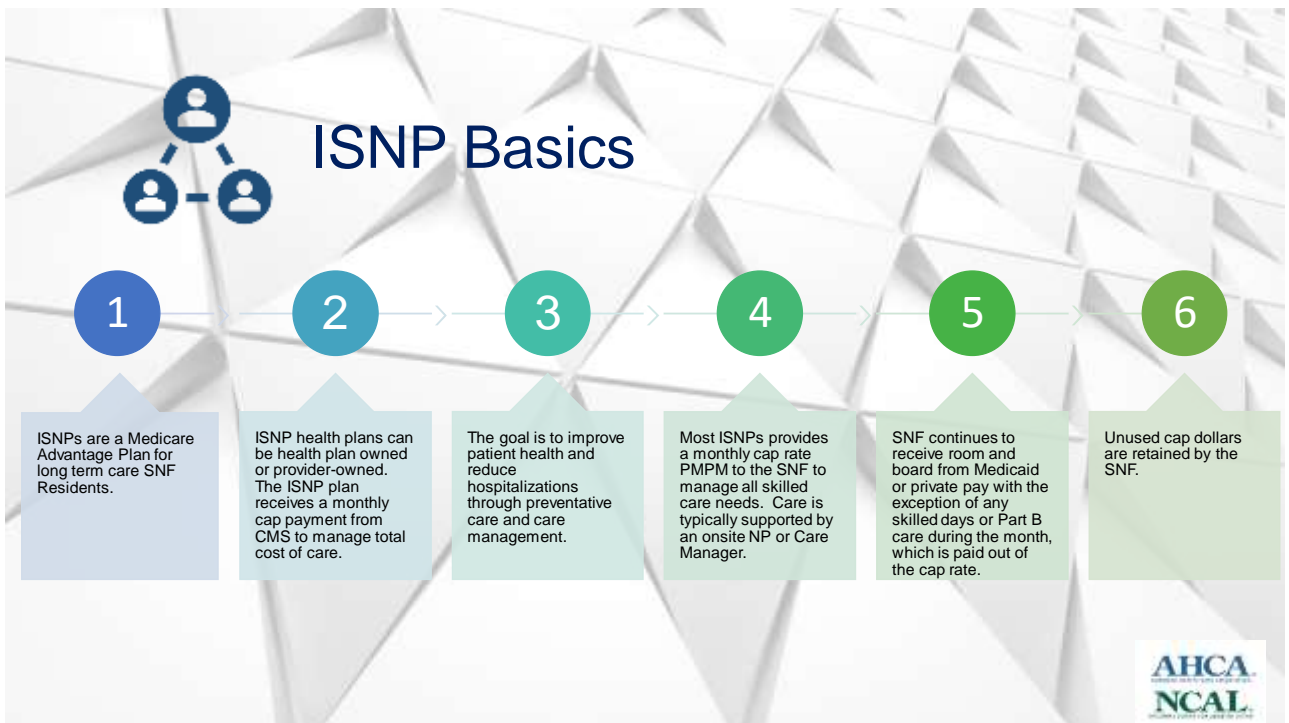
## OH MSSP ACOs

ACO	Service Area
Main Street Rural Health Juniper ACO LLC	AL, AR, IA, KY, MO, NY, OH, OK, TN, TX, VA, WV
Main Street Rural Health Magnolia ACO LLC	AL, AR, IN, KY, LA, MO, OH, TN, TX
Collaborative ACO 30, LLC	AL, AZ, AR, CA, GA, GU, IL, IN, IA, MN, NJ, NM, NY, NC, ND, OH, WI, WY
Northeastern/Midwest Region MSSP 2023	AL, DE, FL, MD, MO, NH, NJ, OH, PA, SC, WV
Responsive Care Solutions, LLC	AR, CO, DE, FL, KS, MD, MA, MN, NJ, NC, OH
Main Street Rural Health Cottonwood ACO LLC	AR, IN, MI, MN, OH, TN, TX
Steward National Care Network, Inc.	AZ, FL, MA, NH, OH, PA, RI, TX, UT
CVS ACO	AZ, OH
Vytalize Health ACO	CA, LA, MS, NH, NJ, NY, OH, SC
Trinity Health Integrated Care	DE, FL, ID, IL, IN, MI, NY, OH, PA
USMM ACCOUNTABLE CARE PARTNERS, LLC	FL, IL, MI, MO, OH, PA, TX, VA, WA, WI
Main Street Rural Health Hawthorn ACO LLC	IL, IA, KY, MO, NY, OH, WV
Healthcare Solutions Network	IN, KY, OH
LTC ACO	IN, MA, NH, OH, TX, VA, WV
AHN Accountable Care Organization, LLC	IN, OH
Mercy Health Select, LLC	KY, MD, OH, PA, VA
ACO West Virginia	MD, OH, PA, WV
WV MSSP CHC Enhanced	MD, OH, WV
Advantage ACO	MI, OH
Independence Health Accountable Care Organization	MI, OH
ProMedica Health Network, Inc.	MI, OH
Adena Healthcare Collaborative, LLC	OH
Cleveland Clinic Medicare ACO, LLC	OH
Health Centers of Ohio ACO LLC	OH
IHC Quality Partners, LLC	OH
Kettering Physician Partners Accountable Care LLC	OH
OH MSSP 2024 Enhanced	OH
OhioHealth Medicare ACO	OH
Summa Accountable Care Organization	OH
University Hospitals Coordinated Care Organization	OH
PA MSSP Legacy + Gateway Enhanced	OH, PA
Heritage Valley Healthcare Network ACO, LLC	OH, PA, WV
WV MSSP 2016 Enhanced	OH, WV



# OH REACH ACOs

ACO REACH	City
Collaborative Care Partners LLC	Cleveland
CHS ACO Op Co LLC	Blue Ash
Circulo Health ACO, LLC	Columbus



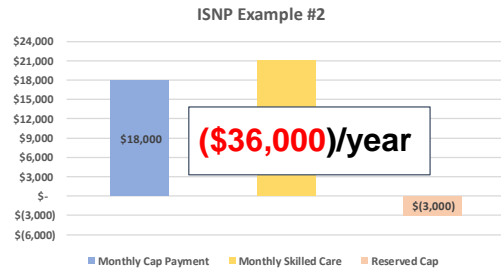
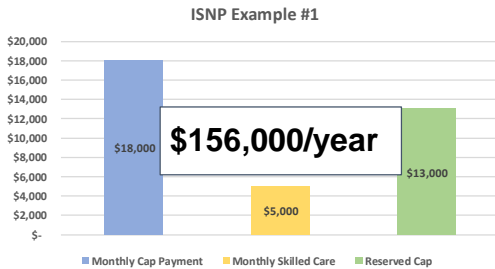


## ISNP Basics

- Patient/Family Education**
  - The health plan conducts patient/family education events in the facility.
- Patient Enrollment**
  - Patients/families voluntarily enroll in the plan.
- NP/Care Manager Assessment**
  - Initial assessment and ongoing evaluations to assess risk and provide intervention.
- Enhanced Benefits**
  - Plan provides enhanced benefits to patient and incentives to facility.



## ISNP Economics



30 residents with \$600 cap PMPM = \$18,000/month





## Head to Head Comparison

	ACOs	ISNPs
<b>Affiliation</b>	Owned/operated by a hospital or physician group	Owned/operated by a health plan (or provider owned)
<b>Risks</b>	Medicare withhold, LOS/Utilization reduction, loss of referrals.	Financial risk of outspending cap dollars.
<b>Payments</b>	CMS pays all providers directly. Gain share paid by convenor.	Monthly capitation payments and quarterly or annual incentive payments.
<b>Patient enrollment</b>	Attributed through primary care physician.	Voluntary enrollment by resident/family.
<b>Focus</b>	Operate under total cost of care threshold	Operate under capitation payment



## Resources



# AHCA/NCAL PHM Supports



PHM Council

- Established to convene and support LTC providers leading in PHM



PHM Education

- [PHM Summit](#)
- May 22-23, San Antonio, TX
- 94% overall satisfaction for 2022



# Population Health Management Innovation Lab

<https://educate.ahcancal.org/phminnovationlab>



### PHM Innovation Lab

Population Health Management (PHM) is a term that describes the application of various interventions and strategies aimed at improving the health outcomes and managing the costs of a targeted group of individuals. PHM models vary based on the degree of risk, degree to which payment is tied to quality, reliance on data analytics, and level of care coordination.





## Additional Resources

[Population Health Management Webpage](#)

[Medicare Webpage](#) – Medicare Advantage Information at the bottom of the webpage



## Questions?



**IMPROVING LIVES** *by*  
**DELIVERING SOLUTIONS** *for*  
**QUALITY CARE**