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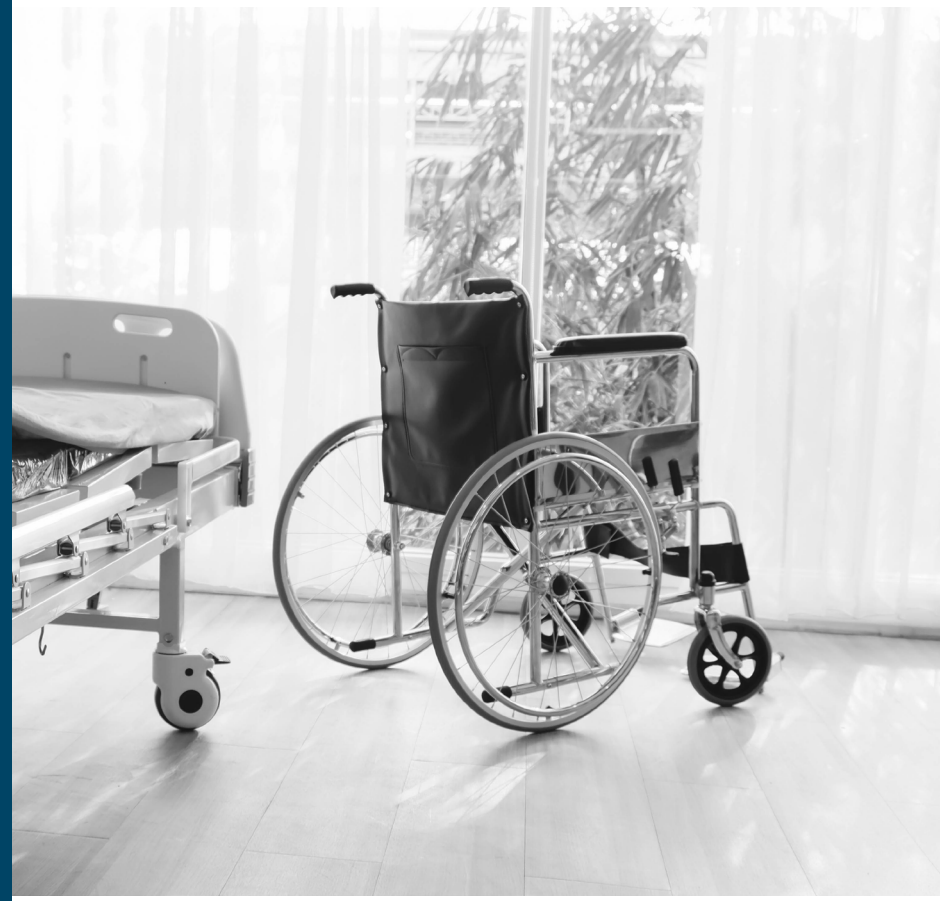
DMEPOS



Medicare Advantage in Focus

David Chandler

ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

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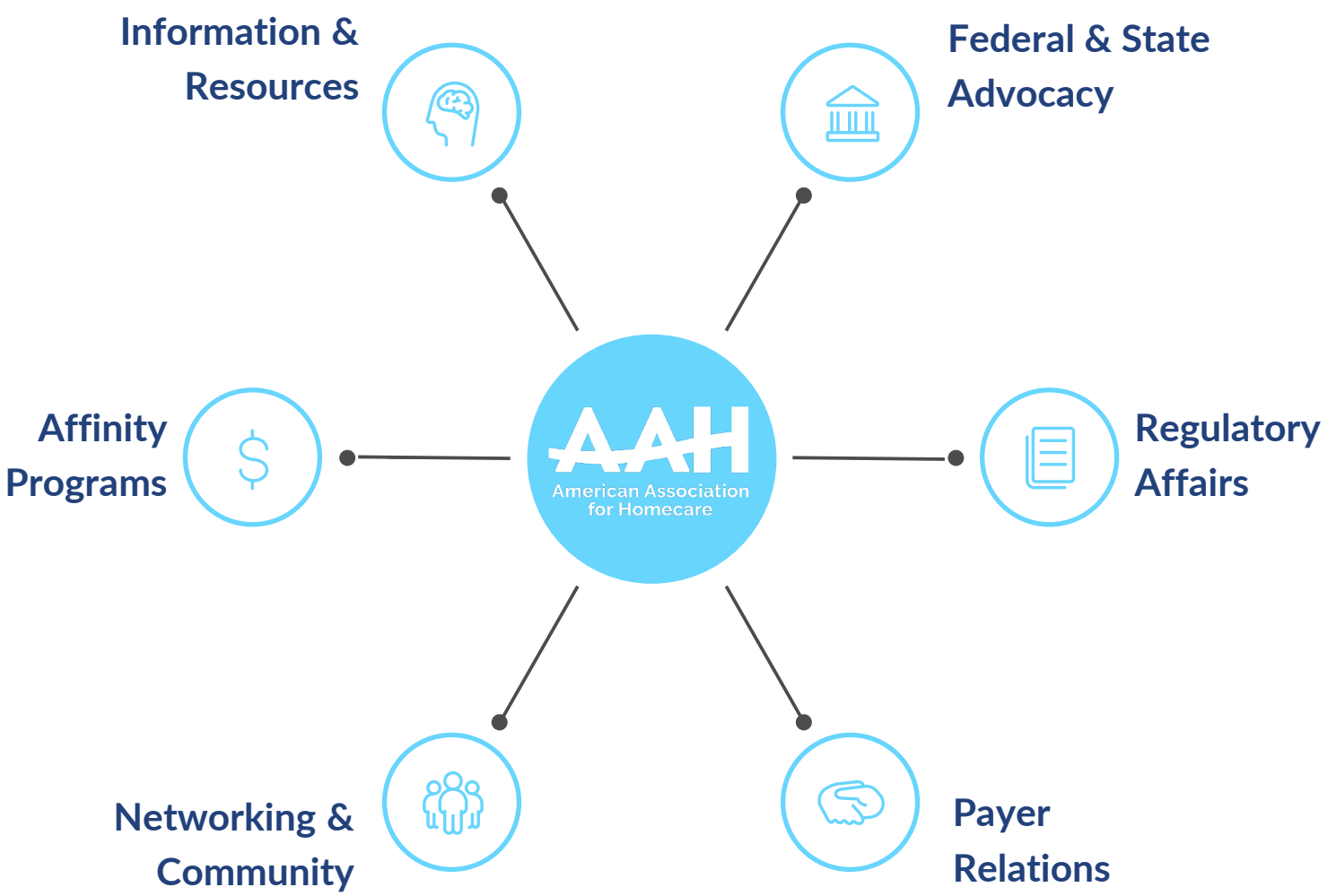

CONNECT. ADVOCATE. EMPOWER.

AAHomecare is the national advocacy voice for the HME community, working to strengthen the HME benefit at the state and federal level, protecting end users and the companies who care for them in partnership with allied organizations.

AAHOMECARE
American Association for Homecare

By the Numbers

AAHomecare is hard at work bringing wins that impact your bottom line, helping ensure access to patient care.

- **Over 200 meetings/year** with state and federal legislators, governmental agencies, and payers on HME priorities
- **10 member-driven councils**, providing networking opportunities and strategic collaboration to address key issues impacting your business.
- **35+ advocacy and operational resources** created in last 3 years by AAHomecare's product-focused councils

$ ROI for the Industry Since 2022

$4.5 BILLION

Member Locations

3,000

Patients Served by Members

16,000,000

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Medicare Advantage

Background

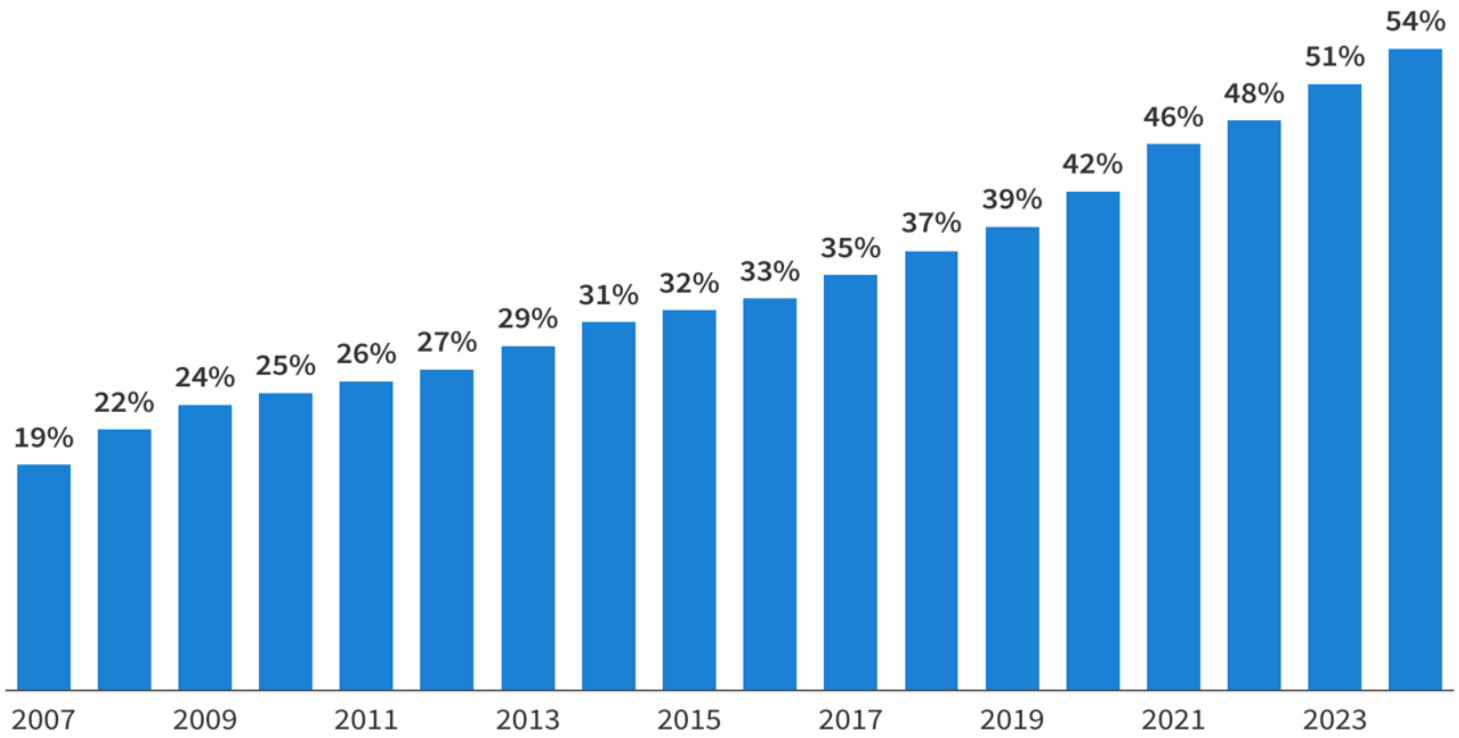
Medicare Advantage Environment

- >32.8 Million enrolled in Med Advantage
- >54% of Medicare beneficiaries enrolled in Med Advantage
- More than doubled since 2007, CBO estimates 64% by 2034
- $462 billion of total federal Medicare spending (54%)
- MedPAC January 2024 report MA risk scores are 20.1% higher than if FFS
- MedPAC estimated that MAP was paid 123% of the cost of similar FFS beneficiaries totaling $88 billion
- 3,959 plans available nationwide in 2024 (1% decrease over 2023-39 fewer plans)
- 56% HMO, 42% PPO, 1% Regional PPO
- 99.7% of Medicare beneficiaries have access to Med Advantage
- The average Medicare beneficiary has the choice of 43 plans by 8 firms in 2024
- 7 out of 10 MAP enrollees with Prescription Drug Coverage have no additional premium

Source: KFF analysis of CMS Medicare Advantage Enrollment Files and Medicare Enrollment Dashboard

Figure 1

Total Medicare Advantage Enrollment, 2007-2024



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.6 million people are enrolled in Medicare Parts A and B in 2024.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024.

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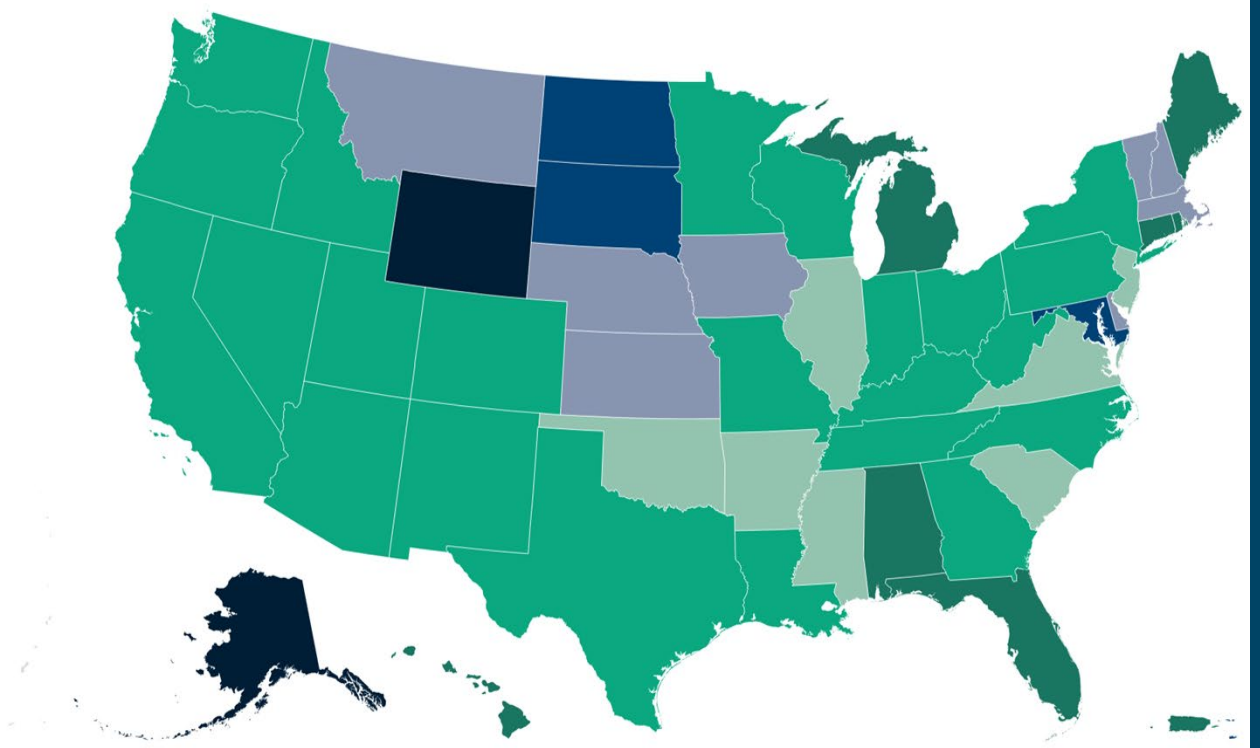
Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2024, by State

Click on the buttons below to see enrollment data for 2024 and 2014:

2024 2014

< 20% 20%–30% 30%–40% 40%–50% 50%–60% ≥ 60%



Note: Includes only Medicare beneficiaries with Part A and B coverage.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2014 and 2024.

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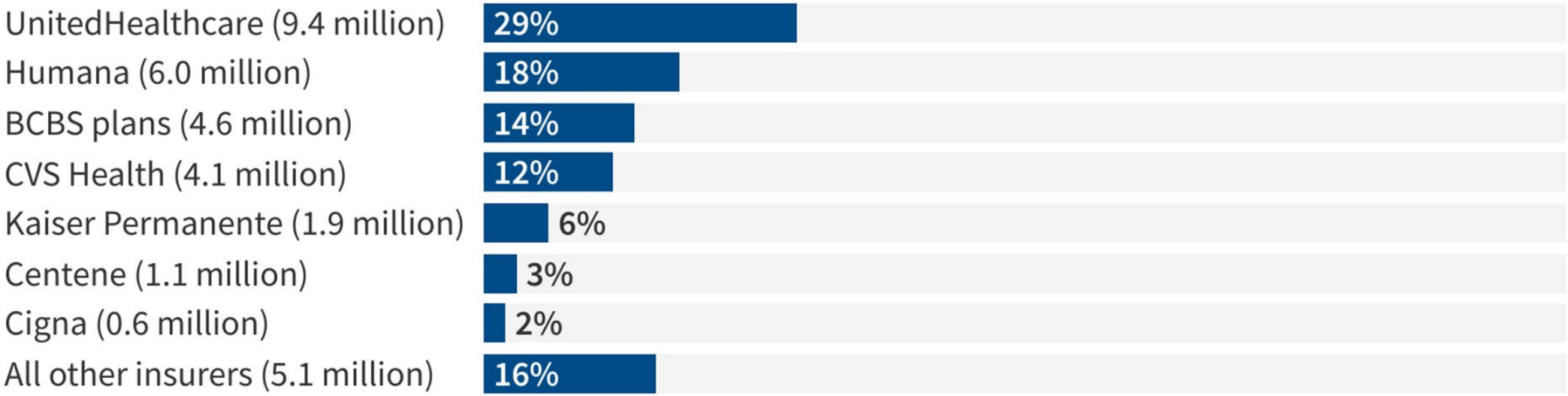
Figure 8

Medicare Advantage Enrollment by Firm or Affiliate, 2024

Total Medicare Enrollment, 2024: 32.8 million



Note: BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans (Elevance). Non-BCBS Elevance plans are 2% of total enrollment and are included in all other insurers. All other insurers includes firms with less than 2% of total enrollment. Percentages may not sum to 100% due to rounding.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2024.

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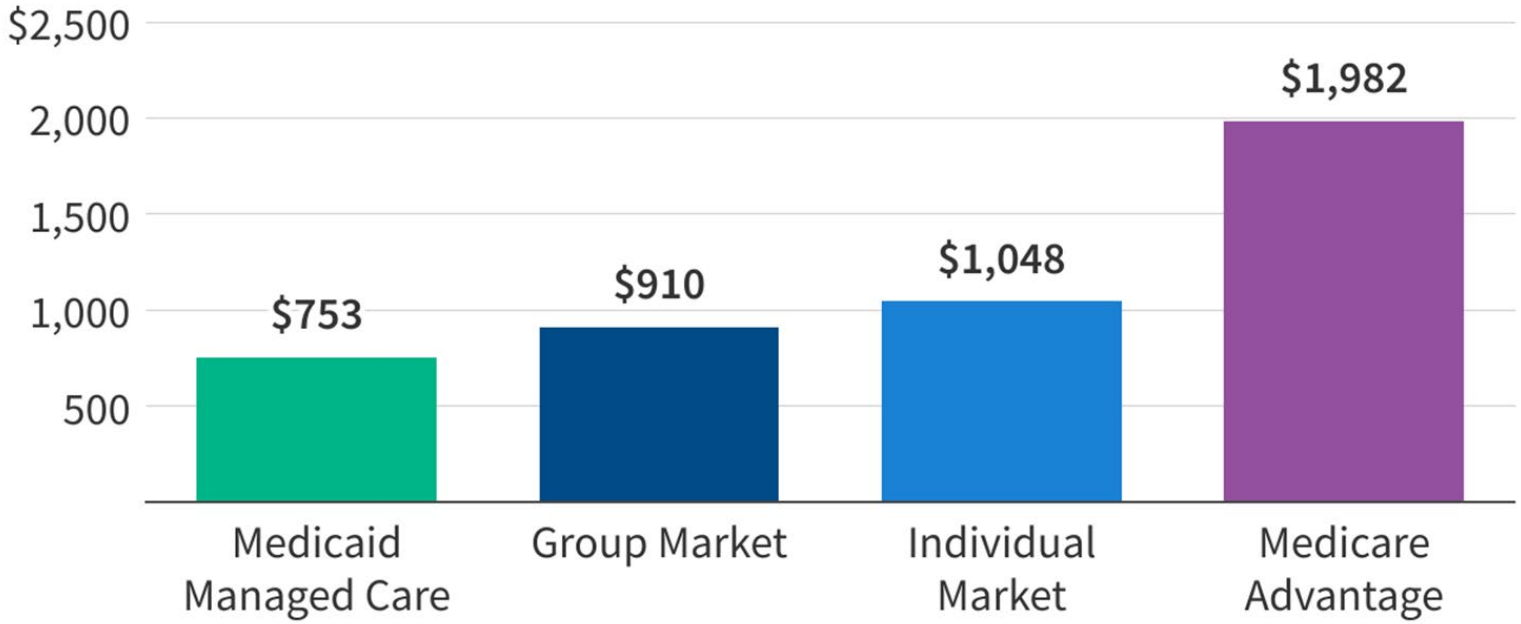
Figure 1

Gross Margins are Highest in Medicare Advantage in 2023

Gross Margins Per Enrollee, 2023



Note: Gross margins per enrollee are the amount by which total premium income exceeds total claims costs, divided by the number of enrollees. Gross margins include administrative costs, tax liability, and profits.

Source: KFF analysis of Exhibit of Premiums, Enrollment and Utilization data from Mark Farrah Associates Health Coverage Portal TM.

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Medicare Advantage Bonus Payments

- *"A key feature of the quality bonus program is the star rating systems. Star ratings are used to determine two parts of a Medicare Advantage plan's payment: (1) whether the plan is eligible for a bonus, and (2) the portion of the difference between the benchmark and the plan's bid that is paid to the plan. The benchmark is the maximum amount the federal government will pay for a Medicare Advantage enrollee and is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95 percent in high-cost counties to 115 percent is low-cost counties. The bid is the plan's estimated cost for providing services covered under Medicare Parts A and B."*
- Plans may but are not required to use bonus payments to cover the cost of supplemental benefits.
- $ 11.8 Billion bonus expected in 2024. Decrease in star ratings due to ending of pandemic era policies.
- $12.8 Billion bonus in 2023 was 28% higher than 2022 ($2.8 billion)
  - 2023-medicare-star-ratings-fact-sheet.pdf (cms.gov)
    - Fall Risks Average 2.9
    - SNP Average 3.3
    - Diabetes Care 4.1

MAP Bonus/Enrollment Summary

Total Bonus Spending by Firm Tracks Enrollment in 2024

Firm	Enrollment Share	Share of Bonus Spending	Total Bonus Spending	Average Bonus Per Enrollee	Share of Enrollees in Plans with Bonuses
UnitedHealthcare	29%	29%	$3.4B	$365	74%
Humana	18%	21%	$2.5B	$422	88%
BCBS plans	14%	14%	$1.7B	$364	70%
CVS Health	12%	9%	$1.1B	$265	53%
Kaiser Permanente	6%	8%	$976.4M	$516	99%
Centene	3%	0%	$34.8M	$32	8%
All others	17%	18%	$2.1B	$368	72%

Note: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans (Elevance). Non-BCBS Elevance plans are less than 2% of total enrollment. Plans that received at least a 4-star quality rating in 2023 (or were too new or had too low enrollment to be assigned a star rating) are eligible for quality bonus payments.

Source: KFF analysis of CMS Enrollment and Plan Quality and Performance Ratings Files, 2024

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MEDPAC
Advising the Congress on Medicare issues
The Medicare Advantage program: Status report
Stuart Hammond, Andy Johnson, and Luis Serna
January 12, 2024

MA quality bonus program costly, not a good basis for judging quality

- Quality bonus program (QBP) accounts for at least $15 billion in MA payments annually, and has serious flaws:
  - Large and geographically dispersed contracts
  - Too many measures, some based on small sample
  - Cannot be compared to FFS in local market
- QBP does not promote the use of high-value care, nor provide beneficiaries with meaningful information about local plan quality
- Commission recommended replacing the QBP with a value incentive program that would address its many flaws *(June 2020)*

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2024 Final Rule Breakdown

CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- Prior Authorization
  - Prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.
  - Codifying sub regulatory guidance that indicates prior authorized equipment cannot be later denied for medical necessity.
  - Requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary.
  - Minimum 90-day transition period when an enrollee switches to a new plan, new plan may not require prior authorization for an active course of treatment.

XYZ Company 111 Maple Ave. Anytown, ST 00000 111-1111 www.xyzcompany.com	To: ABC Payer Fax number: 555-5555
	From: XYZ Company Fax number: 111-1111
	Date: 1/1/0001
	Regarding: 90-day transition authorization for Jane Doe
	Phone number for follow-up: 111-1111

New enrollee for ABC Medicare Advantage Plan.

This is a new auth request to put an existing auth that is within the 90-day transition period in ABC payer's auth format. Please process this quickly per the 90-day transition Medicare final rule.

Jane Doe is waiting for delivery of their DME which was already prior authorized and reviewed for medical need by 123 Medicare Advantage plan (previous Medicare payer for this member).

SAMPLE COVER SHEET

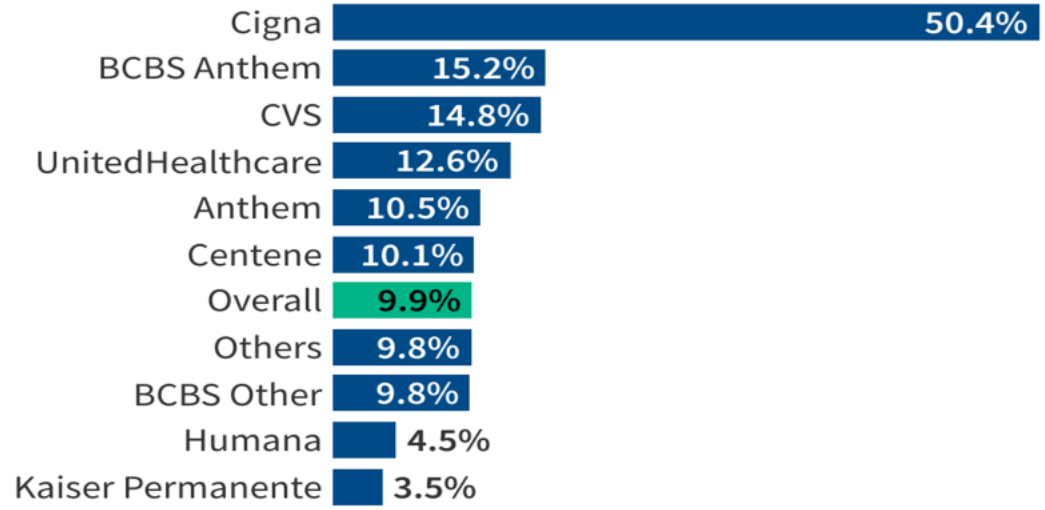
- Call out as new enrollee
- Reference 90-day transition rule
- Reference previously authorized

PA Appeals per Medicare Advantage Plan

Figure 8

Across Most Firms, A Small Share of Denied Prior Authorization Requests Were Appealed

Share of adverse and partially favorable prior authorization determinations that were reconsidered in 2022



Note: Denied requests include determinations that were partially favorable or adverse.

Source: Limited Data Set, Contract Year (CY) 2022 Part C and D Reporting Requirements Data

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PA Denials Overturned per MAP

Figure 9

Across All Firms, at Least Two-Thirds of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2022

Source: Limited Data Set, Contract Year 2022 Part C and D Reporting Requirements Data

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Prior Authorization in Medicare Advantage

Appendix Table 1

Use of Prior Authorization by Medicare Advantage Insurers in 2021

Medicare Advantage Insurer	Prior Authorization Requests per Enrollee	Share of Requests Fully or Partially Denied	Share of Denials Appealed	Share of Appeals that Overturned Initial Decision
Overall	1.5	6%	11%	82%
Anthem	2.9	3%	7%	75%
BCBS Plans	2.2	6%	7%	76%
Centene	2.6	10%	7%	94%
Cigna	1.3	8%	19%	80%
CVS	0.8	12%	20%	90%
Humana	2.8	3%	11%	70%
Kaiser Permanente	0.3	12%	1%	30%
Others	1.7	5%	9%	70%
UnitedHealthcare	0.8	9%	10%	85%

Source: CMS Public Use File, Contract Year 2021 Medicare Part C Reporting Requirements

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CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- Utilization Management
  - MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare regulations.
  - When coverage criteria are not fully established, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.
  - MA plans establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare policies.

CMS: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

- Marketing Requirements
  - CMS is prohibiting ads that do not mention a specific plan name as well as ads that use works and imagery that may confuse beneficiaries or Medicare logos in a way that is misleading, confusing, or misrepresents the plan.
  - CMS also reinstates important protections that prevent predatory behavior and finalized changes that strengthen the role of plans in monitoring agent and broker activity.
  - Protecting Medicare beneficiaries by ensuring they receive accurate information about Medicare coverage and are aware of how to access accurate information from other available sources.

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2025 Final Rule Breakdown

CMS: Medicare Program; Changes to the Medicare Advantage and Medicare Prescription Drug Benefit for Contract Year 2024 and 2025 (CMS-4205-F)

- Establish Guardrails for Agent and Broker Compensation
  - Prohibits separate payments to the to agents or brokers that may interfere with a broker's ability to objectively assess and recommend the plan that best fits a beneficiaries health care needs.
  - Sets a single increased compensation rate for all plans to be updated annually and revise the scope of items and services included within agent and broker compensation. Eliminates administrative fee payments to the brokers.

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CMS Interoperability and Prior Authorization Final Rule

(Released January 2024)

CMS Interoperability and Prior Auth Final Rule

- **AAHomecare submitted comments in March 2023 for the proposed rule**
- **Impacts: Medicare Advantage, Medicaid, and Medicaid MCO**
- **Purpose: Enhance communication and transparency**
- **Key provisions with 2026 effective date:**
  - Patient Access API
  - PA decision time frames (72 hours for expedited and 7 days for standard)
    - Denial reason requirements
    - Reporting obligations
- **Key provisions with 2027 effective date:**
  - Provider Access API
  - Payer-to-Payer API

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Data RFI (May 2024)

CMS Medicare Advantage DATA RFI May 2024

- RFI for information and suggestions for data requests CMS should be utilizing for analysis of MA Plans
- AAHomecare Payer Relations Council Submitted Comments Urging CMS to do the following:
  - Beneficiary Access to Care
    - MA Plans should be required to publish data demonstrating sufficient access to care
    - Provider networks should be publicized and include metrics to show sufficient care for all product categories for DME and in each geographical area
    - CMS should require data beyond the attestation form to ensure access to care including beneficiary satisfaction, complaints, and the number of DMEPOS suppliers by geographic area and product category based on claims data for billing within last 12 months

CMS Medicare Advantage DATA RFI May 2024

- Prior Authorization
  - MA Plans should publish data regarding its appeals process for PA Decisions
  - MA Plans should be required to publicly disclose and report use of any form of AI as part of claims processing or PA processes.
  - MA Plans should be required to publicly disclose and report all PA statistics for DMEPOS items by product category. All subcontractors and TPA should be required to report the same data.
    - The number of PAs requested
    - The number of PAs approved
    - The number of PAs denied
    - The number of PAs partially approved or denied
    - The number of PAs appealed
    - The number of PAs that are overturned after appeal and at which level of appeal
    - The total number of PAs approved and denied within prescribed timeline (i.e. quarterly)
    - The number of PAs that are denied based upon technical versus medical need reasons
  - CMS should establish guidelines that Prior approved items cannot later be reversed for medical necessity reasons
  - MA Plans should be required to report the credentials or certifications of the individuals participating in “Peer to Peer” reviews.

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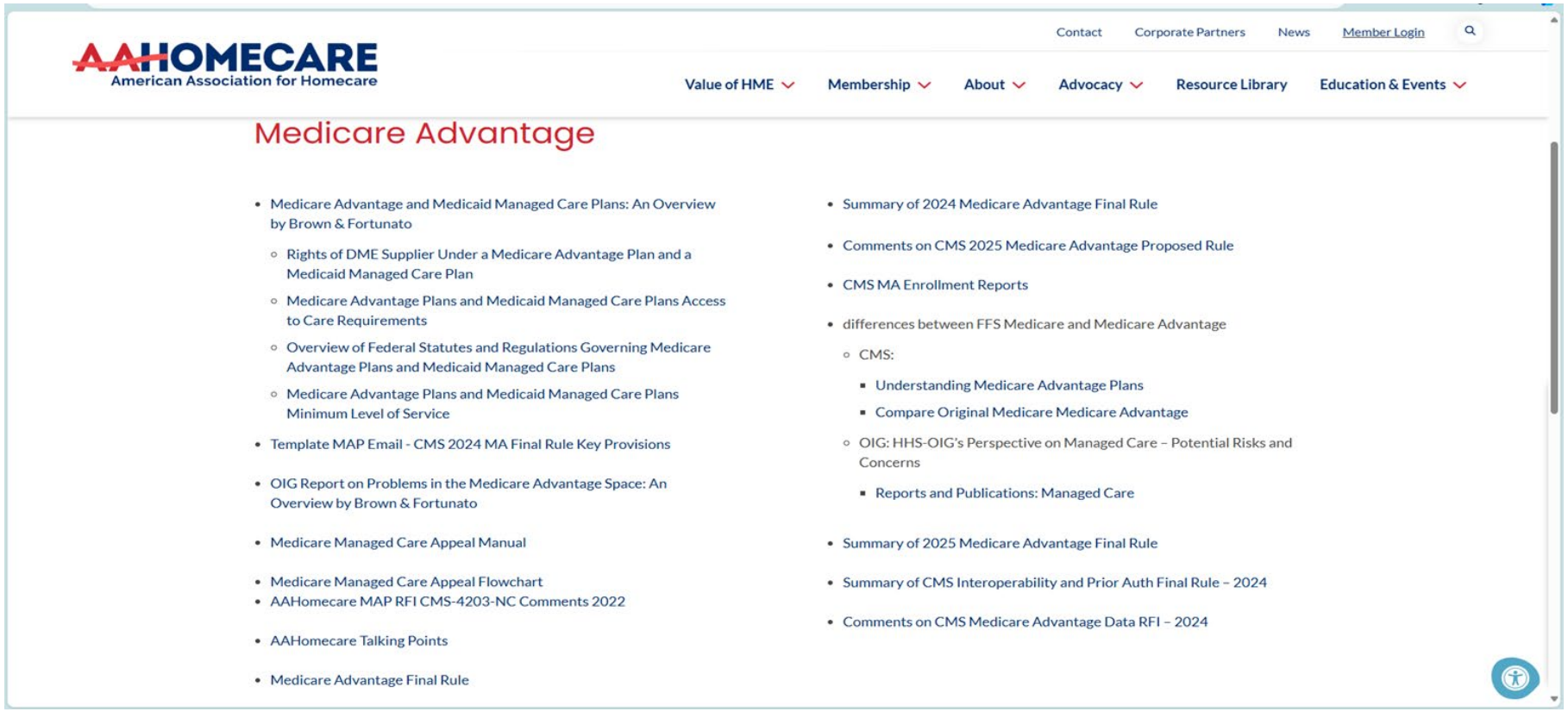
Resources

Medicare Advantage Resources



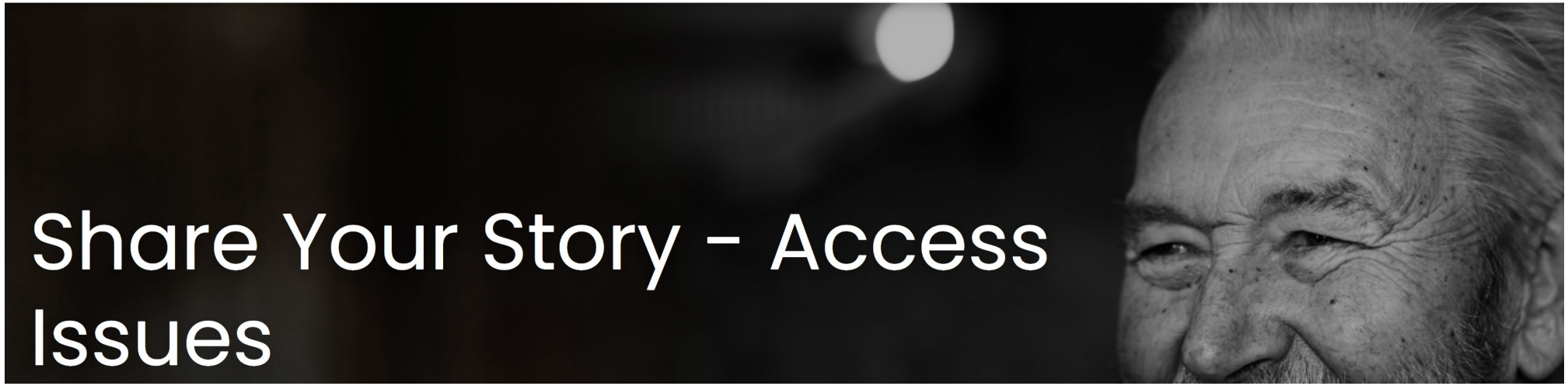
https://aahomecare.org/medicare-advantage

Educate Medicare Beneficiaries on Differences of Medicare Advantage and Traditional

- CMS Resources:
  - https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf
  - https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage
- OIG: HHS-OIG's Perspective on Managed Care – Potential Risks and Concerns
  - https://oig.hhs.gov/reports-and-publications/featured-topics/managed-care/

We Need End User Stories - Access Issues

- Suppliers can direct customers to the following pages to upload their stories, either written or via video:
  - CGM access issues: aahomecare.org/Access-Issues-Upload-Form-CGM.
  - NIV access issues: aahomecare.org/Access-Issues-Upload-Form-NIV



Key Takeaways

- Patient complaints – 1-800-MEDICARE
- Stakeholder complaints – Regional Office Contacts and https://dpap.lmi.org
- Encourage end-users to share their story:
  - CGM access issues: aahomecare.org/Access-Issues-Upload-Form-CGM
  - NIV access issues: aahomecare.org/Access-Issues-Upload-Form-NIV
- AAHomecare continues to provide global industry feedback and proposed solutions directly to CMS Part C leadership
- Educate payers/request information on their processes
  - Utilize AAHomecare Summary of 2024 MA Final Rule
  - Utilize template letter with questions in your outreach to MA plans
- Check out resources available: AAHomecare.org

AAHomecare Needs You

- AAHomecare needs members to meet the challenges ahead. All dues to AAHomecare directly support lobbying, research, and public awareness efforts that are part of our advocacy program.

- To join, contact Michael Nicol, Senior Director of Membership Services: michaeln@aahomecare.org or 410-299-7100.

MEMBERSHIP CONSULTATION

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Thank You

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