14TH ANNUAL ADVANCED FORUM ON

MANAGED CARE

Disputes and Litigation

Medicare Managed Care Think Tank
Deep Dive into the Latest Legal and Regulatory Developments

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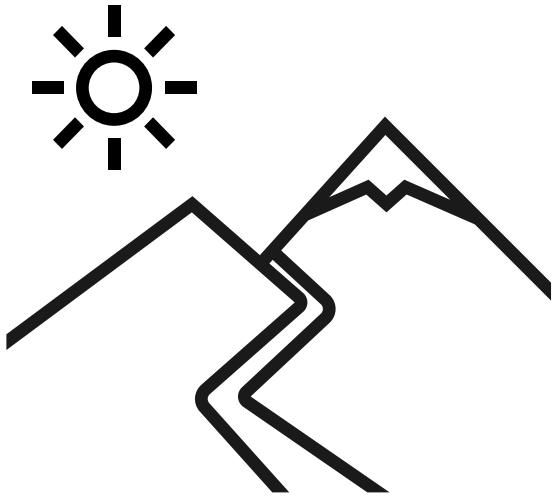
Roadmap

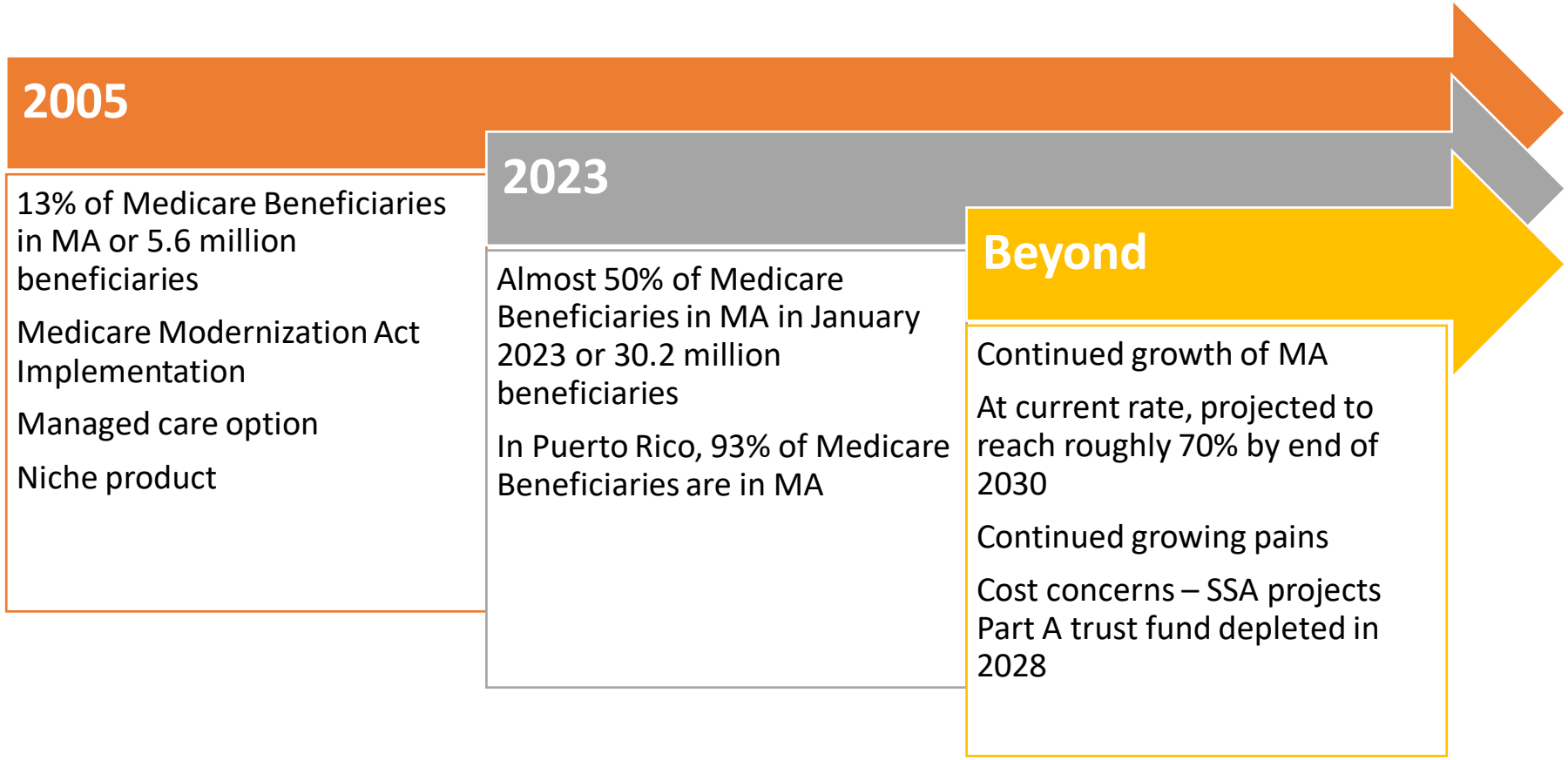


- Opening Remarks and Introductions
- Discussion Topics
  - Risk Adjustment
  - Inflation Reduction Act
- BREAK
- Discussion Topics
  - CY 2024 MA/Part D Final Rule
  - D-SNPs
- Final Q&A/Wrap-Up

Medicare Managed Care

Overview of an evolving industry

Medicare Advantage Growth Snapshot



Medicare Program from A to D

Original Medicare Traditional Medicare Fee for Service (FFS)

- Part A – Inpatient / hospital coverage
- Part B – Outpatient / medical coverage

Part C – Medicare Advantage

- Original Medicare replacement option
- Includes Parts A and B medical coverage

Part D – Prescription Drug Benefit

- Standalone Prescription Drug Plan (PDP) or
- Medicare Advantage Prescription Drug Plan (MA-PD)

Medicare Supplemental Insurance for Original Medicare

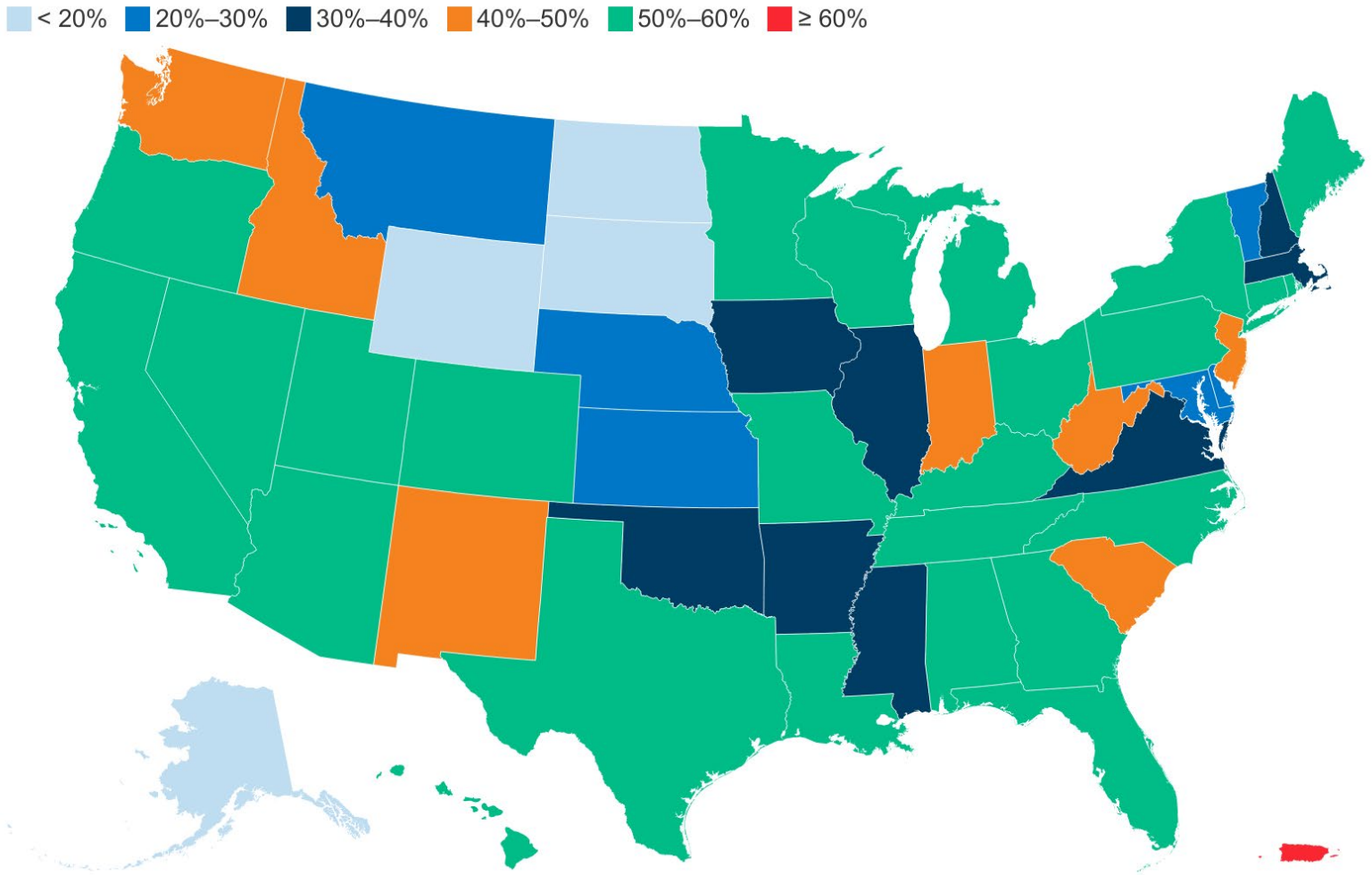
- Costs not covered by Medicare
- NAIC Model Standards
- Standardized Benefit Packages
- Cannot be combined with MA
- No Rx coverage – need PDP
- State regulated

The Value of Medicare Managed Care

- Comprehensive Benefits
  - Integrated dental, hearing, and vision coverage
  - More than 1200 plans offered SSBCI in 2022 (400% increase)
- Financial Security
  - Capped OOP costs
  - MA premiums declined 8% 2022 to 2023
- Health Outcomes
  - MA enrollees more likely to receive preventative services
  - Lower rates of hospital stays, ED visits, and 30-day readmissions
- High Satisfaction
  - 94% of survey respondents satisfied with MA coverage
  - 90% satisfied with prescription drug coverage

Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022

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Key MA and Part D Resources

MA (Part C)

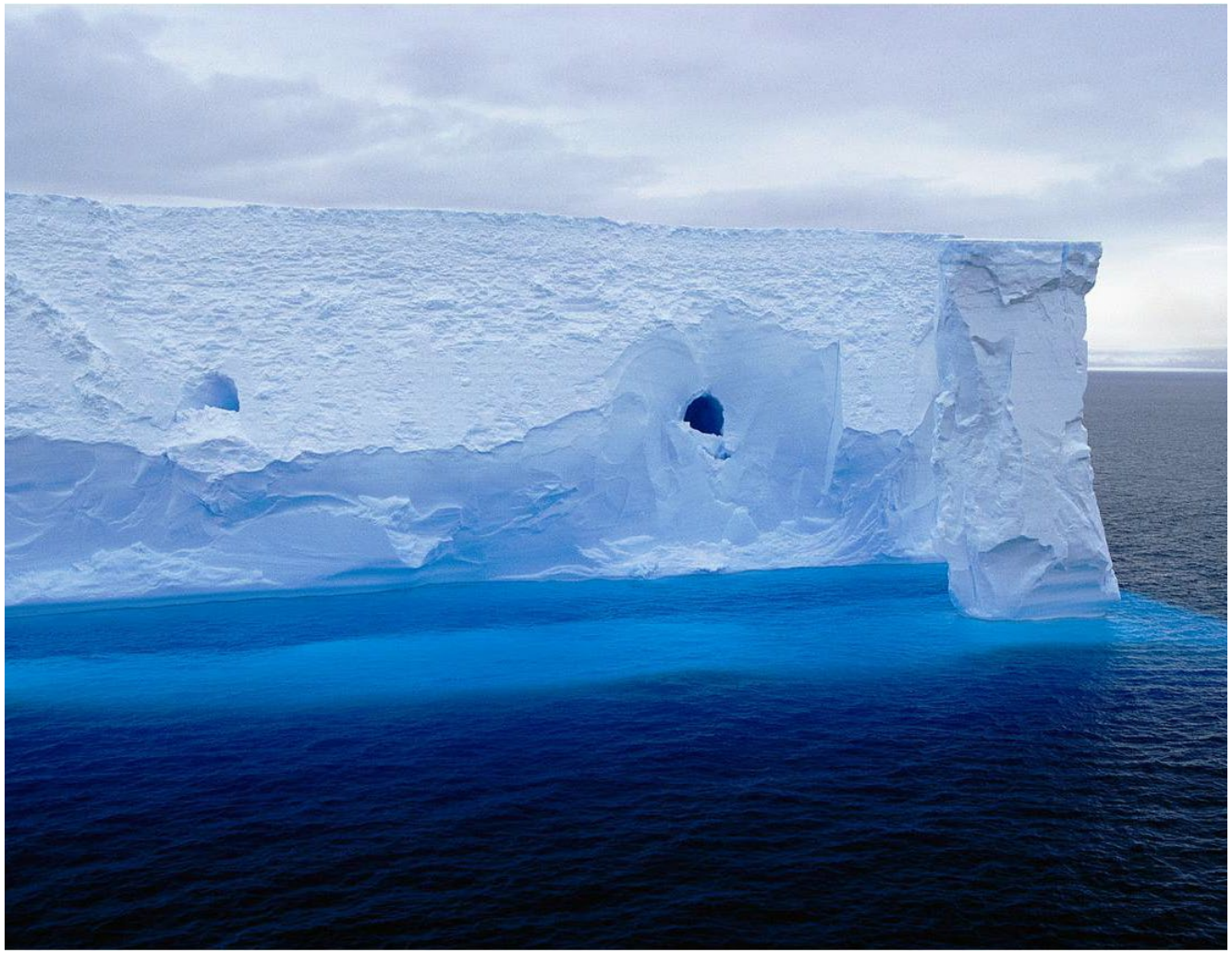
- Title XVIII of the Social Security Act, Part C, §1851, et. seq., 42 U.S.C. § 1395w-21, et seq.
- 42 C.F.R. Part 422
- CMS Medicare Managed Care Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors

Part D

- Title XVIII of the Social Security Act, Part D, § 1860D-1, et seq., 42 U.S.C. § 1395w101, et. seq.
- 42 C.F.R. Part 423
- CMS Medicare Prescription Drug Benefit Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors

Laws and Regulations: Tip of the Iceberg

- Voluminous sub-regulatory requirements
- Manuals
- HPMS Memos
- Bid Guidance
- Materials formerly known as “Call Letters”
- Reporting Requirements



Welcome to the Think Tank

Meet Your Team

- Name, Organization, Role
- Why did you sign up for the workshop?
- Most frequently asked questions about Medicare?
- Upcoming opportunities
- Challenges on your plate

Format

- Presentation of Discussion Topic
- 20- to 30-minute think tank
  - Experiences with implementation
  - Operational challenges
  - Legal questions
  - Policy concerns
  - Wins/losses
- 10- to 15-minute debrief
  - Learnings
  - Next steps

Risk Adjustment

Putting risk management to the test

Medicare Advantage Risk Adjustment

Adjustment to capitated payments to account for member demographics and the relative health of members

Relative health compared to average beneficiary: The HCC Model

Medical conditions from a given year are used to predict expenditures in the next year

Disease groups are referred to as Hierarchical Condition Categories (HCCs)

Disease groups contain major diseases and are broadly organized into body systems

HCC assigned to a disease is determined by the diagnosis codes submitted

Only selected diagnoses are included in the risk adjustment models

Risk factors are additive when the diseases are not closely related

Risk Score Calculation (Simplified)

All conditions coded appropriately		Some conditions coded with poor specificity		No conditions coded	
76 year female	0.468	76 year female	0.468	76 year female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
DM w/ vascular CC (HCC 15)	0.608	DM w/o CC (HCC 19)	0.181	DM not coded	
Vascular disease w/CC (HCC 104)	0.645	Vascular disease w/o CC (HCC 105)	0.324	Vascular disease not coded	
CHF (HCC 80)	0.395	CHF not coded		CHF not coded	
Disease Interaction*	0.204	No Disease Interaction		No Disease Interaction	
Total RAF	2.497	Total RAF	1.15	Total RAF	0.645
PMPM Payment	**$1,873**	**PMPM Payment**	**$863**	**PMPM Payment**	**$484**
Annual Payment	**$22,473**	**Annual Payment**	**$10,350**	**Annual Payment**	**$5,805**

Jonathan Hendrickson, Principal, Consulting Actuary, Milliman, "Medicare Advantage Risk Adjustment and False Claims Liability," October 16, 2015. Used with permission. For illustration only. Dollar amounts are not current.

Alleged Upcoding Puts a Bulls-Eye on MA

- Sen. Chuck Grassley (R-IA): “paint a giant bulls-eye” for lawmakers to go after, referencing upcoding and improper payments in MA
- Grassley highlighted “upcoding, which is falsely claiming the illness or disease of a patient and billing for services at a higher level of complexity than documented.”
- Called on providers to act as whistleblowers

“Grassley: Upcoding, Improper Pay Put A Bulls-Eye on MA for 2023,” Inside Health Policy, January 3, 2023.

HHS Budget Proposal

- MA risk adjustment reviews ***before*** payment to confirm diagnoses submitted with beneficiaries' medical records
  - Focus on diagnoses and beneficiaries at a higher risk of improper pay
- 85% MLR for supplemental benefits
- Provider ID reported in encounter data

Enforcement Environment: CMS

MA Plan Requirements	CMS Enforcement
• RA data must be accurate, complete, and truthful • RA data certified by Chief Financial Officer • Meet ICD coding guidelines • Delete codes that do not meet requirements • 60-day Overpayment Rule • Vendor oversight	• RADV Audits test accuracy of RA data • Guidance not updated since 2014 • Does not address chart reviews, IHAs • Scrutiny and pressure to increase oversight

Audits are not a Health Plan's Biggest Concern

Final 2023 MA RADV Rule

- Key Policy Changes
  - Exclusion of FFS Adjuster
  - Extrapolation starting in Plan Year (PY) 2018
    - No extrapolation of overpayments for PYs 2011-2017
- Application
  - Flexibility in sampling and extrapolation methodology
  - Focus on high risk HCCs
  - Focus on contracts with high coding intensity and/or error rates
- CMS expects to recoup $4.7B over 10 years
- OIG RADV-like audits to follow suit

Enforcement Environment: OIG Scrutiny of Risk Adjustment

"MA companies may be using both chart reviews and HRAs more than their peers to maximize risk-adjusted payments inappropriately"

"Unlinked chart reviews and in-home HRAs may be particularly vulnerable to misuse by MA companies to maximize risk-adjusted payments inappropriately."

"CMS acknowledged concerns that in-home HRAs could be used by some MA companies primarily for the gathering of diagnoses for payment rather than to provide treatment and/or followup care to beneficiaries."

"[M]echanisms such as chart reviews and HRAs should not be misused to collect diagnoses that inappropriately increase payments to MA companies and do not result in improved care for MA beneficiaries.

Billions in Estimated Medicare Advantage Payments Diagnoses Only Reported Only on Health Risk Assessments Raise Concerns (Sept. 2020); Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments (Sept. 2021)

Enforcement Environment: OIG Scrutiny of Risk Adjustment

Sampling of OIG MA Compliance Audit Findings

MAO	Report Date	Years Audited	Percent of HCCs Not Validated	Percent Disagreement with HCC Determination	Estimated Overpayment
BCBS Michigan	February 2021	2015-2016	76%	0%	$14.5M
Anthem	May 2021	2015-2016	61%	2%	$3.47M
UPMC	November 2021	2015-2016	69%	8%	$6.4M
Healthfirst	January 2022	2015-2016	65%	0%	$5.2M
Wellcare	August 2022	2015-2016	51%	3%	$3.5
Humana	September 2022	2016-2017	77%	5%	$34.4M
Highmark	November 2022	2015-2016	60%	1%	$6.2M
BCBS RI	November 2022	2016-2017	79%	13%	$4.8M
Cigna	December 2022	2016-2017	70%	7%	$5.9M

Enforcement Environment: DOJ/Qui Tam Litigation

False Claims Act Prohibits: Retaining Overpayments

Intent can be actual knowledge or reckless disregard – no requirement of actual intent to defraud

- **<u>Key Issues in MA RA Litigation</u>**
  - Coding Guidance
  - Retrospective Reviews
  - Prospective Reviews
  - Monitoring and Oversight
  - Provider Oversight and Engagement
  - In-Home Assessments

Enforcement Environment: DOJ/Qui Tam Litigation

Significant Medicare Advantage Risk Adjustment Litigation

Case	Government Intervention	Status
U.S. v. Janke	Yes	Settled in 2010 for $22.6M
U.S. ex rel. Swoben v. SCAN Health Plan	No*	Settled in 2012 for $3.8M
U.S. ex rel. Swoben Secure Horizons	Yes	Voluntarily dismissed October 2017
U.S. ex rel. Valdez v. Aveta, Inc.	No	Settled in 2020
U.S. ex rel. Graves v. Plaza Medical Centers Corp.	No	Settled in October 2017
U.S. ex rel. Silingo, v. Mobile Medical Examination Services Inc.	No	Settled in 2020
U.S. ex rel. Ledesma v. Censeo Health LLC	No	Settled in 2018
U.S. ex rel. Sewell v. Freedom Health, Inc.	Yes	Settled in 2017 for $32.5 M
U.S. ex rel. Poehling v. UnitedHealth Group Inc.	Yes	Ongoing
U.S. ex rel. Cutler v. Cigna Corp.	No	Ongoing
U.S. v. Anthem Inc.	Yes	Ongoing

Inflation Reduction Act

Disrupting prescription drug pricing

IRA Prescription Drug Provisions

- Price Negotiation
- Inflation Rebates
- Part D Redesign
- Insulin Cost Sharing Capped at $35
- Vaccine Cost Sharing Eliminated
- Expanded LIS Eligibility
- Implementation of Drug Rebate Rule Delayed

Implementation Challenges for Plans

- Congress waived notice and comment rulemaking
- Part B drug coinsurance adjustment in 2023
- Part D redesign phased in beginning 2023
- CMS Price Negotiations are likely to destabilize pharmacy benefit pricing

Part B and D Inflationary Rebates - Overview

IRA §§ 11101 and 11102

- For certain drugs and biologicals, manufacturers must return to HHS any amounts from price increases that exceed inflation
  - Generally, single source drugs/biologicals
  - Exclusion for certain preventative vaccines
- Rebates calculated by HHS
  - Compare price data to benchmark period
  - Reduction or waiver for shortages and severe supply chain shortages
- Rebates paid by manufacturers to HHS are deposited in Medicare Trust Fund
- No indication that payments to MA or Part D sponsors will be adjusted

Inflationary Rebates and Part B Coinsurance

- Original Medicare
  - General Rule: 20% coinsurance after deductible
  - IRA: 20% coinsurance on Part B rebatable drugs must be based on inflation-adjusted payment amount
  - Exclusion for units included in bundled payments
- Medicare Advantage
  - MA cost sharing differs plan-by-plan
  - Copayments may apply to Part B services including drugs
- CMS Guidance
  - Nov 2022 – Part B drugs covered by MA plans are subject to rebate statute
  - Feb 2023 – “CMS seeks comment from the public on operational considerations, such as the best source of information to determine the number of units of a drug furnished to MA enrollees and how to remove units in accordance with . . . the Act”
  - Mar 2023 – HHS publishes list of 27 Part B rebatable drugs

Medicare Drug Price Negotiation Program

IRA §§ 11001

- Establishes Medicare Drug Price Negotiation Program (“Negotiation Program”)
- Allows Medicare to negotiate “maximum fair prices” for certain high spend prescription Part B and Part D drugs
- Drug manufacturers will enter into agreements to negotiate with CMS
- CMS will publish maximum fair prices for negotiated drugs for each year
  - 2026: 10 Part D drugs
  - 2027: 15 Part D drugs
  - 2028: 15 Part B & D drugs
  - 2029: 20 Part B & D drugs
- Non-compliant manufacturers may be subject to civil monetary penalties / excise taxes

Medicare Drug Price Negotiation Program

- Drugs subject to negotiations
  - High spend drugs
    - At least $200 million between June 1, 2022 and May 31, 2023
  - No generic or biosimilar equivalents
  - Covered under Part B or Part D
  - At least 7 years (small molecule) or 11 years (biological) from FDA-approval
- Drugs excluded from negotiations
  - “Small biotech exception”
    - For drugs with less than 1% of Part B or Part D spend & at least 80% of manufacturer’s total spend
  - Orphan drugs
  - Plasma-derived products

Negotiation Program: Current Guidance

- CMS Guidance
  - Jan 2023 – CMS publishes public memo outlining process for Negotiation Program implementation
    - CMS will implement “by program instruction or other forms of program guidance”
  - Jan 2023 – CMS requests comment regarding “burden estimates or any other aspect of this collection of information” relating to “small biotech exception”
  - March 2023 – CMS publishes initial guidance regarding implementation of the Negotiation Program
    - Highly detailed overview of how the Negotiation Program will operate
    - Invites public comment on manufacturer agreement, data elements, negotiation process, definition of maximum fair price, compliance monitoring
    - Comments due April 14

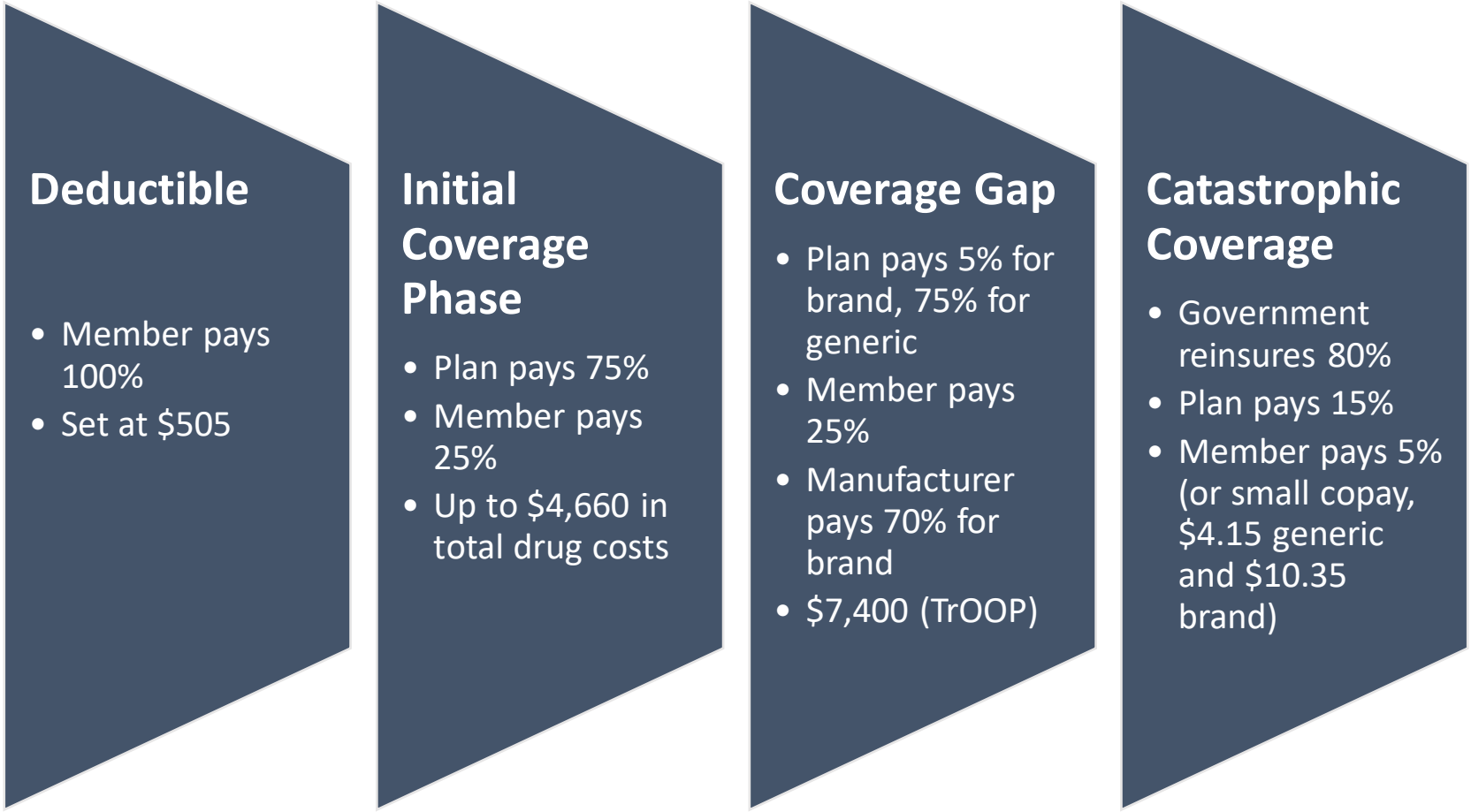
Negotiation Program: Upcoming Dates

- Operating on an accelerated timeline
  - Summer 2023: CMS to issue revised Negotiation Program guidance
  - Sept 2023: CMS publishes list of 10 Part D drugs selected for 2026 negotiations
  - Oct 2023: Manufacturers enter into negotiation agreements with CMS
  - Feb 2024: Negotiations begin
  - Aug 2024: Negotiations end
  - Sept 2024: CMS publishes maximum fair prices
  - Jan 2026: Prices for first 10 drugs go into effect

Negotiation Program: Industry Impact

- Novelty of government having authority to negotiate drug prices
- Ambiguity surrounding negotiation process, selection criteria
- Changes in pharmaceutical research and development
  - Shift to prioritizing biotechs, drugs with longer runways
  - Decline in drug developments generally
- Possible impact to commercial drug prices

Part D Redesign: Part D Standard Benefit for 2023



Part D Redesign: Major Provisions

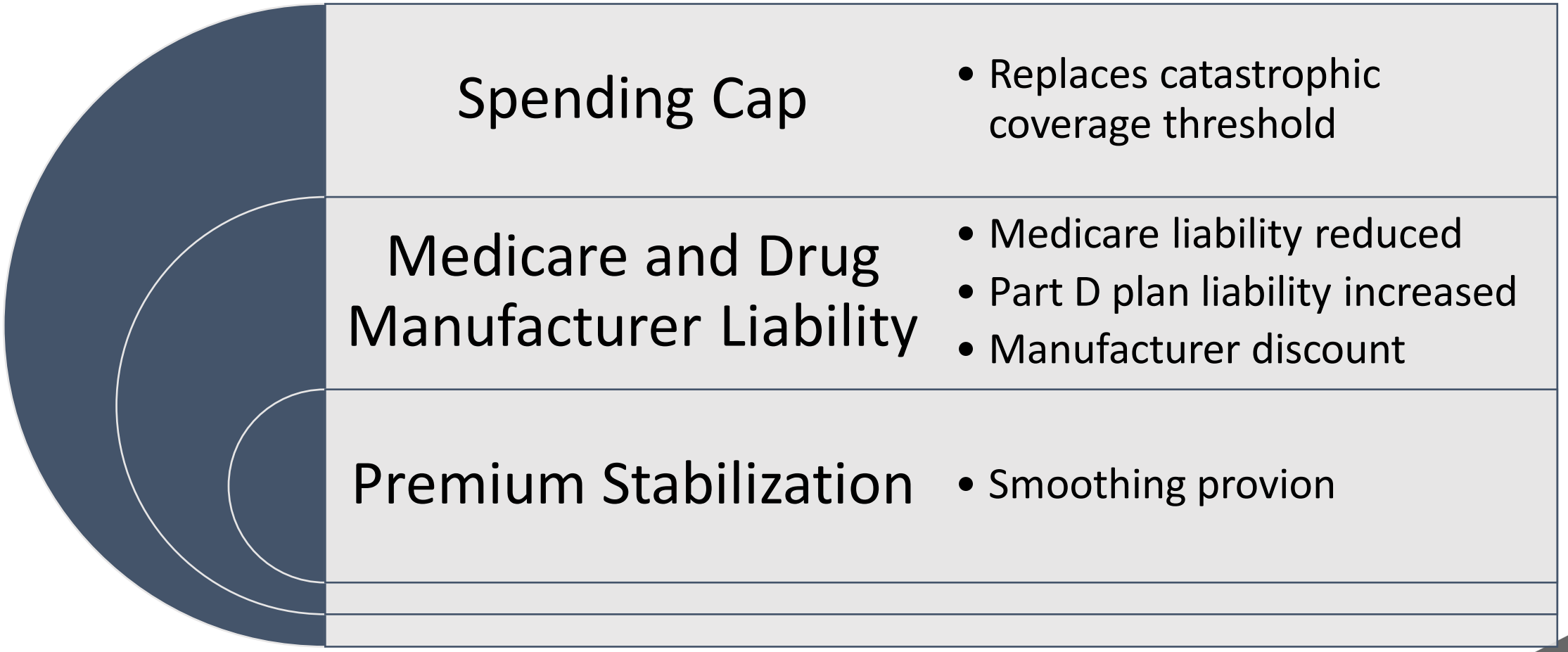
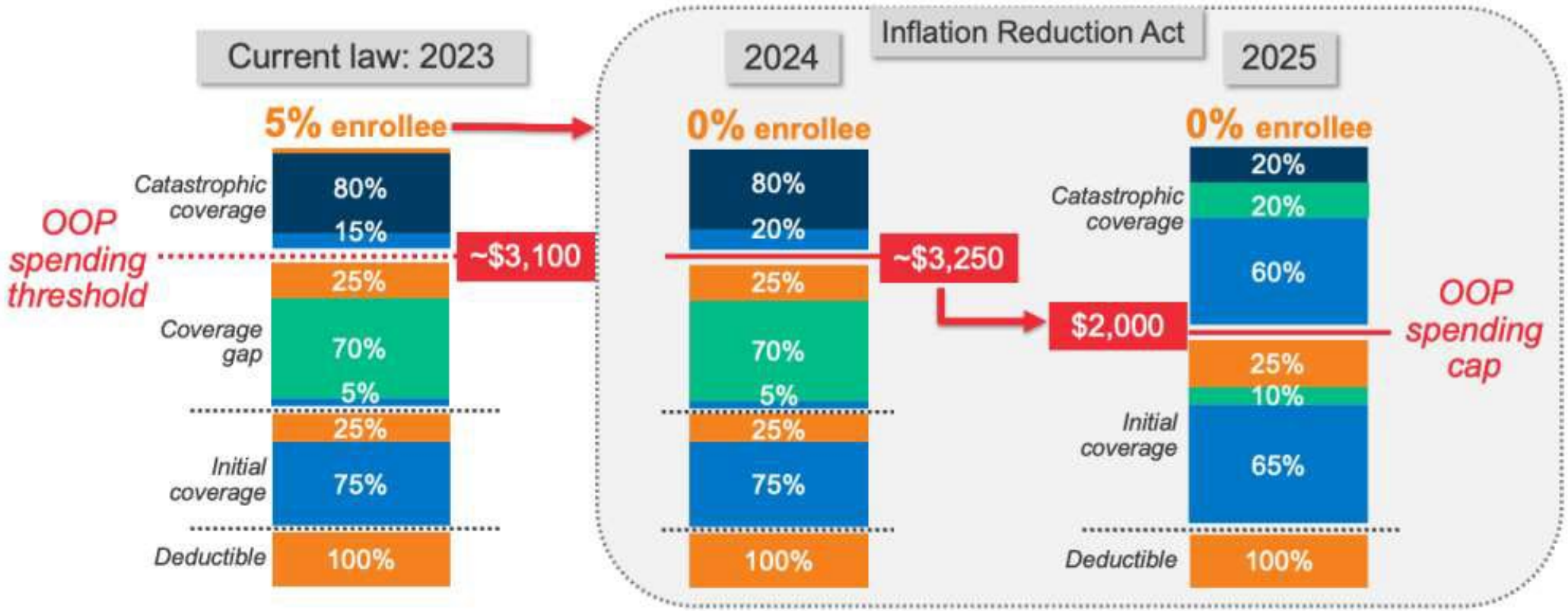


Figure 2

Changes to Medicare Part D for Brand-Name Drug Costs

*Share of **brand-name drug** costs paid by:* Enrollees Part D Plans Drug manufacturers Medicare



NOTE: OOP is out-of-pocket. The out-of-pocket spending threshold will be $7,400 in 2023 and is projected to be $7,750 in 2024 and $8,100 in 2025, including what beneficiaries pay directly out of pocket and the value of the manufacturer discount on brand-name drugs in the coverage gap phase. These amounts translate to out-of-pocket spending of approximately $3,100, $3,250, and $3,400 (based on brand-name drug use only).

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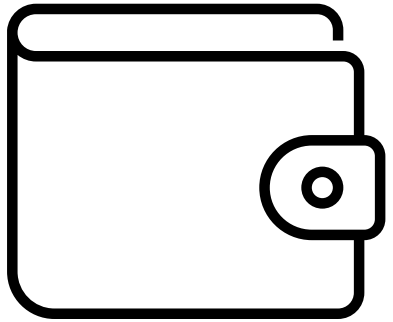
Part D Redesign: Spending Cap

- Changes for 2024:
  - Eliminates 5% beneficiary coinsurance in catastrophic phase
  - Effectively caps out-of-pocket costs at approximately $3,250
- Changes beginning 2025:
  - Hard cap on out-of-pocket spending at $2,000 per year
  - Subject to inflation increases

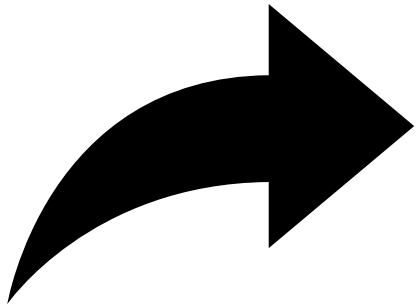


Part D Redesign: Medicare, Plan and Manufacturer Liability

Liability for Costs Above Cap	Liability for Costs between Deductible and Cap
• Medicare: 80% → 20% (brand) / 40% (generic) • Part D plans: 15% → 60% (brand and generic) • Manufacturers: 20% price discount (brand)	• Coverage gap eliminated • Part D plans: 75% (initial) / 5% (gap) → 65% • Applies to LIS and non-LIS • Manufacturer Discount: 70% (gap) → 10%

Changes effective January 2025

Part D Redesign: Premium Stabilization



- 2024-2029: Premium increases capped at 6% from prior year
- 2030: Beneficiary share of the cost of standard drug coverage (currently 25.5%) lowered to ensure that premium does not increase by more than 6%
- Option to spread OOP costs over the year (smoothing)

Part D Redesign: Projected Impacts

Beneficiary Impacts

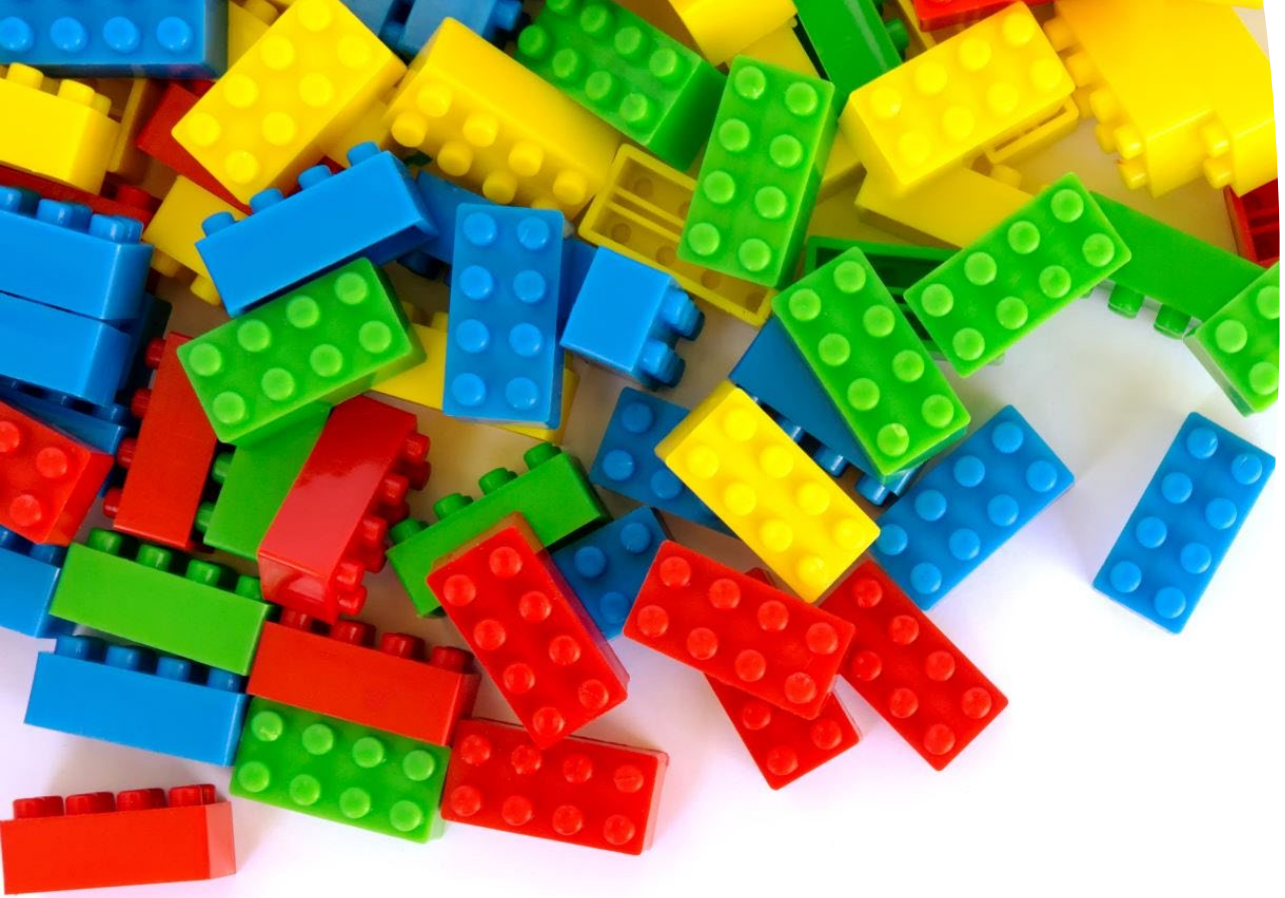
- Savings for enrollees with high OOP costs
- 1.4M enrollees with OOP costs > $2,000 in 2020
  - Average $3,335/person
  - Includes 1.3M enrollees spending above catastrophic coverage threshold
  - $2,700 in OOP costs (brand)
- With cap, savings of $1,355 (40%)
- Top 10% (145,000 enrollees) would have saved $3,567 (64%)
- Potential for higher Part D premiums
- May be mitigated by premium stabilization

Part D Plan Impacts

- Increased liability above spending cap
- Increased liability below cap (elimination of coverage gap)
- Increased liability for LIS beneficairies
- Increase in portion of payments that are risk-adjusted
  - Accuracy
  - Aligned incentives
- Incentive to manage costs
  - Utilization management
  - Increased generic drug utilization
- Opportunity to engage in implementatoin

MA/Part D Regulatory Update

CY 2024 Proposed Rule



CY 2024 Proposed Rule: Major Provisions

- Prior Authorization Streamlining
- New Marketing Requirements
- Behavioral Health Network Adequacy
- Incorporating Health Equity Index (HEI) into Star Ratings
- Expanding Medication Therapy Management (MTM) Eligibility
- Low-Income Subsidy (LIS) Expansion
- Enrollee Notification for Provider Contract Termination
- Part D Formulary Flexibility
- Translation of Materials
- Telehealth Accessibility

Prior Authorization

- MAOs prohibited from denying coverage based on criteria not found in Original Medicare coverage policies
  - Organizational coverage policies based on clinical literature or common treatment guidelines
  - Support for coverage policy decisions made available to CMS and public
- 90-day transition period for enrollees switching MA plans
- Utilization Management (UM) Committee
  - UM Committee will conduct an annual review to ensure that the MAO's prior authorization policy is consistent with Original Medicare

Marketing Requirements

- Changes to prevent potentially misleading marketing:
  - Prohibition on ads that do not mention a specific plan name
  - Prohibition on advertising benefits within a service area where those benefits are not available
  - Prohibition on content that may confuse MA with Original Medicare
  - Prohibition on marketing savings based on certain comparisons
  - Prohibition on superlatives without support
  - TPMOs to disclose all plans the TPMO sells
- Changes focusing on beneficiary education:
  - Annual written notice of right to opt-out of phone calls
  - Agents must explain the effect of enrollment choice on current coverage
  - Standardized list of pre-enrollment questions

Behavioral Heath Network Adequacy

- MAOs required to include Clinical Psychology Licensed Clinical Social Workers and Prescribers of Medication for Opioid Use Disorder as specialty types for network adequacy evaluation
  - Subject to base standards for distance and wait times
  - Subject to provider minimums
- Some behavioral health services may qualify as emergency services not subject to prior authorization
- MAOs must establish programs to coordinate covered services with community and social services to behavioral health programs to close treatment gaps

Health Equity Index (HEI) in Star Ratings

- HEI Reward for Star Ratings
  - Rewards plans that provide high-quality care to individuals with Social Risk Factors (SRFs)
  - Reduces the weight of patient experience/complaints in Star Ratings
- Modification to Hold Harmless Policy
  - Proposal to exclude quality improvement measures only for 5-star plans
  - CMS currently excludes quality improvement measures for 4-star and higher plans

Expanding MTM Eligibility

- Plans must include 10 core chronic conditions in MTM targeting criteria
  - 9 “core chronic conditions” identified by CMS + HIV/AIDS
- Max number of prescribed drugs a Part D sponsor may require to qualify to MTM lowered from 8 to 5
- Annual cost threshold for MTM eligibility lowered to match the average annual cost of 5 generic drugs

LIS Expansion

- Implementation of IRA
- Full LIS eligibility expanded to include incomes up to 150% of the federal poverty level
- Permanent LI NET program codified
  - Current LI NET is a temporary program which provides Part D coverage for low-income beneficiaries who qualify for Medicaid but do not yet have prescription drug coverage

Enrollee Notification of Provider Contract Termination

- Enrollee notification requirements for provider contract terminations
  - Both no-cause and for-cause
- Stringent requirements for primary care and behavioral health providers
  - 45 days before effective date of termination
  - Telephone and written
  - Must include names and phone numbers of other in-network providers and info about how to request continuation of care with current provider

Part D Formulary Flexibility

- Formulary substitution permitted for biologic drugs in these situations:
  - a new interchangeable biological product substituted for its corresponding reference product
  - a new unbranded biological product substituted for its corresponding brand name biological product

Materials Translation

- D-SNP sponsors must provide materials on a standing basis in any non-English language that is the primary language of at least 5% of individuals in a service area
- Requirement includes accessible formats
- Provider directories must list providers' cultural and linguistic capabilities (including ASL proficiency)
- FIDE SNPs, HIDE SNPs, and AIPs must follow the same translation requirements as MA plans + languages required by Medicaid
- Cultural competency requirement

Telehealth Accessibility

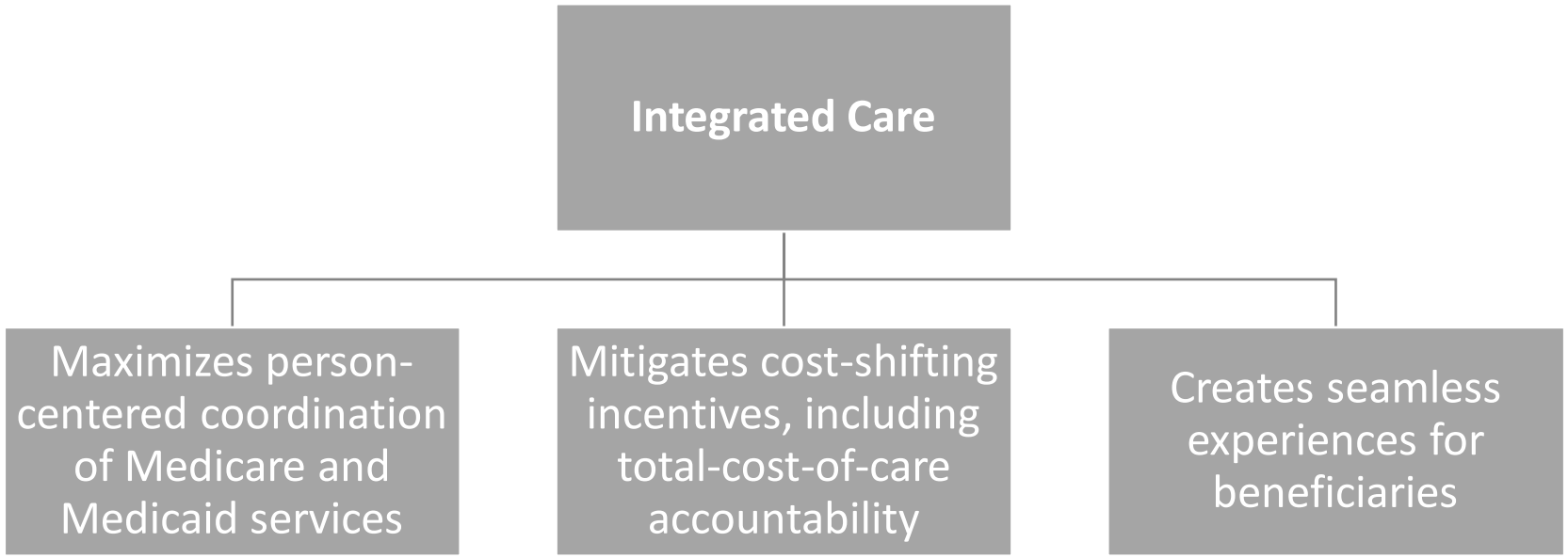
- MAOs will be required to implement procedures to identify enrollees with low digital health literacy and offer them digital health education
- CMS is giving MAOs significant flexibility when creating and implementing these new procedures

MA Challenge: Implementing Sweeping Changes Across Multiple Domains

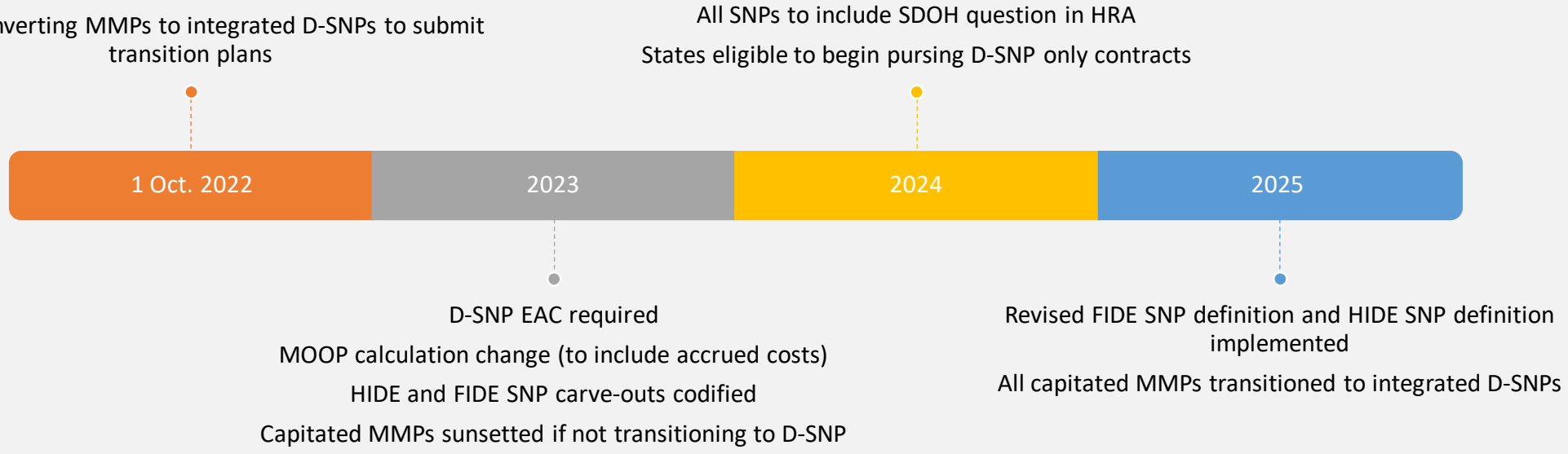
Dual Eligible Special Needs Plans

Toward better experiences and better outcomes

Improving Experiences for Dually Eligible Individuals



D-SNP Implementation Timeline

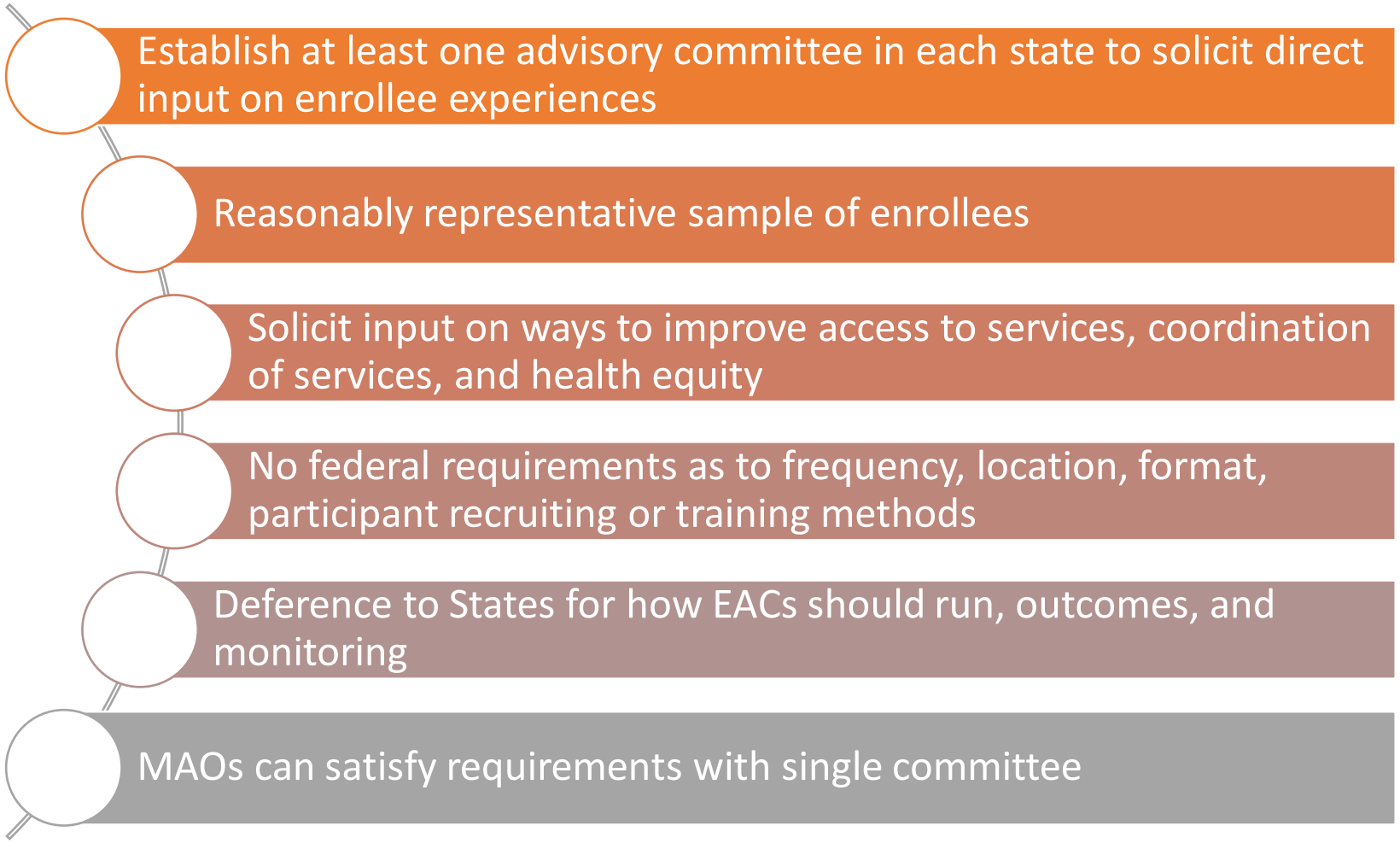


Enrollee Advisory Committee (EAC)

- Medicare Medicaid Plans (MMP) and Program of All-Inclusive Care (PACE) organizations continue to use EAC to solicit input to
  - help identify and address barriers to high-quality, coordinated care
  - Solicit input on ways to improve access to covered services
  - Achieve health equity for underserved populations
  - Receive feedback on Plan processes

- CMS believes that the establishment of D-SNP EAC is a valuable beneficiary protection to ensure that enrollee feedback is heard by D-SNPs and to help identify and address barriers to high-quality, coordinated care

Enrollee Participation in Plan Governance



Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments

- Many dually eligible individuals contend with social risk factors related to food insecurity homelessness, lack of access to transportation, and low levels of health literacy.
- CMS believes that the addition of these questions to HRA will provide a more complete picture of each enrollee's risk factors that will improve coordination of necessary services that might help with food insecurity, housing instability or transportation and improved access to covered services.

Social Determinants of Health and Health Risk Assessments

- At least one question on food security, housing stability and access to transportation required as part of HRAs
- Screening instruments to be specified in sub-regulatory guidance but questions will not be standardized
- Results must be addressed in individualized care plan.
- Did not finalize proposal to collect HRA data but will consider whether to do so in the future
- Effective beginning CY 2024

Expanded Universe Subject to Unified Appeals and Grievance Procedures

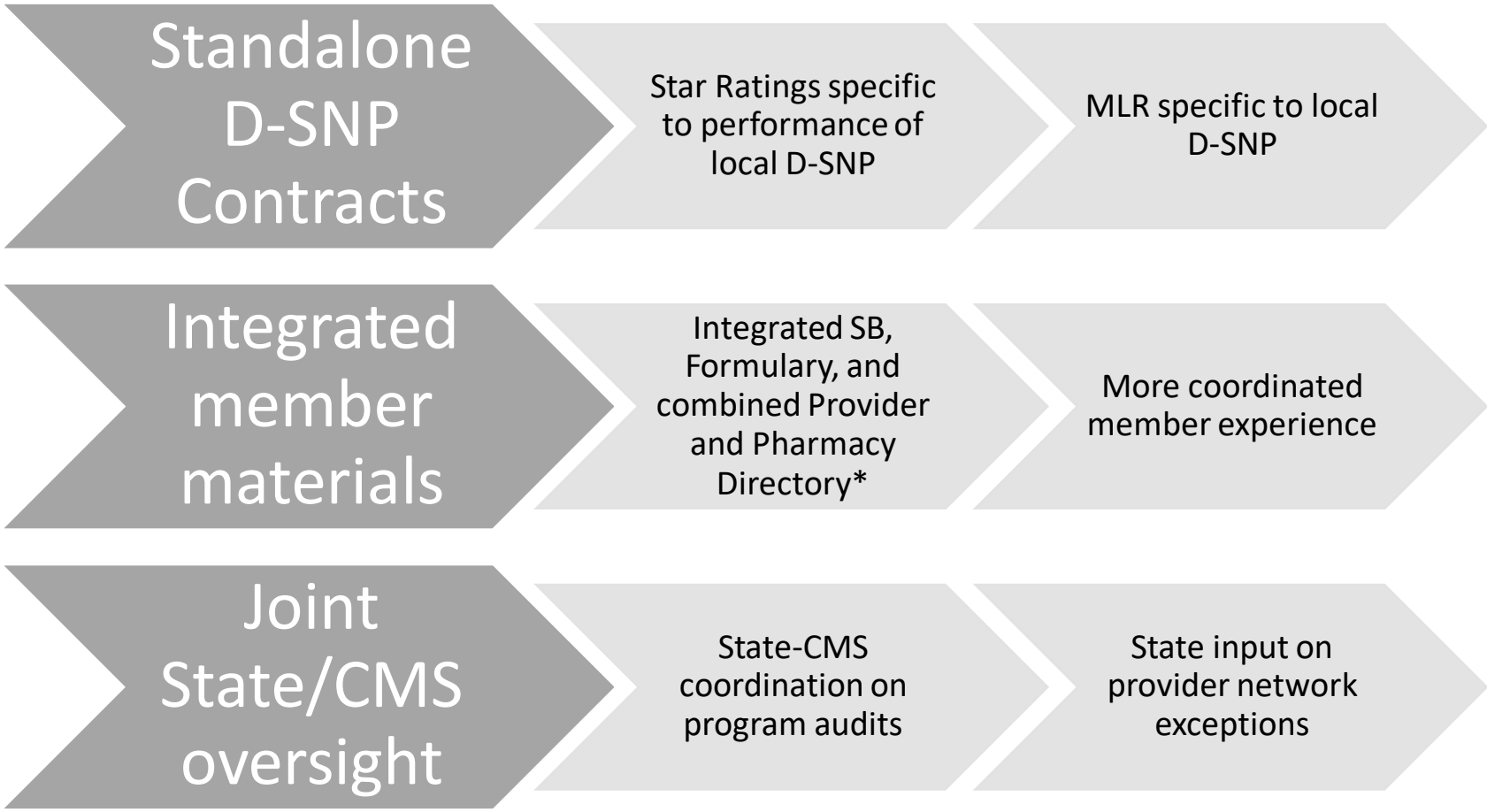
- Since 2021, enrollees in certain D-SNPs go through one Medicare-Medicaid appeals process at plan level
- Previously limited to FIDE SNPs and HIDE SNPs with exclusively aligned enrollment
- Universe expanded to include Medicaid managed care plans that meet the following conditions:
  - Enrollment limited to beneficiaries enrolled in an affiliated Medicaid managed care plan;
  - Medicaid benefits covered under a capitated contract held by the MAO, its parent organization, or an affiliated entity
  - Medicaid coverage includes primary and acute care (including cost-sharing) plus at least one of the following: Medicaid home health services, certain medical supplies, equipment, and appliances, or nursing facility services

Unified Appeals and Grievance Procedures: What is Required?

- Unified notices of appeals
- Unified timeframes for internal and external appeals
- No more than five levels of appeal
- Continuation of benefits pending first level decision
- Training for hearing officers to adjudicate both claims types
- Providing information on presenting evidence and testimony
- State Medicaid representation rules

Notices, timeframes, representation rules follow Medicaid guidelines

Additional Pathways for Integration through State Contracts



SNP Proposals* for CY 2024

DSNP Look-alike Plans

- Closes a loophole in existing rules for D-SNP look-alike plans
- CMS will not contract (or renew a contract) with non-SNP MA plan segment if 80% of enrollment is eligible for Medicaid
- Exception for new plans with enrollment < 200
- Allows CMS to sever a segment from an MA plan and allow the remaining segments of that MA plan to continue
- Allows CMS to eliminate existing D-SNP look-alike segments prevent new D-SNP look-alikes

HAVE A QUESTION?