Issue Brief

FEDERAL ISSUE BRIEF • February 22, 2016

KEY POINTS

- CMS proposes an increase to Medicare Advantage payment rates by 1.35 percent.
- When factoring in risk-coding tendencies, the average change in MA insurers' revenue is expected to increase by 3.55 percent.

CMS Issues 2017 Medicare Advantage and Part D Advance Notice and Draft Call Letter

The Centers for Medicare and Medicaid Services has issued proposed updates to the Medicare Advantage and Part D programs through the 2017 Advance Notice and Draft Call Letter. CMS is proposing updates to the program designed to improve the accuracy of payments to plans serving beneficiaries who are dually eligible for Medicare and Medicaid.

The 228 page Advance Notice and Draft Call Letter is available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/; select "Announcements and Documents." Comments can be submitted through March 4, 2016. The final rate announcement will be published by April 4, 2016. Comments can be submitted electronically to AdvanceNotice2017@cms.hhs.gov.

Much of the following material is from CMS' fact sheet.

A GROWING AND IMPROVING PROGRAM

The Medicare Advantage and Part D programs continue to grow.

- *Enrollment* — is at an all-time high of more than 17.1 million — or 32 percent — of Medicare beneficiaries.
- *Plan quality* — percentage of MA enrollees in four or five star contracts is at 71 percent.
- *Premiums* — today are lower than before the Affordable Care Act went into effect, dropping about 10 percent between 2010 and 2016.

2017 ADVANCE NOTICE/PAYMENT CHANGES

Net Payment Impact

The ACA requires a new methodology for calculating each MA county rate as a percentage of fee-for-service spending in each respective county. For 2017, all counties will be fully transitioned to the new rate methodology, that is the rate will be 100 percent and no blending.

The chart below shows the expected impact of proposed policy changes on plan payments relative to last year.

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

Year-to-Year Percentage Change in Payment	
Impact	**2017 Advance Notice**
Effective Growth Rate	3.0%
Transition to ACA rules	-0.8%
Rebasing/Re-pricing	TBD[1]
Improved star ratings	0.1%
Risk model revision	-0.6%
MA coding intensity adjustment	-0.25%
Normalization	-0.1%
Expected Average Change in Revenue from Advance Notice Policies	1.35%
Coding trend	2.2%
Expected Average Change in Revenue	3.55%

[1] *Rebasing/re-pricing impact is dependent on finalization of average geographic adjustment index and will be available with the publication of the Rate Announcement*

Risk Adjustment Model

CMS is proposing to implement a new Risk Adjustment Model for 2017. The proposed new model has separate coefficients for partial benefit dually eligible beneficiaries, full benefit dually-eligible beneficiaries, and non-dually eligible beneficiaries.

Coding Pattern Adjustment

Each year, as required by law, CMS makes an adjustment to plan payments to reflect differences in diagnosis coding between Medicare Advantage organizations and FFS providers. In CY 2017, CMS proposes to make an adjustment reflective of the statutory minimum.

Using Encounter Data

CMS calculates risk scores using diagnoses submitted by FFS providers and by Medicare Advantage Organizations. Historically, CMS has used Medicare Advantage diagnoses submitted into CMS' Risk Adjustment Processing System. In recent years, CMS began collecting encounter data from MA organizations to develop more accurate payment models. In 2016, CMS began using diagnoses from encounter data to calculate risk scores, by blending encounter data-based risk scores with RAPS-based risk scores. In 2017, CMS is proposing to continue using a blend, using a higher percentage of encounter data-based risk scores.

Employer Group Waiver Plans

Employer Group Waiver Plans serve specific employer groups, and are either offered through negotiated arrangements between MA plans and employer groups or by the employer directly. Because of the nature of these unique agreements, EGWPs do not compete against other plans through the bidding process, and therefore have little incentive to submit lower bids. CMS has previously waived bidding requirements for Part D for EGWPs and set payment amounts for Part D plans based on the competitive bids submitted for non-EGWP Part D plans. CMS is proposing a similar waiver and payment policy for EGWP Part C plans for 2017.

continued

2017 DRAFT CALL LETTER

Star Ratings — Adjusting for Socioeconomic Status

Medicare Advantage plans that achieve high star ratings are eligible for Quality Bonus Payments.

CMS is proposing to implement a new analytical adjustment for a subset of Star Rating measures that is meant to adjust for plans serving dually eligible enrollees and/or enrollees receiving the low income subsidy, as well as enrollees with disabilities.

Percentage Add-on to Applicable Percentage for Quality Bonus Payments	
Star Rating	**2017 QBP Percentage***
Fewer than 3 stars	0%
3 stars	0%
3.5 stars	0%
4 stars	5%
4.5 stars	5%
5 stars	5%

**The QBP percentage is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area.*

Service Category Cost-Sharing Requirements

CMS has traditionally afforded plans that adopt a lower, voluntary maximum out-of-pocket limit greater flexibility in establishing Parts A and B cost sharing than is available to plans that adopt a higher, mandatory MOOP limit. The number of Medicare Advantage plans with voluntary MOOPs has decreased significantly over the past several years. To address this, CMS is proposing to reduce the cost sharing limit for skilled nursing facility stays (days 1 through 20) in CY 2017 and CY 2018, to reduce cost sharing flexibilities for other service categories, and to make other adjustments. In addition, CMS is requesting comments about other incentives to encourage Medicare Advantage organizations to offer plans with a lower voluntary MOOP for enrollees. Such incentives could include flexibilities to highlight voluntary MOOP plans in marketing materials or a special indicator or priority sorting on Medicare Plan Finder.

Drug Utilization

CMS is proposing a number of updates intended to address drug utilization within the Part D program.

- Allowing Part D plans to designate specific drugs for which a beneficiary's initial fill could be limited to a one month supply, regardless of whether the drug is otherwise available as an extended days' supply. This change should eliminate waste when patients' initial doses may change or if they are removed from therapy due to side effects, adverse reactions, or lack of clinical response. After the first one month supply, the change to extended days' supply would be seamless for the beneficiary.

continued

- Encouraging sponsors to inform beneficiaries directly of additional formulary drugs that become available mid-year, as such drugs may provide more value or better quality options.
- Adding, by 2017 (or possibly sooner), a link from the Medicare Plan Finder website to the Medicare Drug Spending Dashboard to raise beneficiary awareness.

Opioid Use

The Administration is committed to addressing the growing opioid epidemic. CMS is proposing a number of updates in the 2017 Draft Call Letter. Specifically, CMS is proposing expectations for Part D plans to implement edits to prevent opioid overutilization at point of sale. CMS is also reminding Part D sponsors that beneficiaries who are in need of medication-assisted treatment should not be subject to unnecessary hurdles. Part D formulary and plan benefit designs that hinder access to MAT, either through overly restrictive utilization management strategies or high cost-sharing, will not be approved.

The following information is from the Notice.

CALCULATION OF FEE-FOR-SERVICE COST

The FFS cost for each county is a product of (1) the national FFS cost, or United States per-capita cost, and (2) a county-level geographic index called the average geographic adjustment.

For 2017, CMS is proposing to update the claims data used to calculate the AGAs, and to continue the repricing of historical data in the AGA calculation. CMS is also proposing a change to the tabulation of county-level risk scores, which are used to standardize the AGAs for the risk profile of the population. CMS will re-price the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2010–2014 to reflect the most current (i.e., FY 2016) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2016) Geographic Practice Cost Index. For 2017, CMS also will continue to adjust historical FFS claims to account for section 3133 of the ACA, which replaced 75 percent of hospital Medicare Disproportionate Share Hospital Payments with uncompensated care payments beginning on October 1, 2013. Consistent with the methodology implemented for 2016, CMS would adjust claims for fiscal year 2010 through FY 2013 for each DSH hospital to reflect the reduction in DSH payments and the allocation of the UCP by incorporating the corresponding requirements of the final FY 2016 Inpatient PPS rule.

To determine the CY 2017 applicable percentages for counties in the 50 States and the District of Columbia, CMS will rank counties from highest to lowest based upon their 2016 average per capita FFS costs, because 2016 is the most recent FFS rate rebasing year prior to 2017. CMS will then place the rates into four quartiles. For the territories, CMS will assign an applicable percentage to each county based on where the county rate falls in the quartiles established for the 50 States and the District of Columbia. CMS is publishing the 2017 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows.

continued

FFS Quartile Assignment Rules Under the Affordable Care Act	
	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

If there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS will calculate the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change — the average of 107.5 percent and 100 percent.

CMS is proposing to make an additional adjustment to the 2012, 2013, and 2014 claims to account for shared savings payments and shared losses made to Medicare Shared Savings Program ACOs and Pioneer ACOs. The key aspects of these adjustments include the following.

- Allocate ACO shared savings or shared loss amounts geographically, as applicable based on each ACO's unique experience, according to the distribution of counties in which each ACO's assigned beneficiaries reside.
- Represent such allocated shared savings payments and shared losses on per-capita basis based on total FFS enrollment as of July 1 of the experience year.
- Exclude per-capita shared savings and losses attributed to beneficiaries in ESRD status as of July 1 of the experience year.

For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the zip code associated with the beneficiary's mailing address. Beginning with the 2017 ratebook, CMS is proposing to use the county provided by the Social Security Administration, which is the same county assignment as the ratebook FFS claims and enrollment.

IME PHASE OUT

Section 161 of the Medicare Improvements for Patients and Providers Act of 2008 amended section 1853(k)(4) of the Act to require CMS to phase out indirect medical education amounts from MA capitation rates. Pursuant to section 1894(d)(3) of the Act, PACE programs are excluded from the IME payment phase-out. Payment to teaching facilities for indirect medical education expenses for MA plan enrollees will continue to be made under fee-for-service Medicare.

For purposes of making this adjustment for 2017, CMS will first calculate the 2017 FFS rates including the IME amount. This initial amount will serve as the basis for calculating the IME reduction that CMS will carve out of the 2017 rates. The absolute effect of the IME phase-out on each county will be determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2017 is 4.8 percent of the FFS rate. To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2017 ratebook.

continued

MEDICARE ADVANTAGE CODING PATTERN ADJUSTMENT

For 2017, CMS proposes to update the MA coding adjustment factor to the statutory minimum of 5.66 percent. In order to properly pay health plans that enroll sicker-than-average beneficiaries, CMS adjusts payments to MAOs for the relative risk of their enrolled population. CMS uses claims data from FFS to estimate the risk adjustment model and applies this model to diagnostic data submitted by MAOs. While this approach is a significant improvement over previous risk adjustment methodologies (which relied largely on demographic data), it can result in higher payments for the same levels of risk when MAOs submit diagnoses more comprehensively than is done in FFS. The higher level of reported diagnoses can arise for a variety of reasons including plans seeking to better understand the health status of their enrollees so they can provide better care to plans reporting more diagnoses for enrollees to generate higher revenue.

UPDATE OF THE RXHCC MODEL

For 2017, CMS is proposing to implement an updated version of the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by stand-alone Prescription Drug Plans and Medicare Advantage-Prescription Drug Plans.

The 2017 model will encompass the following changes:

1) Update to reflect the 2017 benefit structure; and, 2) Updates to the data years used to calibrate the model.

MEDICARE PART D BENEFIT PARAMETERS FOR THE DEFINED STANDARD BENEFIT: ANNUAL ADJUSTMENTS FOR 2017

The following parameters are updated using the "annual percentage increase:"

Deductible: From $360 in 2016 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $3,310 in 2016 and rounded to the nearest multiple of $10.

Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.95 per generic or preferred drug that is a multi-source drug, and $7.40 for all other drugs in 2016, and rounded to the nearest multiple of $0.05.

Maximum Co-payments up to the Out-of-Pocket Threshold for Certain Low Income Full Subsidy Eligible Enrollees: From $2.95 per generic or preferred drug that is a multi-source drug, and $7.40 for all other drugs in 2016, and rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $7419 in 2016 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.95 per generic or preferred drug that is a multi-source drug, and $7.40 for all other drugs in 2016, and rounded to the nearest multiple of $0.05.

COMMENT

The material presented here is but a fragment of the data and requirements presented in the notice and call letter. The information is probably a confusing nightmare to financial reimbursement experts, and a delight to actuaries and statisticians. Anyone involved in submitting bid requests needs to fully review the material in the call letter.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting