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CMS 2016 Rate Announcement & Call Letter

OVERVIEW

On April 6th, the Centers for Medicare and Medicaid Services (CMS) released the 2016 Rate Announcement and Call Letter, which makes payment and policy updates to Medicare Advantage (MA) and Medicare Part D prescription drug plans. This comes after CMS accepted comments on the Advance Notice and draft Call Letter that was released on February 20th.

The Rate Announcement and Call Letter is available here.

ESTIMATED RATE CHANGES

CMS will *increase* MA payment rates by an average of 1.25 percent, though this will vary by region and plan. This Advance Notice would have *decreased* MA payment rates by an average of 0.95 percent. When combined with expected growth in plan risk scores due to coding, CMS estimates that the average revenue change would be an increase of 3.25 percent, compared to a 1.05 percent increase in revenue projected in the Advance Notice.

Actual plan payments will vary by county benchmarks, plan bids, and quality performance.

POLICY CHANGES

The Rate Announcement and Call Letter makes the following policy changes:

- **In-Home Enrollee Risk Assessment:** CMS has previously expressed concern that in-home enrollee risk assessments are inappropriately used to increase beneficiary risk scores, recording diagnoses not subsequently confirmed in clinical encounters and providing little care coordination benefit. CMS finalizes a set of best practices for in-home assessments and encourages all MA plans to adopt them. Under the best practices, all in-home assessments would be performed by physicians, or qualified non-physician practitioners. The best practices also include eight standard clinical and care coordination elements.

  CMS will continue to collect and analyze data regarding care provision following in-home visits in CY 2015. CMS did not include its previous proposal to exclude diagnoses collected in-home risk assessments for payment purposes.

- **Star Ratings:** Notably, CMS did not finalize its policy that would have made changes to the Star Rating program to account for plans that may be penalized for serving high numbers of dual eligible and Low-Income Subsidy (LIS) beneficiaries. This policy would have reduced by fifty percent the relative weights of seven measures that have significantly different outcomes for dual eligible and LIS beneficiaries. CMS will continue to consider adjustments to address this issue.

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CMS will make the following changes to measures in the 2016 Star Ratings:

- CMS will add the following new measure: Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D).
- CMS will reinstate the following measures: Breast Cancer Screening (Part C); Call Center – Foreign Language Interpreter and TTY Availability measures (Part C & D) and Beneficiary Access and Performance Problems (Part C & D).
- CMS is will retire the following measures: Cardiovascular Care: Cholesterol Screening (Part C); Diabetes Care: Cholesterol Screening (Part C); Diabetes Care: Cholesterol Controlled (Part C); and Appropriate Treatment of Hypertension in Diabetes (Part D).

- **Full Transition to Updated Risk-Adjustment Methodology:** In 2014, CMS began phasing-in the use of an updated risk-adjustment methodology that uses more recent data and coding practices. For the past two years, CMS has been blending this new method. In 2016, CMS will implement the updated method fully. Risk-adjustment for PACE payments will remain unchanged.

- **Preferred Cost-Sharing Pharmacies (PCSP)**: Part D plans are permitted to form networks of "preferred cost sharing pharmacies" that offer lower cost-sharing to beneficiaries than other covered pharmacies. CMS is concerned about beneficiary access to PCSPs and about the transparency of PCSP network access. CMS finalizes three policies related to PCSPs:
  - CMS will publish information on PCSP access for each plan offering a preferred cost-sharing benefit structure. Information on 2016 access levels will be published on CMS.gov in the fall.
  - CMS will require plans whose PCSP networks are outliers in 2016 to disclose in marketing materials, including websites, that their plan's PCSP network offers lower access. Outliers will be set at the bottom 10th percentile compared to all Part D plans in given geographic type, using 2014 data.
  - CMS will work with plans that were extreme outliers in 2014 to address concerns about beneficiary access and marketing representations relating to preferred cost sharing. CMS will notify these plans in or around April 2015 that it intends to address 2016 PCSP access issues with them during bid negotiation.

- **Accuracy of Provider Directories:** CMS describes concerns that MA plans are failing to comply with current requirements for accurate provider directories. CMS proposes additional guidance regarding this standard, including frequent contact between plans and providers to ensure accuracy of information and real-time updates to online resources. CMS also announces new direct monitoring and audits of MA plan provider directories and possible future rulemaking to standardize the format of directories. CMS is considering, beginning on or after 2017, instituting a new regulatory requirement for MAOs to provide, and regularly update, network information in a standardized, electronic format for eventual inclusion in a nationwide provider database.

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- **Value-Based Contracting:** CMS indicates its interest in better understanding how MA plans use alternative payment models to create quality and efficiency incentives among network providers. CMS will begin reaching out to plans on a voluntary basis, but indicated future rulemaking may require data submission on such value-based contracts.

- **Total Beneficiary Cost:** By statute, CMS has authority to deny bids that propose too significant an increase in costs or decrease in benefits. CMS intends to keep the level of acceptable increase to $32 per member per month.