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CMS 2017 Advance Notice & Draft Call Letter

OVERVIEW

On February 19th, the Centers for Medicare and Medicaid Services (CMS) released the 2017 Advance Notice and draft Call Letter, which propose payment and policy updates for Medicare Advantage (MA) and Medicare Part D prescription drug plans.

CMS will be accepting comments through March 4th. The final 2017 Rate Announcement and Call Letter, including the final MA and fee-for-service growth percentages and final county-level benchmarks, will be published on April 4th.

The Advance Notice and draft Call Letter are available here.

ESTIMATED RATE CHANGES

In the Advance Notice, CMS proposes to increase MA payment rates by an average of 1.35 percent. When combined with expected growth in plan risk scores due to usual coding adjustment, CMS estimates that the average payment change will be an increase of 3.55 percent.

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

POLICY PROPOSALS

The draft Call Letter includes the following policy proposals:

Changes to Risk-Adjustment Model

CMS proposes to implement an updated version of the CMS Hierarchical Condition Category (HCC) risk-adjustment model for CY 2017, to more accurately capture the full cost of serving Medicare-Medicaid (dual-eligible) and low-income subsidy beneficiaries. The updated model would include separate risk-adjustment subcategories such as partial-benefit dual-eligible beneficiaries; full-benefit dual-eligible beneficiaries; and non-dual-eligible beneficiaries. The proposed change would improve the accuracy of payments made to plans and would tend to increase payments for plans serving more dual-eligible and low-income beneficiaries.

Changes to Star Ratings

MA plans that receive high-star ratings are eligible for quality bonus payments. Stakeholders have raised concerns that the current star-rating system makes it difficult for plans serving dual-eligible and low-income enrollees to achieve high-star ratings. CMS requested public comment on possible changes to this methodology in fall 2015.

In the draft Call Letter, CMS proposes to implement an interim adjustment to the star ratings based on socioeconomic and disability status. An adjustment factor based on the proportion of low-income subsidy, dual eligible, and disabled enrollees served by the plan would be added to or subtracted from an MA contract's overall star rating to adjust for the average disparity.

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This policy is considered interim while the Office of the Assistant Secretary for Planning and Evaluation (ASPE) undertakes a more comprehensive review of the star-rating system.

Employer Group Waiver Plans

Employer Group Waiver Plans (EGWPs) serve employer and union-only groups. CMS proposes set payments for all MA EGWPs based on non-EGWP plan bids submitted for 2017 instead of allowing EGWPs to also submit bids. CMS has already established this policy for EGWP Part D prescription drug plans.

The Medicare Payment Advisory Commission (MedPAC) suggested this policy change, noting that EGWPs have no incentive to submit low bids since they do not have to compete for beneficiaries. According to MedPAC, the change could save between $1 billion and $5 billion over five years.

Service Category Cost-Sharing

CMS proposes to continue its policy of giving plans with lower voluntary maximum out-of-pocket (MOOP) greater flexibility in establishing Part A and Part B cost-sharing than plans with a higher, mandatory MOOP. CMS cites that the number of MA plans with voluntary MOOPs has decreased. In response to this, CMS proposes to reduce the cost-sharing limit for skilled nursing facilities stays for days 1 through 20, in CY 2017 and CY 2018. This is intended to reduce cost-sharing flexibilities for other service categories.

CMS also seeks comment on other possible incentives to encourage MA organizations to offer plans with lower voluntary MOOPs for enrollees.

Drug Utilization

CMS proposes to implement policies to address drug overutilization. Currently, many plans allow beneficiaries to fill a two- to three-month supply of medication at once (extended days' supply). CMS proposes that Part D plans would be allowed to designate specific drugs for which a beneficiary's initial fill would be limited to a one-month supply. This is intended to reduce waste that may result from a patients' initial dose changing or a patient being removed from therapy due to side effects or lack of clinical response. CMS proposes that after the first one-month supply, the drug could be dispensed as an extended days' supply. CMS also proposes to add a hyperlink on the Medicare Plan Finder website to the Medicare Drug Spending Dashboard to raise enrollee awareness.

Opioid Use

CMS proposes to strengthen its system that allows Part D plans to share information about beneficiaries with patterns of opioid overuse. This system discourages beneficiaries from switching carriers after their plan discontinues coverage of opioid prescriptions when a problem has been identified. Plans will now be required to update this information sharing system within seven days of making a beneficiary-level coverage decision.

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CMS indicates that it will not approve Part D formulary and plan benefit designs that impose prior authorization requirements to hinder access to medication-assisted treatment for opioid addiction, such as buprenorphine, naloxone, and naltrexone. Methadone is not addressed by this Advance Notice because it does not meet the Part D requirement that it must be dispensed only upon a prescription at a pharmacy. CMS seeks comment on whether this requirement is a barrier to treatment.

TOPICS NOT ADDRESSED IN THE DRAFT CALL LETTER

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. For the first time in three years, CMS did not propose to change its current policy of allowing in-home health-risk assessments.

Health Insurance Tax: In December 2015, Congress passed a one-year suspension of the Affordable Care Act's health insurance tax, as part of its most recent budget. Many industry stakeholders expected CMS to lower payment rates to offset this increase in plan revenue, but CMS did not include a payment adjustment related to this one-year moratorium in the draft Call Letter.