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CMS 2017 Rate Announcement & Call Letter

OVERVIEW

On April 4th, the Centers for Medicare and Medicaid Services (CMS) released the 2017 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 19th.

The Rate Announcement and Call Letter are available here.

ESTIMATED RATE CHANGES

CMS will increase MA payment rates by an average of 0.85 percent. This marks a decrease from the Advance Notice, which would have increased the MA payment rates by an average of 1.35 percent.

When combined with expected growth in plan risk scores due to usual coding adjustments, CMS estimates that the average payment change will be an increase of 3.05 percent. In the Advance Notice, CMS had estimated that the average payment change would have been an increase of 3.55 percent.

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

POLICY CHANGES

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

Changes to Risk-Adjustment Model

CMS finalizes its proposal to implement an updated version of the CMS Hierarchical Condition Category (HCC) risk-adjustment model for CY 2017. The new model will more accurately capture the full cost of serving Medicare-Medicaid (dual-eligible) and low-income subsidy beneficiaries. The updated model will include separate risk-adjustment subcategories such as partial-benefit dual-eligible beneficiaries; full-benefit dual-eligible beneficiaries; and non-dual-eligible beneficiaries. The change will improve the accuracy of payments made to plans and will 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 proposed changes to this methodology in fall 2015.

CMS finalizes its proposal 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 will 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) completes a more comprehensive review of socioeconomic status in Medicare payment programs.

Employer Group Waiver Plans

Employer Group Waiver Plans (EGWPs) serve employer and union-only groups. In the Advance Notice, CMS proposed to set payments for all MA EGWPs based on non-EGWP plan bids submitted for 2017 instead of allowing EGWPs to also submit bids. The Medicare Payment Advisory Commission (MedPAC) had suggested this policy change, noting that EGWPs have no incentive to submit low bids since they do not have to compete for beneficiaries. CMS finalized this proposal with modifications.

CMS will use the average bid-to-benchmark ratio for individual market plans from the prior payment year to calculate the Part C base payment amount for EGWPs. In response to stakeholder comments, CMS will phase-in this policy over two years. For CY 2017, the bid-to-benchmark ratio has been calculated using a blend of individual market plan bids and EGWP bids for 2016. Beginning in 2018, the bid-to-benchmark ratio will be calculated using individual market plan bids only.

Encounter Data

CMS uses diagnoses from encounter data to calculate risk scores. Historically, risk scores have been calculated using a blend of encounter data risk scores and Risk Adjustment Processing System (RAPS) scores. CMS will continue to use a blend, but will use a higher percentage of encounter based risk scores than in 2016.

In PY 2017, risk scores will be calculated with a blend of 25 percent weighting of encounter data and fee-for-service (FFS) and a 75 percent weighting of RAPS and FFS. This calculation includes a lower percentage of encounter data than proposed in the Advance Notice, which proposed weighting both encounter data scores and RAPS scores at 50 percent. The use of encounter data will be fully phased-in by 2020, when risk scores will be 100 percent based on encounter data.

Drug Utilization

CMS finalized 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 finalized its proposal to allow Part D plans to designate specific drugs for which a beneficiary's initial fill will 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. After the first one-month supply, the drug may be dispensed as an extended days' supply. CMS will also add a hyperlink on the Medicare Plan Finder website to the Medicare Drug Spending Dashboard to raise enrollee awareness.

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Opioid Use

CMS finalized its proposal to strengthen its system that allows 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 be required to update this information sharing system within seven days of making a beneficiary-level coverage decision. By 2018, plans will be required to adopt systems that will reject claims for opioid prescriptions at the pharmacy for patients who have reached a certain threshold. CMS will review the 2016 and 2017 experience to inform the content of the CY 2018 call letter.