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CMS 2018 Advance Notice and Draft Call Letter

OVERVIEW

On February 1st, the Centers for Medicare and Medicaid Services (CMS) released the 2018 Advance Notice and draft Call Letter, which propose policy and payment updates for Medicare Advantage (MA) and Medicare Part D prescription drug plans for calendar year 2018.

This document summarizes major provisions of the proposed rule. CMS will accept comments via email at AdvanceNotice2018@cms.hhs.gov until 6:00 PM on March 3, 2017. The Advance Notice and draft Call Letter are available here.

ESTIMATED RATE CHANGES

The proposed policies in the Advance Notice would increase MA payment rates by an average 0.25%, with an expected total average change in revenue of 2.75% after applying a 2.5% coding trend adjustment.

Specific plan payments will vary by county fee-for-service (FFS) benchmarks, plan bids, risk adjustments, and quality scores.

POLICY PROPOSALS

The draft Call Letter includes the following major policy proposals:

Changes to Risk-Adjustment Model

In calculating the payment risk score, CMS proposes to continue using the same blend for payment year 2018 as was used in payment year 2017. It will weigh the risk score calculated with diagnoses from the Risk Adjustment Processing System and FFS by 75 percent and the risk score calculated with diagnoses from the Encounter Data System and FFS by 25 percent. The weighted portion employing encounter data was originally slated to increase to 50 percent but concerns about resulting reductions in Star ratings delayed the change.

Cost-Sharing Requirements

Consistent with the final 2017 Call Letter, CMS proposes to eliminate cost sharing for the first 20 days of the Skilled Nursing Facility benefit for 2018 to align with FFS Medicare. CMS is also proposing to add cost sharing thresholds for three areas: cardiac rehabilitation services, intensive cardiac rehabilitation services, and pulmonary rehabilitation services. The purpose of these thresholds is to protect against potentially discriminatory high cost sharing.

In addition, CMS proposes to increase the Emergency Care/Post Stabilization Care cost-sharing limit for plans in 2018, to incentivize beneficiaries to use primary and specialty care services for routine care and reduce the misuse of emergency room visits. MA plans that have a lower than required maximum out of pocket amount will be able to maintain a higher cost sharing limit for these types of services.

Opioid Utilization Controls

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The rule proposes several policies to reduce opioid overutilization, while maintaining access to necessary medications. Part D plans would be required to make the following updates to the Overutilization Monitoring System:

- Modify the Overutilization of Opioids criteria to identify individuals who: receive opioids from more than three prescribers and more than three pharmacies; or more than four prescribers and any number of pharmacies;
- Modify the Retrospective Drug Utilization criteria to identify individuals who use opioids with an average daily morphine equivalent dose exceeding 90mg for any duration during the measurement period;
- Implement hard formulary-level safety edits based on an observed opioid overutilization in the plan to prevent opioid abuse at the point of sale; and
- Reduce false positives by establishing exclusions for hospice care, certain cancer diagnoses, and other situations in which frequent or high-dose opioid usage is determined to be medically necessary.

Changes to Star Ratings

Stakeholders have raised concerns that the current Star Rating system makes it difficult for plans serving dual-eligible and disabled enrollees to achieve the high Star Ratings required for bonus payments. In response to these concerns, CMS proposes the following updates for 2018 Star Rating measures:

- Modify the Beneficiary Access and Performance Problems measure so that it accounts for civil monetary penalty deductions and more recent data;
- Remove the Getting Care Quickly, Customer Service, and Care Coordination measures from Part C Improvement Measures; and
- Add Medication Reconciliation Post Discharge and Improving Bladder Control measures.

Employer Group Waiver Plans (EGWPs)

Employers and union-only groups may offer retirees supplemental coverage for Medicare in the form of an EGWP. CMS proposes to continue administratively setting rates for EGWPs.

For 2017, the bid-to-benchmark ratio was calculated using a blend of individual market plan bids and EGWP bids from 2016. CMS is soliciting comment on whether the 2018 bid-to-benchmark ratio should be calculated based on a combination of individual market bids and EGWP bids or individual market bids only.