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CMS 2018 Rate Announcement and Final Call Letter

OVERVIEW

On April 3rd, the Centers for Medicare and Medicaid Services (CMS) released the 2018 Rate Announcement and Call Letter, implementing policy and payment updates for Medicare Advantage (MA) and Part D prescription drug plans for calendar year 2018. As part of the Final Call Letter, CMS issued a Request for Information (RFI) seeking recommendations on changes to MA or Part D that could encourage innovation and beneficiary choice.

This document summarizes major provisions of the final rule. The Final Call Letter is available here.

CMS will accept comments on the RFI at PartCDcomments@cms.hhs.gov until April 24, 2017. Commenters should include "2017 Transformation Ideas" in the email subject line.

RATE CHANGES

CMS finalized policies expected to increase MA plan revenue by 0.45%, with a total change in revenue of 2.95% after a 2.5% coding trend adjustment. The proposed rule would have increased revenue by 0.25% with an expected 2.75% revenue increase after the coding trend adjustment was applied.

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

MAJOR POLICY PROVISIONS CHANGED FROM PROPOSED RULE

CMS implemented the following major provisions in the final rule that differ from the proposed rule:

Changes to Risk-Adjustment Model

CMS will increase the percentage of risk scores based on a blend of Risk Adjustment Processing System (RAPS) and FFS data to 85%. CMS currently uses 75% of RAPS and FFS data to calculate scores. The remaining 15% of risk scores will be calculated using a blend of diagnoses from the encounter data submissions and FFS.

This is a reversal in direction from the prior year Call Letter, which had anticipated an increase in the weighted portion employing encounter data from 25% in 2017 to 50% in 2018.

Requirement to Report Full and Accurate Encounter Data

CMS indicated that although it is reducing the portion of risk scores based on blended encounter data, plans must still submit full and accurate data to CMS. Plans are expected to conduct voluntary audits of their data and reporting processes. In the final rule, CMS reminds plans it will be conducting select site visits to identify areas for improvement in encounter reporting.

Cost-Sharing Requirements

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The final rule includes the following cost sharing provisions:

Skilled Nursing Facility (SNF) Services

CMS will continue to allow cost sharing during the first 20 days of the SNF benefit in plans that voluntarily adopt a lower Maximum Out Of Pocket (MOOP) limit for Parts A and B cost sharing. The Draft Call Letter proposed eliminating cost sharing during the first 20 days of a stay to be consistent with FFS Medicare.

Specific Rehabilitative Services

CMS proposed but decided not to implement maximum cost sharing amounts for three specific services: cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation. These proposals were intended to protect beneficiaries against potentially discriminatory plan designs. In the final rule, CMS reminds plans that other regulatory standards regarding maximum cost sharing and benefit design continue to apply.

Emergency Care/Post-Stabilization Care

The final rule increases the maximum copay for Emergency Care and Post-Stabilization Care from $75 to $100 for plans that voluntarily adopt a lower MOOP and from $75 to $80 in plans with a higher, "mandatory" MOOP limit on total Parts A and B cost sharing.

CHANGES TO OPIOID PROGRAMS

The final rule finalizes opioid provisions that are similar to the proposed rule:

Opioid Utilization Measurement and Monitoring Criteria

Part D plans will be required to implement new Overutilization Monitoring System criteria which identifies an individual for outreach or intervention if:

- In the most recent six months, the individual has filled opioids with an average morphine equivalent dose exceeding 90 mg for any duration; and,
- He or she received opioids from more than three prescribers and more than three pharmacies, or received opioids from more than five prescribers regardless of the number of pharmacies. (This threshold was increased from at least four prescribers regardless of the number of pharmacies).

Individuals with cancer diagnoses or those receiving Medicare hospice or palliative care are excluded. In addition, Part D plans are required to treat prescribers associated with the same Tax ID Number as the same to avoid false positives.

Drug Utilization Controls

In response to comments by Part D plans and beneficiary advocates, CMS will not require Part D plans to implement a "hard edit" in cases where beneficiaries seek to fill more than a specific morphine-equivalent amount of opioids. Hard edits require prescribers to intervene before an

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individual can fill his or her medication. CMS is finalizing the rule by encouraging Part D plans to implement formulary-level soft or hard edits, at the plan's discretion.

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 higher Star Ratings required for bonus payments. To address concerns, CMS is finalizing updates to Star Rating measures that include, but are not limited to:

- Using an analytic adjustment to Star Ratings accounting for the impact of dual-eligible and disabled enrollees on a plan's Star Ratings. Beginning in 2019, CMS will remove the 2019 Star Ratings measure and introduce a revised measure that does not account for enforcement actions;
- Continuing the existing Beneficiary Access and Performance Problems (BAPP) measures in 2018. Beginning in 2019, CMS will decouple BAPP measures from audits and enforcement actions, including Civil Money Penalties and reductions for plans under sanctions. CMS will engage stakeholders on additional discussions regarding this process, and will introduce a revised BAPP measure in 2019;
- Removing the Getting Care Quickly, Customer Service, and Care Coordination measures from Part C Improvement Measures; and,
- Adding Medication Reconciliation Post Discharge and Improving Bladder Control measures.

Employer Group Waiver Plans (EGWPs)

Employers and union-only groups may use an EGWP to offer retirees supplemental MA coverage. CMS proposes to continue administratively setting rates for EGWPs.

For 2017, the bid-to-benchmark ratio was calculated using a 50-50 blend of individual market bids and EGWP bids from 2016. CMS will continue using methodology used to calculate 2017 EGWP payment rates when calculating 2018 rates.

REQUEST FOR INFORMATION

CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice and procedural changes to MA and Part D that could improve the program. These changes could include ways to increase transparency, flexibility, and simplify the MA and Part D program. It could also include more flexible plan designs and changes to network composition.

Specifically, CMS seeks comment and proposals that could impact:

- Benefit design;
- Operational or network composition flexibility;
- Supporting the doctor-patient relationship in the context of care delivery; and,
- Changes to Star Rating calculations and related payments to plans.

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In the RFI, CMS seeks responses that cite data and specific examples that can increase benefit flexibility, innovation, and provide less expensive plan choices in the Medicare program.

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