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2019 Advance Notice & Draft Call Letter

OVERVIEW

On February 1st, the Centers for Medicare and Medicaid Services (CMS) released Part II of the Advance Notice and the draft Call Letter, which propose policy and payment updates for Medicare Advantage (MA) and Part D plans for calendar year 2019. Part I of the Advance Notice was released at the end of 2017. The Advance Notice was released in two parts to allow for a 60-day comment period for the MA risk adjustment changes proposed in Part I.

The proposed policy changes in the 2019 Advance Notice and draft Call Letter are expected to increase revenue to participating plans by 1.84%, though the rebasing/re-pricing impact has yet to be determined and the estimate does not include an adjustment for the underlying coding trend. CMS expects the underlying coding trend will increase risk scores by an average of 3.1% in 2019.

This document summarizes key provisions of Part I and II of the Advance Notice and draft Call letter. CMS will accept comments on Part I and II through March 5, 2017 and policies will be finalized in the 2019 Rate Announcement and final Call Letter on April 2, 2017. The text of the proposals is available here, and the fact sheet is here.

MA RISK ADJUSTMENT MODEL

Part I of the Advance Notice proposes several changes to the CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model that calculates risk scores to account for aged and disabled beneficiaries in MA plans. As mandated by the 21st Century Cures Act, CMS is proposing changes to the conditions and types of data that are factored into risk score calculations.

New Conditions

CMS proposes to consider the following conditions in 2019 CMS-HCC calculations:

- Drug Abuse, Uncomplicated, Except Cannabis;
- Drug/Alcohol Dependence, or Abuse/Use with Complications;
- Reactive and Unspecified Psychosis;
- Personality Disorders; and
- Chronic Kidney Disease Moderate (Stage 3).

New Condition Count Model

CMS also seeks comment on which of two potential CMS-HCC models should be implemented to account for the number of conditions a beneficiary has:

- *Payment Condition Count Model* – This model would consider up to 10 conditions that a beneficiary has that are included in the MA payment model. CMS estimates it would increase MA risk scores by an average of 1.1%, with some plans' risk scores increasing by over 3% and some plans' risk scores decreasing by nearly 2%.

- *All Condition Count Model* – This model would consider up to 15 conditions that a beneficiary has. CMS estimates that it would decrease risk scores by 0.28%, although the change varies significantly with some plans experiencing increases of nearly 8% and others experiencing decreases of almost 12%.

CMS has expressed a preference for the Payment Condition Count Model. The model changes would be gradually phased-in by 2022.

Use of Encounter Data

The proposed condition count models rely on encounter data rather than data submitted to the Risk Adjustment Processing System (RAPS) to calculate risk scores. In 2016, CMS began incrementally supplementing inpatient RAPS data with encounter data. For 2018, CMS is calculating risk scores with 15% encounter data and fee-for-service (FFS) diagnoses plus 85% data submitted to RAPS and FFS diagnoses using the 2017 CMS-HCC model. To calculate 2019 risk adjustment payments, CMS will use a weight of 75% for risk adjustment payments calculated using the 2017 CMS-HCC model and weight of 25% for payments calculated using the new CMS-HCC model applied to encounter and FFS data. Encounter data-based risk scores would be calculated exclusively with the new risk adjustment model, while RAPS-based risk scores would be calculated with the current risk adjustment model. The proposed phase-in schedule is below:

Calendar Year	New CMS-HCC Model	2017 CMS-HCC Model
2019	25%	75%
2020	50%	50%
2021	75%	25%
2022	100%	-

PART D RISK ADJUSTMENT MODEL

Part II of the Advance Notice proposes technical changes to the Part D risk adjustment model, RxHCC, to reflect the 2019 benefit structure and rates. Similar to the new CMS-HCC, encounter data is being phased-in to the RxHCC. For 2018, risk scores were calculated using 15% encounter data and FFS diagnoses plus 85% RAPS data and FFS diagnoses. For 2019, the weight of encounter data and FFS diagnoses will increase to 25%, while the weight of RAPS data and FFS diagnosis will decrease to 75%.

Coding Pattern Adjustment

CMS proposes coding pattern adjustments of 5.90% to account for differences in diagnosis coding between MA and FFS. This is almost identical to the coding pattern adjustment of 5.91% for 2018.

Employer Group Waiver Plans (EGWPs)

Employers and union-only groups may offer retirees supplemental coverage in Medicare in the form of an EGWP. CMS proposes to continue to waive the Bid Pricing Tool bidding requirements for all MA EGWPs. For 2017 and 2018, CMS has calculated the bid-to-benchmark (B2B) ratio using a 50-50 blend of individual market bids and EGWP bids from 2016. For 2019, CMS is proposing to set EGWP payments using only individual market plan bids to calculate the B2B ratios. CMS is soliciting comment on alternative policies to pay EGWPs.

Opioid Response

The draft Call Letter proposes a number of strategies to address the opioid crisis in the Part D program, including:

- Enhancing the overutilization monitoring system to identify additional beneficiaries who take prescription opioids in combination with other drugs that increase the risk of an adverse opioid-related event;
- Making technical revisions to Pharmacy Quality Alliance measures and adding a new measure: Concurrent Use of Opioids and Benzodiazepines; and
- Requiring point-of-sale safety edits at pharmacies, including:
    - A hard formulary-level safety edit for opioids with a cumulative morphine-equivalent dosage level of 90 mg or more per day with seven day supply, barring certain exceptions such as hospice care. Hard safety edits, once triggered, can only be overridden by the plan, which is expected to follow prescriber attestation in typical cases;
    - A supply limit for initial fills of prescription opioids for the treatment of acute pain. CMS seeks comment on the specific day supply limitation (e.g. – seven days) and whether a daily dose maximum should be established; and
    - Soft safety edits, which can be overridden by a pharmacist, for the prescription of multiple long-acting opioids.

CMS Star Ratings

For 2019, the draft Call Letter proposes technical changes to a number of MA and Part D Star Rating measures and would remove the following measures:

- Beneficiary Access and Performance Problems Measure (MA and Part D); and
- Reducing the Risk of Falling (Part C) would be temporarily removed for 2019 due to a change in the measure. It would be added back to the display page in 2020 and included in 2021 Star Ratings.

CMS proposes to add the following measures for 2019:

- Statin Use in Persons with Diabetes (Part D); and
- Statin Therapy for Patients with Cardiovascular Disease (MA).

The Advance Notice also proposes to change the practice of reducing Star Ratings appeal measure ratings due to data incompleteness. Under current regulations, plans that are identified during an audit to have significant data incompleteness issues may have their appeals measures reduced to one star. CMS proposes to implement a scaled reduction that is based on the degree of missing data so that plans with the most significant data incompleteness will be penalized more than plans with minor data incompleteness.

Supplemental Benefits

CMS has issued the interpretation that offering tailored supplemental benefits based on health condition, including cost-sharing reductions, is consistent with the uniform treatment of similarly situated individuals. These benefits must be available to all who meet the health-condition based criteria, and must not be discriminatory in nature by denying vulnerable/medically needy individuals care or violate uniform premium

requirements. CMS will review benefit designs to ensure that the overall impact is non-discriminatory and that higher cost enrollees are not being excluded from tailored benefits in favor of healthier populations.

One criterion for MA supplemental benefits, which are funded through rebate dollars and plan premiums, is that they be primarily health related. CMS has historically not allowed supplemental benefits for items or services that are primarily for daily maintenance to compensate for physical impairments. For 2019, the draft Call Letter proposes to expand the scope of this standard to allow supplemental benefits that: compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization. For example, wheelchair ramps and fall prevention devices could be covered under the new standard.

CMS will establish a dedicated mailbox to answer MA plan questions about allowable tailored benefits.

Health Risk Assessment

MA plans are required to conduct an HRA within 90 days of enrollment, though plans have been prevented from including HRA completion as part of a Rewards and Incentives (RI) Program whose expense is included in premium bids. Due to the important role of HRAs in assessing member risk and care needs, beginning in 2019 MA plans may include the completion of an HRA as a permitted health-related activity in an RI Program, and include it in the bid as a non-benefit expense.