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2019 Rate Announcement & Call Letter

OVERVIEW

On April 2nd, the Centers for Medicare and Medicaid Services (CMS) released the Rate Announcement and Call Letter, which propose policy and payment updates for Medicare Advantage (MA) and Part D plans for calendar year 2019. The finalized policy changes are expected to increase revenue to participating plans by 3.40%, up from the 1.84% that was projected in the Advance Notice and draft Call Letter. In addition, CMS expects the underlying coding trend will increase risk scores by an average of 3.1% in 2019.

This document summarizes key provisions of the Rate Announcement and Call Letter. The press release and fact sheet may be viewed here. The text of the regulation is available here.

MA RISK ADJUSTMENT MODEL

The Rate Announcement will implement several changes to the CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model for MA plans.

New Conditions

Beginning in 2019, CMS will modify the CMS-HCC adjustment calculations by updating the reference data and adding the following conditions to CMS-HCC risk adjustment calculations:

- HCC 56 – Substance Use Disorder, Mild, Except Alcohol and Cannabis*;
- HCC 55 – Substance Use Disorder, Moderate/Severe, or Substance Use with Complications*;
- HCC 58 - Reactive and Unspecified Psychosis;
- HCC 60 - Personality Disorders; and
- HCC 138 - Chronic Kidney Disease, Moderate (Stage 3).

**Note* – The Advance Notice used the term "Drug Abuse" for these HCCs. The Rate Announcement has changed the term to "Substance Use Disorder," but the new HCCs are otherwise unchanged.

Payment Condition Count Model

CMS announced that it will begin to implement the new Payment Condition Count Model in 2020. The Advance Notice proposed implementing a new condition count model 2019, but CMS delayed implementation to allow more time for stakeholders to adjust. The new model is scheduled to be fully phased in by 2022, as was proposed in the Advance Notice.

In the Advance Notice, CMS indicated that the Payment Condition Count Model would consider up to 10 conditions that a beneficiary has that are included in the MA payment model. The Advance Notice's fact sheet also estimated that the new model would increase MA risk scores by an average of 1.1%, if implemented in 2019. CMS has not released an updated projection for the new 2020 implementation date.

Use of Encounter Data

In 2016, CMS began incrementally supplementing inpatient Risk Adjustment Processing System (RAPS) data with encounter data to calculate risk scores. 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 finalized its proposal to 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 will be calculated exclusively with the new risk adjustment model (with the additional HCCs), while RAPS-based risk scores would be calculated with the current risk adjustment model.

These changes do not apply to the Program for All-Inclusive Care for the Elderly (PACE). For PACE enrollees, CMS will continue to calculate risk scores by pooling risk adjustment-eligible diagnoses from encounter data, RAPS, and FFS claims.

Coding Pattern Adjustment

CMS finalized a coding pattern adjustment 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. None of the three options to change to the methodology we will be implemented in 2019, and further stakeholder feedback is invited for potential future changes.

Frailty Factor Adjustment

CMS will update frailty factors for PACE plans and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) so that they are consistent with changes to the CMS-HCC for 2019. CMS will continue the practice of comparing a blended frailty score for FIDE SNPs to PACE frailty to assess whether FIDE SNPs have a similar average level of frailty as PACE.

PART D RISK ADJUSTMENT MODEL

CMS did not finalize its proposal to update the Part D risk adjustment model, RxHCC, and will continue to use the 2018 RxHCC model in 2019. CMS will work on recalibrating the RxHCC model for 2020 based on the Bipartisan Budget Act's changes to plan liability for brand name drugs.

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 violating 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 interpreted this criterion as excluding supplemental benefits for items or services that are primarily for daily maintenance to compensate for physical impairments. Starting in 2019, the Call Letter expands the scope of supplemental benefits to include health care benefits that are medically appropriate and recommended by a licensed provider to:

- Diagnose, prevent, or treat an illness or injury;
- Compensate for physical impairments;
- Act to ameliorate the functional/psychological impact of injuries or health conditions; or
- Reduce avoidable emergency and health care utilization.

The Call Letter provides the example of fall prevention devices, and similar items or services, as supplemental benefits that would be eligible under the new standard. CMS will issue further guidance on this topic prior to the CY 2019 bid submissions in June 2018. In the draft Call Letter, CMS indicated that it would establish a dedicated mailbox to answer plan questions about allowable supplemental benefits. While the final Call Letter does not include a dedicated mailbox for supplemental benefits inquiries, it does note that Kim Levin (Kimberlee.Levin@cms.hhs.gov) may be reached for questions regarding Part C issues.

Enhanced Disease Management (EDM) for Special Needs Plans (SNPs)

Beginning in 2019, CMS will allow Dual-Special Needs Plans (D-SNPs) and Institutional-Special Needs Plans (I-SNPs) to offer EDM to beneficiaries as a supplemental benefit. While traditional MA plans have offered EDM benefits, SNPs were previously barred from offering this benefit. Chronic Condition-SNPs may not offer EDM as a supplemental benefit as these plans already offer comprehensive targeted disease management.

EMPLOYER GROUP WAIVER PLANS (EGWPS)

Employers and union-only groups may offer retirees supplemental coverage in Medicare in the form of an EGWP. CMS will continue to waive the Bid Pricing Tool bidding requirements for MA employer plans, but notes that such plans must submit the MA section of the Plan Benefit Package.

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 finalized its proposal to set EGWP payments using only individual market plan bids to calculate the B2B ratios. Individual market ratios will be adjusted based on the proportion of EGWP enrollees in Preferred Provider Organizations (PPOs) versus Health Maintenance Organizations (HMOs). CMS will seek comment on whether additional adjustments should be applied to regional PPOs and rural local PPOs.

OPIOID RESPONSE

The Call Letter finalizes a number of strategies to prevent misuse among specific groups of opioid users, such as: new users, chronic users, those with uncoordinated care, and those who use opioids with benzodiazepines. For 2019, CMS will:

- Enhance the Overutilization Monitoring System so that it can identify beneficiaries who: use high levels opioid prescriptions from multiple prescribers or pharmacies; and/or take prescription opioids in combination with other drugs that increase the risk of an adverse opioid-related event.
- Make technical revisions to Pharmacy Quality Alliance measures and adding a new measure: Concurrent Use of Opioids and Benzodiazepines.

The Call Letter also notes that it expects Part D plans to implement the following point-of-sale safety edits at pharmacies in 2019:

- A hard safety edit for opioid prescriptions that exceed a seven day supply for the treatment of acute pain. CMS did not finalize a morphine milligram equivalent (MME) threshold for this safety edit. Hard safety edits can generally only be overridden by the plan.
- A care coordination safety edit for opioid prescriptions that cumulatively exceed a maximum of 90 MME per day. This care coordination edit can only be overridden if the pharmacist has a documented

discussion with a prescriber who confirms intent. Plans may implement a hard safety edit for prescriptions that exceed 200 MME and may include prescriber and pharmacy counts.

- A soft safety edit for duplicative long-acting opioids and the concurrent use of opioids and benzodiazepines. Soft safety edits can be overridden by the pharmacist, but prompt additional review at the time of dispensing.

CMS recommends that the following beneficiaries be excluded from safety edits: residents of long-term care facilities; individuals receiving hospice, palliative, or end-of-life care; and individuals being treated for active cancer-related pain. CMS also recommends that precautions are taken to ensure that safety edits do not prevent access to buprenorphine and other forms of Medication Assisted Treatment.

CMS STAR RATINGS

For 2019, the Call Letter will implement technical changes to a number of MA and Part D Star Rating measures. In addition, it will remove the Beneficiary Access and Performance Problems Measure for MA and Part D plans and add the following measures:

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

The Call Letter will also change the practice of reducing Star Ratings appeal measure ratings due to data incompleteness. Under current regulations, plans that are identified as having significant data incompleteness issues may have their appeals measures reduced to one star. Beginning in 2019, CMS will 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.

HEALTH RISK ASSESSMENT (HRA)

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.

BLUE BUTTON 2.0

The Call Letter encourages MA plans to implement data release platforms that meet or exceed the capabilities of Blue Button 2.0, an initiative launched by CMS in March 2018 to provide Medicare beneficiaries with a platform to share and access claims data across a variety of tools using the increasingly prevalent Fast Healthcare Interoperability Resources (FHIR) format. CMS has indicated that it may require plans to implement such platforms in future rulemaking.