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Calling for Ideas—CMS Releases Final 2018 Medicare Advantage and Part D Rate Announcement and Call Letter

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On 3 April 2017, the Centers for Medicare & Medicaid Services (CMS) released its final Medicare Advantage (MA) and Part D Rate Announcement and Call Letter (Call Letter) for calendar year 2018. The Call Letter is part of CMS's annual process for setting payment rates, performance requirements, and other rules that apply to MA and Part D plans. CMS previously released the 2018 Advance Notice and draft Call Letter on 1 February 2017. Compared to the draft Call Letter, the final Call Letter increased rates for MA plans by a modest amount and adopted other fairly minor tweaks to the MA and Part D programs. Of perhaps greater note, CMS also released a request for information (RFI) asking for new ideas that the agency could implement in the future to promote flexibility in the MA and Part D programs. Key provisions of the final Call Letter and RFI are summarized below.

Rate Changes

In the final Call Letter, CMS announced an average expected rate increase for MA plans in 2018 of .45% compared to the amounts MA plans received in 2017. This is a slight bump up from the .25% rate increase that was proposed in the draft Call Letter. After taking into account an additional 2.5% increase based upon coding trends, CMS estimates that the rate for an average MA plan will increase by 2.95% in 2018. This is slightly less than the increase from 2016 to 2017, when the rate for an average MA plan increased by 3.05%.

Encounter Data

CMS is reducing the use of encounter data in its risk score for MA plans. Encounter data are used to track information about the care a beneficiary receives from a provider. CMS began collecting encounter data from MA plans in 2012 and began factoring them into plans' risk scores in 2016, in combination with plans' Risk Adjustment Process System (RAPS) scores, which are based on traditional fee-for-service data. In 2017, MA plans' risk scores are based upon a blend of RAPS score (75%) and encounter data (25%), and, in the draft Call Letter, CMS proposed to keep the same ratio for 2018. CMS previously had indicated that 50% of MA plans' risk scores would be based on encounter data in 2018. CMS has stated that encounter data are an important tool for improving the accuracy of risk adjustment payments; however, industry stakeholders have criticized the data as not being accurate. In response to comments on the draft Call Letter, CMS has reduced the use of encounter data to 15% and increased the use of RAPS score to 85% in MA plans' risk scores for 2018. CMS also committed in the final Call Letter to work with stakeholders to improve the reliability of encounter data going forward.

Employer Group Plan Waiver Plans

In last year's Call Letter, CMS announced that it planned to end the previous bidding process for MA employer plans, known as Employer Group Waiver Plans (EGWPs), and replace it with a payment methodology by 2018 under which rates are administratively set based on county-specific benchmark data. For 2017, CMS used a hybrid process that combined the bid and benchmark process to determine rates. Instead of implementing the benchmark process in 2018 as planned, CMS in the final Call Letter decided to continue to use the hybrid process for 2018 and base 2018 EGWP payments on the rates paid in 2017. CMS has committed to study the issue for 2019 and intends to seek additional input from EGWP plans and other stakeholders. This is a win for industry stakeholders, because a full transition to benchmark data would have led to lower payments.

Star Ratings

While there were no significant changes to the Star Ratings system, CMS did provide some clarification on Star Ratings adjustments for audits and enforcement actions. By way of background, in March 2016, CMS suspended the automatic reduction of overall Star Ratings for contracts that are under sanctions, pending re-evaluation of this policy. In the final Call Letter, CMS announced that audits and enforcement actions will continue to be a factor under the Beneficiary Access and Performance Problems (BAPP) measure for 2018 Star Ratings, but CMS will eliminate this factor from the BAPP measure for 2019. BAPP reflects CMS sanctions, civil monetary penalties related to beneficiary access, and Compliance Activity Module data. CMS will seek additional input on revisions to the BAPP measure for 2019.

CMS did not finalize any changes to the longstanding policy of reducing a contract's measure rating to 1 star based on the determination that a contract's measure data are incomplete, biased, or erroneous. However, CMS did indicate that it would welcome industry feedback on making star rating reductions reflect the proportionality of errors in a contract's submitted measure data.

There had been some hope by industry that the final Call Letter would remove what industry describes as a "glitch" that unfairly caps the quality bonus payments that flow from certain Star Ratings. Under a provision in the Affordable Care Act, since 2012, Star Ratings have been used to help to determine payments for MA plans. Quality bonus payments are paid to MA plans that receive four or more stars. However, the statute also includes a provision that imposes a cap on MA plan benchmarks that prevents benchmarks from exceeding the amounts that would have been calculated prior to 2012. Under the previous Administration, CMS had interpreted the cap to effectively cap quality bonus payments, despite some indications that this was not Congress's intent. There was hope by industry that the new Administration would reverse course, but the final Call Letter was silent on the issue.

Drug Utilization Review for Opioid Abuse

In 2013, CMS launched the Overutilization Monitoring System (OMS) to identify inappropriate opioid use among MA beneficiaries. The final Call Letter finalized modifications to the OMS criteria to identify beneficiaries who may be overutilizing opioids. The new criteria will identify beneficiaries who, during the most recent six months, used opioids with a daily average morphine equivalent dose (MED) greater than 90 mg for any duration and those who received opioids from (i) more than 3 prescribers and more than 3 pharmacies, or (ii) more than 5 prescribers regardless

of the number of dispensing pharmacies. Part D sponsors are expected to work with prescribing physicians and beneficiaries identified under this system to address the risks associated with overuse.

Part D sponsors are also expected to implement real-time safety alerts at the pharmacy based on cumulative MED. The draft Call Letter proposed to require Part D sponsors to implement a formulary-level hard opioid safety edit based on a cumulative MED. However, after receiving negative feedback regarding access to appropriate therapies, operational concerns, and the need for beneficiary and prescriber education about the proposed edits, CMS did not finalize this proposed requirement. CMS continues to expect Part D sponsors to implement formulary-level soft and/or hard cumulative MED opioid safety edits for 2018, as they see fit. CMS clarified that safety edits are not intended to substitute for physician judgment or dictate a prescribing limit, and Part D sponsors that implement hard edits are expected to have systems in place that allow for exceptions to the edit if the prescriber attests that the higher MED is medically necessary and without requiring additional clinical criteria. CMS expects to issue additional guidance on how existing and new hard MED edits should be implemented and resolved.

Service Category Cost-Sharing Requirements

In the final Call Letter, CMS mostly continues its previously implemented cost-sharing requirements. CMS reiterated its commitment to granting greater flexibility to establish cost-sharing requirements to MA plans that set lower, voluntary maximum out-of pocket limits compared to plans that set higher, mandatory maximum out-of pocket limits. CMS adopted an increase in the emergency care/post-stabilization care limit, but did not finalize additional considered cost-sharing thresholds for cardiac and pulmonary rehabilitation services.

Tiering Exceptions

CMS reiterated clarifying guidance in the final Call Letter regarding the meaning of "preferred" and "non-preferred" drugs in the context of multi-tier and mix-tier formularies. "Preferred drug" is defined as a drug with more favorable cost-sharing for the beneficiary. Plan sponsors should base eligibility for a tiering exception on whether the alternative drug is on a formulary tier that has lower cost-sharing than the tier on which the drug resides. CMS clarified further that approval of a tiering exception is to the lowest applicable tier when alternative drugs are in multiple lower tiers. CMS will be updating the Prescription Drug Benefit Manual to reflect these clarifications.

Request for Information

As a signal of its commitment to make additional policy changes in the future, CMS included with the final Call Letter an RFI that solicits feedback and recommendation from stakeholders regarding potential "regulatory, sub-regulatory, policy, practice, and procedural changes" to promote "transparency, flexibility, program simplification and innovation to transform the MA and Part D programs." CMS specifically requests ideas regarding benefits design, operational or network composition flexibility, supporting the doctor-patient relationship in care delivery, facilitating individual preferences, and the way plans are paid and monitored and measured. CMS highlights ideas relating to Star Ratings and their alignment to quality of care in terms of measure inclusion and exclusion as an example of the types of ideas it would like to receive. CMS will accept comments through 24 April 2017, at PartCDcomments@cmsh.hhs.gov. Submissions should include "2017 Transformation Ideas" in the subject line.

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