Better Medicare Alliance Webinar:

Medicare Advantage and Part D 2019 Advance Notice and Draft Call Letter

February 8, 2018

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RATE NOTICE CRASH COURSE PAGE

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Opening Remarks

Congresswoman Allyson Y. Schwartz

President & CEO

Better Medicare Alliance

Advance Notice and Draft Call Letter Comment Process

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- On December 27, 2017, the Centers for Medicare & Medicaid Services (CMS) released Part 1 of the Medicare Advantage 2019 Advance Notice. CMS proposed changes to the Hierarchical Condition Categories Risk Adjustment model that adjusts payments to Medicare Advantage plans. CMS also proposed increasing the use of encounter data in risk scores.
- On February 1, 2018, CMS released Part 2 of the Medicare Advantage 2019 Advance Notice and Draft Call Letter, which includes methodological changes for calendar year 2019 for Medicare Advantage capitation rates and payment policies.
- Part 1 of the 2019 Advance Notice can be viewed here. Part 2 can be viewed here.

Key Dates:

- There is a 30-day official comment period and stakeholders have until 6:00 p.m. EST on Monday, March 5, 2018, to formally submit comments to CMS. The Final Notice and Call Letter will be released 60 days after the Advance Notice and Draft Call Letter, on April 2, 2018.
- Search for "CMS-2017-0163" at http://www.regulations.gov to formally submit comments.

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Key Elements in the Advance Rate Announcement and Draft Call Letter

Payment Rate Updates

- Medicare Advantage Rates
  - Rebasing/Re-pricing
  - Coding Intensity
  - Normalization
- Medicare Advantage Benchmarks
  - Benchmark Caps
  - A/B Benchmarks

Key Part C Policy Proposals

- Uniformity of Benefits
- Supplemental Benefits
- Diabetes Prevention Program
- Risk Adjustment Model
- Encounter Data
- Star Ratings & Quality
- Special Needs Plans
- Employer Group Waiver Plans

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Medicare Advantage Rates

Year-to-Year Change in Part C Payment (2019 v. 2018)	2019 Advance Notice	2018 Final Notice
Effective Growth Rate (Trend)	4.35%	2.70%
Rebasing/Re-pricing	TBD	0.30%
Change in Star Ratings	-0.20%	-0.40%
Risk Model Revision	0.28%	N/A
MA Coding Intensity Adjustment	0.01%	-0.25%
Encounter Data Transition	-0.04%	N/A
EGWP Payment Policy	-0.30%	N/A
Normalization	-2.26%	-1.90%
Expected Average Change in Revenue from Part C Methodology	**1.84%**	**0.45%**

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Medicare Advantage Rates

Benchmark Caps

- Benchmark caps, established by the Affordable Care Act, cap the benchmarks in certain counties to pre-ACA levels, effectively reducing or eliminating the added quality bonus payments to plans in those areas
- CMS *did not* address benchmark caps in this advance notice

A/B Benchmarks

- CMS calculates benchmarks using data from all FFS Medicare beneficiaries, regardless of whether they have both Part A and B coverage
- This calculation method results in arbitrarily low benchmarks in certain counties where more beneficiaries are only enrolled in Part A (and not in Part B)
- BMA has asked CMS to calculate benchmarks using only FFS data from A+B beneficiaries, but CMS *did not* address this in the notice

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Uniformity of Benefits

- The Medicare Advantage uniformity rule is the requirement that plans must offer the same benefits equally to all enrollees in a particular plan
- Historically this has meant that plans may not offer certain, targeted supplemental benefits to some beneficiaries but not others
- CMS has reinterpreted this rule to permit MA organizations the ability to provide certain benefits (such as reduced cost sharing or lower deductibles) for certain enrollees that *meet specific medical criteria,* but they must offer those benefits to all enrollees who meet that criteria
- CMS believes this new flexibility will help plans manage the care for particularly vulnerable enrollees and create incentives for them to use evidence-based services better manage chronic diseases
- CMS *does not* specify which services may be offered or to which types of enrollees
- CMS states: "If a plan wants to propose a targeted supplemental benefit offering but has questions as to whether it is allowable, *CMS will establish a special mailbox following issuance of the final Call Letter*"

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Supplemental Benefits

- Until now, CMS has allowed plans to offer certain benefits above and beyond those covered by Traditional Medicare only if they are directly health-related, but not if their primary purpose is "daily maintenance"
- CMS is expanding the scope of the primarily health-related supplemental benefit standard
- Under this new interpretation, supplemental benefits are considered "primarily health-related" if they:
    1. Diagnose, prevent, or treat an illness or injury;
    2. Compensate for physical impairments;
    3. Act to ameliorate the functional/psychological impact of injuries or health conditions; and/or
    4. Reduce avoidable emergency and healthcare utilization
- Supplemental benefits under this new interpretation must still be medically appropriate and ordered by a licensed provider as part of a care plan
- *CMS will issue detailed guidance for plans as they prepare for 2019 benefit offerings*

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Medicare Diabetes Prevention Program

- The Medicare Diabetes Prevention Program expanded model begins April 1, 2018.
- The goal of the program is to prevent the onset of type 2 diabetes in beneficiaries with an indication of prediabetes.
- Medicare Advantage plans must cover the program, and may offer Medicare Diabetes Prevention Program-like benefits as a supplemental benefit virtually.
- *While CMS does not ask for additional comment, guidance is needed to ensure suppliers, health plans, and beneficiaries are able to participate in the successful implementation of the Medicare Diabetes Prevention Program.*

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Condition Count in Risk Adjustment Model

- CMS is proposing a new risk adjustment model, called the "Payment Condition Count Model," which would account for the number of conditions a beneficiary has among those conditions that are included in the payment model.
- CMS also discusses an alternative – the "All Condition Count Model" – which would account for all conditions that a beneficiary has, including conditions that are included in the payment model and those that are not included.
- *CMS is requesting comment on the phase-in of the "Payment Condition Count Model," which would increase Medicare Advantage risk scores by an estimated average of 1.1%.*

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Phase-in of the Payment Condition Count Model

	Proposed "Payment Condition Count" CMS-HCC Model	2017 CMS-HCC Model
2019	25%	75%
2020	50%	50%
2021	75%	25%
2022	100%	N/A

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Additional Conditions in Risk Adjustment Model

- CMS proposes including additional adjustments for a beneficiaries' mental health, substance abuse, and chronic kidney disease conditions to the risk model. The following condition categories would be added:
  - Drug Abuse, Uncomplicated, Except Cannabis
  - Reactive and Unspecified Psychosis
  - Personality Disorders
  - Chronic Kidney Disease, Moderate (Stage 3)
- *CMS requests comments on including additional Mental Health, Substance Abuse, and Chronic Kidney Disease Conditions in Risk Adjustment Model.*

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Encounter Data

- In 2012, CMS began collecting encounter data from Medicare Advantage, which includes clinical diagnoses, care, and treatments.
- In 2016, CMS initiated a transition to using Encounter Data for calculating risk scores. CMS blends the current submission Risk Adjustment Processing System (RAPS), and FFS Medicare diagnoses with the new encounter data and FFS Medicare diagnoses to create a weighted risk score.
    - 2016: CMS used 10% encounter data and 90% RAPS
    - 2017: CMS used 25% encounter data and 75% RAPS
    - 2018: CMS used 15% encounter data and 85% RAPS
- *CMS requests comment on calculating risk scores in 2019 using a blend of 25% encounter data, and 75% RAPS, which would result in an estimated negative 0.4% payment adjustment to Medicare Advantage.*

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Medicare Advantage Star Rating System

- CMS is proposing to add new measures to the 2019 Star Ratings, including Statin Therapy for Patients with Cardiovascular Disease (Part C).
- CMS is proposing to decouple audits and enforcement actions from Star Ratings.
- CMS will continue to apply the categorical adjustment index for duals to 6 Part C measures, and 2 Part D measures.
- The changes in Star Ratings would result in an estimated negative 0.2% payment adjustment to Medicare Advantage.
- *CMS is requesting comments on proposed Star Rating measures in 2019, the removal of measures in 2019, and potential future measures.*

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Special Needs Plans

- Congress only authorized Special Needs Plans (SNPs) through December 31, 2018, therefore, CMS does not have the authority to allow SNPs to be offered in calendar year 2019 without Congressional reauthorization.
- CMS is proposing to allow D-SNPs and I-SNPs to offer Enhanced Disease Management as a supplemental benefit to improve care coordination and enhance the experience of care for beneficiaries.
- CMS continues to examine the need for SNP-specific network adequacy evaluations.
- *CMS requests comment on allowing D-SNPs and I-SNPs to offer Enhanced Disease Management as a supplemental benefit and SNP-specific network adequacy evaluations.*

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Employer Group Waiver Plans

- CMS is proposing to fully transition to using only individual market plan bids to calculate bid-to-benchmark ratios to set EGWP payments, which would result in an estimated negative 0.3% payment adjustment to Medicare Advantage.
- CMS is considering maintaining the current payment methodology that weights individual plan bids and EGWP plan bids from 2016 by 50 percent.
- CMS is also considering an additional step in calculating bid-to-benchmark ratios to account for the difference in proportion of beneficiaries enrolled in HMOs vs. PPOs.
- *CMS requests comments on whether to fully transition to the new methodology or maintain the current methodology, and account for the difference in proportion of beneficiaries in HMOs vs. PPOs.*

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Key Next Steps

- Provide feedback on BMA priorities and other concerns.
- BMA will comment on the Advance Notice and Draft Call Letter.
- Continue working with BMA to advocate for policy priorities that can be found here.

Questions or Comments?

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