The 2018 Advance Notice and Draft Call Letter for Medicare Advantage

BETTER MEDICARE ALLIANCE

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Summary

Introduction

On February 1, 2017, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Advantage 2018 Advance Notice and Draft Call Letter, which includes methodological changes for calendar year 2018 for Medicare Advantage capitation rates, payment policies, as well as other policies impacting beneficiaries, providers, and other stakeholders. The Rate Notice is the portion of the proposal that deals with elements strictly related to payment updates and the Draft Call Letter contains proposals related to the Quality Rating System and information related to bid preparation. This paper summarizes key elements in the 2018 Advance Notice and Draft Call Letter.

- The 2018 Advance Notice and Draft Call Letter can be viewed here.
- The CMS Fact Sheet can be viewed here.

Key Takeaways

The 2018 Advance Notice and Draft Call Letter indicate a commitment to stability in Medicare Advantage. CMS proposed a modest update to payment based on updated Fee-For-Service (FFS) Medicare cost trends and shifting demographics in Medicare. CMS responded to stakeholder feedback and requested additional feedback on slowing the implementation of certain policies, including the phase-in to Encounter Data as a diagnosis source and the move to a new methodology for Employer Group Waiver Plans (EGWPs). CMS also acknowledged that benchmark caps are an impediment to incentivizing quality. There was also discussion of improvements to the Star Rating System. However, other important issues in Medicare Advantage, such as implementation of the Medicare Diabetes Prevention Program, improving provider directory accuracy, and value-based arrangements, were not discussed.

Key Dates

There is a 30-day official comment period and stakeholders have until **6:00 p.m. EST on March 3, 2017** 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 3, 2017**.

CMS Estimate of Change in Payment for 2018

Key Takeaway

CMS states it expects Medicare Advantage payment to stay roughly flat in 2018 based on the payment and policy changes it is proposing, which is lower than what has been finalized in recent years. The estimate is a nationally-averaged estimate and does not include additional factors such as rebasing, Health Insurance Tax implementation, and coding differences between plans. The estimate will likely change in the Final Notice as Growth Rates and other elements are updated and changed.

Background

The Year-to-Year Percent Change in Payment is a number CMS releases in its Fact Sheet that includes estimates of the payment impacts it has quantified. The purpose is to help stakeholders compare the proposed payment for the next year to the current payment levels. This estimate does not include all variables. For example, it does not include rebasing/re-pricing, which is a county-level adjustment to improve relative cost accuracy. CMS states it plans to rebase/re-price the final rates, which will likely have a relatively small impact nationally but variable impact geographically. CMS also estimates a small negative nationally-averaged impact due to the recent reduction in trend of overall individuals in 4 or higher Star Rated plans. However, Star Ratings, and associated payment impacts, vary by plan and contract. (See below for more information on proposals related to the Star Rating System).

CMS Proposal

CMS estimates a Year-to-Year Percent Change in Payment for 2018 of +0.25%, before considering rebasing, impacts of the Health Insurance Tax, and coding differences. In the past three years, the finalized Percent Change in Payment estimate ranged from +0.4% to +1.25%.

Updated Medicare Advantage Growth Rate

Key Takeaway

One portion of the Year-to-Year Percent Change in Payment is the Growth Rate (or "Effective Growth Rate") used to update Medicare Advantage payment. This Growth Rate is based on FFS spending at the county level. CMS proposes a 2018 Medicare Advantage Growth Rate that is roughly in line with last year's update and an improvement from the previewed rate CMS released in fall 2016.

Background

Medicare Advantage uses a capitated payment system that pays health plans a monthly amount per beneficiary. These capitated payments are based on county-level benchmarks, which are set using FFS spending in each county, and are risk-adjusted to account for each beneficiary's demographic and disease profile. County benchmarks are adjusted annually based on cost trends in FFS Medicare (among other factors). Medicare Advantage health plans bid against this benchmark, and if they bid below the benchmark they are able to apply a portion of that "rebate" amount to additional benefits for beneficiaries. The Advance Notice provides a nationally-averaged Medicare Advantage Growth Rate and not county-specific updates; a Rate Book with county-specific benchmarks will be released with the Final Notice. The nationally-averaged Medicare Advantage Growth Rate update will likely change in the Final Notice as CMS receives more updated data during the 60 days between Advance and Final Notice.

CMS Proposal

CMS is proposing a nationally-averaged Medicare Advantage Growth Rate for 2018 of +2.8%. This is an increase from the +2.31% 2018 Growth Rate CMS previewed in November. In the past three years, the finalized Medicare Advantage Growth Rate ranged from -3.4% to +4.2%.

Coding Intensity Adjustment

Key Takeaway

CMS is proposing to increase the annual reduction to risk scores, called the coding intensity adjustment, by the statutory minimum.

Background

Payment in Medicare Advantage is risk-adjusted for each beneficiary using a risk score based on the individual's demographic and disease profile. CMS reduces risk scores by a certain percentage each year in what is called the coding intensity adjustment. Per statute, CMS applies this risk score reduction to account for what it describes as the coding pattern differences between Medicare Advantage and FFS Medicare. This adjustment reduces all Medicare Advantage risk scores by a certain percentage, resulting in reduced payment. In current law this risk score reduction must increase by at least an additional -0.25% each year until it reaches at least -5.91% in 2018, and remains no less than -5.91% for all subsequent years.

CMS Proposal

CMS proposes to increase the coding intensity adjustment by the statutory minimum, 0.25%, resulting in a proposed 2018 coding intensity adjustment of -5.91% (an increase from -5.66% in 2017).

FFS Normalization

Key Takeaway

CMS proposes a change in the methodology for calculating the FFS Normalization Factor, which is used to keep the Medicare Advantage risk adjustment model accurate and account for changes in demographics and coding in FFS Medicare. This change would result in a negative impact in payment for 2018, especially for End Stage Renal Disease (ESRD) and Program of All-Inclusive Care for the Elderly (PACE) payments.

Background

The Medicare Advantage risk adjustment model is calibrated using diagnosis and cost information from beneficiaries in FFS during a historical period. Medicare Advantage risk scores estimate incremental costs for a variety of beneficiary characteristics (e.g., age or gender) and health conditions. Medicare Advantage risk scores are intended to account for the degree to which a Medicare Advantage beneficiary's expected costs are more or less than the expected cost of the average FFS beneficiary. To keep the risk adjustment model accurate, CMS uses a FFS Normalization Factor to ensure the model accurately reflects the average FFS beneficiary and accounts for demographic and coding changes in FFS Medicare. CMS stated that the baby boomers aging into Medicare resulted in FFS risk scores increasing at a slower, less predictable rate, and the new calculation better accounts for the variation in the historical risk score data. In 2015, CMS changed the FFS Normalization Factor calculation methodology from a linear to a quadratic function to better capture the increased proportion of younger, baby boomer beneficiaries. However, CMS now states it no longer thinks the quadratic function accurately reflects the data, and also points out a large spike in 2016. As a result, CMS is now proposing to go back to the linear function it used before 2015. Historically, an increase in FFS Normalization Factor results in a reduction in payment.

CMS Proposal

CMS is proposing a FFS Normalization Factor of 1.017 for 2018 (up from 0.998 in 2017), estimated by reverting to the linear methodology (used prior to payment year 2015). CMS estimates this proposed change in FFS Normalization Factor would result in a -1.9% impact on 2018 payment. This factor could change in the Final Notice. For example, last year, CMS finalized a FFS Normalization Factor of 0.998, 0.5% higher than the proposed factor (the change was due to a calculation error).

ESRD NORMALIZATION

Individuals who have kidney failure (ESRD) are eligible for Medicare. Congress recently passed a law that removes a previous law restricting certain ESRD individuals from enrolling in Medicare Advantage. This change will go into effect in 2021, and will likely result in an increase of ESRD beneficiaries in Medicare Advantage. Currently there are roughly 100,000 individuals with ESRD enrolled in Medicare Advantage. Due to multiple factors, including differences in costs for dialysis treatment in FFS versus Medicare Advantage due to difficulty negotiating prices for dialysis treatment in Medicare Advantage, data show that ESRD payment in Medicare Advantage is inadequate.

Payment for ESRD beneficiaries, including risk adjustment, is calculated separately from non-ESRD beneficiaries and therefore ESRD has a separate FFS Normalization Factor. CMS is proposing a 1.080 ESRD FFS Normalization Factor for 2018, up from 0.994 in 2017. Though CMS did not release an impact estimate, this increase would likely result in an impactful reduction in ESRD payment.

PACE NORMALIZATION

PACE provides comprehensive, coordinated medical and social services within a capitated payment to certain elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. The program aims to keep individuals in the home rather than requiring nursing home care. PACE is a relatively small program, and currently less than 50,000 individuals are enrolled and it is not available in all states. Payment for PACE beneficiaries, including risk adjustment, is calculated separately from non-PACE beneficiaries and therefore PACE has a separate FFS Normalization Factor. CMS is proposing a 1.082 PACE FFS Normalization Factor for 2018, up from 1.051 in 2017. Though CMS did not release an impact estimate, this increase would likely result in an impactful reduction in PACE payment.

Encounter Data as Diagnosis Source

Key Takeaway

CMS reiterates its continued commitment to eventually phasing into Encounter Data as a diagnosis source for risk adjustment. However, due to implementation concerns, CMS proposes to freeze the phase-in at the 2017 levels and requests comments on developing an adjustment to ensure stability during implementation.

Background

In 2012, CMS began collecting Encounter Data from Medicare Advantage. This data includes diagnosis and treatment data for all services and items provided to a Medicare Advantage beneficiary. In 2016, CMS initiated a transition to using Encounter Data as a data source for diagnoses used to calculate risk scores. For 2016, CMS decided to blend the current diagnosis code submission system, known as the Risk Adjustment Processing System (RAPS), with the new Encounter Data System (EDS) to create a weighted risk score. In 2016, risk scores were weighted 90% to the previous RAPS system and 10% to the new Encounter Data System. In 2017, the blend is 75% RAPS and 25% EDS. Last year, CMS stated it would like to increase the EDS phase-in blend to 50% RAPS and 50% EDS for 2018 and 100% EDS by 2020. There has been widespread concern that implementation of this change has been too fast and has resulted in inaccuracies and undue burden.

CMS Proposal

CMS states that due to concerns about stability in payment and smooth implementation, it proposes to freeze implementation for 2018 and keep the same blend as 2017, which was 75% RAPS and 25% EDS.

Employer Plan Payment Change

Key Takeaway

CMS is considering whether it should fully phase into the new payment methodology for Medicare Advantage employer group plans, called Employer Group Waiver Plans (EGWPs). The new methodology bases EGWP payment on non-employer bids and would result in a reduction to EGWP payment.

Background

Millions of retirees receive their Medicare coverage via Medicare Advantage employer plans, also known as EGWPs. Last year, CMS finalized a proposal to terminate the previous EGWP bid process and replace it with set EGWP payment amounts in each county. The set payments are based on a set of four national percentages calculated using enrollment-weighted county bid to benchmark ratios using non-employer data. These four percentages represent the percent of the county benchmark an EGWP will receive, based on the quartile the county falls into (Medicare Advantage counties are categorized into quartiles based on FFS costs to account for unwarranted geographic variation). The new methodology does not account for the fact that EGWPs, unlike non-employer Medicare Advantage plans, are much more likely to be Preferred Provider Organizations (PPOs) than Health Maintenance Organizations (HMOs). PPOs tend to have higher bids than HMOs due to higher costs related to their broader networks. CMS decided to phase-in the new methodology over two years and calculated the four percentages for 2017 by blending 50/50 the new methodology (using non-employer bid to benchmark ratios) with ratios calculated using the last year of bid-to-benchmark data from EGWPs (from 2016, before EGWP bidding was terminated). The resulting percentages for 2017 were: 88.7%, 92.2%, 93.3%, and 93.6%. For example, if payment for a 4-Star plan in a certain county (in the highest cost FFS quartile) was $800, a 4-Star EGWP in that county would receive 88.7% of $800, or $709.6 (before risk adjustment). Last year, CMS estimated the change to the new methodology would reduce EGWP payment by 2.5%.

CMS Proposal

CMS is soliciting comments on whether it should fully phase into the new payment methodology for Medicare Advantage EGWPs for 2018 as planned or freeze at the 2017 blended phase-in level and use the ratios used in 2017. CMS did not release what the bid-to-benchmark ratios would be if it fully phased-in to the new methodology, which would use 2017 non-employer bids and benchmarks to calculate the four percentages applied to benchmarks.

Benchmark Caps

Key Takeaway

CMS states it shares stakeholder concern that the benchmark cap diminishes quality incentives. However, despite legal arguments that have been made that CMS has the regulatory authority to address the issue, CMS reiterated its previous stance that it does not think that it has the authority to fix the policy administratively.

Background

The benchmark cap limits Medicare Advantage payment at the pre-Affordable Care Act (ACA) level (plus growth updates). Implementation of the benchmark cap policy prevents 4-Star or higher plans in certain counties from receiving the quality bonuses they have earned. This results in millions of beneficiaries in these counties being denied the enhanced benefits enabled by quality incentives.

CMS Proposal

CMS states it shares concerns with stakeholders that the benchmark cap undermines quality incentives. CMS also reiterates its previous stance that it does not think that it has the authority to fix the policy administratively. Further action on this issue is possible in the Final Notice.

Double Bonus County Calculation

Key Takeaway

CMS is proposing a change to the double bonus calculation that would result in less counties qualifying for a double bonus.

Background

In current law, a qualifying county can qualify for a double quality bonus payment (10%, unless it hits the benchmark cap) if it meets three criteria: is in a Metropolitan Statistical Area with a population of more than 250,000 (as of 2004); has at least 25% of Medicare-eligible beneficiaries enrolled in Medicare Advantage (as of December 2009); and has per capita spending for 2018 that is below the national average for 2018. CMS states that the calculation for the third criterion is currently inaccurate. This is because when calculating the county per capita costs, CMS currently excludes the portion of the claim payments to hospitals for the costs of direct graduate medical education (GME). Whereas, when calculating the national per capita costs, CMS includes payments for GME costs. CMS is proposing to fix this inconsistency by including CMS in costs for both the county and national calculation. This will result in higher county per capita costs, which means less counties will meet the third criterion and thus will not qualify for a double quality bonus.

CMS Proposal

CMS is proposing a change in the calculation methodology for double bonus counties. CMS states the change could impact 15 counties, making them no longer eligible for the double bonus. This estimate is based on the 2017 Rate Book and could change with the updated 2018 Rate Book.

Star Ratings System

Key Takeaway

CMS is continuing Star Rating System adjustments for plans with a high percentage of dual eligible beneficiaries. CMS is proposing changes such as the inclusion of telemedicine in measure calculations, as well as routine updates to other measures. CMS is also expressing a commitment to developing care coordination measures and is requesting feedback on measure calculation for individuals with advanced illness. CMS is proposing to continue implementation of the use of audit and enforcement actions as Star Ratings measures.

Background

Medicare Advantage plans are awarded Star Ratings, at the contract level, between 1 and 5 based on performance on certain quality measures in the Star Rating system. If a health plan receives 4+ Stars, it is eligible for a Quality Bonus Payment (QBP) that increases the amount of payment it receives to provide care for its beneficiaries. Star Ratings also help consumers determine the quality of Medicare Advantage options. Star Ratings are constructed using multiple performance and satisfaction measures using both the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Each year CMS updates measures, and has been conducting long term research on how to accurately account for Star Ratings for plans with a high proportion of low-income and disabled beneficiaries.

CMS Proposals

STAR IMPACT ON PAYMENT

As mentioned in the CMS Estimate of Change in Payment for 2018 section above, CMS is predicting a nationally-averaged impact on payment of -0.4% to due to Star Ratings, likely due to a slight decrease in enrollment in 4-Star or higher plans.

INTERIM ADJUSTMENT

CMS is proposing to continue to use the same Categorical Adjustment Index (CAI) adjustment to the Star Ratings in 2018 as it used in 2017. The CAI interim adjustment is related to each plan's proportion of dual eligible beneficiaries, and/or enrollees receiving the low-income subsidy, and individuals with disabilities. CMS explains that the adjustment aims to account for the impact of dual-eligible and disabled status on plans' Star Ratings.

TELEHEALTH AND REMOTE ACCESS TECHNOLOGIES

CMS is asking for feedback on the potential inclusion of telehealth and/or remote access technology encounters as eligible encounters in various quality measures, including both Medicare covered telehealth services and/or telehealth provided using Medicare Advantage supplemental benefits. The National Committee for Quality Assurance (NCQA), which develops measures on behalf of CMS, is specifically interested in whether this inclusion might be appropriate for certain behavioral health services.

AUDIT AND ENFORCEMENTS ACTIONS

The current Beneficiary Access and Plan Performance Problems (BAPP) measure is based on compliance audits and associated enforcement action. Though the measure has been in use for Star Ratings since 2010, in November 2016 CMS requested general comments on the measure and on potentially rewriting and revising it. Stakeholders have expressed concern, stating the Star Ratings System should focus on measure related to outcomes and care delivery and be independent of audit findings and related enforcement actions. CMS states that after reviewing comments it is going ahead with modifications to the current BAPP measure.

EXCLUSIONS FOR ADVANCED ILLNESS

CMS is requesting feedback about whether specific illnesses and health care utilization (e.g., the use of palliative care services) may warrant an exclusion, and, if so, which measures should be excluded and how to implement in a way that does not result in lessened incentives for providing high quality care to these beneficiaries.

Potential New Star Rating Measures

CARE COORDINATION

CMS states it is working to expand efforts to better evaluate effective care coordination with a goal to identify potential new care coordination measures. CMS is working with contractors to conduct research and engage in discussions with expert panels and high performing plans to develop these measures, and is considering whether the measures should be focused on subgroups of Medicare Advantage enrollees or all Medicare Advantage enrollees. CMS states it is "considering the activities that best represent care coordination, such as ensuring seamless transitions across settings, appropriate follow up after inpatient and emergency department visits, utilizing appropriate health IT tools to share information, communication across providers, and comprehensive assessments, as well as the relationship between the plan and provider in care coordination activities."

TRANSITIONS OF CARE

CMS is welcoming feedback about a new measure intended to improve the quality of care transitions from an inpatient setting to home. The potential measure would have four indicators: notification of inpatient admission to primary care practitioner on the day of admission or the following day; receipt of discharge information to primary care practitioner of specific discharge information on the day of discharge or the following day; patient engagement after inpatient discharge (e.g., clinic visits, visits to the home, or telehealth) provided by primary care practitioner within 30 days after discharge; and medication reconciliation post-discharge (currently a HEDIS measure).

OTHER MEASURE CMS IS EXPLORING INCLUDE

- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions;
- Depression Screening and Follow-Up;
- Alcohol Screening; and
- Opioid Overuse.

Elements Not Included in the Rate Notice/ Call Letter

Medicare Diabetes Prevention Program (MDPP)

Starting January 1, 2018, MDPP services will be covered for eligible Medicare beneficiaries, at zero cost-sharing, under all Medicare health plans. MDPP is an evidence-based 12-month intervention aimed at improving outcomes for individuals with diabetes, specifically weight loss. MDPP started as a demonstration project and after it was proven to be effective, it was recently added as a covered benefit in Medicare. CMS released a memo on MDPP to Medicare Advantage plans on November 23, 2016. CMS does not provide more MDPP implementation information in the Call Letter. More guidance is expected in 2017.

Provider Directory Improvements

After recently releasing a report outlining issues with the accuracy of Medicare Advantage provider directories, CMS did not include any discussion or proposals on the issue.

MACRA/Value-Based Arrangement Goals

The Medicare Modernization and CHIP Reauthorization Act of 2015 (MACRA) changes the way physicians are paid in Medicare. MACRA transitional implementation starts in 2017 and full implementation starts in 2018. MACRA will impact Part B payment and FFS spending. CMS did not include a discussion about how MACRA will impact Medicare Advantage, including the calculation of Medicare Advantage benchmarks based on changes to FFS payment due to MACRA. CMS also did not discuss the data it has been collecting from plans on value based arrangements with providers.

Health Insurance Tax

Medicare Advantage plans are subject to the Health Insurance Tax (HIT), which is a tax on all health insurance companies. The tax was first implemented in 2014, and in current law the tax increases each year from $8 billion in 2014 to $14.3 billion for 2018. As part of a budget omnibus bill passed in December 2016, Congress placed a 1-year moratorium on the HIT tax for 2017. CMS did not provide guidance on how plans should submit their bids if there is another 1-year moratorium, or repeal, of the tax.

Using Only Part A and B FFS Data for Benchmarks

The Medicare Payment Advisory Commission (MedPAC) made a recommendation to Congress stating that Medicare Advantage benchmarks should be calculated using only FFS data from individuals with both Part A and B. Currently the data used to calculate benchmarks, and thus estimate average costs in a county, includes all FFS data, including data from individuals with only Part A (or only Part B). This results in less accurate Medicare Advantage benchmarks. This change could likely be done administratively or legislatively.

Release of Encounter Data

CMS has been collecting Encounter Data from plans since 2012 and has started to use the data for risk adjustment. CMS also plans to release the data to be used for research, much like FFS data is publicly available. CMS has not announced when it plans to make the Encounter Data available to researchers.

What to Expect in the Final

The Medicare Advantage Growth Rates are likely to change slightly in the Final Notice due to updated data. Changes to other proposed policies, including FFS Normalization Factor calculation, and changes to Encounter Data and EGWPs, could also occur in the Final Notice and Call Letter, as has been the case in previous years. Additionally, CMS could include a policy change related to benchmark caps, or other policies it addressed, in the Final Notice and Call Letter that was not included in the proposed. In the Final Notice and Call Letter, CMS will address the comments it received and it will also release all payment data, including the Rate Book by county and detailed ESRD and PACE payment information.

Conclusion

It is essential to the rule-making process in Medicare Advantage that all stakeholders, including beneficiaries, provide comments and input to CMS to inform its decision-making for finalized payment and policies for the following year. Submissions can include question, comments, concerns, or general process knowledge or insights that could inform policymakers. During the comment period, and leading up to the Final Notice and Call Letter on April 3, Better Medicare Alliance (BMA) and other advocacy organizations will submit constructive comments and encourage policy-makers to finalize policies that support the high-quality care Medicare Advantage is providing for Medicare beneficiaries.

Stakeholders have until **6:00 p.m. EST on Friday March 3, 2017** to formally submit comments to CMS through the following address: **AdvanceNotice2018@cms.hhs.gov**.