BETTER MEDICARE
ALLIANCE

SUMMARY OF THE 2017 FINAL RATE NOTICE

On April 4, 2016 the Centers for Medicare & Medicaid Services (CMS) released the 2017 Medicare Advantage Final Rate Notice and Call Letter that can be viewed here. Below is a summary of the key issues Better Medicare Alliance (BMA) raised in response to the Advance Rate Notice, released in February, and the policies finalized in the Final Rate Notice.

EMPLOYER GROUP WAIVER PLANS (EGWPS)

Issue

- BMA encouraged CMS not to implement the proposed change to EGWPs, which CMS said would result in a negative 2.5% payment reduction to employer, union, and government Medicare Advantage (MA) retiree coverage. The proposal terminated the current EGWP bid submission process and replaced it with set payment amounts for EGWPs calculated using non-EGWP individual MA bid amounts. BMA encouraged CMS to implement a phase-in period if the proposal was finalized.

Final Rule

- CMS finalized the proposal to terminate the current EGWP bid process, but decided to phase-in the new methodology over two years. In 2017, county EGWP rates will be calculated using a blend of 50% 2016 EGWP bid amounts and 50% the new EGWP payment methodology that uses non-EGWP individual MA bid amounts. In 2018 and future years, EGWP county payment amounts will be entirely based on the new methodology.

RISK ADJUSTMENT MODEL CHANGES

Issue

- In order to determine the projected cost of care for a beneficiary, CMS determines a unique risk score for each beneficiary. The CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model is used to create a risk score by using the health of patients to predict how much that patient may cost in the following year. CMS has raised concerns that the CMS-HCC risk adjustment model is not sensitive enough to fully predict the costs associated with sick, high-risk beneficiaries who are dually eligible for Medicare and Medicaid. Duals are divided into “fully dual eligible” and “partially dual eligible” individuals on the basis of the Medicaid benefits that these individuals are eligible to receive. The CMS proposal segmented the model into six new sub-categories, based on Medicaid status and age, to calculate risk scores with the goal of achieving better payment accuracy. BMA supported the goals of the policy change, but expressed concern about the impact of the change on the model and a lack of transparency on the impact of the changes.

Final Rule

- CMS adopted a change to the CMS-HCC risk adjustment model for 2017 that sub-segments individuals based on Medicaid status and age. Under the new methodology, CMS will divide beneficiaries into six groups: 1) Full benefit dual aged; 2) Full benefit dual disabled; 3) Partial benefit dual aged; 4) Partial benefit dual disabled; 5) Non-dual aged; and 6) Non-dual disabled. BMA will continue to work to ensure implementation of the new risk model is smooth and achieves the intended results.

ENCOUNTER DATA

Issue

- Risk scores in MA are calculated to determine the expected health care cost of a beneficiary. Historically, MA risk scores were calculated using diagnoses from codes submitted to the Risk Adjustment Processing System (RAPS). MA encounter data has been collected since 2012. In 2016, CMS began to use diagnoses from the Encounter Data System (EDS) to calculate risk scores. In 2016, the blend is 10% EDS and 90% RAPS. For 2017, CMS proposed increasing the risk score blend to 50% EDS and 50% RAPS. BMA raised concerns that this blend would phase-in the change too quickly and that providers and other stakeholders needed more time and analysis to ensure the transition to EDS is not disruptive.

Final Rule

- Instead of boosting the EDS portion of the blend from 10% to 50%, CMS decided to use 25% EDS and 75% RAPS as a diagnosis source for risk adjustment in 2017. CMS also announced plans to move to a blend of 50% EDS and 50% RAPS in 2018, 75% EDS and 25% RAPS in 2019 and 100% EDS in 2020. BMA will work to ensure there is a stable and accurate transition to EDS.

STAR RATINGS SYSTEM CHANGES

Issue

- Health plans are awarded Star Ratings between 1 and 5 based on certain quality measures in the Star Rating system in MA. 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. The money is used to provide additional benefits not covered under Traditional FFS Medicare such as dental, hearing and vision care. CMS proposed changes to address concerns that the current Star Ratings methodology disadvantages plans serving a high percentage of enrollees who are dually eligible for Medicare and Medicaid. CMS proposed implementing a Categorical Adjustment Index (CAI) adjustment, which is related to each plan's proportion of dual eligible beneficiaries, and/or enrollees receiving the low income subsidy, and individuals with disabilities. This change would be an interim adjustment to the Star Rating system while CMS continues to design more comprehensive methodological changes.

Final Rule

- CMS is implementing the interim CAI adjustment, which will likely impact a small number of plans and an estimated 278,000 enrollees. BMA continues to evaluate the proposal to ensure it does not result in lower quality standards for vulnerable beneficiaries. BMA will work with CMS and its partners to ensure the permanent changes to the Star Rating system encourage value-based contracting and high quality care and outcomes for all beneficiaries.