A SUMMARY AND ANALYSIS OF THE FINAL RATE ANNOUNCEMENT AND 2018 CALL LETTER FOR MEDICARE ADVANTAGE AND PART D

WRITTEN BY

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On April 3, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information – the “Call Letter.” The Final Call Letter took into account the comments received from the Advance Notice, which was released February 1, 2017.

The Call Letter reflects the new administration’s commitment to flexibility for Medicare Advantage Organizations (MAOs) through its pause on new proposals and rollbacks on several regulations. CMS noted it will continue to explore additional avenues for simplification and innovation in the Medicare Advantage (MA) and Part D programs. With that, CMS issued a Request for Information (RFI) for ideas for changes to the program’s regulations, sub-regulatory guidance, and practices and procedures. CMS will accept feedback through April 24, 2017, at PartCDcomments@cms.hhs.gov, with the subject line “2017 Transformation Ideas.”

Some areas for input CMS specifically calls out are recommendations regarding “benefit design, operational or network composition flexibility, supporting the doctor-patient relationship in care delivery, and facilitating individual preferences.” CMS is also looking for ways to change how plans are paid, monitored, and measured. Finally, CMS seeks information on how to simplify rules and policies for beneficiaries, providers, and plans. CMS specifically provides the example of Star Ratings and their alignment to quality of care and exclusion or timing of changes and the method of assessment as possible feedback. Given CMS’ use of stakeholder comments in the 2018 Final Call Letter, the RFI may prove a good avenue for encouraging valuable program changes over the next several years.

MAJOR HIGHLIGHTS OF THE ADVANCE NOTICE AND CALL LETTER:

Rates and Trend: The final trend is 2.73% inclusive of underlying trend and prior period adjustments. The underlying trend was only -0.01% from the Advance Notice, and the correction to the prior period was lower than expected (-0.03% vs. +0.02%), resulting in a modest decrease in the net specified amount trend. The applicable amount trend, which is used to calculate the pre-Affordable Care Act (ACA) ceiling amounts, decreased from 2.70% to 2.53%.

• Encounter Data: CMS finalized a decrease in the use of encounter data, with the final blend of 85% Risk Adjustment Processing System (RAPS) / 15% Encounter Data System (EDS) in 2018.

• Coding Pattern Adjustment: CMS finalized modifying the adjustment factor for MA coding pattern differences by -0.25%, statutory minimum adjustment under the ACA. This is added to prior years’ coding pattern adjustment and brings the total to -5.91%.

• Normalization Factors: The estimated factor of 1.017 is unchanged from the Advance Notice. CMS affirmed it will continue to use the linear methodology rather than the quadratic methodology used in the past. The impact on rates is -1.90%.

• Employer Group Waiver Plan (EGWP): CMS finalized it will continue its approach from 2017 in calculating EGWP county payment rates. However, CMS also finalized it will not move forward with the use of only individual market plan bids from 2017 to calculate bid-to-benchmark ratios in calculating the 2018 MA EGWP payment rates and will instead continue with the phased-in ratio in which EGWP bids are weighted 50%.

• Star Ratings: CMS decided not to change the Beneficiary Access and Performance Problems (BAPP) measure as proposed and announced plans to include the measure in the 2018 Star Ratings using the current methodology. CMS indicated plans to introduce a revised measure to be included on the 2019 display page, which will remove enforcement actions from the 2019 Star Ratings. CMS also postponed their proposal to more heavily weight care coordination within Star Ratings beginning with the 2019 ratings.

• Star Ratings and the Categorical Adjustment Index (CAI): CMS finalized to continue the use of CAI without making any changes. CMS found applying the CAI resulted in a modest improvement to 2017 Star Ratings.
CMS ESTIMATES AN OVERALL INCREASE OF 0.45% IN PAYMENTS TO MA PLANS AS RESULT OF TREND, REBASING ADJUSTMENTS, AND CHANGES TO STAR RATINGS.

• Service Category Cost-Sharing Requirements: CMS did not finalize the change to Skilled Nursing Facility (SNF) cost-sharing or cost thresholds for cardiac rehabilitation services, intensive care cardiac rehabilitation services, and pulmonary rehabilitation services. CMS did finalize the increase for the Emergency Care/Post-Stabilization Care limit for plans for CY 2018.

• Drug Utilization Review (DUR): CMS did not finalize the mandate to implement hard edits to prevent opioid overuse at pharmacy point of sale (POS). CMS did finalize the revisions to the retrospective DUR criteria used to identify opioid overutilizers to align with Centers for Disease Control and Prevention (CDC) guidelines.

• Puerto Rico: There were numerous comments on various aspects of the calculation of Puerto Rico county benchmarks. CMS adjusted the calculation of Fee-for-Service (FFS) experience for Puerto Rico to reflect the higher proportion of zero-dollar beneficiaries, resulting in an estimated increase of 4.4%. Based on comments, CMS also adjusted the calculation of FFS costs for Puerto Rico to include only FFS beneficiaries with both Part A and Part B.

• Authorized Generics: CMS is revising its interpretation of the regulatory term “dedicated to generic drugs” to include authorized generics.

Gorman Health Group’s (GHG’s) industry experts have collaborated to provide GHG’s summary and analysis of the Final Notice and Call Letter below. Have questions about the summary? Contact us to start a dialogue.

FINANCIAL IMPACT
Part C Payment Changes

CMS has estimated an overall increase of 0.45% in payments to MA plans as result of trend, rebasing adjustments required by the ACA, and planned and proposed changes to Star Ratings. Further, CMS estimates plans’ improvements in coding accuracy will increase rates by another 2.50% for a total of 2.95%. The summary below provides CMS’ estimates of the factors impacting the estimated payment increase with a description of each factor and change versus the Advance Notice.

<table>
<thead>
<tr>
<th>Year-to-Year Change in Part C Payment (2018 v. 2017)</th>
<th>2018 Advance Notice</th>
<th>2018 Final Notice</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Growth Rate (Trend)</td>
<td>2.80%</td>
<td>2.70%</td>
<td>Modest decrease in trend versus the Advance Notice.</td>
</tr>
<tr>
<td>Rebasing/Re-pricing</td>
<td>Not Available</td>
<td>0.30%</td>
<td>Change in estimated FFS rates at a county level; positive impact is not surprising based on counties with quartile increases representing more MA enrollees than those decreasing or remaining the same.</td>
</tr>
<tr>
<td>Change in Star Ratings</td>
<td>-0.40%</td>
<td>-0.40%</td>
<td>No change in estimate from Advance Notice.</td>
</tr>
<tr>
<td>MA Coding Intensity Adjustment</td>
<td>-0.25%</td>
<td>-0.25%</td>
<td>No change from Advance Notice. This is the incremental coding intensity adjustment established by ACA (statutory minimum).</td>
</tr>
<tr>
<td>Normalization</td>
<td>-1.90%</td>
<td>-1.90%</td>
<td>No change from Advance Notice. This is the impact on rates resulting from normalization factor applied to correlate historical and predictive risk scores.</td>
</tr>
<tr>
<td>Expected Average Change in Revenue from Part C Methodology</td>
<td>-0.25%</td>
<td>-0.45%</td>
<td>This is the estimated change in Part C rates/revenue due to trend and methodology changes.</td>
</tr>
<tr>
<td>Coding Trend</td>
<td>2.50%</td>
<td>2.50%</td>
<td>CMS estimates revenue impact of improved coding accuracy by plans; this is CMS aggregate estimate of individual plan performance, not a trend or methodology impact.</td>
</tr>
<tr>
<td>Expected Average Change in Revenue from Advance Notice Policies</td>
<td>2.75%</td>
<td>2.95%</td>
<td></td>
</tr>
</tbody>
</table>
CMS FINALIZED THE MOVE BACK TO LINEAR METHOD TO CALCULATE THE NORMALIZATION FACTOR FOR 2018.

**Trend:** MA plans’ payment from CMS is based on benchmarks that are published annually for each U.S. county. Plans bid against the benchmarks. Bids reflect a plan’s estimated costs to provide Medicare Part A and B benefits plus administrative costs and a reasonable profit. Plans receive the lesser of their bid or the benchmark. In addition, if the bid is less than the benchmark, a plan will receive a share of this savings in the form of a rebate. Hence, plans’ revenue is directly tied to these benchmarks.

The ACA provided a six-year phase-in period, which was completed with the 2017 benchmarks. The phase-in of rates, as required by the ACA, was completed with the 2017 rates, so county-level benchmarks are calculated using the specified amount, or FFS cost with applicable trend. For the specified amount, CMS projects the 2018 average per capita FFS cost then calculates the percentage difference from the 2017 projected cost to determine a one-year trend. There is no attempt to add a factor to correct for prior year errors. However, the applicable amount trend is still relevant for calculation of the ceiling applied to county-level benchmarks for bid purposes.

<table>
<thead>
<tr>
<th>Benchmark Trends</th>
<th>Advance Notice 2018</th>
<th>Final Notice 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified Amount Trend</td>
<td>2.79%</td>
<td>2.73%</td>
</tr>
<tr>
<td>Applicable Amount Trend (used to calculate ceiling)</td>
<td>2.70%</td>
<td>2.53%</td>
</tr>
</tbody>
</table>

**Rebasings/Re-pricing:** CMS estimates rebasing will increase 2018 rates by 0.30%. This is likely due to upward quartile changes impacting counties with a disproportionate number of MA members – 14.9% of MA members versus 3.6% – based on data reported in the Advance Notice. It is important to note quartile changes are phased in over two years.

**Star Ratings:** CMS has proposed changes to certain measures and weightings but no major changes in methodology.

**MA Coding Intensity Adjustment:** The ACA has mandated a minimum coding intensity adjustment to MA risk scores to compensate for the observed gap that has developed between MA and FFS risk scores. CMS believes MA plans have become increasingly good at improving the completeness and accuracy of diagnosis reporting compared to the FFS claim data upon which the risk adjustment model is based. Risk scores reflect the correlation between diagnoses and costs reported on FFS claims. If MA plans report more complete and accurate data than is found in the FFS claim database, CMS is concerned plans may be compensated more than was contemplated in the design of the risk adjustment model. The ACA mandates a minimum adjustment to MA payments each year to offset this gap. The amount of the adjustment increases annually through 2018, at 0.25% per year. The minimum adjustment for 2018 is 5.91%. While the ACA gives CMS the authority to make a larger adjustment if they have data to support a larger adjustment, CMS will not do so for 2018. Most commenters were pleased the adjustment did not exceed the statutory minimum, but a few commenters suggested the discontinuation of the MA coding intensity adjustment, however, this will not happen just yet. CMS is required to apply the adjustment until they recalibrate the risk adjustment model utilizing the data received through the Encounter Data Processing System (EDPS).

**Normalization**

CMS has observed risk adjustment data from prior periods yields various results when used to predict costs in later years under the Hierarchical Condition Category (HCC) model. As a result, the historical data used to calibrate the HCC scores may not yield an average risk score of 1.0 when applied in the current year. However, for risk adjustment to properly reflect relative risk, the average must equal 1.0. CMS compensates by moving the whole scale up or down by a factor that is designed to yield an average of exactly 1.0 when applied to current year data. The Part C normalization factor for 2018 is 1.017 as compared to 2017 factor of 0.998. Risk scores in 2018 are divided by this factor, scaling them down slightly, so the average overall will be normalized to 1.0. There were concerns surrounding the usage of the 2016 data in the calibration of the HCC model for 2018 because of the unusually high risk score reflected for 2016. The high risk score seemed like an anomaly that may not continue in future years and, therefore, should be carved out of the analysis. CMS conducted due diligence internally as well as with external firms to verify the 2016 risk score calculation. It was determined a portion of the high risk score in 2016 was a result of changes in diagnostic coding patterns due to the transition from International Classification of Diseases, Ninth Revision (ICD-9) to International Classification of Diseases, Tenth Revision (ICD-10), in addition to changes in payment incentives for FFS Medicare.
Encounter Data as a Diagnosis Source for 2018

Last year, CMS continued the transition to encounter data-based risk scores by weighting the risk score calculated with diagnoses from RAPS and FFS by 75% and the risk score calculated with diagnoses from the EDPS and FFS by 25%. For Payment Year (PY) 2018, CMS finalized a decrease in the weight on encounter data, making the final blend 85% RAPS / 15% EDPS. This decrease is a sign CMS wants to take the transition to EDPS slower than originally anticipated to allow health plans to further enhance their operational process for EDPS. Since CMS lowered the overall weight encounter data submissions will have on a health plan’s risk score, no other adjustment will be applied at this time.

Cap on Benchmarks

The ACA included a provision the benchmark for a county must be capped at the amount that would have been the benchmark under the old law ("applicable“ amount). This provision further specifies the comparison must include the Quality Bonus Payment (QBP) and has the effect, in some cases, of preventing plans in affected counties from receiving the full QBP to which they might otherwise be entitled. Commenters encouraged CMS to explore options to re-interpret the application of ceilings to QBPs and/or pursue change. Although CMS acknowledged it shares the commenters’ concern with rate-setting mechanisms that diminish incentives for MA plans to improve quality, CMS did not identify new discretion to eliminate the application of this ACA provision.

This ceiling prevents plans in affected counties from receiving the full QBP to which they might otherwise be entitled. The table below shows, in counties where 30% of MA members reside, plans are not able to receive the full 5% QBP. In counties representing 10% of MA members, the ceiling has the effect of reducing the benchmark before any QBP.

<table>
<thead>
<tr>
<th>2018 Counties Affected by ACA Ceiling – Based on March 2017 Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td># Counties – 2018</td>
</tr>
<tr>
<td>Enrollees (3/17)</td>
</tr>
<tr>
<td>% of Enrollees</td>
</tr>
</tbody>
</table>

MA EGWPs

CMS finalized it will continue its approach from 2017 in calculating EGWP county payment rates. CMS will continue with the phased-in ratio in which EGWP bids are weighted 50%. The ratio used to set MA EGWP payment rates will continue to reflect a blend of individual market plan bids from 2016 and EGWP bids from 2016, with individual market plan bids weighted by 50% and EGWP bids weighted by 50%.

Part D Payment Changes

Part D payment methodology will be updated to reflect the 2018 benefit structure and update the data years used to calibrate the risk adjustment model.

Standard Benefit Category

<table>
<thead>
<tr>
<th>Standard Benefit Category</th>
<th>Annual Percentage Trend for 2018</th>
<th>Prior Year Revisions</th>
<th>Annual Percentage Increase (API) for 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>API – applies to all items except out-of-pocket (OOP) and copayments</td>
<td>3.94%</td>
<td>-2.62%</td>
<td>1.22%</td>
</tr>
<tr>
<td>July Consumer Price Index (CPI) – applies to OOP threshold</td>
<td>2.47%</td>
<td>-0.30%</td>
<td>2.17%</td>
</tr>
<tr>
<td>Applies to copayments</td>
<td>2.41%</td>
<td>-0.20%</td>
<td>2.20%</td>
</tr>
</tbody>
</table>
Part D Risk Corridors
There are no changes in the Part D risk corridors. These corridors result in shared gains and losses between Part D plans and CMS when gains and losses exceed certain amounts. The risk corridors remain at +/- 5% and +/- 10% of expected claim cost.

ACA Issuer Tax
CMS confirmed plans must address requirements implemented under the ACA, including the health insurance providers’ fee, or issuer tax. The ACA imposes an issuer tax, a fixed-dollar amount, which is apportioned among health insurance issuers in proportion to their earned premium revenue.

2018 FINAL CALL LETTER
The Call Letter provides information that needs to be taken into consideration in preparing 2018 bids for Part C and Part D programs.

Annual Calendar
CMS provides a combined calendar listing of key dates and timelines for operational activities for MA, Medicare Advantage Prescription Drug (MA-PD), Prescription Drug Plan (PDP), Medicare-Medicaid Plan (MMP), and Cost Plans. The calendar is available on Page 69 of the Final Call Letter.

Social Security Number Removal Initiative (SSNRI)
The Medicare Access and CHIP Reauthorization Act (MACRA) included a mandate to remove the Health Insurance Claim Number (HICN) from Medicare cards. Beginning in 2018, the current Social Security-based HICN will be replaced with a Medicare Beneficiary Identifier (MBI). MBIs will be assigned to all Medicare recipients, and cards will be mailed to beneficiaries beginning no earlier than April 2018. For questions about how SSNRI will impact various systems, please refer to the contact list provided in the Health Plan Management System (HPMS) memorandum released on November 18, 2016, titled “Social Security Number Removal Initiative (SSNRI) Selected Updates for Medicare Advantage and Part D Plans.”

Incomplete and Inaccurate Bid Submissions
As usual, CMS provides guidance on proper bid submission procedures and repercussions of incomplete or inaccurate bid submissions. CMS reminds plans of the requirements for a complete bid submission, due on June 5, 2017. Just as in past years, CMS will not accept incomplete bid submissions, absent extraordinary circumstances, past the deadline. CMS also reminds plans of their authority to impose sanctions or to non-renew the contract for Part C submissions that are not complete, timely, and accurate.

CMS will issue a compliance notice or request for a corrective action plan (CAP) to organizations and sponsors that submit clearly inaccurate bids on June 5, 2017, or otherwise violate bidding procedures. Some possible actions that could trigger a compliance action include:

• Resubmission of bids prior to CMS authorization for bid modification.
• Failure to meet Part C and D requirements or failure to meet established thresholds.

ENHANCEMENTS TO THE 2018 STAR RATINGS AND BEYOND

New and Returning Measures for 2018
• Medication Reconciliation Post Discharge – (Part C) – CMS included this measure on the 2017 display page and will move the revised measure into the 2018 Star Ratings. CMS is considering rolling this indicator into a more comprehensive measure of care transitions with other indicators. This measure will be classified as a process measure with a weight of 1 for the 2018 Star Ratings. This measure will not be triple-weighted beginning with the 2019 ratings as proposed in the Advance Notice.
• Improving Bladder Control (Part C) – CMS temporarily moved this measure to the display page in 2016 and 2017. CMS will return this measure to Star Ratings beginning in 2018. The measure will return with an initial weight of 1.

Changes to Measures for 2018
• CMS made some minor methodology changes to numerous measures.
• CMS is looking for measures where performance has “topped out” to transition to the display page as measures are added in 2017.
Removal of Measures from Star Ratings

- High Risk Medication (HRM) (Part D) – Based on feedback to the Draft CY 2017 Call Letter, the HRM measure remained in Star Ratings for 2017. CMS will move this measure to the display page for 2018 (based on 2016 data) and will continue to provide HRM measure reports to Part D sponsors through the Patient Safety Analysis website and to identify outliers.

- Reducing the Risk of Falling (Part C) – This measure will remain in Star Ratings in 2018. Because the National Committee for Quality Assurance (NCQA) made several changes to this measure, the revised questions will be first collected in 2018, and there will be no data for this measure for the 2019 and 2020 Star Ratings.

Adjusting Star Ratings for Audits and Enforcement Actions

Last March, CMS suspended the reduction in the overall and summary Star Ratings of contracts under sanction while CMS reevaluates the impact of sanctions, audits, and civil money penalties (CMPs) on Star Ratings. After the November request for comments, CMS proposed a revision to the BAPP measure. The current BAPP measure is based on CMS’ sanctions, CMPs, and Compliance Activity Module (CAM) data and has been in use for Star Ratings since 2010. Currently, the BAPP measure receives a weight of 1.5 and is classified as an access measure.

In the Draft Call Letter, CMS proposed a number of revisions to the BAPP measure for the 2018 Star Ratings. After comments, however, CMS decided to retain the current BAPP measure in the 2018 Star Ratings. CMS will not reinstate the reduction in the overall and summary Star Ratings of contracts that are under sanction for the 2018 Star Ratings.

Beginning with the 2019 Star Ratings, CMS intends to remove all enforcement actions and the reduction for plans under sanction due to audit from this measure. Due to this change, CMS will retire the current BAPP measure for the 2019 Star Ratings and introduce a new BAPP measure on the 2019 display page. CMS is considering removing enforcement actions such as CMPs and sanctions from the measure. CMS will seek additional input in the fall Star Ratings Request for Comments. Key Compliance, Operations, and

Star Ratings professionals should review and provide input during the fall comment period. CMS strives for consistency and accuracy in audit process and enforcement and continues to make improvements in these areas. Since these areas as well as other operational issues resulting in less severe enforcement actions currently inform the BAPP measure, any proposed revisions should be reviewed with an eye towards consistency.

Data Integrity

CMS reminds organizations their policy has been to reduce a contract’s measure rating to 1 star if CMS determines incomplete, biased, or erroneous data has been submitted. These reductions would include cases where CMS identifies mishandling of data, inappropriate processing, or implementation of incorrect practices by the organization/sponsor that resulted in incomplete, biased, or erroneous data. CMS notes they continue to identify new vulnerabilities where inaccurate or biased data could exist and, therefore, intend to enhance data integrity reviews to identify incomplete or biased Star Ratings measure data. For this reason, GHG recommends a thorough evaluation of all data used as a basis for Star Ratings to evaluate for incomplete or erroneous processes which may result in incorrect data.

CMS piloted a new program audit protocol in 2016 evaluating Part D sponsors’ Medication Therapy Management (MTM) programs. After the pilot phase, CMS will review and apply any relevant MTM program audit findings for data integrity reviews for the MTM Comprehensive Medication Review (CMR) Completion Rate measure that could demonstrate systemic failures by sponsors which resulted in biased MTM data.

CMS received concerns from sponsors regarding CMS’ use of audit findings to determine the completeness of Independent Review Entity (IRE) data used for Star Ratings because only a small subset of sponsors are audited each year, and most result in data integrity reductions. Last November, CMS released an HPMS memo, “Industry-wide Appeals Timeliness Monitoring,” in which CMS discussed a large-scale monitoring project that will be implemented in 2017 (beginning with 2016 data on Part C organization determinations and reconsiderations (ODAG process) and Part D coverage determinations and redeterminations (CDAG process)). CMS cites this as a way for the
agency to assess the completeness of the data at the IRE across all contracts. CMS will review the findings and use them for the Star Ratings data integrity reviews for the four appeals measures, as appropriate, beginning with the 2018 Star Ratings. GHG sees this monitoring effort, already underway, as a step towards addressing concerns regarding consistency as it will provide a full picture of timeliness across all contracts. It remains to be seen whether the agency will also leverage this newly submitted data in their evaluation of timeliness during program audits, either by reducing or eliminating the duplicate burden of providing universes for timeliness or by adjusting internal timeliness thresholds based on industry performance.

CMS noted it will examine the appeals timeliness monitoring results with the aim of finding a method for scaled reductions instead of the standard reduction to 1 star. CMS is requesting additional input about other sources or bases on how to implement such scaled reductions.

2018 Star Ratings Program and the Categorical Adjustment Index (CAI)

CMS notes its application of the CAI for 2017 Star Ratings resulted in a modest movement of the Star Ratings. For 2018, CMS is proposing to continue the use of the CAI using the same methodology. The CAI values will be updated annually and published in the Final Call Letter. Low-income subsidy (LIS)/dual-eligible (DE) status for the 2018 Star Ratings will be based on the Medicare enrollment data from CY 2016. Please see the Call Letter for the proposed 2018 CAI values.

For the 2018 Star Ratings program, the analysis and criteria used to select measures for adjustment were the same as those used for the 2017 Star Ratings program. The measures proposed for adjustment for the 2018 Star Ratings are the following Part C measures for MA (MA-only, MA-PD) and 1876 contracts: Breast Cancer Screening, Osteoporosis Management in Women Who had a Fracture, and Diabetes Care – Blood Sugar Controlled. For the 2018 Star Ratings program, the two Part D measures – Medication Adherence for Hypertension (RAS antagonists) and Medication Therapy Management (MTM) Program Completion Rate for CMR – are proposed for adjustment for MA-PDs and PDPs.

Puerto Rico Update: For the 2017 Star Ratings, to address the lack of LIS, an additional adjustment was applied for contracts that solely serve the population of beneficiaries in Puerto Rico to make the application of the CAI equitable for contracts in Puerto Rico. CMS continues to explore alternative data sources for Puerto Rico but in 2018 will continue to employ the methodology developed for the additional adjustment using the 2015 data from the American Community Survey and CY 2016 Medicare enrollment data.

Because of the lack of LIS, Puerto Rico also has a unique challenge related to the medication adherence measures. CMS will continue to reduce the weights for the adherence measures to zero for the summary and overall rating calculations and maintain the weight of 3 for the adherence measures for the improvement measure calculations for contracts that solely serve the population of beneficiaries in Puerto Rico.

2018 CMS Display Measures Slated for Addition to 2019 Star Ratings

Several new measures with important operational implications for plans and providers are slated for addition to the 2019 ratings (for which the measurement period is already underway). These new measures require a cohesive strategy to perform well and may be a surprise to many providers:

- Statin Therapy for Patients with Cardiovascular Disease (Part C) and Statin Use in Persons with Diabetes (Part D) – Since the Healthcare Effectiveness Data and Information Set (HEDIS®) statin measures overlap with the measures developed by the Pharmacy Quality Alliance (PQA), CMS included only one of the HEDIS® measures on the 2017 display page and will retain it on the 2018 display page. After gaining experience with the new treatment guidelines and metric, CMS plans to include this measure in the 2019 Star Ratings.

- Hospitalizations for Potentially Preventable Conditions – CMS first included this measure on the 2017 display page with plans to move it into the 2018 Star Ratings. Due to concerns from NCQA, CMS proposes to continue this as a display measure for 2018 and move it to the 2019 Star Ratings.

- Change from Advance Notice: Non-recommended Prostate-Specific Antigen (PSA)-based Screening in Older Men – CMS is no longer considering this measure for addition for 2019 Star Ratings.
Forecasting to 2019 and Beyond

Looking to measures slated for addition beyond the 2019 ratings, CMS is emphasizing important areas which are not rapidly or easily influenced. It is important not to underestimate the runway needed to enhance operations for success on these measures in time to achieve high ratings once these measures are added to the program. Because these measures can be used as proxies for high-quality care that improves health outcomes and potentially improves medical cost management, these future new measures are also worthy of near-term activity.

Innovations in Health Plan Design

CMS provides a quick summary of the two current payment and service delivery models they are testing: the MA Value-Based Insurance Design (MA-VBID) and the Part D Enhanced MTM model tests, which both began on January 1, 2017. CMS received stakeholder suggestions and input on both these programs and will use this input for further program development.

SECTION II – PART C

Overview of CY 2018 Benefits and Bid Review

CMS has interpreted and applied the regulatory standards for service category cost-sharing standards and amounts, Per Member Per Month (PMPM) Actuarial Equivalence factors, and Total Beneficiary Cost (TBC) requirements for CY 2018 and has provided guidance on these requirements. CMS is not making specific adjustments or allowances for changes due to the ACA such as the medical loss ratio (MLR) or health insurance providers’ fee.

Plans with Low Enrollment

At the end of March, CMS notified affected MAOs that have fewer than 500 enrollees, or fewer than 100 for Special Needs Plans (SNPs), and have been in existence for three or more years of their decision not to renew these plans. Plans with low enrollment located in service areas that do not have a sufficient number of competing options will not receive this notification, as determined by CMS. MAOs receiving this notice must either confirm or provide a justification for renewal.

Meaningful Difference

CMS will continue to evaluate meaningful differences among CY 2018 non-employer and non-Cost contractor plans offered by the same MAO, in the same county, and under the same contract. CMS is not changing their methodology and will consider a difference of at least $20 PMPM between the out-of-pocket cost (OOPC) for each plan offered by the same MAO in the same county to be meaningful for purposes of applying the meaningfully different standard. The evaluation process will be the same as the Final CY 2017 Call Letter. CMS will release a detailed explanation in mid-April 2017 via an HPMS memo titled “CY 2018 MA Bid Review and Operations Guidance.”

CMS received many comments recommending the inclusion of provider network and premium in the meaningful difference evaluation. CMS agreed with the commentators that there is merit in evaluating differences in provider networks in this context and will consider the inclusion of premium in the meaningful difference evaluation for future years. CMS hopes to issue sub-regulatory guidance on this over the next year.

As a first step, in CY 2018, organizations may offer similar benefit packages through a plan that uses the contract-level network and another plan that uses the provider-specific plan (PSP) network, therefore excluding PSPs from the meaningful difference evaluation in CY 2018.

Total Beneficiary Cost (TBC)

Many comments requested an adjustment to the TBC threshold due to the health insurance providers’ fee. To provide flexibility for CY 2018 plans in addressing this factor, CMS is increasing the TBC threshold from $32 PMPM to $34 PMPM for most plans. Detailed TBC requirements and examples will be provided in mid-April 2017 via an HPMS memo titled “CY 2018 MA Bid Review and Operations Guidance.”

In the Draft Call Letter, CMS proposed it will exclude adjustments from the TBC calculation for CY 2017 plans that are consolidated into a CY 2018 plan. In the Final Call Letter, CMS stated it will maintain the TBC evaluation used during CY 2017 for consolidating plans and will address the details of this process in the HPMS memo described above.

Finally, if CMS allows a correction to the 2018 TBC following the submission deadline, the MAO is not permitted to change its formulary as a means to satisfy the TBC requirement.

Maximum Out-of-Pocket (MOOP) Limits

CMS provides the MOOP limits for CY 2018 on Page 121 of the Call Letter. As a reminder, although
the MOOP requirement is for Part A and Part B services, an MAO can include supplemental benefits as services subject to the MOOP. MA plans may establish as their MOOP any amount within the ranges shown in the table.

**PMPM Actuarial Equivalent (AE) Cost-Sharing Limits**

As indicated in the Final CY 2018 Call Letter, CMS has decided to permit cost-sharing for the first 20 days of the Skilled Nursing Facility (SNF) benefit for CY 2018. Therefore, SNF has been added back to the AE evaluation.

**Part C Cost-Sharing Standards**

For CY 2018, CMS will continue the current policy of affording MA plans greater flexibility in establishing Part A and Part B cost-sharing by adopting a lower voluntary MOOP limit than is available to plans that adopt the higher, mandatory MOOP limit. See Page 124 of the Final Call Letter for the CY 2018 In-Network Service Category Cost-Sharing Requirements.

**Major Changes in Cost-Sharing Requirements for CY 2018:**

- In the Draft Call Letter, CMS proposed not permitting cost-sharing for the first 20 days of the SNF benefit for CY 2018. Many commenters pointed out, as long as the overall SNF benefit is actuarially equivalent to original Medicare, the flexibility to impose cost-sharing in the first 20 days provides MAOs the opportunity to increase the number of plans they offer with a lower, voluntary MOOP amount. Due to the comments, CMS has decided not to finalize the change and will maintain the same SNF cost-sharing limit permitted in CY 2017 for MA plans with voluntary MOOPs. CMS notes, however, plans are still not permitted to apply a service category deductible or a per-stay amount to the SNF benefit.

- CMS proposed three additional cost-sharing thresholds for cardiac rehabilitation services, intensive cardiac rehabilitation services, and pulmonary rehabilitation services. These services have been an area of concern for CMS based on research conducted with organizations having higher than expected cost-sharing amounts or benefits designs that were not fully transparent to beneficiaries. CMS is NOT finalizing the addition of these cost-sharing categories for CY 2018.

- The Emergency Care/Post-Stabilization Care limit for plans has been increased for CY 2018 to better align cost-sharing with actual costs and as an incentive to use primary and specialty care services for routine care and avoid using the emergency room for non-emergent routine services. The voluntary MOOP amount has been increased from $75 to $100, while the mandatory MOOP amount has been increased from $75 to $80. CMS expects having different limits based on the plan’s MOOP amount will encourage organizations to offer benefit packages with a lower voluntary MOOP amount while maintaining beneficiary protections.

CMS expects to add other limits for inpatient acute and inpatient psychiatric days in future years. For example, CMS is considering additional limits for shorter stays for both inpatient acute and inpatient psychiatric applicable in CY 2019 and encourages organizations to take this into consideration for benefit design in 2018.

**EGWPs**

In CY 2017, CMS waived the requirement for MA employer plans to submit an MA or Part D Bid Pricing Tool (BPT), but employer plans must complete and submit the MA portion of the Plan Benefit Package (PBP) in accordance with CMS requirements. Organizations should make a good-faith effort in projecting CY 2018 member months for each plan and place the amount in Section A-2 of the PBP. The following question must be completed for all MA and 1876 Cost Plan organizations: “Indicate CY 2018 total projected member months for this plan.”

**CMS Monitoring and Compliance Activities Regarding Encounter Data**

MAOs are required to submit encounter data for each item and service provided to an MA plan enrollee. For PY 2018, CMS lowered the weight EDPS would carry for the overall risk score calculation to 15%, with RAPS having a weight of 85%. For PY 2017, the RAPS and EDPS risk scores are weighted 75% and 25%, respectively. There is some angst amongst the health plan community about the negative impact the transition to EDPS is having on the health plan’s risk score, and the decrease in weight will be a welcome change to health plans while CMS explores how to reduce the impact of the transition from RAPS to EDPS.

CMS reminds MAOs of the requirement to certify to the accuracy, completeness, and truthfulness.
CMS finalized the use of seven new performance measures to guide oversight and enforcement of encounter data submissions.

of their encounter data (based on best knowledge, information, and belief). CMS also notes they are conducting site visits with a sample of MAOs to understand different approaches to and issues with encounter data processing and to identify areas where CMS can improve technical assistance and guidance. These proposed monitoring measures will be used to review and evaluate whether an MAO’s encounter data submissions meet the regulatory standards applicable to RAPS and encounter data.

It is no surprise CMS will now be using performance measures related to encounter data submission to guide oversight and enforcement in this area to monitor complete and accurate submissions. CMS is implementing compliance actions for some failures to comply with the regulatory submission standards. The past few years, CMS has been taking a harder look at the data submission process and ways to measure “complete” and “accurate” submissions. The proposed measures, which have been finalized for 2018, provide substance around ways health plans should be tracking and validating their risk adjustment data submissions. Furthermore, these measures provide health plans a direct link to required processes that need to be followed for data submissions, which is something that has always been a little grey in the past.

CMS is focusing monitoring and compliance activity in these areas:

- **Operational Performance**: Refers to submitters’ performance related to encounter data submission requirements such as certification to submit, non-submission, and frequency of submission.

- **Completeness Performance**: Refers to both the overall volume of encounter data records as well as to the completeness of data within an encounter data record.

- **Accuracy Performance**: Refers to the reasonableness of encounter data patterns. Measures addressing the reasonableness of specific data elements or reasonable patterns in submitted data would be considered under the area of accuracy.

CMS has identified the following seven measures to guide its evaluation and oversight of MAO data submission. The established benchmarks and performance thresholds for these measures will be communicated through the Call Letter, HPMS memos, or other guidance communication method:

- **(Operational Performance O1)** Failure to complete end-to-end certification – All MA, MA-PD, Programs of All-inclusive Care for the Elderly (PACE), and standalone Part D plans are required to adhere to the risk adjustment data submission requirements in place. Upon establishing one of those plans, the MAO is required to register and become certified to submit RAPS and EDPS files to CMS. Failure to become certified will result in not passing this measure.

- **(Operational Performance O2)** Failure to submit any encounter data records – Once certified, MAOs are required to submit files in accordance with the timeline established under Operational Performance Measure O3.

- **(Operational Performance O3)** Failure to submit encounter data records on a timely basis – Timing of submissions is established based on the amount of membership within the plan as outlined in the Advance Notice.

- **(Operational Performance O4)** Excessive encounter data submission at the end of the risk adjustment data submission window – One of the objectives of the data submission process is for health plans to be able to validate the accuracy of their risk score for accepted encounter claims. In order to do this effectively, health plans must submit consistently throughout the year.

- **(Completeness Performance C1)** Extremely low volume of overall encounter data record submissions – Low volume of claims submissions can happen for a number of reasons. MAOs need to ensure all capitated providers are submitting claims and the submissions conducted are picking up ALL claim types.

- **(Completeness Performance C2)** Extremely low volume of accepted encounter data records by service type – CMS will be using benchmarks developed utilizing all MA data by regions. This measure is to deter MAOs from omitting any service types in their submissions.
• (Completeness Performance C3) Low matching rate of inpatient encounter data records to inpatient no-pay records – CMS will utilize the claim submissions certain hospitals are required to submit for “informational purposes only” to cross reference with the health plan’s encounter data submissions to look for gaps.

Quota Share Reinsurance
CMS indicated in the Draft CY 2018 Call Letter quota share reinsurance is not permissible under the Section 1855(b) requirement for MAOs to assume full financial risk. Quota share is a form of proportional (pro rata) reinsurance where the insurer and the reinsurer share risk based upon an agreed percentage, in some cases from the first dollar of expenses.

The Draft Call Letter also requested comments to assist in developing a proposal to establish the aggregate value specified in the statutory exception to this rule, which would be adopted in future rulemaking.

In the Final Call Letter, CMS noted it is reversing this interpretation due to clarity received through comments. CMS acknowledges the details of an arrangement (whether reinsurance or otherwise) for an MAO to share, transfer, or otherwise shift the risks identified in the exceptions listed in the statute are generally not limited by the statutory text. The statute permits MAOs to share risk proportionally as long as the risk (the type and amount) is in the exceptions. CMS may provide further clarifying guidance and/or potential future rulemaking to which MAOs would be held accountable at that time.

SNP-Specific Networks
CMS currently assesses MA network adequacy at the contract level, however, CMS is interested in exploring the potential benefits of establishing separate network adequacy evaluations of SNP-specific networks, given the different needs of the populations. All SNPs are required to limit enrollment to beneficiaries who meet the eligibility criteria for the type of SNP and to follow the same rules as non-SNP MA plans, but the key difference is SNPs provide focused care to special target populations based on their unique healthcare needs.

CMS seeks comment on how and whether SNP-specific networks do and should differ from non-SNP MA plan networks in order to provide adequate access to covered services in light of the needs of the SNP-covered population.

Based on the feedback from SNP stakeholders, CMS announced it will move forward with developing SNP-specific network adequacy evaluations.

PART D UPDATES

Approval of Tiering Exception Requests
In the Final Call Letter, CMS clarifies 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 requested drug resides, thereby making it a “preferred” drug. Eligibility should not be based on the label of the tier containing the alternative drug(s).

CMS also clarifies, in situations where the requested drug has alternatives in multiple lower tiers and the plan sponsor has approved the request for a tiering exception, the plan must apply the cost-sharing for the lowest applicable cost-sharing tier that contains alternatives for the requested drug. Consistent with the manual provision, the lowest cost-sharing tier is the “applicable lower cost-sharing tier.”

Finally, CMS is revising its interpretation of the regulatory term “dedicated to generic drugs” to include authorized generics. With this, “to the extent a formulary tier is made up of only generic drugs or authorized generics, such a tier is considered dedicated to generics whether or not specific authorized generic drug products are adjudicated at the cost-sharing applicable to such tier and a plan sponsor may exclude that tier from the tiering exception process.”

The term “authorized generic” drug is used to describe an approved, brand name drug that is marketed as a generic product without the brand name on its label. It may be marketed by the brand name drug company or another company with the brand company’s permission. In some cases, even though it is the same as the brand name product, the authorized generic may be sold at a lower cost than the brand name drug. As part of their required annual reports, New Drug Application (NDA) holders must notify the Food and Drug Administration (FDA) of any authorized generic drugs marketed under their approved NDAs. The FDA publishes a list of reported authorized generics and updates that list quarterly. The FDA publishes the list of authorized generics at the following link: FDA Listing of Authorized Generic Drugs.
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Changes to the Overutilization Monitoring System (OMS) Opioid Overutilization Methodology

In the Final CY 2017 Call Letter, CMS announced its intention to modify the OMS opioid overutilization criteria based on experience from compliance activities, additional analyses, and updates to the Centers for Disease Control (CDC) guideline for prescribing opioids for chronic pain. In response to the CY 2017 Call Letter, CMS received support for the proposed changes and is pursuing these modifications in the Final Call Letter with some changes from the draft. For example, response to comments, CMS increased the number of prescribers from four to five. See Page 157 for details.

CMS’ Expectation for Hard Formulary-Level Cumulative Opioid Morphine Equivalent Dose (MED) Point of Sale (POS) Safety Edits in CY 2018

CMS also stated in the Final 2017 Call Letter they expected all sponsors to implement a hard edit of 200mg MED (average MED method rather than consecutive high-MED days), at a minimum in 2018, using reasonable controls to limit false positives. In addition to a hard edit, sponsors may also choose to continue to implement soft edits in 2018.

CMS has decided not to finalize the proposal that all sponsors implement a hard edit. As in 2017, Part D sponsors are expected to implement hard and/or soft formulary-level safety edits based on a cumulative MED approach at POS at the pharmacy to prospectively prevent opioid overutilization. CMS recommends, if a soft opioid safety edit is implemented, the threshold be set at levels greater than 90 MED. For a hard opioid safety edit, CMS recommends a threshold at 200 mg MED or more.

Addressing Chronic Use of Benzodiazepine Sedative-Hypnotics (BSH) in the Medicare Part D Population

There continue to be concerns regarding the risks and benefits of benzodiazepine use, especially in the elderly, due to an increased risk of falling. After CMS assessed the PQA measure, CMS will not add the measure to the Star Ratings or display measures at this time since the overall use of BSH medications in the elderly is not an absolute contraindication per the Beers Criteria, and the BSH rates were low for most Part D contracts. CMS will continue to monitor BSH rates, and CMS will consider outreach to outlier contracts in the future, if necessary.

Coordination of Benefits (COB) User Fee

The 2018 COB user fee will be collected at a monthly rate of $0.116 for the first nine months of the coverage year (for an annual rate of $0.087 per enrollee per month), for a total user fee of $1.05 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2018 bids.

Part D Low Enrollment

As a reminder, CMS may non-renew Part D plans that do not have sufficient enrollees to establish they are viable plan options. CMS urges sponsors to voluntarily withdraw or consolidate any standalone plan with less than 1,000 enrollees. By April 2017, CMS will notify plans with less than 1,000 enrollees of available options for consolidation/withdrawal options.