Issue Brief

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KEY POINTS

- The release sets payment rates to Medicare Advantage Plans for calendar year 2017.
- CMS has included revised adjustment for plans that serve a significant population of dual-eligible beneficiaries and an adjustment to these plans' 5-Star rating. This adjustment will allow some plans to achieve a higher star rating and, as a result, additional revenue.
- MHA and members of the national hospital community have argued that the same sociodemographic factors that influence performance of MA plans can affect hospital payments for serving poorer communities with lower health status and assets.

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CMS Finalizes 2017 Payment and Policy Updates for Medicare Health and Drug Plans

The Centers for Medicare and Medicaid Services has issued final updates and changes to the Medicare Advantage and Part D programs. The 250 page "Announcement of Calendar Year 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" is at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Select "2017 Announcement."

In addition, the following sites include information on certain aspects of the Rate Announcement and Call Letter.

A general fact sheet on the 2017 Rate Announcement and Call Letter is at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-04.html.

More information on Puerto Rico and the 2017 Rate Announcement and Call Letter is at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-04-2.html. More information on steps the U.S. Department of Health & Human Services has taken to help ensure that residents of Puerto Rico continue to have access to quality and affordable health care and a more sustainable future is at: http://www.hhs.gov/about/news/2016/02/18/hhs-fact-sheet-working-solve-health-care-challenges-puerto-rico.html.

More information on Medicare Employer Retiree Plans (Employer Group Waiver Plans) and the 2017 Rate Announcement and Call Letter is at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-04-3.html.

The final policies are similar to those proposed on February 16. On average, the expected revenue change is 0.85 percent without accounting for the expected growth in coding acuity that has typically added another 2.2 percent. The final revenue increase is somewhat smaller than the increase estimated in the February Advance Notice primarily due to technical updates in the risk adjustment normalization factor.

CMS says a revised methodology used to risk adjust payments to plans will more accurately reflect the cost of care for dually-eligible beneficiaries. CMS also will implement an interim adjustment to the star ratings to reflect the socioeconomic and disability status of a plan's

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enrollees. Additionally, CMS's finalized policies will provide much needed stability to the Medicare Advantage program in Puerto Rico.

CMS is also finalizing policies that will further combat opioid overutilization by encouraging safeguards before an opioid prescription is dispensed at the pharmacy and maintaining access to needed medications.

RECENT TRENDS IN MEDICARE ADVANTAGE AND PART D

As noted in the February draft letter and again in this final letter, CMS reiterates that the Medicare Advantage and Part D programs continue to grow.

- Enrollment – has increased to more than 17.1 million — or 32 percent— of Medicare beneficiaries.
- Plan quality – percentage of MA enrollees in four or five star contracts is at 71 percent. About one-third of prescription drug plan enrollees are in standalone Part D plans with four or more stars, compared to 27 percent of enrollees in such plans in 2009.
- Premiums – today are lower than before the Affordable Care Act went into effect, dropping about 10 percent between 2010 and 2016.

2017 RATE ANNOUNCEMENT

Net Payment Impact

The chart below shows the expected impact of policy changes on plan payments relative to last year.

Impact	2017 Draft Notice	2017 Rate Announcement
Effective Growth Rate	3.0%	3.1%
Transition to ACA Rules	-0.8%	-0.8%
Rebasing/Repricing[1]	n/a	0.0%
Improved star ratings	0.1%	0.1%
Risk model revision	-0.6%	-0.6%
MA coding intensity adjustment	-0.25%	-0.25%
Normalization	-0.1%	-0.6%
Expected Average Change in Revenue from Prior Year	**1.35%**	**0.85%**
Coding Trend	2.2%	2.2%
Expected Average Change in Revenue	**3.55%**	**3.05%[2]**

[1] *Rebasing/re-pricing impact was dependent on finalization of average geographic adjustment index and is only available with the publication of the Rate Announcement.*
[2] *Totals may not add due to rounding.*

Risk Adjustment Model

As part of the announcement, CMS will implement a new Risk Adjustment Model for 2017. The new model has separate coefficients for partial benefit dually-eligible beneficiaries, full benefit dually-eligible beneficiaries, and nondually-eligible beneficiaries.

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MHA has been a national leader in calling for adjustments to performance-based payments to reflect sociodemographic status. This effort includes modeling enhancements that account for community- and ZIP code-level demographic influences not included in CMS' model for readmissions penalties under the traditional Medicare program. Recognition that these factors can influence the performance of health plans is a positive development in promoting a system that more accurately reflects community-based health disparities.

Coding Pattern Adjustment

Each year, as required by law, CMS makes an adjustment to plan payments to reflect differences in diagnosis coding between MA organizations and FFS providers. In CY 2017, CMS is making an adjustment reflective of the statutory minimum.

Using Encounter Data

CMS has used diagnoses submitted into CMS' Risk Adjustment Processing System. In 2016, CMS began using diagnoses from encounter data to calculate risk scores, by blending encounter data-based risk scores with RAPS-based risk scores. In 2017, CMS will continue using a blend, with a higher percentage of encounter data-based risk scores than in 2016. However, as a result of stakeholder feedback, a lower percentage of encounter-data based risk scores will be used in 2017 than was proposed in the Advance Notice. Specifically, for payment year 2017, risk scores will be calculated with a blend of a 25 percent weighting of encounter data and FFS and a 75 percent weighting of RAPS and FFS, with the intent to fully phase in the use of encounter data by 2020.

Medicare Employer Retiree (Employer Group Waiver Plans)

CMS notes that it has authority under the Social Security Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members in order to facilitate the offering of such plans. CMS will implement an alternate payment policy for Medicare Employer Retiree Plans beginning in 2017. In response to stakeholder feedback, CMS says it will phase-in this policy over two years, and will improve the timeliness of the proposed new payment system by providing CY 2017 final Medicare employer retiree plans local county payment rates now rather than in August.

2017 CALL LETTER

Star Ratings: Adjusting for Socioeconomic Status

Medicare Advantage plans that achieve high star ratings are eligible for Quality Bonus Payments.

Reducing Inappropriate Use of Opioids in Medicare Part D

For 2017, CMS expects Part D sponsors to implement formulary-level cumulative opioid point-of-sale edits, using a soft edit, hard edit or both to prevent opioid overutilization and to work toward a hard edit, at a minimum, in 2018 with reasonable controls to limit false positives at the point-of-sale.

Drug Utilization

- CMS is finalizing a number of updates intended to address drug utilization, waste and costs within the Part D program.
- Allowing Part D plans to designate specific drugs for which a beneficiary's initial fill could be limited to

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a one month supply, regardless of whether the drug is otherwise available as an extended days' supply. This change should eliminate waste when patients' initial doses may change or if they are removed from therapy due to side effects, adverse reactions or lack of clinical response. After the first one month supply, the change to extended days' supply would be seamless for the beneficiary.

- Encouraging sponsors to inform beneficiaries directly of additional formulary drugs that become available mid-year, as such drugs may provide more value or better quality options.
- Adding, by 2017 (or possibly sooner), a link from the Medicare Plan Finder website to the Medicare Drug Spending Dashboard to raise beneficiary awareness.

KEY CHANGES FROM THE ADVANCE (DRAFT) NOTICE

Growth Percentages: Attachment I provides the final estimates of the National MA Growth Percentage and the FFS Growth Percentage and information on deductibles for MSAs.

Table I-1 below shows the National per capita MA growth percentage for 2017. CMS has calculated the final MA growth percentage and the FFS growth percentage based on the assumption of a 0.5 percent update for the physician fee schedule for 2017.

An adjustment of 0.1 percent for the combined aged and disabled is included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled change is used in the development of the ratebook.

Table I-1: National Per Capita MA Growth Percentage for 2017

	Prior Changes	Current Changes			
	2003 to 2016	2003 to 2016	2016 to 2017	2003 to 2017	NPCMAGP for 2017 With §1853(c)(6)(C) adjustment[1]
Aged+Disabled	50.20%	50.35%	2.98%	54.84%	3.08%

[1] *Current changes for 2003-2017 divided by the prior changes for 2003 to 2016.*

The Affordable Care Act requires the Medicare Advantage benchmark amounts be tied to a percentage of the county FFS amounts. Table I-2 below provides the change in the FFS USPCC which will be used in the development for the county benchmark. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for 2017 divided by projected FFS USPCC for 2016 as estimated in the 2016 Rate Announcement released on April 6, 2015.

Table I-2: FFS USPCC Growth Percentage for CY 2017

	Aged + Disabled	Dialysis — only ESRD
Current projected 2017 FFS USPCC	$825.20	$7,023.24
Prior projected 2016 FFS USPCC	$800.21	$7,155.20
Percent Change	3.12%	-1.84%

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Table I-3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2016 and 2017. In addition, for 2017, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2017. These data were furnished by the Office of the Actuary.

Table I-3: Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2016 and 2017

	2016	2017	Change	2017 non-ESRD
Part A Benefits	$39.57	$39.43	−0.4%	$37.52
Part B Benefits[1]	$118.86	$125.73	5.8%	$116.05
Total Medicare	$158.43	$165.16	4.2%	$153.57

Calculation of FFS Rates: CMS is finalizing the methodology that it proposed for calculating FFS rates with two modifications. First, the rebasing of DME claims in non-competitively bid areas (non-CBAs) are based on the blended fee amounts instead of the proposed use of the fully adjusted fees. The blended payments, which have been used in payment since January 2016, are based on 50 percent of the unadjusted fee schedule amount and 50 percent of the fully adjusted fee amounts scheduled to be implemented in July 2016. This change is being made because the fully adjusted fees for 2016 have not yet been announced. Second, the Secretary has directed the Office of the Actuary to adjust the fee-for-service experience for beneficiaries enrolled in Puerto Rico to reflect the propensity of zero dollar claimants nationwide.

Medicare Advantage Employer Group Waiver Plans: CMS is finalizing the methodology that it proposed for calculating EGWP county payment rates with two modifications. First, in order to release final EGWP county payment rates in the Rate Announcement, CMS will use the average bid-to-benchmark ratio for individual market plan bids from the prior payment year to calculate the Part C base payment amounts for EGWPs. For example, the EGWP county payment rates for 2017 have been calculated using 2016 bid-to-benchmark ratios. Second, to provide employers and MAOs more time to adapt to this payment change, CMS is providing a two-year transition to the new EGWP county payment rate methodology.

CMS-HCC Risk Adjustment Models for CY 2017: CMS will fully implement the 2017 CMS-HCC Risk Adjustment model proposed in the Advance Notice, but have updated the coefficients using an updated denominator. Attachment VI contains the revised coefficients.

Normalization Factors: CMS is updating the 2017 normalization factors that were proposed in the Advance Notice. The 2017 Normalization factors are as follows.

- CMS-HCC model used for MA plans is 0.998
- CMS-HCC model used for PACE organizations is 1.051
- CMS-HCC ESRD functioning graft model is 1.051
- CMS-HCC ESRD dialysis model is 0.994
- RxHCC model is 0.976

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Encounter data as a diagnoses source for 2017: CMS will calculate 2017 risk scores by adding 25 percent of the risk score using encounter data and FFS diagnoses with 75 percent of the risk score using RAPS and FFS diagnoses.

PROPOSALS ADOPTED AS ISSUED IN THE ADVANCE NOTICE

As in past years, policies proposed in the Advance Notice that are not modified or retracted in the Rate Announcement become effective in the upcoming payment year. Clarifications in the Rate Announcement supersede materials in the Advance Notice.

MA Benchmark, Quality Bonus Payments and Rebate: The Affordable Care Act established a new benchmark methodology beginning in 2012. In the Advance Notice CMS announced the continued implementation of the methodology used to derive the benchmark county rates, how the qualifying bonus counties will be identified, and how transitional phase in periods were determined. The continued applicability of the star system was also announced. This Announcement finalizes these proposals.

IME Phase Out: For 2017, CMS will continue phasing out indirect medical education amounts from MA capitation rates.

ESRD State Rates: CMS will continue to determine the 2017 ESRD dialysis rates by state as it specified in the Advance Notice.

Clinical Trials: CMS is continuing the policy of paying on an FFS basis for qualified clinical trial items and services provided to MA plan members that are covered under National Coverage Determination 310.1.

Location of Network Areas for PFFS Plans in Plan Year 2018: The list of network areas for plan year 2018 is available on the CMS website at http://www.cms.gov/PrivateFeeforServicePlans/, under PFFS Plan Network Requirements.

Adjustment for MA Coding Pattern Differences: CMS will implement an MA coding pattern difference adjustment of 5.66 percent for payment year 2017.

Frailty Adjustment for PACE organizations and FIDE SNPs: CMS is finalizing the 2017 frailty factors as proposed.

Medical Loss Ratio Credibility Adjustment: CMS is finalizing the credibility adjustment factors as published in the MLR final rule (CMS-4173-F).

RxHCC Risk Adjustment Model: CMS will implement the updated RxHCC Risk adjustment model proposed in the Advance Notice. Attachment VI contains the risk adjustment factors for the RxHCC model.

Part D Risk Sharing: The 2017 threshold risk percentages and parameters for Part D risk sharing will be finalized as stated in the Advance Notice.

Part D Benefit Parameters: Attachment V provides the 2017 Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy.

Part D Calendar Year Employer Group Waiver Plans: CMS is finalizing the Part D CY EGWP prospective reinsurance policy as proposed.

COMMENT

The material presented here is but a sliver of the data and requirements presented. Anyone involved in submitting bid requests, need to fully review the material in the Final Call Letter.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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