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CLIENT ALERT

2015 Payment Notice and Final Call Letter: A Mixed Bag for Medicare Advantage and Prescription Drug Plans

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On April 7, 2014, the Centers for Medicare & Medicaid Services ("CMS") released the Announcement of Calendar Year ("CY") 2015 Medicare Advantage ("MA") Capitation Rates and Medicare Advantage and Part D Payment Policies ("Announcement") and Final Call Letter ("Call Letter").

The Announcement follows and responds to public and stakeholder comments on the February 21, 2014, Advance Notice and Draft Call Letter. Specifically, the Announcement describes the payment and risk adjustment methodology changes that will affect 2015 payments for MA and Part D plans and the Part D and retiree drug program benefit parameters for 2015. The Call Letter outlines policy modifications and other considerations for plan sponsors preparing bids for the 2015 contract year, which are due by June 2, 2014. See the previous Epstein Becker Green Client Alert on the Advance Notice.

Epstein Becker Green projects that the cumulative impact of the policies and factors affecting 2015 MA plan payments in the Announcement and Call Letter will result in an approximate 2 to 2.5 percent reduction in average payments as compared to 2014 levels. Payments to individual plans will vary significantly depending on a variety of factors. CMS used its discretion through the Announcement and Call Letter to mitigate some of the payment reductions proposed in the Advance Notice. However, several factors, including a lower than expected fee-for-service growth percentage, ensure that many plans will still face premium increases and benefit cuts.

These payment policies will impact a wide range of stakeholders, such as MA and Part D plan sponsors, pharmacy benefit managers, pharmacies, drug manufacturers, and the vendors that provide services and products to this segment of the health care industry. This Client Alert addresses some of the more significant payment policies in the Announcement. If you would like to discuss how the Announcement and Call Letter may impact your organization, please contact one of the authors of this Client Alert or the Epstein Becker Green attorney who regularly handles your legal matters.

PROVISIONS AFFECTING MA PAYMENTS

Estimated 2 to 2.5 Percent MA Plan Payment Reduction

As set forth in our earlier Client Alert, we had projected that the policies in the Advance Notice would lead to a 4.5 percent reduction in MA payments. Based on our analysis of the changes CMS made in the final Announcement, Epstein Becker Green projects an approximate 2 to 2.5 percent reduction in average 2015 MA plan payments as compared to 2014 levels, when all factors impacting payments are considered. This estimate is made through a comprehensive assessment of all the quantifiable positive and negative factors in the Announcement and Call Letter affecting payments.

However, it is important to note that payments to individual plans will vary significantly depending on a variety of factors. One key driver is whether a plan is eligible to receive a 5 percent quality bonus payment ("QBP") in 2015. The QBP is available only for plans that received an overall star rating of at least 4.0 for 2014. Plans with a rating of less than 4.0 stars therefore may see payment reductions that are significantly greater than 2 to 2.5 percent — which in turn will result in greater premium increases and benefit cuts.

As indicated in the Advance Notice, CMS will not extend the three-year demonstration program — which provided quality bonuses to MA organizations with ratings of 3 stars — beyond its scheduled conclusion in 2014.

Other important factors impacting the final level of payments to MA plans include:

- **Service Area** – In general, capitation rates for MA plan payments are determined at the county level. Complex statutory formulas determine the rates for each county, based on factors that include CMS estimates of Fee-for-Service ("FFS") costs in the county based on claims data, how the county's costs rank compared to other counties, and the MA Growth Percentage and FFS Growth Percentage. In general, county rates will experience significant cuts in 2015.

- **MA Growth Percentage –** The change in the national per capita MA growth percentage (affecting MA benchmarks and potentially MA plan rates) is negative 4.07 percent, approximately 0.52 percent lower than estimated in the Advance Notice, which is reflective of an underlying trend change of negative 0.07 percent. The MA growth percentage must also account for adjustments to estimates for prior years. This negative MA Growth Percentage is used to calculate rates in some counties.

- **FFS Growth Percentage** – The Aged/Disabled FFS United States per capita cost ("USPCC"), which will be used for the county portion of the benchmark, is reduced 3.3 percent to $768.8, significantly lower than the 1.65 percent reduction projected in the Advance Notice. This negative FFS Growth Percentage is broadly used in calculating county rates.

- **2015 Coding Adjustment Factor** – As proposed in the Advance Notice, CMS will apply a 5.16 percent coding pattern adjustment factor to MA payments, the lowest amount possible under the statute.

- **Normalization Factors** – CMS will alter the way it adjusts (or "normalizes") beneficiary risk scores under the risk adjustment models used in 2015. In response to comments, CMS will change its FFS normalization calculation to be based on four years instead of the two years proposed in the Advance Notice. Industry stakeholders urged the use of what CMS calls a "quadratic functional form," rather than the linear methodology proposed in the Advance Notice for determining 2015 normalization factors, in order to reflect more recent changes in population trends. These changes made by CMS are estimated to increase MA plan payments by approximately 4.3 percent over what they would have been, using the 2014 normalization factor methodology.

CMS Drops Proposal to Limit Use of In-Home Health Risk Assessments for Risk Adjustment Purposes

In response to strong stakeholder opposition, CMS will not implement for 2015 its discretionary proposal that diagnoses derived from in-home enrollee health risk assessments would not be accepted by CMS for risk adjustment purposes. CMS stated that it remains concerned that many home visits are being used to derive diagnoses for payment purposes rather than treatment purposes. Instead of implementing its Advance Notice proposal, CMS will track how many diagnoses are identified in home visits and evaluate what effect the assessments have on care provided to beneficiaries.

Positive Change in Weighting of Hierarchical Condition Categories ("HCC") Risk Adjustment from Advance Notice

The Announcement confirms the continuation of the approach implemented in 2014, to utilize an updated, clinically revised CMS-HCC risk adjustment model and to blend risk scores calculated using the updated model with risk scores calculated using the 2013 model. However, CMS has decided to weight the risk scores from the 2013 CMS-HCC model by 67 percent and the risk scores from the 2014 CMS-HCC model by 33 percent. This is a significant change from the Advance Notice, which proposed to weight the risk scores from the 2013 model by 25 percent and the 2014 model by 75 percent. This change in methodology is estimated to increase MA payments by 1.1 percent.

One-Year Delay in Transition to International Statistical Classification of Diseases and Related Health Problems - 10 ("ICD-10") Code Sets

The Advance Notice alerted plans that diagnoses collected in 2014 and used for 2015 risk scores would be affected by the scheduled ICD-10 conversion date. However, the "Protecting Access to Medicare Act of 2014" was enacted on April 1, 2014. One provision of the law delays the adoption of ICD-10 standard code sets by one year, to October 1, 2015.[1] Therefore, ICD-10 code sets will not be used for 2015 risk scores.

[1] Pub. L. 113-93, § 212 (2014).

CMS Will Implement as Proposed Its Accounting for Changes in FFS Reimbursement for Uncompensated Care and Durable Medical Equipment ("DME") Bidding

In the Advance Notice, CMS proposed adjusting MA benchmark rates to reflect changes in the uncompensated care methodology for hospitals under FFS. CMS also proposed changes to account for lower FFS spending since the implementation of the DME Competitive Bidding Program. Both of these proposals are being implemented through the Announcement.

PROVISIONS AFFECTING PART D PAYMENT

CMS Declines to Change Part D Risk Adjustment Model – CMS confirmed that it will not implement in 2015 its proposal from the Advance Notice to update the prescription drug hierarchical condition categories ("RxHCC") risk adjustment model for stand-alone Part D plans ("PDPs") and MA prescription drug ("MA-PD") plans. This proposal would have included MA-PD data in the model calibration. Most commenting stakeholders requested that CMS seek additional industry input and provide additional time to plan for implementation in the interest of payment stability.

Annual Adjustments for Defined Standard Benefit Parameters

As required by statute, the Part D benefit parameters must be indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. This ensures that the actuarial value of the standard drug benefit changes year-to-year to correspond to changes in Part D drug expenses, so that the benefit continues to cover a constant share of drug expenses. The revised 2015 parameters, which are the same as those proposed in the Advance Notice, are as follows:

	2014	2015
Deductible	$310	$320
Initial Coverage Limit	$2,850	$2,960
Out-of-Pocket Threshold	$4,550	$4,700
Total Drug Spending Out-of-Pocket Threshold for Those Ineligible for Coverage Gap Discount	$6,455	$6,680
Estimated Total Drug Spending Out-of-Pocket Threshold for Those Eligible for Coverage Gap Discount	$6,690.77	$7,061.76
Minimum Co-Pay in Catastrophic Portion of Benefit • Generic/Preferred Source Drug • All Other Drugs	 $2.55 $6.35	 $2.65 $6.60
Retiree Drug Subsidy • Cost Threshold • Cost Limit	 $310 $6,350	 $320 $6,600

CALL LETTER POLICIES

CMS announced in letters to members of Congress on March 10, 2014, that it would put on hold several significant changes relating to the use of preferred pharmacies and certain other policy changes in Part D that were announced in a January 10, 2014, Proposed Rule. CMS has not yet issued a final rule, and the timing is unknown. Meanwhile, the Call Letter proposes several narrower policy clarifications and changes for MA and Part D plans.

CMS Will Deny Clearly Inaccurate Part D Plan Bids

The Call Letter confirms the CMS warning in the draft Call Letter that sponsors submitting clearly inaccurate Part D bids for 2015 will receive a compliance notice letter and/or a corrective action plan. Plan sponsors may not be provided an opportunity to revise their bids to correct inaccuracies, which will lead to denial of the bids. Examples from the Call Letter of what CMS considers to be clear inaccuracies include a bid for an enhanced plan but not a basic plan, a bid for a non-defined standard plan that does not meet Part D benefit parameters, and a Part D bid that includes an incorrect crosswalk between the plan benefit package and formulary.

Provisions Relating to Star Ratings

- **Mitigation of Proposed Weighting Changes** – CMS simulated the effects of its proposal in the draft Call Letter to reduce the weights of three Part D Medication Adherence Measures from 3 to 1.5 and found that this would reduce overall star ratings for numerous MA-PD plans so that they would no longer be eligible for QBPs. Stakeholders also commented that such reweighting could be contrary to programmatic efforts to increase coordination of care. As such, CMS will maintain the weight of 3 for the Adherence Measures in the 2015 Star Ratings. CMS is additionally modifying the weight of the improvement measure from a weight of 3 to a weight of 5.

- **Enhancements and New Measures –** CMS will proceed with adoption of a new 2015 measure, Special Needs Plans ("SNPs") Care Management, in addition to changes to the following 2015 measures: Breast Cancer Screening (Part C), Annual Flu Vaccine (Part C), High Risk Medication (Part D), Medication Adherence for Diabetes Medications (Part D), Beneficiary Access and Performance Problems (Parts C and D), and Medication Adherence Measures (Part D). As described in the Advance Notice, CMS is providing early notification of potentially more significant changes to measures in 2016, such as removing pre-determined measure thresholds.

- **At the End of 2014, CMS Will Start to Terminate Plans with Less Than Three Stars in Three Consecutive Years** – CMS repeated its discussion from the draft Call Letter that it will move forward with terminating at the end of 2014 the MA and PDP contracts for organizations that, for three consecutive years, fail to achieve at least three stars on their Part C or D performance ratings. MA-PD contracts can be terminated if they received a Part C summary rating of less than

three stars in each of the most recent three consecutive rating periods, or a Part D summary rating of less than three stars in each such period.

- **No Change to Star Rating Methodology for D-SNPs** – CMS confirmed that it has no plans to adjust its Star Ratings methodology for SNPs serving beneficiaries dually eligible for Medicare and Medicaid ("D-SNPs") in spite of comments from stakeholders that allowances should be made for such plans due to challenges posed in serving the dual-eligible population.

New Disclosure Rules Go into Effect with the Possibility of Limits on MA Provider Contract Termination and Network Changes in the Future

As proposed in the draft Call Letter, CMS is implementing in 2015 several measures addressing notice and mitigation of provider contract terminations. Plans will be required to notify CMS when planning network changes that the plan deems significant. CMS and the plan will determine, in consultation, whether additional actions are required to ensure the plans network continues to meet Medicare adequacy standards. Also, plans must notify CMS at least 90 days prior to any no-cause network provider contract terminations deemed by the plan to be significant. CMS continues to consider notice and comment rulemaking to require earlier notice to providers and enrollees of provider contract terminations. In addition, CMS says that it would grant enrollees a special enrollment period to switch plans when an enrollee is affected by a substantial mid-year provider network termination initiated by an MA plan without cause.

CMS Focus on the Use of Preferred Pharmacies Continues Despite Postponement of Proposed Regulation

In its March 10, 2014, letter to members of Congress, CMS said that it would not proceed with the significant changes relating to the use of preferred pharmacies in Part D that were announced in a January 10, 2014, Proposed Rule.

Nevertheless, CMS used the Call Letter to re-emphasize its concern about beneficiaries potentially being misled into enrolling in some plans with limited access to preferred pharmacies. CMS reiterated in the Call Letter that it has contracted for a study of beneficiary access (including time and distance) to preferred cost sharing in order to evaluate whether to set network adequacy standards for preferred pharmacies.

CMS also stated that in the interim, it will take appropriate action in the case of plans with preferred pharmacies that offer too little meaningful access, such as requiring more preferred pharmacies during the bid negotiation process. Lastly, CMS said that beginning in 2015, it will no longer use the terms "preferred" and "nonpreferred" pharmacies, but rather will describe such pharmacies as offering preferred or standard cost-sharing.

CMS Will Not Implement Additional Coverage Requirements for Enhanced Alternative ("EA") Plans

In the interest of minimizing beneficiary disruption, CMS announced that it will not implement its proposal to require that EA plans provide reduced cost sharing for all covered generics in the coverage gap. In prior years, CMS has allowed Part D plan sponsors, as part of an EA benefit design, to offer reduced cost sharing in the coverage gap for a subset of Part D drugs.

Auto-Enrollment for Medication Therapy Management ("MTM")

CMS used the Call Letter to remind sponsors that enrollees must be auto-enrolled for MTM if they meet the criteria for targeted beneficiaries. Plan sponsors may commence targeted medication review ("TMR") or intervene with the enrollee's prescriber without waiting for an enrollee to accept the offer of a comprehensive medication review. CMS encourages the development of consensus on "more robust" definitions for MTM, comprehensive medication review, and drug therapy recommendations. CMS stated that without such consensus, it is likely to develop and impose additional standards in future rulemaking. CMS also said that sponsors not complying with MTM program requirements may be subject to compliance actions, that CMS will develop new audit performance elements for MTM programs, and that CMS may pilot MTM program audits as early as the 2014 or 2015 audit season.

In the draft Call Letter, CMS stated that plan sponsors may elect to offer MTM to an expanded population of beneficiaries and that these additional associated costs may be incorporated into the administrative costs of plan bids. In response to comments, CMS indicated that it would provide further guidance on the ability to report such activities as "quality improvement activities" for purposes of calculating medical loss ratios.

Modification to Employer Group Waiver Plan ("EGWP") Formulary Review

CMS stated in the draft Call Letter that the base-level formularies that EGWPs submit to CMS for approval during the formulary review process must include the total number of tiers that they want to use with their employer clients. The base-level formularies may then be enhanced for individual EGWP clients without having to seek additional CMS approval. In the Call Letter, CMS modified its position so that the sponsors need only submit the EGWP base formulary with the highest number of tiers that may be offered.

Expanded Coverage of Remote Access Technologies

For 2015, CMS will allow MA plans to cover services delivered through remote access technologies, such as real-time interactive audio and video technologies, as a mandatory supplemental benefit. CMS said that such services cannot be characterized as a Part C basic benefit if they go beyond the services that are covered by the limited telehealth benefit covered by the Medicare FFS program.

Prior Authorization Requirements to Determine Part D Drug Status

CMS currently allows Part D plans to use prior authorization ("PA") at Point-of-Sale ("POS") to determine whether a drug is covered under Part D or whether it is not covered (e.g., because it is covered under Parts A or B). In the Call Letter, CMS establishes certain criteria for identifying drugs with the greatest risk of non-Part D uses and says that it expects Part D plan sponsors to implement POS edits for PAs on such drugs. In response to comments, CMS declined to give more specificity about the drugs or drug classes that should be subject to PA. However, CMS said it intends to conduct outlier checks during the formulary review process and will share the results with sponsors so they can determine whether to add a PA or use other means for ensuring Part D coverage (such as through retrospective review).

Clarifying Guidance on Tiered Cost Sharing of Medical Benefits

Expanding on guidance in Chapter 4 of the Medicare Managed Care Manual, CMS clarified that plans may charge different cost sharing amounts for physicians or group practices in order to encourage members to seek care from providers favored by the plan based on quality and efficiency standards. Under such tiered cost sharing, beneficiaries must be charged the same amount for any specific physician and all physicians must be available and accessible to all plan members.

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This Client Alert was authored by **Mark E. Hamelburg, Thomas E. Hutchinson, S. Lawrence Kocot,** *and* **Philo D. Hall**. *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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