

CMS Proposes Significant Rate Cuts and Other Changes to Medicare Advantage and Prescription Drug Plans

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The Advance Notice (“Advance Notice”) of Methodological Changes for Calendar Year (“CY”) 2015 for Medicare Advantage (“MA”) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter was released by the Centers for Medicare & Medicaid Services (“CMS”) on February 21, 2014.

The Advance Notice describes proposed payment and risk adjustment methodology changes for MA and Medicare prescription drug benefit (“Part D”) plans. It also includes CMS’s preliminary estimates of factors that will affect 2015 payments for MA and Part D plans and the Part D and retiree drug program benefit parameters for 2015. The draft Call Letter outlines policy modifications and other considerations for plan sponsors preparing bids for the 2015 contract year.

A wide range of stakeholders are impacted by these proposals, including 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. Stakeholders may comment on the Advance Notice and draft Call Letter by 6:00 p.m. ET on March 7, 2014. Please visit the Medicare Advantage [Announcements and Documents web page](#) for more information about how to submit comments. If you would like to discuss submitting comments, please contact one of the authors of this Client Alert or the Epstein Becker Green attorney who regularly handles your legal matters. Final payment rates and the final Call Letter are to be released on April 7, 2014.

The March 7 comment deadline is also the same day that comments are due on a proposed CMS rule that would significantly change the Part D program for contract year 2015, along with other changes to the Part D and the MA programs (the “January 10, 2014, Proposed Rule”). See the [previous Epstein Becker Green Client Alert on the January 10, 2014, Proposed Rule](#). The January 10, 2014, Proposed Rule’s changes are not included in the draft Call Letter but could still be implemented for 2015 if, as CMS

expects, the final rule is released around the time of the April 7 release of the final payment rates and Call Letter.

PROVISIONS AFFECTING MA PAYMENTS

Estimated Four and a Half Percent MA Plan Payment Reduction

Prior to the release of the Advance Notice, a general consensus had emerged among analysts and stakeholders that, following statutory formulas, payments to MA plans would be reduced by 6 to 7 percent. While in the Advance Notice the administration projects a reduction in MA plan benchmarks of 1.9 percent, Epstein Becker Green projects that MA plans could face an approximate 4.5 percent reduction in MA plan payments from 2014 levels when all factors impacting payment rates are considered. While a 4.5 percent reduction is less than anticipated, it is still a significant payment reduction that will result in premium increases and benefit cuts. The following are some of the main factors impacting payment:

- **MA Growth Percentage** – CMS announces that the estimated change in the national per capita MA growth percentage (affecting MA benchmarks and potentially MA plan rates) is negative 3.55 percent, approximately 1.5 percent lower than anticipated. This reflects an underlying trend change of negative 0.07 percent and required adjustments to estimates for prior years.
- **Fee-for-Service (“FFS”) Growth Percentage** – Instead of the projected flat growth percentage, the current estimate of the increase in the Aged/Disabled FFS United States per capita cost (“USPCC”), which will be used for the county portion of the benchmark, is reduced 1.65 percent to \$795.11.
- **Minimal Mitigation to Expected 2015 Coding Adjustment Factor Update** – CMS has increased the adjustment factor for MA coding pattern differences by 0.25 percent, the lowest amount possible under the statute. As such, the updated adjustment factor for 2015 is 5.16 percent.
- **Preliminary Normalization Factors** – CMS proposes to alter the way it adjusts (or “normalizes”) beneficiary risk scores under the risk adjustment models used in 2015. CMS will change its FFS normalization calculation to be based on two years instead of five. This change increases MA plan payments by approximately 3 percent over what they would have been under the 2014 FFS normalization factor.

CMS Proposes New Limits on Using Diagnoses from In-Home Health Risk Assessments for Risk Adjustment Purposes

Not included in our projection of a 4.5 percent payment reduction are the impacts of CMS’s proposal that diagnoses derived from in-home enrollee health risk assessments cannot be submitted to CMS for a risk-adjusted payment. It is notable that CMS

exercised its policy discretion in a way that will reduce payments to plans. The significance of this further payment reduction will vary from plan to plan.

Hierarchical Condition Categories (“HCC”) Risk Adjustment

CMS proposes to continue in 2015 the approach implemented in 2014, which is to utilize an updated, clinically revised CMS-HCC risk adjustment model and to blend risk scores calculated using the updated model with the risk scores calculated using the old 2013 model. CMS will weight the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. This is different from the earlier projections of a 100 percent phase-in of the 2014 model.

Quality Bonus Payment Demonstration Ends, as Expected

The Affordable Care Act (“ACA”) authorized CMS to make quality bonus payments (“QBPs”) to MA organizations that meet quality standards of at least four stars when scored under a five-star rating system. CMS has been conducting a three-year demonstration program, which is scheduled to conclude in 2014, to test whether providing scaled QBPs to MA organizations with three-star scores led to more rapid improvements in quality scores. CMS confirms in the Advance Notice that it proposes to **not** extend the QBP program beyond its scheduled conclusion in 2014.

Expected Transition to International Statistical Classification of Diseases and Related Health Problems-10 (“ICD-10”) Code Sets

CMS reminds plans that the change from ICD-9 to ICD-10 code sets is scheduled to take place by October 1, 2014. Because risk scores for plan payments are based on diagnoses from the previous year, 2015 risk scores will be calculated using data from both ICD-9 codes (from dates of service January 1, 2014, to September 30, 2014) and ICD-10 codes (from dates of service October 1, 2014, to December 31, 2014). This increases the importance for MA plans and their network physicians to effectively transition to the ICD-10 to record accurate diagnoses.

Mixed Results of Accounting for Changes in FFS Reimbursement for Uncompensated Care and Durable Medical Equipment (“DME”) Bidding

CMS proposes to adjust MA benchmark rates to reflect changes in the uncompensated care methodology for hospitals under FFS, which will likely increase payments in urban areas. Additionally, MA benchmark changes will account for lower FFS spending under the DME Competitive Bidding Program, which may outweigh the benefit of the uncompensated care adjustment in certain markets.

PROVISIONS AFFECTING PART D PAYMENT

Changes to Part D Risk Adjustment Model – CMS proposes certain changes to the Part D risk adjustment model for stand-alone Part D plans (“PDPs”) and MA prescription

drug (“MA-PD”) plans. Among the changes in the updated model is the inclusion of MA-PD data in the model calibration. As Part D costs in MA-PD plans historically are lower than those of PDPs, this could lower risk adjustment payments attributable to Part D benefits. This, in turn, would tend to increase premiums and/or reduce plan benefits. Further analysis will be necessary to determine the ultimate impact on individual plans.

Annual Update to Part D Benefit Parameters

CMS is required by statute to update the parameters for the defined standard Part D prescription drug benefit annually. These updated parameters are to be indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries. The revised 2015 parameters are as follows:¹

	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	\$2.55	\$2.65
• All Other Drugs	\$6.35	\$6.60
Retiree Drug Subsidy		
• Cost Threshold	\$310	\$320
• Cost Limit	\$6,350	\$6,600

CALL LETTER POLICIES

The draft Call Letter does not include the changes in the January 10, 2014, Proposed Rule. Instead, the draft Call Letter proposes several important, but more limited, policy clarifications and changes.

Threat to Deny Clearly Inaccurate Part D Plan Bids

CMS says that sponsors submitting clearly inaccurate Part D bids for 2015 will receive a compliance notice letter and/or a corrective action plan. More importantly, CMS warns sponsors that they might not be provided an opportunity to revise their bids to correct

¹ Per the ACA, cost-sharing percentages are changing to fill in the coverage gap phase of the Part D benefit. By 2020, beneficiary cost sharing for all covered brand and generic drugs and biological products will equal 25 percent until the beneficiary reaches catastrophic coverage.

inaccuracies, leading, therefore, to denial of the bids. Examples of bids that CMS says are clearly inaccurate are those that have 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

- **Proposed Weighting Changes** – CMS solicits comments on potentially reducing the weights of three Part D Medication Adherence Measures from 3 to 1.5.
- **Enhancements and New Measures** – CMS proposes a new 2015 measure, Special Needs Plans (“SNPs”) Care Management, as well as changes to 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). CMS also proposes potentially more significant changes to measures in 2016, such as moving to a new scoring methodology for the 2016 Star Ratings by removing the pre-determined measure thresholds. As noted in the draft Call Letter, CMS believes that these pre-determined measure thresholds result in a loss of information when “aggregating up to the overall and summary ratings.”
- **Termination of Plans with Less Than Three Stars in Three Consecutive Years** – Under previously enacted regulations, CMS has authority to terminate 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. The final year of a transition period for the rule is 2014. Accordingly, CMS says that it will terminate such contracts for 2015 when ratings are released in the fall of 2014.
- **No Change to Star Rating Methodology for D-SNPs** – CMS declines to adjust its Star Ratings methodology for SNPs serving beneficiaries dually eligible for Medicare and Medicaid (“D-SNPs”) despite requests that CMS make allowances for such plans due to certain challenges posed by serving the dual-eligible population. CMS maintains in the draft Call Letter that organizations “can develop and implement approaches that enhance access to and coordination of care and improve the quality of care, which would then be reflected in higher Star Ratings.” CMS believes its existing payment and Star Ratings methodologies “adequately address differences between these populations and other MA enrollees.”

New Disclosure Rules and Possible Future Limits on MA Provider Contract Termination and Network Changes

In response to recent high-profile provider contract terminations, CMS discusses and requests comment on several measures addressing notice and mitigation of contract

terminations. This includes requiring submission to CMS of written plans detailing the steps that plans would take to ensure that impacted enrollees are able to secure new providers that meet their needs. CMS is also considering notice and comment rulemaking to require earlier notice to providers and enrollees of provider contract terminations.

Potential New Rules Relating to the Use of Preferred Pharmacies

The January 10, 2014, Proposed Rule includes a variety of significant changes relating to the use of preferred pharmacies in Part D, including allowing more pharmacies to become preferred and imposing new restrictions around pharmacy payments. The draft Call Letter discusses potential additional requirements. CMS says that it is concerned that beneficiaries may be enrolling in some plans with limited access to preferred pharmacies, which could be attributed to misleading the beneficiaries or otherwise violating CMS marketing rules. Accordingly, CMS says that it will study beneficiary access (including time and distance) to preferred cost sharing in order to evaluate whether to set network adequacy standards for pharmacies offering preferred cost sharing. CMS also said that while it was not adopting preferred pharmacy network adequacy standards at this time, the agency could take actions for 2014 and 2015 regarding plans with preferred cost sharing that offer too little meaningful access, such as requiring more preferred pharmacies during the bid negotiation process.

Additional Guidance for Enhanced Alternative (“EA”) Plans

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. For 2015, CMS proposes to require that EA plans provide reduced cost sharing for all covered generics in the coverage gap. Further, if an EA plan provides reduced cost sharing for brand drugs in the coverage gap, the plan would have to reduce cost sharing for all brands. However, CMS asks for comment on whether it should apply a different policy to brand drugs. CMS believes that the change in policy is necessary to ensure that EA plans offer meaningfully different benefits from standard plans, given the cost-sharing reductions in the gap that are now required of all Part D plans.

Medication Therapy Management (“MTM”)

The January 10, 2014, Proposed Rule significantly expands the classes of the beneficiaries to be targeted for MTM. Although CMS is not proposing any additional MTM policy requirements in the draft Call Letter, CMS reminds sponsors that enrollees must be auto-enrolled for MTM when they meet the criteria for targeted beneficiaries. Sponsors need not wait for an enrollee to accept the offer of a comprehensive medication review before commencing targeted medication review (“TMR”) or intervening with the enrollees prescriber. CMS encourages industry to reach consensus on “more robust” definitions for MTM, comprehensive medication review, and drug therapy recommendations, otherwise CMS will develop and impose additional standards in future rulemaking. CMS also believes that plan sponsors may elect to offer

MTM to an expanded population of beneficiaries, and these additional associated costs may be incorporated into the administrative costs of plan bids.

Employer Group Waiver Plan (“EGWP”) Formularies

CMS clarifies that base-level formularies that EGWPs submit for approval to CMS 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 CMS approval.

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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 or if you would like to discuss submitting comments on either the Advanced Notice or the January 10, 2014, Proposed Rule, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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