

## **CMS Takes a Measured Approach to Medicare Advantage and Part D Plan Payment Rates and Policy Changes for 2016**

### ***Increased Part D Drug Costs Set the Stage for Higher Beneficiary Premiums***

by **Thomas E. Hutchinson, S. Lawrence Kocot, and Philo D. Hall**

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The Advance Notice (“Advance Notice”) of Methodological Changes for Calendar Year (“CY”) 2016 for Medicare Advantage (“MA”) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter<sup>1</sup> was released by the Centers for Medicare & Medicaid Services (“CMS”) on February 20, 2015. 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 2016 payments for MA and Part D plans and the Part D and retiree drug program benefit parameters for 2016. The draft Call Letter outlines policy modifications and other considerations for plan sponsors preparing bids for the 2016 contract year.

In a break from prior years, when the Advance Notice signaled deep MA rate cuts and substantial CMS policy shifts, CMS is proposing only minor adjustments to MA and Part D plan payment and policies for 2016. Some individual plans will be more impacted than others by the new payment rates based on their location and enrollee mix; however, the biggest impact in 2016 may be felt by Part D beneficiaries as the Advance Notice highlights increased drug expenses, signaling that Part D premiums will likely be on the rise for the coming plan year.

Despite the more tempered approach by CMS for 2016, a wide range of stakeholders will be subject to the policy proposals discussed in the Advance Notice and draft Call Letter, 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 6, 2015. If you have questions concerning the content of the Advance Notice and draft Call Letter or would like to discuss submitting comments, please contact one of the authors of

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<sup>1</sup> Centers for Medicare & Medicaid Services, Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter, February 20, 2015, available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf>.

this Client Alert or the Epstein Becker Green attorney who regularly handles your legal matters. Final payment rates and the final Call Letter will be released on April 6, 2015.

### PROVISIONS AFFECTING MA PAYMENTS

#### Estimated 0.5 Percent MA Plan Payment Increase

In the run up to the release of the Advance Notice, many in the industry had feared that payments to MA plans would be significantly reduced, comparable to the reductions proposed last year. The Advance Notice projects a 1.7 percent increase in county benchmarks offset by a 0.9 percent reduction due to the continued phase-in of the new methodology for MA benchmarks established in the Affordable Care Act (“ACA”). It is important to note, however, that the 0.9 percent reduction is a national average. The effects of the reduction could be much more significant (reductions of up to 4 to 5 percent) for plans in counties subject to the six-year phase-in of the ACA methodology.

Epstein Becker Green projects that MA plans could realize an approximate 0.5 percent increase in MA plan payments over 2015 levels when all factors impacting payment rates (benchmark calculations and risk adjustment changes) are considered. At the same time, certain plans in some counties may be subject to payment reductions due to the phase-in and their patient mix leading to premium increases and benefit cuts in certain areas. However, the overall impact of the Advance Notice is that payments to plans will increase slightly or remain flat.

The following are some of the main factors impacting payment:

- **Fee-for-Service (“FFS”) Growth Percentage:** Slightly less than the projected increased 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 increased 1.47 percent to \$780.12.
- **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 2.68 percent, approximately 0.23 percent higher than anticipated. This reflects an underlying trend change of 1.14 percent and required adjustments to estimates for prior years. Consistent with 2015, CMS projects that Congress will prevent Medicare physician payment reductions under the sustainable growth rate from occurring in 2016. The higher MA Growth Percentage compared to the FFS Growth Percentage means that some counties should experience some relief from the ACA’s mandated benchmark caps.
- **Proposed Statutory Minimum Coding Adjustment:** 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 2016 is 5.41 percent.
- **Preliminary Normalization Factors:** Consistent with 2015, CMS proposes to use a “quadratic functional form” to risk scores from the last four years to reflect more recent changes in population trends when calculating FFS normalization.

## **Hierarchical Condition Categories (“HCC”) Risk Adjustment**

CMS proposes to complete the transition in 2016 to 100 percent utilization of the clinically revised CMS-HCC risk adjustment model first proposed in 2014 (“2014 model”). For the last two years, CMS has used a blend of the 2014 model and the prior 2013 model. The full implementation of the 2014 model is the most significant factor offsetting the increases to the benchmarks: a 1.7 percent reduction. This is because the 2014 model excludes several diagnoses that CMS believes were being coded very frequently by certain MA plans that were “most aggressive in coding,” such as stage 1-3 chronic kidney disease and polyneuropathy. CMS states that excluding such diagnoses “makes the payment system fairer.” However, this means that payments to plans for beneficiaries with those chronic conditions will be reduced. As a result, plans with disproportionately large numbers of beneficiaries with chronic conditions, such as special needs plans (“SNPs”), will face larger reductions.

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

CMS notes that the change from ICD-9 to ICD-10 code sets is scheduled to take place by October 1, 2015. Because risk scores for plan payments are based on diagnoses from the previous year, risk scores for 2016 will be calculated using data from both ICD-9 codes (from dates of service January 1, 2015, to September 30, 2015) and ICD-10 codes (from dates of service October 1, 2015, to December 31, 2015). This increases the importance for MA plans and their network physicians to effectively transition to the ICD-10 code sets to record accurate diagnoses.

## **PROVISIONS AFFECTING PART D PAYMENT**

### **Adjusting Part D Risk Adjustment Model to Account for Chronic Hepatitis C Medications**

CMS proposes changes to the Part D risk adjustment model for stand-alone Part D plans (“PDPs”) and MA prescription drug (“MA-PD”) plans. Most notably, CMS makes adjustments to account for the emergence of several high-cost medications for chronic Hepatitis C. While the 2016 Part D model was calibrated using 2013 expenditure data, CMS accounts for the cost of the new Hepatitis C treatment regimen by adding expenditure data from 2014 when such treatments became widely available. CMS thereby increases the Chronic Hepatitis C RxHCC coefficient. CMS notes that the high cure rates of these new chronic Hepatitis C medications pose a challenge as CMS’s prospective RxHCC model is designed to predict future costs based on historical data and is not prepared to account for disease costs that are diagnosed, treated, and cured within one year.

Additionally, MA-PD data will be included in the model calibration as occurred for the 2015 plan year.

### **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 (“annual percentage increase”). Specifically, the annual percentage increase is the “average

expenditures for Part D drugs in the United States for Part D eligible individuals . . . for the 12 month period ending July of the previous year.”<sup>2</sup>

For 2016, it is noteworthy that the benefit parameters reflect an 11.76 percent increase in Part D average per capita drug expenses projected through July 2015. The actuarial value and cost of the Part D benefit increases commensurate with increases in drug expenses, and the Part D benefit covers a constant share of beneficiary drug expense. Therefore, the Medicare Trust Fund will absorb a large percentage of the increasing Part D drug expense; at the same time, Part D beneficiaries’ premiums will likely increase as well.

This update to the benefit parameters reflects higher annual Part D expenses, some of which can be attributed to increasing costs of generics and greater utilization of high-cost specialty drugs. Per capita drug cost increases in Part D should be followed closely in the coming years as an accelerating drug expense trend will result in higher costs to the Medicare Trust Fund and Part D beneficiaries.

The revised 2016 parameters are as follows:

	2015	2016
Deductible	\$320	\$360
Initial Coverage Limit	\$2,960	\$3,310
Out-of-Pocket Threshold	\$4,700	\$4,850
Total Drug Spending Out-of-Pocket Threshold for Those Ineligible for Coverage Gap Discount	\$6,680	\$7,062.50
Estimated Total Drug Spending Out-of-Pocket Threshold for Those Eligible for Coverage Gap Discount	\$7,061.76	\$7,515.22
Minimum Co-Pay in Catastrophic Portion of Benefit		
<ul style="list-style-type: none"> <li>• Generic/Preferred Source Drug</li> <li>• All Other Drugs</li> </ul>	<ul style="list-style-type: none"> <li>\$2.65</li> <li>\$6.60</li> </ul>	<ul style="list-style-type: none"> <li>\$2.95</li> <li>\$7.40</li> </ul>
Retiree Drug Subsidy		
<ul style="list-style-type: none"> <li>• Cost Threshold</li> <li>• Cost Limit</li> </ul>	<ul style="list-style-type: none"> <li>\$320</li> <li>\$6,600</li> </ul>	<ul style="list-style-type: none"> <li>\$360</li> <li>\$7,400</li> </ul>

## CALL LETTER POLICIES

The draft Call Letter proposes several modest policy adjustments and guidance in response to a number of long-running, high-profile issues. However, the policy proposals included in the draft

<sup>2</sup> Social Security Act § 1860D-2(b)(6).

Call Letter are not as controversial as those CMS proposed and withdrew last year in MA and Part D rulemaking for the 2015 plan year.<sup>3</sup> Rather, CMS indicates that several high-profile issues will be subject to further study into 2017.

### Provisions Relating to Star Ratings

- **Adjustments to Star Ratings for Socio-Economic Status:** In response to widespread concern among stakeholders that higher proportions of Medicare-Medicaid dually eligible beneficiaries (“duals”) cause lower star ratings for MA and Part D plans, on September 8, 2014, CMS issued a Request for Information (“RFI”), requesting analysis and research from stakeholders demonstrating the impact of dual status on quality measures. In response to data received to date, CMS believes that additional research is necessary into the cause of any different performance on quality measures for plans with significant proportions of duals. In the interim, CMS proposes to provide relief to plans by reducing by half the weights of six Part C measures and one Part D measure.
- **Termination of Plans with Less Than Three Stars in Three Consecutive Years:** Indicating that its policies for exercising this discretionary termination authority are evolving based on a new understanding of the impacts on beneficiaries, CMS announces a new *timeline* for conducting terminations of plans that have received star ratings of less than three stars in three consecutive years. The 2016 star ratings will be released in late 2015. A plan that is to be terminated under the policy based on a 2016 rating below three stars will receive a non-renewal notice in February 2016 with an effective date of December 31, 2016. When making a termination decision, CMS will not consider a plan’s 2017 star ratings and, as such, any plan that receives a 2016 termination notice will not have its 2017 ratings published or even calculated. CMS does not provide any standards on *how* it determines which plans with less than three stars in three consecutive years will be terminated.
- **Enhancements and New Measures:** CMS proposes a new 2016 measure, Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews, as well as changes to the following existing measures for 2016: Controlling Blood Pressure (Part C), Plan Makes Timely Decisions about Appeals (Part C), Plan All-Cause Readmission (Part C), Osteoporosis Management in Women who had a Fracture (Part C), Complaints about Health/Drug Plan (Part C & D), Improvement Measures (Part C & D), Appeals Auto-forward and Upheld Measures (Part D), Medication Adherence and Diabetes Treatment (Part D), Medication Adherence and Cholesterol (Part D), Obsolete NDCs (Part D), and CAHPS (Part C & D). In 2016, the following measures will be returned to the star ratings: Breast Cancer Screening (Part C), Call Center (Foreign Language and TTY Availability) (Part C & D), and Beneficiary Access and Performance Problems (Part C & D). As announced in last year’s Call Letter, CMS proposes to remove the pre-determined measure thresholds for 2016 star ratings in order to improve the accuracy of the assignment of overall Part C and D summary ratings.

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<sup>3</sup> See the Epstein Becker Green Client Alert at <http://www.ebglaw.com/publications/cms-scaled-back-changes-to-the-medicare-part-d-prescription-drug-and-medicare-advantage-programs-but-some-important-revisions-remain/>.

## Provisions Related to the Exceptions and Appeals Process

- **Highlighting Continued Focus on Compliance with Determination, Appeal, and Grievance Requirements:** Following up on its related August 2014 guidance as well as insights gained from recent plan audits and sanctions, CMS again emphasizes plan and obligations related to coverage denial notices and clinical request documentation. These are areas of “persistent noncompliance.” To further assist plans, CMS will issue a revised standard Part D denial notice.
- **Information at Point of Sale (“POS”):** CMS has heard from beneficiary advocacy groups that coverage determination requests would be more efficient if the standardized rejection notice provided at POS when a prescription cannot be filled contained personalized information, such as the beneficiary name, drug number, and reason for rejection. CMS requests comments from stakeholders on the benefits, costs, and necessary process of requiring such elements in future standard notices.
- **Appeals Tracking System:** CMS is proposing to develop a new Part D appeals tracking system “to receive regular data feeds for all coverage requests received and processed by plans in order to obtain a full data-stream of information from beginning to end.” CMS is considering a similar data system for Part C in the future.

## Access to Preferred Cost-Sharing Pharmacies

As in prior years, CMS continues to express its concern that beneficiaries may be misled into enrolling in some plans with limited access to preferred cost-sharing pharmacies (“PCSPs”), which could be attributed to violations of CMS marketing rules. CMS shares the results of some studies into PCSP access, which indicate that some beneficiaries, particularly in urban areas, have no access to PCSPs. In response, CMS will first publish its findings on PCSP access levels for each plan offering a preferred cost-sharing pharmacy benefit so that beneficiaries will be more fully aware of their drug plan options. Next, during the bid review process, CMS will require outlier plans to either increase access to PCSPs or ensure that they are not marketing themselves as offering preferred cost sharing where it is not truly available.

## Network Adequacy Guidance

CMS expresses concern with reports of MA plans’ online provider directories containing providers whose practices are closed or otherwise not accepting new patients. Such providers cannot be used to satisfy network adequacy requirements. CMS alerts plans that they are expected to establish and maintain a process to verify the true availability of network providers and their continued compliance with adequacy standards. Similarly, online provider directories are expected to be updated in real time with complete information about the availability of listed providers. CMS will pilot in 2015 new audit modules, including assessing plan compliance with provider network adequacy requirements.

## In-Home Health Risk Assessment Guidance

In-home health risk assessments (“HRAs”) are visits to MA beneficiaries performed by non-physician practitioners to assess beneficiary status for care planning and coordination purposes. In prior years, CMS proposed, but did not finalize, a policy to exclude, for payment purposes, diagnoses collected from HRAs that were not confirmed by a subsequent clinical encounter. For 2016, CMS is instead issuing several best-practice standards for HRAs for MA beneficiaries and “strongly encouraging” plans to adopt them. The standards address the substance of the review,

the qualifications of the clinician reviewer, and who receives the final product of the HRA. CMS will also track in 2015 care received by beneficiaries following HRAs.

### **Standardized Initial Health Assessments**

MA plans are required to conduct an initial assessment of each beneficiary's health needs within 90 days of enrollment. CMS does not require that the initial assessment contain standardized components but "strongly encourages" plans to adopt the components of the Centers for Disease Control and Prevention ("CDC") Model HRA in 2016.

### **Value-Based Contracting**

CMS expresses interest in further testing and embracing innovative payment models to improve quality and reduce cost. CMS will commence conversations with MA plans about their utilization of physician incentive payments and value-based contracting to determine how these and similar innovations may be incorporated into MA program policies.

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*This Client Alert was authored by **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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