2017 Medicare Advantage Plan Advance Notice and Draft Call Letter Summary

On February 19, 2016, the Centers for Medicare & Medicaid Services (CMS) released the 2017 Medicare Advantage (MA) and Part D Advance Notice and Draft Call Letter. The CMS notice also applies to MA Special Needs Plans (SNPs).¹ For an overview of SNPs, click here.

Background
Each year, CMS issues an Announcement and Call Letter to MA organizations planning to offer MA and/or Part D plans in the following year. The Announcement and Call Letter includes updates to MA payment rates and guidance to plan sponsors as they prepare their bids for contracts with CMS. The Advance Notice and Draft Call Letter provides preview of CMS’ proposed changes, as well as an opportunity for plans and stakeholders to provide input on the contents of the final Announcement and Call Letter.

Summary
This summary highlights key proposed changes to MA plan payment methodology as well as additional CMS guidance to plans that may be of interest to skilled nursing facilities (SNFs) for plan year 2017. The complete document may be accessed here.

The following proposed provisions and policies are of most note to AHCA members: 1) changes to MA payment methodology and rates, 2) promotion of dual eligible special needs plans (D-SNPs) as a care delivery model for dual eligible beneficiaries, 3) changes to requirements for beneficiary cost-sharing for SNFs, and 4) efforts to foster shifts away from traditional reimbursement methods to alternative payment methods in MA.

Advance Notice and Draft Call Letter Summary

Highlights for AHCA members in-brief include:

- CMS proposals for revised payments to plans for beneficiaries who are partially or fully eligible for both Medicare and Medicaid benefits (duals);
- Refresher guidance on how Medicare Advantage Special Needs Plans that tailor duals (D-SNPs) should coordinate with states;
- Guidance intended to improve beneficiary provider directory information;
- Equalization of out-of-pocket expenses between Part A (e.g., traditional Medicare fee-for-service (FFS) and MA;
- Guidance on MA plan and provider data interoperability; and
- Exploration of MA plan payment to providers using alternative payment methods including value-based purchasing.

¹ Special Needs Plans (SNPs) include Institutional SNPs (I-SNPs), Chronic Condition SNPs (C-SNPs), and Dual Eligible SNPs (D-SNPs).
Detail on the highlights above and other Advance Notice elements are discussed below.

**MA Payment**

**National Per Capita Growth Percentage and the National Medicare FFS Growth Percentage:** The Affordable Care Act (ACA) requires that 2017 MA benchmarks be a set percentage of county-level fee-for-service (FFS) costs rather than MA costs in order to bring MA spending more in line with FFS. CMS estimates an increase of 3 percent in the Aged/Disabled FFS United States per capita cost (USPCC) which will be used for the county portion of the benchmark.

**Coding Pattern Adjustment:** CMS adjusts rates based on higher pattern of coding under MA. For 2017, CMS proposes modifying the adjustment factor for MA coding pattern differences by 0.25 percent, the lowest amount possible under the statute. The proposed updated adjustment factor for 2016 is 5.66 percent. This change is intended to reduce plan up-coding.

**Preliminary Normalization Factors:** Each year, CMS applies a “quadratic functional form” to the historical risk scores to reflect more recent changes in population trends.² Consistent with prior years, CMS proposes to use risk scores from the most recently available five-year period (2012 to 2015). The normalization factor for 2017 is approximately 0.1 percent higher than the 2016 normalization factor.

**Encounter Data as a Diagnosis Source for 2017:** In 2016, CMS initiated the transition to encounter data based risk scores by blending risk scores from the Risk Adjustment Processing System/FFS and the Encounter Data System (EDS), using weights of 90 percent and 10 percent, respectively. For CY 2017, CMS intends to continue using this blend methodology, but proposes to increase the weight of the EDS risk score to 50 percent.

**Hierarchical Condition Categories ("HCC") Risk Adjustment:** The Advance Notice and Draft Call Letter discusses proposed changes to the CMS-Hierarchical Condition Category (HCC) risk adjustment model for plan year 2017 intended to better predict costs for dual eligible beneficiaries. Specifically, CMS proposes to revise the 2017 HCC risk adjustment model to include separate coefficients for partial benefit dual eligible beneficiaries, full benefit dual eligible beneficiaries, and non-dual eligible beneficiaries living in the community; the current risk-adjustment model uses a single factor for all community beneficiaries. The six categories include:

- Full benefit dual aged
- Full benefit dual disabled
- Partial benefit dual aged
- Partial benefit dual disabled
- Non-dual aged
- Non-dual disabled

² “Quadratic functional form” is a regression model intended to better reflect historical population trends to improve the accuracy of the adjustment.
CMS explored creating separate dual factors for full benefit duals and partial benefit duals residing in institutions, but found that separate risk factors did not meaningfully improve the overall predictive accuracy of the institutional model. As a result, CMS proposes to retain a single institutional segment for any dual status. However, CMS proposes to update the institutional model to factor dual status during the payment year (the year the beneficiary is enrolled) rather than the base year (year prior to enrollment).

CMS indicates that these changes will improve the precision of the payments made to plans, and will increase payments for plans serving full benefit dual eligibles. However, the impact on individual MA plans will vary based on the populations enrolled. Plans with high numbers of partial benefit dual eligibles will likely receive lower per-member-per-month (PMPM) rates for these enrollees under the revised model, while plans with high numbers of full-benefit dual eligibles will receive higher PMPM rates for these enrollees under the revised model.

**MA Quality Bonus Payment Percentage:** The ACA provides for CMS to make quality bonus payments to MA organizations that meet quality standards under a five-star quality rating system, referred to as the “quality bonus payment (QBP) percentage.” Similar to 2016, CMS is proposing that plans that achieve four or more stars receive a 5 percentage point QBP bonus. For new MA plans and MA plans with low enrollment, CMS proposes that the QBP will be 3.5 percentage points.

**Employer Group Waiver Plans (EGWPs) Payment:** CMS proposes terminating the bidding process for MA Employer Group Waiver Plans (EGWPs) in 2017. EGWPs do not compete with individual market MA plans, and are offered instead through negotiated arrangements between MA organizations and employers and/or unions and are offered exclusively to retirees. Because these plans do not compete in the open market, CMS believes there is an incentive for EGWPs to bid as close as possible to the benchmark to maximize plan revenue. CMS has found that EGWPs typically bid much higher than individual MA plans despite lower projected risk scores. As a result, the Advance Notice proposes that EGWPs would receive predetermined payments based on individual market (non-EGWP) MA plan bids. CMS indicates that, under this approach, payments to EGWPs will more closely align with payments made to MA plans in the individual market.

The net effect of these changes is expected to increase payments to MA plans by 1.35 percent, on average, in 2017. When combined with expected growth in plan risk scores due to coding (2.2 percent), MA plans are expected to experience an average increase of 3.55 percent. This increase in rates may reduce pressure on plans to further reduce costs, which has historically resulted in reductions to provider reimbursement or reductions in authorized beneficiary length of stay.
**Star Ratings**

**Adjustments to Star Ratings for Duals/LIS/Disabled Status:** In 2016, CMS indicated that statistical evidence shows that there may be a causal relationship between the dual eligible or low income subsidy (LIS) status of an MA plan’s enrollees and that plan’s ability to achieve high ratings on certain Star Ratings measures. However, CMS noted that further research is necessary to determine whether the difference is a result of dual eligible status or other variables (e.g., disability status). Over the past year, CMS conducted extensive research to determine whether there is an association between plan performance on Star Ratings measures and vulnerability of populations enrolled. After reviewing the research, CMS determined evidence exists of differential outcomes for a subset of measures for LIS/dual eligible/disabled populations.

CMS is working with measure developers, National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA), and has requested that they examine their measure specifications used in the Star Ratings Program to determine if measure re-specification is needed. While CMS believes this work is needed before a long-term solution can be identified, the Agency proposes moving forward with an interim solution to account differences in plan performance due to enrollment of these vulnerable populations. Specifically, CMS proposes use of a “Categorical Adjustment Index” factor which would be added to or subtracted from a plan’s overall Star Rating to adjust for the average enrollee population disparity.

CMS indicates that implementation of this methodology would result in “modest negative adjustments” for plans with low proportions of LIS/dual eligible/disabled enrollees and “larger positive adjustments” for plans with high proportions of LIS/dual eligible/disabled enrollees.

**Contract Termination of Plans with Less Than Three Stars:** CMS restates its authority to terminate plan contracts that have failed to receive a rating of three stars or better for three consecutive years. CMS indicates that in February of each year, plans that have failed to achieve three stars in three consecutive years will receive non-renewal notices for the following plan year. Beneficiaries will be notified in March of the current plan year that they will need to select a new plan during the upcoming fall enrollment period. If adopted, this could result in significant disruptions to provider contracting and beneficiary enrollment. Providers would need to closely monitor changes in star ratings of plans with which they contract. Star ratings data can be accessed here.

**Dual Special Needs Plans (D-SNPs)**

**D-SNP Model of Care:** CMS reminds plans and other interested parties that states have the ability, through their contracting with D-SNP sponsors, to require that the D-SNP model of care (MOC) fully integrates long-term services and supports (LTSS) and coordinates the provision of all Medicare and Medicaid services. CMS also indicates that the Agency is interested in working with states to identify criteria that could be added to the CMS review criteria exploring ways for interested states to add specificity to existing elements describing state requirements related to the management of LTSS to the CMS review criteria for D-SNP MOCs.

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3 Low-income subsidy (LIS) beneficiaries receive assistance in paying for their Part D monthly premium, annual deductible, coinsurance, and copayments
In addition, rather than requiring two separate processes for review of D-SNP MOCs, one by the state for Medicaid and one by NCQA for Medicare, CMS proposes a concurrent CMS-state MOC review to reduce the administrative burden on plans seeking to offer integrated D-SNPs. CMS is seeking comments on the potential benefits and challenges of this approach.

CMS’ encouragement of further collaboration with states on D-SNP processes and procedures indicates that the Agency may view these plans as a desirable model for dual eligible benefit coordination and care delivery. To view current basic state and D-SNP approaches, click here.

**Provider Directory Accuracy**

**Guidance on the Future of Provider Directory Requirements and Best Practices:** CMS states that continued stakeholder concerns have deepened the Agency’s concerns regarding provider director accuracy, and indicates they are pursuing wide-scale efforts to monitor network adequacy and provider directory accuracy that are separate from the normal audit process to audit and validate provider network directories. Plans that are found non-compliant may be subject to compliance and/or enforcement actions, including civil money penalties (CMPs) or enrollment sanctions.

CMS also reiterates the Agency’s commitment standardizing requirements for provider directories across plans, and to align requirements with those of Qualified Health Plans (QHPs) in the commercial market as well as Medicaid managed care plans. CMS notes that regulatory updates would be needed to require MA organizations to issue provider directories that include the additional elements, and indicates that the Agency intends to propose such revisions that would encourage the inclusion of the following elements in provider directories:

- Machine readable content (can be read automatically by a web browser or computer system)
- Provider medical group
- Provider institutional affiliation
- Non-English languages spoken by provider
- Provider website address
- Accessibility for people with physical disabilities

In addition, CMS encourages MA plans to institute a practice of incorporating a “warm transfer” policy to their customer service call centers. Under this policy, if a beneficiary contacts a customer service representative to request information about a provider, the customer service representative would close the call by calling the provider’s office, relaying information about the enrollee, and transferring the enrollee to the provider’s office.

**Beneficiary Cost-Sharing for SNFs**

**Part C Cost Sharing Standards:** The ACA placed a mandatory maximum annual limit on all out of pocket medical costs for MA plans, which is referred to as the Maximum Out of Pocket (MOOP). MA plans may also elect a lower voluntary MOOP in exchange for increased flexibility in establishing cost sharing amounts for individual service categories.
For 2017, CMS proposes to reduce the cost sharing limit for voluntary MOOP plans for SNF days 1-20 from $40 per day to $20 per day for beneficiary protection. CMS also notes the Agency’s intention to reduce the cost sharing limit from $20 per day to $0 per day for CY 2018 to align SNF cost sharing with Original Medicare for both voluntary and mandatory MOOP. This proposed reduction in cost sharing could potentially alleviate the risk of bad debt for providers serving beneficiaries enrolled in those plans.

**Health Information Technology**

**Interoperability-MA Plans and Contracted Providers:** CMS notes it is exploring ways to encourage the adoption of technology that supports interoperability between MA plans and contracted providers, and the need for rulemaking to require such adoption. CMS seeks comment from industry stakeholders regarding their experiences with pursuing interoperability, including barriers to success.

**Value-Based Payment**

**Alternative Payment Models**
CMS indicates that it continues to support use of alternative payment models (AMPs) in MA to improve cost efficiency, reduce costs, and improve health outcomes, and has added APM-specific questions to the Part C reporting requirements to learn more about these efforts. Specifically, CMS will ask MA plans to report on the proportion of payments made to providers based on the HHS developed four categories of value based payment:

- Fee-for-service with no link to quality;
- Fee-for-service with a link to quality;
- Alternative payment models built on fee-for-service architecture; and
- Population-based payment.

CMS is also seeking comments from industry stakeholders regarding challenges and concerns associated with the use of APMs in MA.

**Next Steps**

CMS is accepting comments on the Advance Notice and Draft Call Letter through March 4, 2016 at 6 PM Eastern Time. Comments may be submitted electronically to the following address: AdvanceNotice2017@cms.hhs.gov. The Final Announcement and Final Call Letter are expected to be published on April 4, 2016.

AHCA continues to review CMS’ proposals and intends to submit comments on the Advance Notice and Draft Call Letter. Please email suggested comments or questions for submission to CMS by March 1, COB. Suggestions should be directed to Narda Ipakchi at nipakchi@ahca.org.