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CMS Medicare Advantage 2018 Advance Notice Summary

KEY HIGHLIGHTS

February 2017

Risk Adjustment

- Part C Coding Intensity Adjustment: 5.91%
- Part C Normalization Factor: 1.017
- Adjusted Effective Growth Rate average payment boost of 0.25% over 2017.
- EDPS to RAPS Blend Rate for 2018 to remain at 75% RAPS to 25% EDPS
- EDPS Program Proposals:
  - Development of a temporary, uniform, industry-wide risk score adjustment to provide stability and to offset dips during the transition to 100% encounter data-driven payment.
  - Roll-out of seven performance measures to track health plans adoption of EDPS; no punitive aspects for 2018.

Quality Measures

- 5-Star Rating QBP (Quality Bonus Payment) percentage Threshold & Bonus Percentage for 2018 remains unchanged from 2017:
  - Contract with fewer than 4 stars: 0% QBP percentage
  - Contract with greater than or equal to 4 stars: 5% QBP percentage
  - New MA Plans are eligible to receive a QBP percentage increase to the county rates of 3.5%
  - Low Enrollment contracts will be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points (Note: QBP Percentage is a percentage-point increase to the applicable percentage for each county in a qualifying plan's service area)
- Several measure changes including:
  - Two measures from the Display page moved into Star Ratings for 2018:
    - Medication Reconciliation Post Discharge (Part C) – Display page in 2017
    - Improving Bladder Control (Part C) – Display page in 2016 and 2017
- Removal of the High Risk Medication (Part D) from Star Ratings to the Display Page
- Modification to several measures to keep measure consistency with NCQA and PQA
- Adjustments to Star Ratings for Audits and Enforcement Actions:
  - CMS is proposing modifications to the current BAPP – Beneficiary Access and Performance Problems measure based on feedback from key stakeholders and considering a delay in implementation of the revised measure until 2019 Star Ratings/Display page for 2018
  - Categorical Adjustment Index (CAI) – CMS is proposing to continue the use of the interim analytical adjustment, CAI. The overall methodology would remain unchanged for 2018, but would apply to only five measures, as opposed to the seven measures adjusted in the 2017 Star Ratings.

Five Critical Takeaways & Action Concepts

1. *Risk Adjustment Payment Percent Change: 2017 to 2018*

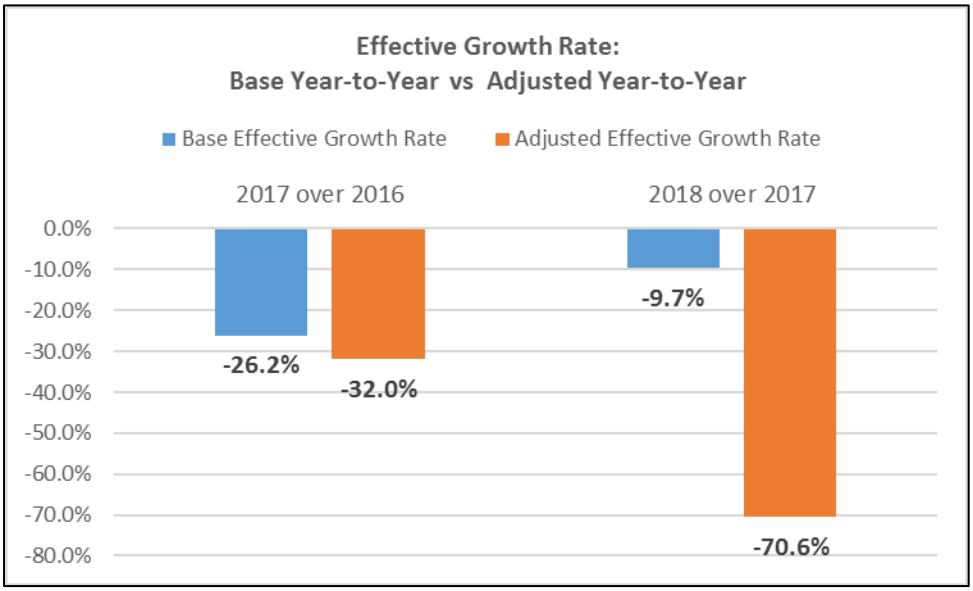
The adjustment variables for the 2018 Advance Notice and both the 2017 and 2016 Final Rate Announcements are listed in the below table in Figure 1a. Figure 1b is a graphic analysis of the Gross and Net Effective Growth Rate data contained in Figure 1a.

Figure 1a: **Year-to-Year Percentage Change in Payment Data Table**

Factors & Adjustment Variable	2016 Final Notice	2017 Final Notice	2018 Advance Notice
Effective Growth Rate: Gross	4.20%	3.10%	2.80%
Transition to ACA Rules	-0.80%	-0.80%	N/A
Rebasing/Re-pricing	-0.30%	0.00%	TBD*
Change in Star Ratings	0.50%	0.10%	-0.40%
Risk Model Revision	-1.70%	-0.60%	0.00%
MA Coding Pattern Adj.	-0.25%	-0.25%	-0.25%
Normalization Factor	-0.40%	-0.60%	-1.90%
Effective Growth Rate: Net	*1.25%*	*0.85%*	*0.25%*

* Rebasing/re-pricing impact is dependent on finalization of average geographic adjustment index and will be available with the publication of the 2018 Rate Announcement

Figure 1b: **Trend in Gross & Net Effective Growth Rate**



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Pulse8 Insight & Call-To-Action:

Effective Growth Rate (EGR) is an estimate for the change in national, per capita healthcare costs that is statistically derived from paid Fee-For-Service (FFS) claims analysis – it is, for all intents and purposes, a healthcare cost inflation rate estimate. CMS uses this Base EGR as a starting point to calculate the % change in each payment year's county-level capitation dollar amount. CMS applies multiple adjustments to the Base EGR to create an Adjusted EGR for the actual calculation of the new payment year's county-level county dollar values.

Figure 1a details the adjustments applied by CMS to the Base EGR to yield an Adjusted EGR. The Base EGR rate change is in decline, due to the industry's adoption of value model programs and the reduction in waste, fraud, and abuse. While the Adjusted EGR follows the Base EGR trend, its rate of decline is accelerated by CMS program adjustments. Figure 1b illustrates the spike in decline:

- *In comparing 2017 to 2016, the Adjusted EGR decline rate as a % of the Base EGR decline rate was **122%**; comparing the proposed 2018 to 2017, the Adjusted EGR decline rate as a % of the Base EGR decline rate is **728%** – that's a spike of **497%** when comparing 2018 over 2017 to 2017 over 2016.*
- *Figure 1c, below, illustrates the big % shifts in terms of county capitation payment rates for a theoretical county whose Payment Year 2015 capitation amount was $800. Figure 1c shows the dollar impact if the proposed 2018 Adjusted EGR were calculated using the 2017 % of Base EGR trend, (i.e. 122% of -9.7%, instead of 497% of -9.7%).*

Figure 1c: **Application of Proposed 2018 Adjusted EGR with Comparison**

Fictitious County Enrollment: 10,000 with an Average Member Months of 10 and Monthly Capitation Payment Rate of $800					
Estimates Using Actual 2018 Advance Notice Adjusted EGR of 0.25%					
Payment Year	Adjusted EGR	Capitation Dollar Amount			
2015		$ 800.00			
2016	1.0125	$ 810.00	Delta PMPM	Delta Total Dollars	
2017	1.0085	$ 816.89	$ 6.88	$ 688,500	
2018	1.0025	$ 818.93	$ 2.04	$ 204,221	
	Change: 2017/2016 to 2018/2017		$ 4.84	$ 484,279	
Estimates Using 2017 Trend-Derived 2018 Adjusted EGR of 0.75%					
Payment Year	Adjusted EGR	Capitation Dollar Amount			
2015		$ 800.00			
2016	1.0125	$ 810.00	Delta PMPM	Delta Total Dollars	
2017	1.0085	$ 816.89	$ 6.88	$ 688,500	
2018	1.0075	$ 823.01	$ 6.13	$ 612,664	
	Change: 2017/2016 to 2018/2017		$ 0.76	$ 75,836	
Delta Actual-to-2017 Trend-Derived Adjusted EGR			**$ (4.08)**	**$ (408,443)**	

In looking at Figure 1a, the primary drivers of the 726% swing in relative Base-to-Adjusted absolute percentage points are the 'Change in Star Ratings' and 'Normalization Factors' adjuster variables. Figure 1c uses some "back of the envelope" math to estimate the cumulative effect of the array of CMS adjustments at Negative $4.08 PMPM in a representative county with a monthly capitation rate of $800, which would represent a $400K hit to a 10,000-member Medicare Advantage plan.

MA plans with 4+ Stars should see the 'Change in Star Ratings' dip of -0.4% estimated average revenue as an indication that CMS projections of the changes for 2018 Quality Payment Program should push borderline payers back to 3.5 Stars at higher rate than in prior years.

The 'Normalization Factor' variable proposed for 2018 is projected to have a -1.9% impact on plan revenue, more than double 2017-to-2016. While -1.9% is a significant debit to plan revenue, it represents the "lesser of two evils," as CMS reverted its 'Normalization Factor' methodology to a linear equation after determining that the quadratic methodology (used since 2015) calculation yield was too punitive and not reasonable.

While the Net Effective Growth Rate for MA plans is a positive estimate for payment year 2018, when compared relatively to the healthcare cost inflation projections, it's entirely possible that the net impact on plan income will drop. MA plans will have to continue to conduct smart, efficient HCC gap closure initiatives.

2. Encounter Data Processing System (EDPS) Performance Measures Program for 2018

CMS is rolling-out of seven performance measures to track health plans' adoption of EDPS. The 2018 Advance Notice proposes three measure categories: Operational Performance, Completeness Performance, and Accuracy Performance.

- Operational Performance Measures: Track plans' certification to submit status, non-submission plans, and frequency of submission.
    - O1 Failure to Complete End-to-End Certification: CMS will assess certification status to identify contracts that have failed to complete end-to-end certification.
    - O2 Failure to Submit Any Encounter Data Records: CMS will assess failure to submit any encounter data records for a given calendar year.
    - O3 Failure to Submit Encounter Data Records on a Timely Basis: CMS will count whether an MAO has submitted files on a timely basis and as frequently as necessary. The frequency standards are based on the enrollment size of a contract as shown in the table below:

Number of Medicare Enrollees in the Contract	*EDR Minimum Submission Frequency*
Greater than 100,000	*Weekly*
50,000 – 100,000	*Bi-Weekly (every 2 weeks)*
Under 50,000	*Monthly*

    - O4 Excessive Encounter Data Submission at the End of the Risk Adjustment Data Submission Window: Submission of an excessive number of records at the end of the submission window indicates that encounter data records have not been submitted timely throughout the year.

- Completeness Performance: Quantifies and qualifies plans' encounter data as to the completeness of data volume down to field level quality checks.
    - C1 Extremely Low Volume of Overall Encounter Data Record Submissions: CMS regulations require submission of encounter data for all items and services provided to an MA enrollee; a low volume of submissions indicates that encounter data is not being submitted for all items and services on a timely basis.
    - C2 Extremely Low Volume of Accepted Encounter Data Records by Service Type: CMS will assess submitters' volume of accepted encounter data records by service type (inpatient, outpatient, professional, DME).
    - C3 Low Matching Rate of Inpatient Encounter Data Records to Inpatient No-Pay Records: Certain inpatient hospitals must submit "informational-only" bills (also known as "No Pay" claims) for MA enrollee discharges. CMS will assess the ratio of total *matched* No Pay claims to total No Pay claims.

- Accuracy Performance: Refers to the reasonableness of encounter data field patterns (e.g., reasonable patterns of HCPCs and diagnosis codes). CMS did not develop an Accuracy Performance measure for 2018, but there will be Accuracy Performance measures in 2019.

Pulse8 Insight & Call-To-Action:

Quote from Pulse8's 2017 Final Notice Commentary, in regards to EDPS integration:

"There are two disciplines MAOs will have to master in order to realize complete risk scores from EDPS. First, the technical mechanics of submitting EDPS data, complemented with strong BI reporting capabilities of MAO-004 results. Next, submitters must "peel back the onion layers" within their own data operations for both RAPS and EDPS output in order to fully understand the workflow, including embedded IT detours, and the applied data manipulations."

CMS' EDPS performance measure program proposal is a direct application of Pulse8's 2017 recommendation: CMS is taking actions that will require plans to "master the two disciplines" for successful submissions workflow. The 2018 performance measure results do not currently carry any punitive consequences, however, it may become necessary for CMS to "use the stick along with the carrot" in 2019 and beyond.

3. Encounter Data Processing System (EDPS) Risk Score Adjustment Proposal

CMS announced the EDPS to RAPS Blend Rate for 2018 will remain at 75% RAPS to 25% EDPS. Furthermore, the 2018 Advance Notice proposed to develop a uniform industry-wide risk score adjustment to provide stability during the transition to 100% encounter data-driven payment.

- The announcement of EDPS to RAPS Blend Rate for 2018 to remain at 75% RAPS to 25% EDPS, represents a two-year (and counting) delay of the original plan for the RAPS/EDPS blend rate to be raised to 50/50 for payment year 2017.
- The proposed EDPS risk score adjustment program dovetails with the announcement to delay the 50/50 split another year: CMS is acknowledging plans' concerns with the EDPS-calculated risk scores.
- The 2018 Advance Notice seeks feedback on the future EDPS risk score adjustment methodology:

- Methodology must include incentive for organizations to submit complete encounter data.
- The level of a potential, uniform, industry-wide adjustment
- The rationale and calculations for deriving such an adjustment
- Whether a uniform adjustment should apply to only full risk beneficiaries, or could be modified to apply to all beneficiaries (including new enrollees)

Pulse8 Insight & Call-To-Action:

Quote from Pulse8's 2017 Final Notice Commentary, in regards to EDPS integration:

"Risk score declines due to discrepancies between RAPS and EDPS will become more pronounced with the spike in EDPS share from 10% to 25%. Pulse8 estimates the net impact to RAF could reach up to -5%, depending on plan preparedness."

Once again, the 2018 Advance Notice proposes a change within the EDPS program that seemingly picks up where our 2017 recommendation left off. MA plans are struggling with EDS and, as a result, their risk scores are being negatively impacted.

Of particular note within the 2018 Advance Notice is the stipulation in the guidelines for the EDPS risk score adjustment program to include an incentive for plans to embrace EDPS and "submit complete data." Pulse8 believes that the risk score adjustment will be linked to the also just announced, EDS Performance Measures Program for 2018 (see item 2 above).

4. Proposed Changes to 5-Star Quality Measures for 2018

Measure Changes:

- CMS is proposing new Star Ratings measures for 2018:
  - Medication Reconciliation Post Discharge (Part C) – Display page in 2017
  - Improving Bladder Control (Part C) – Display page in 2016 and 2017
- New Display Measure: Antipsychotics Use in Persons with Dementia (APD) (Part D)
- Several changes to the following CMS Display Measures for 2018:
  - CAHPS measures (Part C & D),
  - Pneumococcal Vaccination Status for Older Adults (Part C),
  - Hospitalizations for Potentially Preventable Complications (Part C),
  - Statin Therapy for Patients with Cardiovascular Disease (Part C),
  - Formulary Administration Analysis measure (Part D),
  - High Risk Medication (Part D),
  - Drug-Drug Interaction (Part D), and
  - Statin Use in Persons with Diabetes (SUPD) (Part D)
- Modified the following Star Rating Measures for 2018:
  - Improvement Measures (Part C & D),
  - Members Choosing to Leave the Plan (Part C & D),
  - SNP Care Management (Part C),
  - Medication Therapy Management (MTM), Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D),

  - Call Center – Foreign Language Interpreter and TTY Availability (Part C & D),
  - MPF Price Accuracy (Part D),
  - Complaints about the Health Plan (Part C), and
  - Complaints about the Drug Plan (Part D)
- High Risk Medication (Part D) – moved to Display Page
- Removed the Asthma Measures and PQA Antipsychotic Use in Persons with Dementia (APD) measure from the Display page and replaced with PQA Antipsychotic Use in Persons with Dementia (APD) measure

Adjustments to Star Ratings for Audits and Enforcement Actions

BAPP – Beneficiary Access and Performance Problems: CMS is proposing measure changes based on feedback from key stakeholders, including not to reinstate the reduction in overall and summary Star Ratings of contracts under sanction, change the timeframe from July of the measurement year to June of the following year, and Methodology changes:

  - Total deduction for a contract for CMPs capped at 40 point
  - Weight of 1 for 2018 and 1.5 for 2019 to align with other access measures
  - CMS is considering a delay in implementation of the revised measure until 2019 Star Ratings (Display page for 2018)

- Stars Data Integrity Enforcement: CMS proposes to continue to impose the automatic reduction, while potentially increasing the scope of its data integrity reviews to identify problematic data. CMS highlights two programs in particular that may inform data integrity reviews: the new Medication Therapy Management (MTM) program audits and the expanded, industry-wide monitoring of appeals timeliness data:
  - Reduction to measure rating of 1-Star for contracts submitting incomplete, biased, or erroneous data
  - CMS may perform audits or reviews to ensure data validity

- Categorical Adjustment Index (CAI): For the 2018 Star Ratings Program, CMS is proposing to continue the use of the interim analytical adjustment. The overall methodology would remain unchanged for 2018. As opposed to the seven measures adjusted in the 2017 Star Ratings, CAI would apply to only these five measures in 2018:
  - Breast Cancer Screening (Part C),
  - Osteoporosis Management in Women Who had a Fracture (Part C),
  - Diabetes Care – Blood Sugar Controlled (Part C),
  - Medication Adherence for Hypertension (RAS antagonists), and
  - Medication Therapy Management (MTM) Program Completion Rate for CMR (Part D)

Pulse8 Insight & Call-To-Action:

Plans should be prepared for new measures, both display and star ratings, as well as changes to the Audits and Enforcement Measures. Specifically, plans should be aware of the CAI interim adjustment, which CMS continues to refine. While these changes to the 5-Star measures are minimal, there are some changes that could have a financial impact if plans do not have a strong 5-Star Program, including quality measure operations, analytics, and SME Skill attainment.

5. *Forecasting to 2019 and Beyond for Star Ratings:*

CMS gives some insight to what plans can expect for Star Ratings for 2019 and beyond:

- Patient Safety Report Frequency: Propose Patient Safety measures reports be moved to quarterly versus monthly in order to address the impact to monthly measure rates due to the lag time between NDC updates and PDE data submissions
- Changes to Colorectal Cancer Screening: Measure will remain in the Star Ratings to include HEDIS® 2017 specification changes to align with the U.S. Preventative Services Task Force (USPSTF) guidelines

CMS is proposing several changes to Existing Measures:

- Initiation and Engagement in AOD Treatment (IET, Part C measure), Telehealth and Remote Access Technologies, Clinical appropriateness and feasibility of excluding individuals with advanced illness (Part C), Care Coordination measures (Part C), and Center for Medicare and Medicaid Innovation Model Tests
- Temporary removal of Reducing the Risk of Falling Measure (Part C)

Potential new measures for 2019 and beyond

- Care Coordination Measures (Part C), Transitions of Care (Part C), Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C), Opioid Overuse (Part C), Depression Screening and Follow-Up for Adolescents and Adults (Part C), Alcohol Screening and Follow-Up (Part C), Appropriate Pain Management (Part C), Plan Makes Timely Decisions about Appeals (Part C),
- New PQA-endorsed measures in development for future testing/consideration (Part D).
    - Concurrent Use of Opioids and Benzodiazepines: The percentage of individuals 18 years and older with concurrent use of opioids and benzodiazepines.
    - Adherence to Non-Infused Disease-Modifying Agents Used to Treat Multiple Sclerosis: The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement period for disease-modifying agents treating multiple sclerosis.

Pulse8 Insight & Call-To-Action:

CMS continues to keep quality performance at the forefront with gap closure and data integrity oversight being critical for a health plan's 5-Star success. Plans should be prepared to start reporting on potential new measures, specifically Opioid overuse, as it is likely to become a future measure for 5-Star Reporting.