Medicare Advantage Organizations: Final Call Letter 2016

Summary of Key Provisions

On April 6, 2015, the Centers for Medicare and Medicaid Services (CMS) published the Medicare Advantage and Part D Payment Policies and Final Call Letter, after a two-week public comment period on the Draft Call Letter, due to the agency on March 6. The Medicare Advantage (MA) program continues to grow in popularity. Providers know who their beneficiaries are, and what they will be paid for managing the care of their MA patients. Beneficiaries in MA plans are satisfied because the design of the program can offer unique benefits. Approximately one in three Medicare beneficiaries are enrolled in MA plans, and the MA program currently enjoys bi-partisan, bi-cameral support on Capitol Hill.

MA Rate Reduction for 2016

Issue: The Draft Call Letter included an average rate reduction of 0.95%.

Outcome: AMGA was pleased to see that after the agency considered public input on the proposed rate reduction, it finalized a policy that CMS stated will produce an expected average change in revenue from the policies in the Advance Notice of +1.25% for 2016.

CMS-HCC Risk Adjustment Model for CY 2016

Issue: For payment year 2016, CMS proposed to transition entirely to using risk scores calculated from the clinically revised 2014 CMS-Hierarchical Condition Categories (HCC) model in Part C payment for MA beneficiaries, after having used a blend of the 2013 model and the 2014 model for 2014 and 2015.

Outcome: CMS finalized their proposal to transition fully to the 2014 CMS-HCC model for 2016.

Star Ratings and Dually Eligible/Low Income Subsidy Beneficiaries

Issue: CMS research discovered some differences in measure-level performance for Low Income Subsidy (LIS)/Dual beneficiaries in the Star Ratings Program, for a certain subset of six conditions, and intends to conduct additional research on the issue before making any permanent changes to the Star Ratings Program. For the 2016 calendar year, however, CMS proposed to weight, by half, the following six MA measures in question, as an interim step to correct the problem:

- Breast Cancer Screening
- Colorectal Cancer Screening

- Diabetes Care-Blood Sugar Controlled
- Osteoporosis Management in Women Who Had a Fracture
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling

Outcome: After consideration of the public comments it received, CMS decided not to move forward with the proposed interim step to reduce the weights on the identified subset of measures for the 2016 Star Ratings Program, while expressing a commitment to continue to study the issue more precisely and to create a solution that will appropriately address the situation.

Encounter Data as a Diagnosis Source for 2016

Issue: CMS proposed to calculate the 2016 risk score by blending two risk scores calculated as follows: one risk-score calculated using diagnoses with dates of service from the 2015 Risk Adjustment Processing System (RAPS) and fee-for-service (FFS) and another separate risk score using diagnoses with dates of service from 2015 Encounter Data System (EDS) data and FFS. CMS proposes to blend the two risk scores, weighting the risk score from RAPS and FFS by 90% and the risk score from EDS and FFS by 10%.

Outcome: CMS finalized its proposal to use encounter data to calculate risk scores by blending a small percentage of encounter data-based risk scores with RAPS-based risk scores.

Guidance for In-Home Enrollee Risk Assessments

Issue: CMS states that over the past few years, they have observed an increase in in-home visits to assess MA enrollees performed by non-physician practitioners employed by downstream contractors, with the comprehensiveness of the assessments, and resulting care plan, being variable. For 2014 and 2015, CMS had proposed to exclude, for payment purposes, diagnoses collected from the enrollee risk assessments that were not confirmed by a subsequent clinical encounter, but did not finalize the proposal in either case. AMGA shares the CMS concern about individuals who are not part of the healthcare team making in-home enrollee risk assessments. In some cases, MA plans are sending healthcare providers to the homes of MA beneficiaries to provide these assessments, but the clinical information is not being communicated back to the medical group that is responsible for treating the beneficiary. Our members are concerned about a lack of appropriate care coordination when this takes place.

The Advance Notice proposes that in-home assessments be performed by physicians or qualified non-physician practitioners, specifically, advanced practice registered nurses, nurse practitioners, physician assistants or certified clinical nurse specialists. AMGA is in strong agreement with this requirement. The Advance Notices enumerates additional best practices for in-home assessments, to include:

- All components of the Annual Wellness Visit, including a health risk assessment such as the CDC model health risk assessment;
- Medication review and reconciliation;

- Scheduling appointments with appropriate providers and making referrals and/or connections for the enrollee to appropriate community resources;
- Conducting an environmental scan of the enrollee's home for safety risks and any need for adaptive equipment;
- A process to verify that needed follow-up is provided;
- A process to verify that information obtained during the assessment is provided to the appropriate plan provider(s);
- Provision to the enrollee of a summary of the information including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources; and
- Enrollment of assessed enrollees into the plan's disease management/case management programs, as appropriate.

Outcome: While not finalizing these proposals, CMS is strongly encouraging MA organizations to adopt the components in the Centers for Disease Control and Prevention's Model Health Risk Assessment (HRA) beginning in 2016, in addition to the components of the Annual Wellness Visit. CMS believes that adoption of a standardized framework would provide consistency in CMS' data collection across all plans, provide uniform and comprehensive information to support care planning, and promote a proactive approach for initiating preventive and other appropriate care. The CDC HRA guidance can be found at: www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf.

Additional Provisions in the 2016 Call Letter

Other policy changes in the 2016 MA Call Letter include a requirement for MA plans to continue to improve drug utilization review controls, especially with respect to opioid and acetaminophen use; and a requirement for plans to monitor networks of providers more closely to ensure that online provider directories are accurate and network adequacy is maintained. The bid submission deadline for MA plans wishing to continue in the program in 2016 is **June 1, 2015**.