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2015 rate announcement and final call letter — impact on plan sponsors

The Centers for Medicare and Medicaid Services (CMS) has released the 2015 Rate announcement and Final Call Letter containing important information for Medicare Advantage Plan Sponsors. It contains both good news and bad news relative to historical regulation and the release of initial drafts in December and the Advance Notice.

The relative good news

- Plan sponsors might experience an increase to their risk-adjusted revenue as the weights were changed as CMS transitions to the 2014 CMS-HCC model. For 2015, the 2013 and 2014 HCC models will be weighted on a 67%/33% basis. This varies by the coding mix for a given plan, but is generally more favorable.
- Customary CMS-HCC downward adjustments to normalize MA/FFS risk scores were replaced by an approximate 4.3% increase in normalization factors used in the 2015 payment year. Risk adjusted revenue increased compared to the anticipated normalization factors when CMS accelerated recognition of "baby boomer" demographic impacts on the normalization of risk scores.
- CMS will not exclude, but merely study, the impact of diagnoses identified during a home visit that are not confirmed by a subsequent clinical encounter by eliminating diagnoses from claims with "Home" as the place of service.
- CMS did not increase constraints on plan flexibility to make changes in benefits and premiums as dramatically as anticipated:
  - The meaningful differences test that measures out of pocket cost (OOPC) differences between plan offerings remains at the 2014 level of $20.
  - The amount of year-over-year change in a plan, known as the Total Beneficiary Care (TBC) test, was only decreased from $34 to $32 for 2015, but will also reflect anticipated reductions in the benchmarks.
- Anticipated changes to enhanced drug coverage will not be implemented:
  - Coverage of all formulary brands, rather than a list of or tier of brand drugs.
  - Minimum generic gap benefits for drugs in tiers with a mix of generics and brands.

The relative bad news

- Driven by negative trend restatements in 2012 to 2014, the combined growth rate for the rate book (i.e., benchmark) is -3.4%. The growth rate is lower than initial estimates released by CMS in December and in the Advance Notice.
- Plan sponsors will lose the Stars Demonstration program that existed from 2012 to 2014. This will definitely impact the benchmarks and corresponding rebates for MA plans.
  - Benchmark implications vary greatly depending upon county standing in the six-year transition relative to the Medicare FFS targets, but some will be significant.
  - Benchmark implication will vary greatly by quality with bonuses not paid to 3.5 Star plans or on the Pre ACA portion of the benchmark calculation for 4+ Star plans in 6 year transition counties.
  - Benchmark implication will be negative for counties subject to the Pre ACA benchmark cap and could be significant for plans concentrated in those counties.
- CMS will increase the threshold for Meaningful Differences test from $18 to $25 for standalone PDP plan sponsors with two enhanced plans. This will make offering two enhanced plans more difficult.
- While the "good news" of risk adjustment and coding changes tend to mitigate the above rate book trends, the broad outcome is to put even more pressure on Plan sponsor revenue.

Dealing with 2015 challenges

These changes combined will challenge the industry's ability to maintain current premium levels at current member benefits at current margin targets. However, these changes to the benchmark and risk scores will not be adequate in understanding impacts and guiding the strategic planning process while plans are waiting for final policy rule. Success requires going beyond bid pricing logic.

- **Rethink plan design and competitive markets.** The bid process can channel designs into "2014 versus 2015" thinking. Both you and your competitors will be challenged by the 2015 changes. Challenges such as the zero premium plan, loss of stars demo and limitations on year-over-year changes (TBC and OOPC) will require plans to take a fresh look where you may stand in terms of the relative value offered to enrollees to guide the benefit design.

  Overall, a fresh look is warranted to assess where each plan may stand in terms of the relative value they offer to enrollees. This understanding will then help guide design and product offering discussions.
- **Stay serious about quality.** Revenue impacts underscore the importance of achieving and maintaining CMS Stars ratings. This requires a coordinated process focusing on targets, monitoring, and dashboards — and a precise understanding of the return on investment for the various activities.
- **Align risk and risk scores.** Plans will continue to see pressure in documenting member risk scores which, in theory, help achieve alignment with emerging claims cost. In the long term, normalization factors in plan bids continue to assume MA plans will increase risk scores relative to FFS costs, while placing greater controls on documentation of submitted risk score support.

- **Manage the cost of care.** This will become even more important for 2014 and 2015. Margins were already thin for Medicare Advantage plans, and pressure on the bottom line will clearly continue. Plans must therefore evolve in terms of monitoring and controlling the cost of care being provided. This includes not only design and financing innovations, but also network evaluation (contracting, access, quality and efficiency). The process to determine the best strategy for managing cost will require detailed analysis and monitoring of services delivered to uncover emerging issues, trends and opportunities for better medical quality and economic efficiencies.

Optum assistance to plan sponsors

Plans must execute effectively on "levers" available to plan sponsors in the important areas of quality, risk adjustment, and cost of care if they are to achieve their goals for benefits, member premiums and margins. Optum focuses on the extremely important linkage between MA strategies and bottom-line projections for 2015 and beyond. Plan sponsors need such projections to understand how they might best position bids based on the evolving market. Our focus is on quantifying impacts of the various "levers" available, and outlining alternatives in an increasingly constrained pricing environment.

Optum can assist plans in improving results for the key "levers" in 2015:

- **Market positioning:** Optum employs a market assessment and price elasticity modeling to understand the evolving competitive landscape and guide benefit design and pricing decisions.
- **Pharmacy expertise:** Optum employs a team of experts with hands-on experience in PBM finances, formulary design and pharmaceutical issues to address increasing Part D complexities.
- **Stars improvement:** We offer projections, assessments, processes, dashboards and other critical components to improve quality outcomes and resulting revenue impacts.
- **Risk score improvement:** We offer both clinical and operational guidance and delivery to improve risk score documentation — combined with the analytics to illustrate the return on investment and critical path for such initiatives.
- **Cost of care management:** We offer deep experience in care management, network management and hands-on experience in creating transformational provider risk-sharing arrangements.

Optum remains committed to helping our clients achieve their cost, quality and revenue goals with a critical combination of actuarial, care management, quality and risk-based reimbursement solutions and expertise.

Important links to more detail on these levers include:

optum.com/health-plans/clinical-management/quality/compliance/clinical-quality-stars.html

optum.com/health-plans/clinical-management/risk-adjustment.html#

optum.com/health-plans/clinical-management/member-support/clinical-care-management.html

optum.com/health-plans/acquisition.html#

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