CENTERS FOR MEDICARE & MEDICAID SERVICES

2016 Call Letter Updates: Medicare Part D

Elizabeth Flow-Delwiche, PhD
Medicare Drug Benefit & C&D Data Group

Lucia R.H. Patrone, MA
Medicare Drug Benefit & C&D Data Group

Andrea Bendewald, PharmD
Medicare Drug Benefit & C&D Data Group

May 6, 2015

Session Overview

- Parts C & D
  - Timeline for Application of Termination Authority for Contracts with Ratings of Less Than Three Stars in Three Consecutive Years
  - 2016 Revisions to the Star Ratings Program
- Part D
  - Improving Drug Utilization Review Controls
  - Access to Preferred Cost-Sharing Pharmacies
  - Benefit Parameters for Non-Defined Standard Plans
  - Changes to Applying for Exceptions to the Auto-Ship Policy

Timeline for Application of Termination Authority

Contracting Organizations with Ratings of Less Than Three Stars in Three Consecutive Years

Timeline for Application of Termination Authority

- Contracts that achieve less than three stars for three consecutive years for the first time with the release of the CY 2016 ratings in late 2015 will receive non-renewal notices from CMS in February 2016, effective at the end of CY 2016.
- Beneficiaries enrolled in plans offered under the affected contracts will receive notice in March 2016 of their need to elect a new plan during the fall 2016 Annual Election Period to continue Part C or Part D enrollment without interruption during 2017.
- CMS will not calculate or publish CY 2017 star ratings for non-renewed contracts.

2016 Revisions to the Star Ratings Program

Revisions to the Star Ratings Methodology

Removal of all Pre-Determined 4 Star Thresholds

- Measure-level cut points will be based on the data submitted from all contracts for the rating year.

- *The 2016 cut points will be determined employing the same methodology used in the past (e.g., relative distribution and clustering of the data), and we will continue to use the "Reward Factor" for contracts with consistently high performance.*

Revisions to the Star Ratings Methodology (cont.)

Definition of Low Enrollment Contracts

- Only contracts with less than 500 enrollees will be classified as low enrollment contracts; previously the threshold was less than 1000 enrollees.

- *Beginning with the 2016 Star Ratings, contracts with 500 or more enrollees as of July 2014 will not be considered low enrollment contracts; they will be included for Quality Bonus Payments to be made in CY 2017.*

Revisions to the Star Ratings Methodology (cont.)

Contracts with Low Reliability - Cut Points and Overall Ratings

- For the HEDIS measures, we will exclude from the cut point determinations and the overall rating calculations of any contract-specific measure scores that have low reliability.

- *Specifically, the measure scores for any contracts with 500-999 enrollees that have a reliability of less than 0.7 will be excluded from the cut point determinations and the overall rating calculations.*

Measures Added to Star Ratings

Part C

- Breast Cancer Screening (weight of 1)

Part D

- Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (weight of 1)

Parts C & D

- Call Center – Foreign Language Interpreter and TTY Availability (weight of 1.5)
- Beneficiary Access and Performance Problems (weight of 1)

Temporary Removal from Star Ratings

Part C

- Improving Bladder Control

Retired Star Ratings Measures

Part C

- Cardiovascular Care: Cholesterol Screening
- Diabetes Care: Cholesterol Screening
- Diabetes Care: Cholesterol Controlled

Part D

- Appropriate Treatment of Hypertension in Diabetes

Star Ratings Program: LIS/Duals Interim Proposal

- In the draft 2016 Call Letter, we proposed to reduce the weights on a subset of 7 measures in the Star Ratings Program – six Part C measures for MA and one Part D measure for PDP contracts.
- CMS has decided not to move forward with this proposal.
  - Nearly unanimous opposition from stakeholders.
    - Interim proposal did not appropriately address issue.
    - Many respondents felt it was premature to make a modification to the Star Ratings methodology and that such changes threatened its integrity.

Star Ratings Program: LIS/Duals Interim Proposal (cont.)

- CMS and its HHS partners in quality measurement, as well as external measure developers, will continue to research the issue.
  - It is the goal of the research to provide the scientific evidence as to whether sponsors that enroll a disproportionate number of Dual/LIS beneficiaries are systematically disadvantaged by the Star Ratings.
    - Upon completion of additional research, adjustments for the 2017 Star Ratings or other appropriate adjustments would be proposed in the fall Request for Comments.
    - As we continue to explore this important issue, we will continue to be transparent and welcome collaboration with all stakeholders.

Improving Drug Utilization Review Controls

Improving DUR Controls in Part D

- Reduced overutilization of APAP and opioids through 2014

Issue Type	Beneficiaries Exceeding OMS Thresholds		
	2011	2013	2014
APAP	76,581	26,122	6,286
Opioids	29,404	25,347	21,838

Improving DUR Controls in Part D (cont.)

- Sponsors are encouraged to implement a soft, formulary-level cumulative MED POS edit for opioids.
  - Build capacity for more sophisticated POS edit (CY 2017).
- New informational measures will be added to OMS for CY 2016.
- No expansion of overutilization policy to other drugs.
  - Future development and pilot testing will be considered.

Access to Preferred Cost – Sharing Pharmacies

Preferred Cost Sharing Pharmacies

- Based on an analysis of 2014 PCSP networks, CMS has concerns that some plans offer very low access to PCSPs in certain geographic area types compared to other plans. For example, 10% of plans offer access to PCSPs within 2 miles for beneficiaries residing in urban areas.
- CMS is not setting PCSP access standards, but is taking policy steps to improve transparency for beneficiaries considering plans offering preferred cost sharing.

Three-Pronged Approach to Addressing PCSP Access Concerns

- CMS will publish information on PCSP access by geographic area type (urban, suburban, and rural) for each plan offering preferred cost sharing. Information for 2016 will be published on medicare.gov, although CMS plans to make the information available on Plan Finder as soon as practicable.

Three-Pronged Approach to Addressing PCSP Access Concerns (cont.)

- CMS will require plans whose PCSP networks are outliers in 2016 to disclose their plan's outlier status in marketing material. Outliers will be set at the bottom 10th percentile compared to all Part D plans in a given geographic type, using 2014 data.

Three-Pronged Approach to Addressing PCSP Access Concerns (cont.)

- CMS will work with plans who are extreme outliers to address concerns about beneficiary access and marketing representations related to preferred cost sharing.

Benefit Parameters for Non-Defined Standard Plans

Benefit Parameters for Non-Defined Standard Plans: Tier Labeling

- Generic tier labeling will be changing for CY 2016. The option to offer a "non-preferred" generic tier is no longer available. Generic tier options include:
  - Single "Generic" Tier
  - Split-tiering with a "Generic" Tier and a "Preferred Generic" Tier which offers lower cost sharing
- The CY 2016 PBP and formulary submission modules will not be updated to reflect the generic tier label changes due to the time constraints to make the necessary changes. However, changes will be implemented to ensure beneficiary materials and interfaces reflect the new tier labeling.

Benefit Parameters for Non-Defined Standard Plans: Threshold Calculations

2016 Maximum Copay and Coinsurance Thresholds (Standard Network) - 3 or more tiers			
Tier Label	**PreICL & AGC* Copay**	**PreICL Coinsurance**	**AGC Coinsurance**
Preferred Generic Tier	<$20	25%	38%
Generic Tier	$20	25%	38%
Preferred Brand/Brand Tier	$47	25%	65%
Non-Preferred Brand Tier	$100	50%	65%
Injectable Tier	$100	33%	65%
Select Care/Select Diabetes Tiers	$11	15%	65%

*AGC - Additional Cost Sharing Coverage in the Gap

Benefit Parameters for Non-Defined Standard Plans: Benefit Review

- OOPC Methodology/Meaningful Difference Thresholds
  - The methodology to determine Meaningful Difference thresholds is unchanged for CY 2016.
    - The minimum monthly OOPC cost sharing difference between Basic and Enhanced PDP offerings is $18.
    - The minimum monthly OOPC cost sharing difference between enhanced PDP offerings is $30.
- Part D Total Beneficiary Cost (TBC) Measure
  - We will look to engage stakeholders as we consider implementation of this measure for CY 2017.

Benefit Parameters for Non-Defined Standard Plans: Benefit Review (cont.)

- Adult Immunization – sponsors are *encouraged* to consider offering $0 or low cost sharing for vaccines, if not doing so already, to promote improved vaccination rates.
  - $0 cost sharing is *required* when a plan sponsor chooses to offer a 5 or 6 tier formulary structure that includes a dedicated Vaccine-Only Tier, or if offering a Select Care/Select Diabetes Tier that contains vaccine products.

Mail Order and Changes to Applying for Exceptions to the Auto-Ship Policy

Mail Order and Changes for Exceptions to the Auto-Ship Policy

- Changes how sponsors apply for the two available exceptions to the auto-ship policy (announced via HPMS on 10/28/2013 and 12/12/2013).
- Currently, sponsors must first submit an email request for an exception, listing individual contract numbers affected.
- Starting 01/01/2016, sponsors meeting the exception conditions can operate under an exception if they qualify, without first submitting a request to CMS.

Important Dates

Date	Activity
April 10, 2015	PBP & BPT software available in HPMS
May 8, 2015	HPMS available to accept bids
June 1, 2015	Formulary Submission/Transition Attestation (11:59 pm PDT)
June 1, 2015	Bid Submission deadline (11:59 pm PDT)
June 5, 2015	Part D supplemental file submission deadline (12 noon EDT)

Important Dates (cont.)

Date	Activity
June/July 2015	Part C and Part D Bid review activities
Late July/Early August 2015	Rebate reallocation
August/September 2015	Attestations/contracts signed
September 23, 2015	Deadline to submit plan correction requests
October 1, 2015	Marketing begins

Contacts

- General Questions about the CY 2016 Part D Call Letter

  Lucia Patrone (Lucia.Patrone@cms.hhs.gov)

- Part D Policy related questions

  PartDPolicy@cms.hhs.gov

- Part D Benefit related questions

  PartDBenefits@cms.hhs.gov

- Part D Formulary related questions

  PartDFormularies@cms.hhs.gov

- Star Ratings related questions

  PartCandDStarRatings@cms.hhs.gov