

NCPA Summary: Part II of the CY 2021 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

On February 5th, the Centers for Medicare & Medicaid Services (CMS) released Part II of the Calendar Year (CY) 2021 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.¹ CMS released Part I of the Advance Notice on January 6th. CMS will not be publishing a Call Letter for 2021. CMS is proposing to codify much of the guidance typically included in the annual Call Letter through the CY 2021 and 2022 MA and Part D Proposed Rule. CMS will also separately issue Part C and Part D bidding instructions previously provided through the Call Letter. **NCPA is carefully analyzing the advance notice and will be seeking member input prior to commenting by the March 6th deadline.**

Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D). As discussed in the 2020 Call Letter, the COB, OHD, OMP, and OHDMP measures will be added to the display page for 2021 (using 2019 data).

Antipsychotic Use in Persons with Dementia Overall (APD), Antipsychotic Use in Persons with Dementia, for Community-only Residents (APD-COMM), and Antipsychotic Use in Persons with Dementia, for Long-term Nursing Home Residents (APD-LTNH) (Part D). CMS has previously described updated methodology for the APD, APD-COMM, and APD-LTNH measures for the 2019 measurement year for the 2021 display page.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). As discussed in past Call Letters, PQA tested their medication adherence measures, which are used for the Star Ratings, for potential risk adjustment of the measures (i.e., adjustment for socioeconomic status (SES) or sociodemographic status (SDS)). PQA included the following draft recommendations in their Measure Manual:

- All three adherence measures should be risk adjusted for SDS characteristics to adequately reflect differences in patient populations.
- The measures should be adjusted for the following beneficiary-level SDS characteristics: age, gender, dual eligibility/low-income subsidy (LIS) status, and disability status.
- The measures should be stratified by the beneficiary-level SDS characteristics listed above to allow health plans to identify disparities and understand how their patient population mix is affecting their measure rates.

The risk-adjusted adherence measures were endorsed by the National Quality Forum (NQF) in the 2019 Spring cycle (NQF endorsed #0541). CMS will consider implementation of the PQA recommendations in the future for these Star Ratings measures (i.e., for the 2022 measurement year or beyond). Substantive measure changes must be proposed and finalized through rulemaking.

¹ Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II, CMS-2020-0003 (Feb. 5, 2020), available at <https://www.regulations.gov/document?D=CMS-2020-0003-0002>.

Generic Utilization (Part D). CMS plans to develop measures to assess generic and biosimilar utilization in the Medicare Part D program. CMS encourages Part D sponsors to leverage favorable tier placement and effective formulary management tools to incentivize beneficiaries to fill generic alternatives over branded products. Generic dispensing and generic substitution rates, 82% and 91% respectively in 2017, are high on average across the Part D program. However, the remaining branded prescription fills represent a significant opportunity to reduce Medicare expenditures and lower out-of-pocket costs for beneficiaries through the use of generic alternatives.

CMS is interested in comments on the following measure concepts:

1. Generic Substitution Rate (higher is better): Total number of generic fills divided by the sum of brand and generic fills for drugs that had approved therapeutically equivalent generic products that were available on the market at the time of the fill.
2. Generic Therapeutic-Alternative Opportunity Rate (lower is better): Total number of brand fills divided by the sum of brand and generic fills within select drug classes or Brand and generic drugs, as defined in 42 CFR § 423.4. subclasses where both brands and generics are available. Classes consisting of only brand National Drug Codes (NDCs) or only generic NDCs will be excluded from the measure.
3. Biosimilar Utilization Rate (higher is better): Total number of biosimilar fills divided by the sum of reference biologics and biosimilar fills for biologics that had approved biosimilars available on the market at the time of the fill.

CMS also seeks input to help shape more detailed measure specifications, such as:

- What classification system should be used for the Generic Therapeutic-Alternative Opportunity Rate?
- What specific classes or subclasses (where both brands and generics are available) should be excluded, due to significant variability in the safety or effectiveness of the available generic(s) compared to the brand(s)?
- What are the current barriers to generic uptake?

CMS will continue to perform data analysis of current generic coverage, formulary placement, and generic utilization rates in Part D as well as consider the feedback on this measure concept. The goal is to propose to adopt measures that reward sponsors for high rates of generic utilization.

Initial Opioid Prescribing (IOP) Measures (Part D). PQA developed and endorsed three initial opioid prescribing (IOP) measures. These measures are aligned with the CDC Guideline for Prescribing Opioids for Chronic Pain.

- Initial Opioid Prescribing at High Dosage (IOP-HD): Assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of 50 or greater. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation period is the 7-day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 6 days. A lower rate represents better performance.
- Initial Opioid Prescribing for Long Duration (IOP-LD): Assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for more than 7 cumulative days' supply. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation period is the 3-day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 2 days. A lower rate represents better performance.

- Initial Opioid Prescribing for Long-Acting or Extended Release Opioids (IOP-LA): Assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for long-acting or extended-release opioids. To be included in the denominator, individuals would have filled one or more prescriptions for opioids, with a negative medication history for any opioid prescription claim during the lookback period. The opioid initiation period is the 7-day time period when the numerator is assessed and includes the date of the initial opioid prescription plus 6 days. A lower rate represents better performance.

CMS reviewed the IOP measures for potential inclusion in the Part D Patient Safety measure reporting. Of the three IOP measures, CMS believes the IOP-LA and IOP-LD measures best align with the Medicare Part D opioid safety edit guidance. CMS plans to begin reporting only the IOP-LD in the Patient Safety reports for the 2020 measurement year. CMS will consider adding the IOP-LD measure to the Star Ratings in the future pending rulemaking. CMS is interested in stakeholder feedback on these new IOP measures.

DMEPOS Pricing

CMS will continue re-pricing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims, by re-pricing claims from 2014–2018 to reflect the most current DMEPOS prices associated with the Competitive Bidding Program (CBP). Section 1847(b)(5) of the Social Security Act requires that “single payment amounts” replace the Medicare DMEPOS fee schedule amounts for certain DMEPOS items furnished in competitive bidding areas (CBAs). During the lapse in the CBP until Dec. 31, 2020, these single payment amounts are updated by the change in the CPI-U once every 12-month period beginning on the date after the contract periods ended, including mail order items and supplies. CMS will continue to use the most recent single payment amounts without update for non-mail order diabetic supplies to reprice the historical payments for DMEPOS claims. Note that during the DMEPOS CBP gap period, any enrolled supplier may furnish these items, including pharmacies.