Better Medicare Alliance Webinar:

Medicare Advantage and Part D 2019 Final Rate Notice and Call Letter

April 5, 2018

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RATE NOTICE CRASH COURSE PAGE

http://bettermedicarealliance.org/campaigns/rate-notice-crash-course

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Opening Remarks

Congresswoman Allyson Y. Schwartz

President & CEO

Better Medicare Alliance

Policy Timeline

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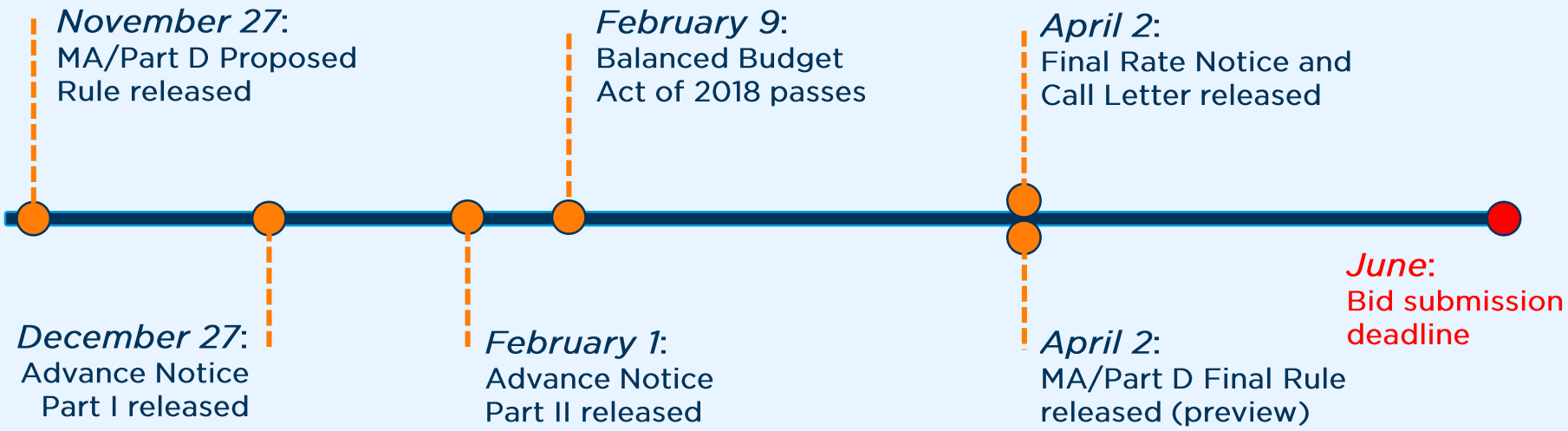

- The MA/Part D Final Rule, BBA 2018, and the Final Notice and Call Letter are interrelated.
- The timeline for issuance or passage of these various policy changes was compressed and can be confusing.
- BBA 2018 included the CHRONIC Care Act, which contained provisions that impact MA.
- CMS will release additional guidance related to the final rule and final notice sometime before the June 2018 bid submission deadline.

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Key Elements in the Final Rate Announcement and Call Letter

Payment Rate Updates

- Medicare Advantage Rates
  - Rebasing/Re-pricing
  - Coding Intensity
  - Normalization
- Employer Group Waiver Plan (EGWP) Payment Methodology

New Benefit Flexibility

- Uniformity of Benefits
- Meaningful Difference
- Supplemental Benefits

Other Key Policy Changes

- Risk Adjustment Model
- Encounter Data
- Star Ratings & Quality
- Special Needs Plans

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Medicare Advantage Rates

Year-to-Year Change in Part C Payment (2019 v. 2018)	2019 Final Notice	2019 Advance Notice	2018 Final Notice
Effective Growth Rate (Trend)	5.28%	4.35%	2.70%
Rebasing/Re-pricing	0.49%	TBD	0.30%
Change in Star Ratings	-0.26%	-0.20%	-0.40%
Risk Model Revision	0.28%	0.28%	N/A
MA Coding Intensity Adjustment	0.01%	0.01%	-0.25%
Encounter Data Transition	-0.04%	-0.04%	N/A
EGWP Payment Policy	-0.10%	-0.30%	N/A
Normalization	-2.26%	-2.26%	-1.90%
Expected Average Change in Revenue from Part C Methodology	**3.40%**	**1.84%**	**0.45%**

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Medicare Advantage Rates

Benchmark Caps

- Benchmark caps, established by the Affordable Care Act, cap the benchmarks in certain counties to pre-ACA levels, effectively reducing or eliminating the added quality bonus payments to plans in those areas
- CMS maintains that new legislation is needed to address benchmark caps

A/B Benchmark Calculation

- CMS calculates benchmarks using data from all FFS Medicare beneficiaries, regardless of whether they have both Part A and B coverage
- This calculation method results in arbitrarily low benchmarks in certain counties where more beneficiaries are only enrolled in Part A (and not in Part B)
- BMA has asked CMS to calculate benchmarks using only FFS data from A+B beneficiaries, but CMS ***did not*** finalize changes in this notice

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Employer Group Waiver Plans

- In 2017, CMS started phasing-in a payment methodology whereby rates are set using individual Medicare Advantage health plan bids rather than EGWP bids.
- In 2019, CMS will fully transition to using only individual plan bids to calculate bid-to-benchmark ratios to set EGWP payments, resulting an estimated average negative adjustment of 0.1%.
- CMS finalized the proposal to adjust the individual plan bid-to-benchmark ratios to account for the difference in the proportion of beneficiaries enrolled in HMOs and PPOs.
- *CMS will monitor how the new payment calculation impacts the market and seek comment on modifications for 2020 that may include additional or different adjustments for regional PPOs and rural local PPOs.*

Components of Benefit Flexibility

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Benefit Uniformity

Requires plans to offer the same benefits to enrollees of the same plan and does not allow for targeted or variable benefits

Meaningful Difference

CMS-established limits on how similar two plans may be, in terms of premiums, cost-sharing, and offered benefits, if they are offered by the same issuer in the same area

Supplemental Benefits

“Primarily health-related” benefits not covered by Traditional Medicare that an MA plan may offer to its enrollees

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Uniformity of Benefits

- The Medicare Advantage uniformity rule is the requirement that plans offer the same benefits equally to all enrollees in a particular plan
- Historically this has meant that plans may not offer variable supplemental benefits, cost sharing for services or items, or deductibles to enrollees in the same plan
- In the MA/Part D proposed rule (82 FR 56336, 56360), CMS explained that it has ***reinterpreted*** the uniformity rule language and has decided to allow certain new permissions
- Under the reinterpretation, in CY 2019, MA plans will be able to offer targeted benefits to groups of enrollees, within a plan, who have certain clinical diagnoses
- For similarly situated, clinically-defined groups of members within a plan, MA plans may:
  - Reduce cost sharing for certain covered benefits
  - Offer lower deductibles
  - Offer specific, tailored supplemental benefits
- CMS believes this new flexibility will allow plans to better manage the care for particularly vulnerable, high-need enrollees by creating incentives for them to use services that are known to improve health

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Meaningful Difference

- Historically, CMS would only approve a bid submitted by an MA organization if its plan benefit package is substantially different from those of other plans offered by the organization in the same area, with respect to premiums, cost sharing, and offered benefits
- In the MA/Part D proposed rule, CMS proposed to eliminate the meaningful difference requirement beginning in 2019 ***only*** for Part C benefits (but not Part D benefits)
- CMS explained that the goal of eliminating the meaningful difference requirement is to improve competition, innovation, available benefit offerings, and provide beneficiaries with affordable plans that are tailored for their unique health care needs and financial situation
- CMS maintains its oversight of approval of bid submissions, and other regulations govern how plans must provide clear information in their marketing and communication materials
- Elimination of meaningful difference requirements is necessary to operationalize new benefit flexibilities, as plans will be able to offer access to health care benefits that are tailored to individual needs, which make it difficult for CMS to objectively measure meaningful differences between plans

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Supplemental Benefits

- Until now, CMS has allowed plans to offer certain benefits above and beyond those covered by Traditional Medicare only if they are directly health-related, but not if their primary purpose is "daily maintenance"
- In the MA/Part D Final Rule, CMS has finalized its proposal to expand the scope of the **"primarily health-related" supplemental benefit standard**
- Under this new interpretation, beginning in CY 2019, supplemental benefits are considered "primarily health-related" if they:
    1. Diagnose, prevent, or treat an illness or injury;
    2. Compensate for physical impairments;
    3. Act to ameliorate the functional/psychological impact of injuries or health conditions; and/or
    4. Reduce avoidable emergency and healthcare utilization
- Supplemental benefits under this new interpretation must still be medically appropriate and ordered by a licensed provider as part of a care plan
- *CMS will issue detailed guidance for plans prior to the CY 2019 bid submission deadline in June 2018*

More Changes to Supplemental Benefits Coming in CY 2020

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- In February, after CMS issued the MA/Part D proposed rule, Congress passed the Bipartisan Budget Act of 2018, which included the CHRONIC Care Act

- Relative to supplemental benefits, BBA 2018 did two things:
  - Expanded supplemental benefits even further than CMS did in the MA/Part D proposed rule
  - Authorized a waiver of the uniformity requirements to permit MA plans to offer targeted supplemental benefits for the **chronically ill** beginning in CY 2020

- The law expands supplemental benefits to include benefits that "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee **and may not be limited to being primarily-health related benefits.**"

To Recap

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	2018	2019	2020
Benefit Uniformity	Benefits must be uniform for all beneficiaries in a plan	MA plans may tailor benefits, such as cost sharing and deductibles, for beneficiaries who are clinically "similarly situated"	MA plans may tailor benefits, such as cost sharing and deductibles, for beneficiaries who are clinically similar CMS may offer waivers of benefit uniformity for benefits tailored to "chronically ill" beneficiaries
Meaningful Difference	CMS establishes meaningful difference standards for plans offered in the same area by the same company	CMS will not enforce meaningful difference requirements	CMS will not enforce meaningful difference requirements
Supplemental Benefits	Must be offered uniformly to every enrollee in a plan	MA plans may tailor supplemental benefits to certain beneficiaries who are clinically "similarly situated"	MA plans may tailor supplemental benefits to certain beneficiaries who are clinically "similarly situated" CMS may offer waivers of benefit uniformity to offer supplemental benefits tailored to "chronically ill beneficiaries"

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Condition Count and Additional Conditions in Risk Adjustment Model

- The 21st Century Cures Act required CMS to evaluate the impact of certain diagnosis and the number of conditions to the risk adjustment model.
- For 2019, CMS will include additional adjustments for mental health, substance abuse, and chronic kidney disease diagnosis. CMS will not include condition count variables in the risk adjustment model.
- In 2020, CMS will begin implementing the proposed "Payment Condition Count" model, which will account for the number of conditions a beneficiary has among those conditions included in the payment model. The model would increase risk scores by an estimated average of 1.1%.
- *CMS will work with stakeholders to share additional information related to the new model in light of the decision to delay implementation.*

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Encounter Data

- In 2012, CMS began collecting encounter data from Medicare Advantage, which includes clinical diagnoses, care, and treatments.

- In 2016, CMS initiated a transition to using encounter data for calculating risk scores. Over time CMS has increased the blend of the current RAPS data with the new encounter data to create a weighted risk score.
    - 2016: CMS used 10% encounter data and 90% RAPS
    - 2017: CMS used 25% encounter data and 75% RAPS
    - 2018: CMS used 15% encounter data and 85% RAPS

- As proposed, in 2019 CMS will use a blend of 25% encounter data, and 75% Risk Adjustment Processing System (RAPS) data, which would result in an estimated negative 0.4% payment adjustment.

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Medicare Advantage Star Rating System

- Quality care in Medicare Advantage is measured and reported through a Star Rating System. CMS estimates Star Rating changes will result in an average negative 0.26% payment adjustment to Medicare Advantage.
- CMS added new measures, including Statin Therapy for Patients with Cardiovascular Disease in Medicare Advantage.
- CMS will scale Star Rating reductions for data completeness issues for appeals measures to help avoid disparate impacts.
- CMS will continue to apply the categorical adjustment index for dually eligible beneficiaries.
- *CMS is working with RAND to establish a Technical Expert Panel, with stakeholders to obtain feedback on the Star Ratings.*

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MA/Part D Final Rule: Medicare Advantage Star Rating System

- Overlapping with the Rate Announcement, CMS will move forward with scaled reductions when Star Rating data for appeals measures is not complete, and a Technical Expert Panel on Star Ratings.
- CMS codified the rules for adding, updating, and calculating measures with the goal of providing plans with stability for multi-year quality initiatives.
- CMS will implement substantive Star Rating changes through regulation and use the call letter to solicit feedback.
- CMS will assign Star Ratings to consolidated contracts based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts for the first and second plan years following the consolidation. *These changes will go into effect for performance periods in 2019, for the 2020 Star Ratings, and 2020 Quality Bonus Payments.*

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Special Needs Plans

- SNPs are a specialized type of Medicare Advantage plan designed to serve frail, disabled, and chronically-ill beneficiaries.
- SNPs were permanently reauthorized in February by the Bipartisan Budget Act. The new law also added D-SNP requirements, which CMS is currently evaluating.
- As proposed, beginning in 2019, D-SNPs and I-SNPs will be able to offer the Enhanced Disease Management supplemental benefit to improve care coordination. SNPs have more certainty and flexibility to care beneficiaries.
- *CMS may re-examine network adequacy standards for SNPs due to feedback that current standards do not account for the unique health care needs and delivery patterns of SNP beneficiaries in the future.*

Other Key MA/Part D Final Rule Provisions

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- *Beneficiary Paperwork:* CMS finalized as proposed electronic delivery of the Evidence of Coverage by the first day of the Annual Enrollment Period, and a hard copy of the Annual Notice of Change 15 days before the Annual Enrollment Period.

- *Definition of Marketing:* CMS finalized as proposed an updated definition of marketing to focus oversight on materials likely to lead to a beneficiary enrollment decision.

- *Preclusion List:* CMS finalized as proposed a preclusion list of providers that plans are not allowed to pay. CMS also rolled back the requirement that providers through Medicare Advantage must be enrolled in Medicare.

- *MLR:* CMS finalized as proposed a reduction in the amount of Medical Loss Ratio data plans submit, and will allow all expenditures related to fraud reduction activities and medication therapy management programs to be included in the percentage of revenue used for patient care.

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Medicare Advantage Summit

- BMA is hosting the second annual Medicare Advantage Summit on May 16-18 in Washington, DC.
- Several sessions will focus on the changes discussed in today's webinar, including a general session panel on the Final Rate Notice and Call Letter moderated by BMA Staff
- To register: https://medicareadvantagesummit.com/

Questions or Comments?

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