



MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: December 7, 2015

TO: Medicare Advantage Organizations
Section 1876 Cost Contract Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Implementation of the Cost Contract Plan Transition Requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The purpose of this memo is to provide guidance on the cost contract transition provisions included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Section 1876(h)(5)(C) of the Social Security Act (the Act) currently provides that cost plans in service areas where there are two or more competing local or regional Medicare Advantage (MA) coordinated care plans be non-renewed by CMS at the end of contract year (CY) 2016

MACRA amended these so called “cost plan competition requirements” and delayed the non-renewal of affected cost plans for a period of two years until the end of CY 2018. In addition, MACRA revised how CMS should calculate the enrollment of MA plans for the purpose of meeting the competition requirements; permitted cost plans to transition to MA plans by CY 2019; and allowed Medicare Advantage Organizations (MAOs) to deem the enrollment of their cost enrollees into successor affiliated MA plans that meet specific conditions.

Now, under MACRA, the determination as to whether an MA plan meets minimum enrollment thresholds for the cost plan competition requirements is based on the MA enrollment in the portion of the cost plan service areas where there are competing MA plans and not the entire Metropolitan Statistical Area (MSA) of those competing MA plans as it was previously. In cases where the service areas of the cost plan and MA plans are in different MSAs, the MA minimum enrollment threshold is based on the MSA in which the actual competition occurs.

Contracting

Voluntarily Non-Renewing Plans and Plans Affected by Competition Requirements Converting to Medicare Advantage

- A cost plan contractor affected by competition requires choosing to transition to MA is not required to transition its entire cost contract and may convert only the affected portion of the service area to an MA plan and maintain the remaining service area of the contract as a cost plan.

- Subject to 42 CFR §422.503(b)(5), entities may operate an MA plan and cost plan in the same service area during the cost plan’s “transition period” which includes the cost plan’s last contract year and the year immediately preceding it.
- During the last cost plan contract year before conversion to an MA plan, the cost plan may not enroll new members except under specific conditions (see *Enrollees Eligible to Enroll in Cost Plan’s Last Contract Year*).
- Cost plan contractors seeking to transition to MA must apply for a new Medicare Advantage Prescription Drug (MA-PD) contract during the transition period for an effective date no later than January 1, 2019. The MA-PD can be held by a separate legal entity from the cost plan but must have the same parent organization or be affiliated via common ownership interest of control. Cost plan contractors may convert their cost plans into MA plans under the approved MA-PD contract. Converted MA plans must meet all requirements with respect to cost and access to benefits.
- Converting cost plans that retain a portion of the cost plan contract must follow all current requirements for a service area reduction, effective no later than January 1, 2019.

Issues Related Specifically to Enrollment in the Last Cost Contract Year and Enrollment Conversions

Enrollees Eligible to Enroll in a Cost Plan during its Last Cost Contract Year

In the last cost contract year, the cost plan may, subject to 42 CFR §422.503(b)(5), enroll new members as specified in section 1876(h)(5)(C)(iv)(II)(aa)-(dd) of the Act. Cost plans in their last contract year may only enroll individuals:

- Who choose enrollment in the cost contract during the annual election period (AEP) for the last cost contract year.
- Whose spouse, at the time of the individual’s enrollment, is an enrollee under the cost contract. (Please note that an individual’s marital status is not an existing factor in determining eligibility for enrollment, therefore, additional guidance will be released regarding enrollment procedures for this new criterion.)
- Who are covered under an employer group health plan that offers coverage through the cost contract.
- Who becomes entitled to benefits under Part A, or enrolled under Part B, and was enrolled in a plan offered by and entity under the same parent organization as the cost plan immediately prior to the individual’s enrollment under the cost contract.

Except under the preceding circumstances, the cost plan will be prohibited from accepting enrollments with effective dates of January 1 or later of the last cost contract year. The cost plan contractor must notify all new enrollees during the last cost contract year that the cost plan is ending.

Enrollees Eligible for Enrollment Conversion

Per 1851(c)(4) of the Act, enrollees eligible for the enrollment conversion are those enrolled in a cost contract in the previous year if:

- The cost contract was extended or renewed for the last cost contract year;
- The cost plan contractor provided timely notice to CMS concerning the conversion of the plan according to the requirements described under *Plan Notification to CMS of Non-Renewal, Conversion of Contract*;

- The converted MA plan is offered by the same entity as the cost plan or by an affiliated organization (i.e., an organization that has a common ownership of control as the cost plan); and
- The converted MA plan is offered in the service area where the enrollee resides.

Note that the cost plan enrollee must also be otherwise eligible for MA enrollment per section 1851(a)(3)(A) of the Act.

In addition, cost plan enrollees who developed End-Stage Renal Disease (ESRD) while enrolled in a cost plan that is converting to a MA plan are eligible for the enrollment conversion into the converted MA plan.

Enrollees in a cost plan that does not offer Part D coverage, as well as those enrollees in a cost plan with Part D coverage (either through the cost plan or through a Part D plan offered by either the same entity or by an affiliated entity) are eligible for the enrollment conversion to a MA plan. As specified in section 1851(c)(4)(B)(ii) of the Act, the enrollment conversion of cost plan enrollees with Part D coverage must transition into a converted MA plan with Part D coverage (MA-PD).

Special Enrollment Period for Those Impacted by the Enrollment Conversion

For enrollees subject to the enrollment conversion, a one-time special enrollment period (SEP) is available. At any time between December 8 and the last day of February of the first contract year the individual is enrolled in the converted MA plan, the individual may:

- Disenroll from the converted MA plan into Original Medicare;
- Enroll in a different MA or MA-PD plan; or
- Enroll in a different cost plan offered by another entity, provided the cost plan is open for enrollment.

An enrollee who is eligible for this SEP may make only one enrollment change during the SEP. For all elections into a different Medicare plan, the individual must meet the other requirements to enroll in that plan (e.g., living within the service area, requirements regarding ESRD, etc.). Note that use of this SEP does not guarantee Part D coverage. If an individual that converted into a MA-PD plan chooses to enroll in a MA-only plan, that individual would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.

Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January or February will have an effective date of the first of the month following receipt of the request.

The SEP ends when the individual makes an enrollment election or on the last day of February of the first contract year the individual is enrolled in the MA plan, whichever occurs first. Any individual who uses this SEP to enroll in Original Medicare or a different cost plan is eligible for a coordinating Part D SEP. An individual with Original Medicare may enroll in a standalone Part D plan, and an individual enrolled in a cost plan may enroll in either the cost plan's optional supplemental Part D benefit or in a standalone Part D plan.

Systems Changes Related to Enrollment and Enrollment Processing

Because new enrollment during the last cost contract year is limited to certain beneficiaries, CMS may need to create a new enrollment source code that identifies why the member can be enrolled. Also, other systems changes may be necessary to allow the enrollment conversion to occur through a mapping process. CMS will release additional guidance regarding any systems or operational processing changes for enrollments during the last contract year and during the transition to the MA plan.

Benefits and Access

Per 1851(c)(4)(A)(v) of the Act, converted MA plans must provide coverage for enrollees converting from the cost plan to maintain enrollees' current providers of services and supplies and course of treatment at the time of the enrollment conversion for a period of at least 90 days after converted enrollment. During this period, the MA plan must pay providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under Original Medicare.

The difference in costs under the converted MA plan and costs under the cost plan for Part A and B services may not exceed a threshold established by CMS.

In reviewing cost plan contractors' applications to offer converted MA plans, we will apply MA contracting standards, including a modified Total Beneficiary Cost (TBC) calculation described below.

Medicare Plan Finder

Cost plans are permitted to provide optional supplemental benefits to enrollees, but not mandatory supplemental benefits. CMS has permitted cost plans to enter optional supplemental benefits into the Plan Benefit Package (PBP) as mandatory supplemental benefits for display on Medicare Plan Finder as an administrative convenience in the past. Cost plans choosing to submit a PBP to CMS for purposes of Medicare Plan Finder will be required to enter all supplemental benefits into the PBP as optional supplemental benefits beginning in CY 2017 to avoid potential beneficiary confusion when comparing cost plans to MA plans.

Notification

Plan Notifications to CMS of Non-Renewal, Conversion of Contract

- Cost plan contractors that are voluntarily non-renewing and converting to MA, must notify CMS by a date to be set by CMS whether or not they will continue, as permitted by MACRA, to offer a cost plan in CY 2017 and/or CY 2018 (section 1876(h)(5)(C)(iv) of the Act).
- Cost plan contractors that are affected by the cost plan competition requirements or that are voluntarily non-renewing and transitioning to MA must notify CMS by January 31 of the year preceding the last contract year, whether they will apply to have the cost contract converted, in whole or in part, and offered as a MA plan (section 1876(h)(5)(C)(iv)(III) of the Act).

Converted MA Plan Notification to Enrollees

Cost plan contractors intending to convert their cost plans to MA must notify each cost plan enrollee by mail by September 15 of the year prior to the enrollment conversion date. This notification must outline that he or she will be enrolled into the MA plan and will receive benefits through that MA plan unless the enrollee chooses otherwise during the AEP for the year.

The notice must include—

- A statement that the individual’s enrollment will be converted into the MA plan.
- The effective date of the coverage in the converted MA plan.
- The opportunity for an individual to select another plan during the AEP.
- Information regarding the SEP, the coverage options available and how to make such an enrollment change.
- A description of differences between the cost plan and MA plan and include specific comparisons of differences in cost-sharing, premiums, drug coverage, and provider networks (section 1851(d)(2)(B)(ii) of the Act).

Because the enrollment conversion is unique from other types of enrollment activities, CMS may need to establish additional criteria for inclusion in the notice; the statute provides that this notice about the enrollment conversion must include other information CMS may specify. CMS will determine whether additional information should be required at a later date.

CMS Notification to Enrollees

CMS identifies and notifies individuals in cost plans affected by the enrollment conversion by September 1 of the year preceding the converted MA plan’s first contract year (1851(c)(4)(D)). This notification will, at a minimum, convey the upcoming change, opportunity to compare and select another plan during the AEP, and the availability of the SEP.

Risk-Adjusted Payments

We remind cost plan contractors that they are required to submit complete and accurate risk adjustment data to CMS for their cost plan enrollees. Cost plans must submit encounter data for all items and services included in the cost report sent to CMS, and must submit risk adjustment-eligible diagnoses on Risk Adjustment Processing System (RAPS) files. Cost plan contractors must submit RAPS data according to the rules for RAPS submissions, and must submit encounter data according to the rules for encounter data submissions. For cost plans transitioning to become MA plans in CY 2017, we note that the 2017 risk scores may be too low if 2016 diagnostic data is incomplete. To calculate risk scores for payment, CMS extracts risk adjustment-eligible diagnoses from FFS claims, but cost plan contractors will need to submit complete diagnosis data in their RAPS submissions and complete encounter data. See the September 12, 2013 HPMS memo “Encounter Data Submissions” for information on CMS’ risk adjustment data requirements.

Agent Broker Fees

Agent/brokers are paid initial compensation when beneficiaries are enrolled in new plans. 42 CR §422.2274 defines like and unlike plan changes. It also defines when initial compensation or renewal compensation should be paid. As such, an enrollee conversion from a cost plan to a MA

plan is considered “unlike plan type change” and in these situations, an agent/broker should be paid an initial compensation.

Please note that CMS will issue guidance on Star Ratings at a later time.

In reviewing cost plan applications to offer converted MA plans, we will apply MA contracting standards, including a modified TBC calculation, as described below for converting cost plans.

The current TBC calculation is used to evaluate if a continuing MA plan proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. This calculation is most recently described in a HPMS memo titled, “Contract Year 2016 Medicare Advantage Bid Review and Operations Guidance” which was issued by CMS on April 14, 2015. A plan’s TBC is the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs (OOPC). The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits.

- As explained in the HPMS memo, the TBC calculation used for continuing MA plans incorporates the following adjustments:
- Technical Adjustments: (1) annual changes in OOPC model software and (2) maximum Part B premium buy-down amount change in the bid pricing tool (no change for CY 2016).
- Payment Adjustments: (1) county benchmark, (2) coding intensity, and (3) quality bonus payment and/or rebate percentages.

The TBC calculation and change threshold defined for MA plans for that particular contract year (e.g., \$32 per member per month in CY 2016) will be used for the enrollment conversion evaluation. Technical adjustments will be included in the calculation, but payment adjustments will be excluded. While Part B premium and plan premium are easily identified by plans and inserted into the TBC calculation, the estimated beneficiary out-of-pocket cost (OOPC) amount must be calculated using an OOPC model in SAS software that is provided by CMS.

In addition to the April 14, 2015 HPMS Memo discussed above, cost plan contractors should review the following three resources to understand how OOPC values are generated and used in the TBC calculation:

1. The following link provides access to the CMS OOPC Resource page which includes previous OOPC Models, Users Guide, methodology, and FAQs that organizations can use to identify technical needs and understand how OOPC values are calculated:
<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/OOPCResources.html>
2. HPMS memo titled, “Medicare Plan Finder (MPF) Plan Version (V1) of Out-of-Pocket Cost (OOPC) Model for CY 2015 and Updated Total Beneficiary Costs (TBC) Data Released on HPMS” issued on January 7, 2015. This memo is released annually in either December or January so that organizations can prepare for the next contract year’s bid

submission by using the OOPC model to calculate OOPC amounts and compare their results to the values generated by CMS and provided in a HPMS posting.

3. HPMS memo titled, “Out-of-Pocket Cost Model for Contract Year 2016 Bid Submissions” which was issued by CMS on April 7, 2015. This memo is released annually in early April so that organizations can calculate the OOPC amount for each of their plans that will be submitted the first Monday in June. As noted above, CMS releases a HPMS memo regarding bid review and operations guidance) in mid-April that includes a detailed description of the TBC calculation. In addition, CMS also posts plan-specific OOPC adjustment values in HPMS later in April and organizations are notified of this posting through a HPMS email.

Cost plan contractors will be provided with the information and tools necessary to submit MA conversion bids the first Monday in June, as required by statute that satisfy the TBC change threshold requirement. The evaluation process will also incorporate the following principles:

- Cost plan contractors must have submitted a Plan Benefit Package (PBP) to CMS the year before transitioning to MA in order to be evaluated for an enrollment conversion.
- Each predecessor cost plan’s PBP will be compared to the successor MA plan’s PBP, based on the CMS plan crosswalk and/or contract consolidation process.
- Predecessor cost plans that include a Part D benefit must include a Part D benefit in its successor MA plan and predecessor cost plans that do not include a Part D benefit must not include a Part D benefit in its successor MA plan. Cost plans that offer Part D benefits through an affiliated stand-alone Prescription Drug Plan will be evaluated based on only medical benefits for both the predecessor cost plan and successor MA plan (i.e., Part D benefits will not be included in the evaluation).
- The TBC evaluation is based on in-network services and mandatory supplemental benefits entered into the PBP as described in the OOPC methodology documentation. NOTE: Out-of-network and optional supplemental benefits are excluded from the OOPC model.
- Cost plan contractors must review available resources and prepare to use the necessary information and tools provided by CMS so that conversion bids submitted on the first Monday in June satisfy TBC requirements and continue to satisfy this requirement following the rebate reallocation period in late July and/or early August.
- CMS expects to communicate with organizations in late June and following the rebate reallocation period in mid-August if their MA bid does not satisfy enrollment conversion requirements in section 1851(c)(4) of the Act or MA contracting standards. Please note that plans not satisfying the modified TBC requirement will not be approved by CMS.
- CMS does not expect to make any exceptions to this evaluation process based on unique situations and/or characteristics of specific predecessor cost plans or successor MA plans.
- Successor MA plan bids must satisfy all CMS requirements as any other MA plan.

To the extent possible, information related to the TBC calculation and relevant OOPC amounts and adjustment values for cost plans will be incorporated into the existing annual memorandums and plan-specific postings. The chart below summarizes major activities and the expected timeline to conduct the TBC evaluation for converting cost plans.

Major Activity	Timeframe
CMS notifies plans affected by competition requirements, which require non-renewal in affected service areas in 2016. Under MACRA, these plans may be renewed for and continue to offer services through contract year 2018	November-Dec, 2015
Cost plans voluntarily non-renewing their contracts notify CMS. These plans are eligible for conversion to MA with enrollment conversion.	January 31 of year preceding non-renewal
Cost plan contractors converting cost plans to the MA program (includes cost plans affected by competition requirements as well as those voluntarily non-renewing) notify CMS of their last contract year, that is, whether their last contract year will be 2016, 2017 or 2018. These plans are eligible for the evaluation process for enrollment conversion. Transitioning plans must follow all MA application and bidding requirements.	January 31, of year preceding transition
CMS issues the Medicare Plan Finder OOPC model, related materials, and posts previous contract year's plan-specific OOPC amount. A HPMS memo will be issued to MA and cost plan contractor organizations.	December or January
CMS issues final Rate Announcement and Call Letter which include information about the TBC calculation and change threshold.	Early April
CMS posts the next year's OOPC model for SAS software and related information to the CMS OOPC Resource web page. A HPMS memo will be issued to MA and cost plan contractor organizations.	Early April
CMS includes detailed description of TBC calculation as part of its annual HPMS memo summarizing bid review and operations guidance that is sent to MA and Cost plan contractor organizations. CMS will use this calculation excluding payment adjustments to determine enrollment conversion status for cost plans.	Mid-April
CMS posts TBC adjustment factors in HPMS and MA and cost plan contractors will be notified through a HPMS email.	Late April
Organizations submit MA plan bids to CMS	First Monday in June
CMS calculates and communicates the national average bid amount and provides a rebate reallocation period for affected plans	Late July/Early August
CMS approves or does not approve bids. CMS issues notices to plans and solicits information for enrollment conversion processes.	Mid-August

Major Activity	Plans Affected by Cost Plan Competition	Plans Voluntarily Non-Renewing	Timeframe
CMS notifies cost plan contractors affected by competition requirements, which require non-renewal in affected service areas in 2016. Under MACRA, these plans may be renewed for and continue to offer services through CY 2018	X		November-December, 2015
Cost plan contractors notify CMS that they are non-renewing		X	January 31 of year preceding non-renewal
Cost plan contractors notify CMS that they will transition to MA	X	X	January 31 of year preceding the last contract year, e.g., 2016, 2017
Converting plans must follow all application and bid requirements and timelines (key dates specified in applicable activities in this table)	X	X	Varies (includes notice of intent to apply, application, bid)
Converting plans must file a MA plan application	X	X	Mid-February of year preceding MA contract year
CMS includes a detailed description of total beneficiary cost (TBC) calculation as part of its annual HPMS memo summarizing bid review and operations guidance that is sent to MA and cost plan contractor organizations. CMS will use this calculation excluding payment adjustments to determine deemed enrollment status for cost plans	X	X	Mid-April
Organizations submit MA plan bids to CMS	X	X	First Monday in June
CMS calculates and communicates the national average bid amount and provides a rebate reallocation period for affected plans	X	X	Late July/Early August
CMS approves or does not approve bids and deemed enrollment	X	X	Mid-August
Converted MA plans must notify each cost enrollee by mail by September 15 of the year preceding the deemed enrollment contract year that the enrollee will be receiving benefits from the MA plan	X	X	September 15
CMS non-renews cost plans that have not notified CMS of their intention to transition to MA	X		October 1, 2018