



## FACT SHEET

**FOR IMMEDIATE RELEASE**

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Contact: CMS Office Media Affairs

(202) 690-6145

### **Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments**

#### Background

This proposed rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act of 2010 (the Affordable Care Act) that are related to the Medicare Advantage (MA, or Part C) and Prescription Drug Benefit (Part D) Programs. This proposed rule also sets forth programmatic and operational changes to the Medicare Advantage and Prescription Drug Benefit programs for contract year 2012 based on our continued experience with the administration of the Parts C and D programs. We are proposing to publish the final rule before the beginning of the 2012 contract year, in time to prepare plans for 2012 bids. Most provisions will be in effect 60 days after the publication of the final rule (see Tables 1 and 2 in the proposed rule for provisions with different effective dates).

In addition to the proposed rule, CMS is posting the 2011 Medicare Plan Star Ratings and announcing a Demonstration Project to accelerate quality bonus payments for four and five-star plans and add quality bonus payments for three and three ½ star plans. The Demonstration Project builds on the quality-related bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance thereby accelerating quality improvements during the three-year period of the demonstration.

#### PROPOSED RULE

The proposed rule addresses the following:

- Implementing provisions of the Affordable Care Act;
- Clarifying various program participation requirements;
- Strengthening beneficiary protections;
- Strengthening Medicare's ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers; and
- Implementing other clarifications and technical changes.

## **Implementing the Provisions of the Affordable Care Act**

Key Affordable Care Act provisions we propose to implement and clarifications to provide for this rule include:

- Limiting cost-sharing under MA and section 1876 cost plans for specified services (administration of chemotherapy services, renal dialysis services, and skilled nursing care) at Original Medicare levels; and limiting cost-sharing for home health services to that charged under Original Medicare.
- Prohibiting MA and section 1876 cost plans from charging cost-sharing for in-network preventive services for which there is no cost sharing under Original Medicare.
- Clarifying that the Secretary is not required to accept any or every Parts C and D bids and to clarifying the Secretary's authority to deny bids that propose significant increases in cost-sharing or decreases in benefits.
- Codifying in regulations the voluntary de minimis policy for subsidy-eligible individuals enrolled in MA-PD Plans and standalone prescription drug plans (Section 3303(b) of the Affordable Care Act).
- Developing regulations to implement a monthly adjustment amount for higher income Part D beneficiaries due to the Income Related Monthly Adjustment Amount.
- Eliminating Part D cost-sharing for Medicare beneficiaries who are eligible for full Medicaid benefits and who are receiving home- and community-based services instead of being institutionalized.
- Codifying statutory changes to close the Part D coverage gap (Section 1101 of the Reconciliation Act)
- Describing the methodology for using quality ratings to determine MA bonus payments provided for in section 1102 of the Reconciliation Act.
- Implementing policies to reduce wasteful dispensing of Part D drugs for beneficiaries in long-term care facilities

## **Clarifying program participation requirements**

These proposals include:

- Prohibiting Part C and D program participation by MA organizations and Part D sponsors whose owners, directors, or management employees served in a similar capacity with another organization that terminated its Medicare contract within the previous 2 years.
- Requiring that Part C organizations employ (1) physicians or other appropriate health care professionals with sufficient medical and other expertise, including knowledge of the Medicare program, to review organization determinations involving medical necessity, and (2) a Medical Director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations regarding medical necessity. Similarly Part D plan sponsors must employ physicians or other appropriate health care professionals with sufficient medical and other expertise, including knowledge of the Medicare program, to review coverage determinations

and a Medical Director who is responsible for ensuring the clinical accuracy of all coverage determinations and redeterminations involving medical necessity.

### **Strengthening beneficiary protections**

These proposals include:

- Requiring that Medicare Advantage organizations and Part D sponsors provide interpreters in their customer call centers for all non-English speaking and limited English proficient callers.
- Requiring Medicare Advantage organizations to periodically disclose specific data for enrollees to use to compare utilization and out-of-pocket costs in the current plan year to the following plan year.
- Extending the mandatory maximum out-of-pocket amount requirements to regional preferred provider organizations (PPOs).
- Prohibiting the use of tiered cost-sharing of medical benefits by Medicare Advantage organizations to ensure greater transparency in benefits for enrollees and to protect them from inappropriate cost-sharing increases.
- Requiring pharmacies to provide a printed notice at the point of sale to beneficiaries explaining how to contact their plan to request a coverage determination.
- Requiring Medicare Advantage organizations' and Part D sponsors' agents and brokers to receive training and testing via a CMS endorsed or approved training program.

### **Strengthening CMS' ability to distinguish for approval stronger applicants for Parts C and D program participation and to remove consistently poor performers**

These proposals include:

- Setting requirements for fiscal solvency of plans participating in Part C or D.
- In the absence of 14 months performance history, denying a new application or service area expansion request based on a lack of information available to determine an applicant's capacity to comply with the requirements of the Part C or Part D program.

Cost and savings analysis

- Taking into account both costs and savings estimated in this proposed rule, we estimate a net savings to the Medicare program of about \$78 billion as a result of the provisions in this proposed rule for fiscal years (FYs) 2011 through 2016.

2011 Medicare Plan Star Ratings

- The Medicare Plan Finder web site provides tools to help beneficiaries compare Medicare health plans with or without prescription drug plans, and stand-alone prescription drug plans. It includes Medicare Plan Star Ratings, which measure plan quality and performance. This information will help beneficiaries choose a plan that meets their specific needs.

- Plans receive a star rating for each category and every individual measure within the category. A contract can get ratings between one to five stars:

- ★ means poor performance
- ★ ★ means below average performance
- ★ ★ ★ means average performance
- ★ ★ ★ ★ means above average performance
- ★ ★ ★ ★ ★ means excellent performance

- Additionally, health and drug plans receive an “Overall Plan Rating” that summarizes all category measures into a single rating: one for health plans, one for health plans with prescription drug coverage, and one for stand-alone prescription drug plans. This overall rating includes half-stars to provide more differentiation between contracts.

Distribution of Overall Plan Ratings for MA-PD Contracts (2011) \* \*\*

Overall Score	Contract Count	%	MA-PD % Weighted By Enrollment
5 stars	3	0.5	1.0
4 stars	74	13.2	23.2
3 stars	271	48.4	60.4
2 stars	48	8.6	7.2
Not enough data to calculate overall rating	104	18.6	3.6
Plan too new to be measured	60	10.7	4.5
Total	560	100	100

\* Half-star ratings are rounded down for these distributions

\*\* These ratings summarize all Part C and Part D measures combined. This star rating distribution is the same as the star rating distribution for purposes of the quality bonus determination under the demonstration.

Distribution of Overall Plan Ratings for PDP Contracts (2011)  
(These scores are the same as Part D summary rating for PDP contracts)

SCORE	PDP Count	PDP %	PDP % weighted by enrollment
5 stars	4	6.1	6.4
4 out of 5 stars	12	18.2	9.3
3 out of 5 stars	39	59.1	83.1
2 out of 5 stars	5	7.6	1.3
Not enough data to calculate summary score*	4	6.1	0.0
Plan too new to be measured**	2	3.0	0.0
<b>Total</b>	<b>66</b>	<b>100</b>	<b>100</b>

\* Half-star ratings are rounded down for these distributions

For plan year 2011, plans that have received fewer than three stars for three consecutive years, will have a “low performer” icon affixed to the plan name on the Medicare Plan Finder. Beneficiaries who are considering a plan that has received the low performer icon should study in more detail all specific quality information provided on [www.Medicare.gov](http://www.Medicare.gov) for the plan they are considering.

Health plans are rated on how well they perform in five different categories:

- Staying Healthy: Screenings, Tests and Vaccines (13 measures)
  - Members have at least one primary care doctor visit in the last year
  - The percentage of members who have had breast cancer screening in the last year
  - The percentage of members who have had colorectal cancer screening in the last year
  - The percentage of members with heart disease who have had cholesterol screening in the last year
  - The percentage of members with diabetes who have had cholesterol screening in the last year
  - The percentage of members who have had glaucoma testing in the last year
  - The percentage of members who have had osteoporosis testing in the last year
  - The percentage of members who have had an annual flu vaccine
  - The percentage of members who have had an annual Pneumonia vaccine
  - The percentage of members taking long-term medications who have been monitored
  - The percentage of members who were advised by their physician to start, increase, or maintain physical activity
  - The percentage of members who improved or maintained their physical health after two years
  - The percentage of members who improved or maintained their mental health after two years

- Managing Chronic (Long-Lasting) Conditions (10 measures)
  - Osteoporosis management
  - Eye exam to check for damage from diabetes
  - Kidney disease monitoring for members with diabetes
  - Percentage of plan members with diabetes whose blood sugar is under control
  - Percentage of plan members with diabetes whose cholesterol is under control
  - Controlling blood pressure
  - Rheumatoid arthritis management
  - Testing to confirm chronic obstructive pulmonary disease
  - Improving bladder control
  - Reducing the risk of falling
  
- Ratings of Health Plan Responsiveness and Care (6 measures)
  - Doctors who communicate well
  - Getting appointments and care quickly
  - Ease of getting needed care and seeing specialists
  - Overall rating of health care quality
  - Members' overall rating of health plan
  - Customer service
  
- Health Plan Member Complaints and Appeals (4 measures)
  - Complaints about the health plan (number of complaints for every 1,000 members)
  - Health plan timely decisions about appeals
  - Fairness of health plan's denials to member appeals, based on an independent reviewer
  - Beneficiary access problems Medicare found during an audit of the plan
  
- Health Plan Telephone Customer Service (3 measures)
  - Time on hold when customer calls health plan (minutes; seconds)
  - Accuracy of Information members get when they call the health plan
  - Availability of TTY/TDD services and foreign language interpretation when Members call the health plan

Drug plans are rated on how well they perform in four different categories:

- Drug Plan Customer Service (7 measures)
  - Time on hold when customer calls drug plan (minutes: seconds)
  - Time on hold when pharmacist calls drug plan (minutes: seconds)
  - Accuracy of information members get when they call the drug plan
  - Drug plan provides pharmacist with up-to-date and complete enrollment information about plan members
  - Drug plan's timeliness in giving a decision for members who make an appeal.
  - Fairness of drug plan's denials to a member's appeal, based on an independent reviewer

- Availability of TTY/TDD services and foreign language interpretation when members call the drug plan
- Member Complaints and Staying with Drug Plan (5 measures)
  - Beneficiary access problems Medicare found during an audit of the plan
  - Complaints by members about joining and leaving the drug plan (rate per 1,000 members)
  - All other complaints about the drug plan (per 1,000 members)
- Member Experience with Drug Plan (3 measures)
  - Drug plan provides information or help when members need it
  - Members' overall rating of drug plan
  - Members' ability to get prescriptions filled easily when using the drug plan
- Drug pricing and Patient Safety (4 measures)
  - Completeness of the drug plan's information on members who need extra help
  - Drug plan provides accurate price information for Medicare's Plan Finder web site and keeps drug prices stable during the year
  - Drug plan's members 65 and older who received prescriptions for certain drugs with a high risk of side effects, when safer drug choices may be possible
  - Using the appropriate blood pressure medication recommended for people with diabetes

### **Medicare Advantage Quality Bonus Payment Demonstration**

The Affordable Care Act introduces quality bonus payments into the Medicare Advantage program as part of the national strategy for implementing quality improvement in health care.

Beginning in 2012, quality bonuses are paid to Medicare Advantage plans that earn 4 or more stars in a 5-star quality rating system.

- MA plans earning either 4 or 5 stars will get the same percentage bonus.
- MA plans earning fewer than 4 stars get no bonus.

Under authority in Section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended, CMS will test an alternative method for computing quality bonus payments. This alternative method will be applied on a nationwide basis to all MA plans. Plans will be automatically enrolled in the demonstration and need not apply to participate.

Quality bonus payments will be computed along a scale; the higher a plan's star rating, the greater the bonus payment percentage. Five-star plans will receive a higher quality bonus payment than 4-star plans. Quality bonus payments will also be available to plans with ratings of 3 and 3.5 stars in lower amounts. Further, quality bonus payments for new and low enrollment plans will be altered slightly from ACA levels to be consistent with the scaled bonuses under the demonstration. In no circumstance will the quality bonus payments under the demonstration be less than what they would have been under the ACA. Quality bonus determinations under the demonstration will be based on quality ratings under the existing 5-star quality rating system. For

2012, under the demonstration, plan star ratings for purposes of determining quality bonus payments will be based on a combined MA and Part D rating, which is the average of the plan's MA and Part D quality ratings.

The Demonstration Project tests whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in Medicare Advantage program quality scores, compared to the current law bonus structure.

The table in Appendix 1 compares the current law and demonstration approaches to computing quality bonus payments.

The Demonstration Project supports CMS' goal of ensuring that Medicare Advantage beneficiaries receive coordinated, efficient, high-quality care. The demonstration reflects four key principles:

- Provide a strong incentive for Medicare Advantage plans to improve performance at various star rating levels.
- Provide additional incentive to achieve quality improvement. The demonstration would accelerate the quality bonus payment phase-in for plans with four or more stars and would introduce quality bonus payments for plans with three stars.
- Create a difference between the bonus payment percentages for four and five star plans, to test whether the difference moves plans to achieve five-star ratings.
- Ensure that all plans will receive a quality bonus that least as great as the quality bonus they would have received under the Affordable Care Act.

This is a nationwide three-year demonstration that will be in effect from 2012 to 2014. The demonstration accelerates the phase-in of quality bonus payments. For 5-star plans, the quality bonus payment is larger in the initial years for two reasons: not only is the quality bonus payment percentage phase-in accelerated but the percentage is applied to the blended benchmark. Also, 5-star plans will not be subject to the cap on the blended benchmark under the ACA. For 3-star to 4-star plans, the current law rule applies, where the quality bonus payment percentage is applied only to the new FFS quartile benchmark before this new benchmark is blended with the legacy benchmark in effect prior to the Affordable Care Act.

#### *Demonstration evaluation*

The evaluation will test the hypothesis that using a scaled approach to quality bonus payments – making quality bonus payments available to four rating levels (3-star, 3.5-star, 4-star, and 5-star plans) instead of two rating levels under current law (4-star and 5-star plans) – will lead to more rapid and larger program-wide increases in plan quality scores during the three-year period of the demonstration than CMS' modeling shows would occur under current law.

#### *MA payment rules unchanged by demonstration*

The Affordable Care Act rules for Medicare Advantage payment that would not be changed under the demonstration are:

- Methodology for tying the county benchmark to the average FFS cost in the county, where a county's average FFS cost relative to all other counties determines whether the county benchmark is set at 95%, 100%, 107.5%, or 115% of its average FFS cost.
- Methodology for determining county transition periods (2-year, 4-year or 6-year) for phasing-in of blended benchmarks.
- Methodology for identifying "qualifying counties" that are eligible for a double bonus.
- Rules for determining the level of Medicare Advantage beneficiary rebate, based on star ratings.
- Application of the cap on the blended benchmark for plans with ratings with less than five stars.

### **Opportunity to appeal quality bonus payment determination**

While the statute does not specify a process for appealing low star ratings, CMS, using the authority set forth in 1856(b)(1) of the Act, sets forth in the proposed rule a proposed administrative review process available to Medicare Advantage organizations that may take effect sometime before or once the demonstration project is completed. In the interim, CMS is setting up a process through which Medicare Advantage organizations may seek review of their star rating for quality bonus payment determinations while quality bonus payments are made under the demonstration.

The interim appeal process is a two-step process. The first step allows the Medicare Advantage organization to receive a technical report that explains how their quality bonus payment determination was made. The technical report is designed primarily to allow Medicare Advantage organizations a full explanation of how the values were determined for each performance area and how those values were in turn incorporated into the methodology used to calculate the quality bonus payment. The 2012 quality bonus payment determinations will be based on the 2011 five-star Plan Ratings released November 2010. CMS will issue more detailed guidance on the interim appeals process shortly.

If after reviewing the technical report, the Medicare Advantage organization believes that CMS was incorrect in its quality bonus payment determination, the Medicare Advantage organization may request an appeal to be conducted by a hearing officer designated by CMS. In the event that the hearing officer finds that CMS' quality bonus payment determination was incorrect, we would recalculate the organization's quality bonus payment status based on the hearing officer's findings. The hearing officer will be required to issue a decision on or before May 15 of the year preceding the year in which the plans for which the quality bonus payment is to be applied will be offered. This deadline will afford Medicare Advantage organizations time to incorporate their quality bonus payment status into their plan bids, due by the first Monday in June.

## Appendix 1

### Proposed Demonstration Approach for QBP Increases

	Level of Star Rating	QBP%		Actual Demo QBP% after blending benchmarks*			Actual Current Law QBP% after blending benchmarks		
		Current Law	Demo	2 year counties	4 year counties	6 year counties	2 year counties	4 year counties	6 year counties
	<b>5 star plans</b>								
	2012	1.5%	5%	5.00%	5.00%	5.00%	0.75%	0.38%	0.25%
	2013	3%	5%	5.00%	5.00%	5.00%	3.00%	1.50%	1.00%
	2014	5%	5%	5.00%	5.00%	5.00%	5.00%	3.75%	2.50%
	2015 (ACA rules)	5%	5%	5.00%	5.00%	3.33%	5.00%	5.00%	3.33%
	<b>4 star plans</b>								
	2012	1.5%	4%	2.00%	1.00%	0.67%	0.75%	0.38%	0.25%
	2013	3%	4%	4.00%	2.00%	1.33%	3.00%	1.50%	1.00%
	2014	5%	5%	5.00%	3.75%	2.50%	5.00%	3.75%	2.50%
	2015 (ACA rules)	5%	5%	5.00%	5.00%	3.33%	5.00%	5.00%	3.33%
	<b>3.5 star plans</b>								
	2012	none	3.5%	1.75%	0.88%	0.58%	none	none	none
	2013	none	3.5%	3.50%	1.75%	1.17%	none	none	none
	2014	none	3.5%	3.50%	2.63%	1.75%	none	none	none
	2015 (ACA rules)	none	none	none	none	none	none	none	none
	<b>3 star plans</b>								
	2012	none	3%	1.5%	0.75%	0.50%	none	none	none
	2013	none	3%	3.00%	1.50%	1.00%	none	none	none
	2014	none	3%	3.00%	2.25%	1.50%	none	none	none
	2015 (ACA rules)	none	none	none	none	none	none	none	none

Notes: (1) Under the demonstration, a qualifying plan is a plan with a star rating from three to five stars.

Qualifying plans serving qualifying counties receive a double QBP percentage for those counties.

(2) The final year of the demonstration would be 2014. In 2015, when QBPs return to current law levels, 6-year transition counties will be in year 4 of the transition to benchmarks based on 100% of the FFS quartile benchmark.

(3) New MA plans will receive increases to the new FFS-based part of their benchmark that is equal to +3 percent in 2012 and 2013, and +3.5 percent in 2014. In 2012, low enrollment plans as defined by the Secretary will be subject to increases of +3 percent to the portion of their benchmark that is based on the new FFS-based rate.

\* For 5 star plans, CMS will apply the QBP percentage to the blended benchmark. In contrast, for plans with 3 to 4.5 stars, the current law rule applies, where the QBP percentage is applied only to the new FFS-based rate before blending with the pre-Affordable Care Act benchmark. Also for 5-star plans only, CMS will not apply the provision to cap the blended benchmark at the level of the pre-Affordable Care Act benchmark.