



CMS 2011 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN
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CMS

Dale Summers: Good afternoon. As Jill mentioned, I'll be focusing on Medicare Advantage benefits review, and following me will be Kady, who will focus on Part D. Just to get started today, I wanted to give you a little bit of an overview of what our agenda will include. The first part of the presentation focuses on the process. The second part, which will be the most exciting part of my slide presentation today, will be on the actual benefit and design and cost-sharing requirements, and then we'll finish things up with some things you need to look out for, as far as submitting quality bids. We have some important dates on this next slide.

As you can -- as you're probably already aware, the PBP and the bid pricing tool software is available in HPMS already, and actually you can submit your bids a bit early, so that you can make sure things are working before the big date, which is June 6, and that's the date that all bids are due in. The next item on my slides talks about the bid review activities, and I want to get into those in just a minute, because this deals with what CMS will be doing once we receive your bids, and then how we'll be communicating back out to you, but we'll come back to that in just a moment.

The next item talks about rebate reallocation. This is going to be a bit earlier this year, as has been mentioned previously in the presentation, due to the annual election period being changed, so it's important that we focus on getting things submitted that are accurate and complete the first time, to the extent possible. And then of course we have attestations, and also the plan corrections, and we have plan corrections on the list here, but we really don't expect to see that many of them. They've really declined over the years, and we really expect that to be a rare circumstance, where a plan correction is submitted.

Sort of focusing on the bid review activities, and this is during June and July, essentially when your bids are submitted to CMS on June 6, we're going to be conducting reviews, make sure that the bids are meeting our standards. We will communicate to the plans. Our goal is the last week in June, to provide -- basically provide information to you, as far as what the issues are, and what actions need to be taken. A couple of things that we need to point out is that we're doing the best we can to coordinate our interaction with the plans, but you do need to be aware that there are several points of contact, as far as reviewing bids.

We have the Office of Actuary, and they have some contractors who will be working with the plans. We also have the Part D group, or MDBG, which are reviewing the Part D portions of bids and will be working with you, and the Medicare Advantage group, or sometimes referred to as MCAG, will be looking at the Medicare Advantage cost-sharing requirements, and also we have a contractor who works on the notes review in the plan benefit package.

So you will be hearing from different parties within CMS, but please rest assured we're doing the absolute best we can to coordinate so that things work as smoothly as possible. I just want to point out a few things to you, and you're probably

CMS 2011 Medicare Advantage And Prescription Drug Plan

aware of many of these resources already, but there are tools available to you. The final regulation is available to you, and also the call letter, which was just issued. We are anticipating issuing an HPMS memo that will relate to MA benefits over the course of the next several days, or early next week. This will fill in the gaps of some of the information that was not in the call letter.

As far as the Chapter 4 in the Medicare managed care manual, that's always something important to refer to, and the out of pocket -- the out of pocket cost or OOPC model -- basically there will be a presentation here a little bit later about the OOPC model, and this is another important tool that you should use in your preparation of bids. One thing that we need to point out as well is if you have policy questions related to the MA benefit, you should submit those to the link that is on the slide here, and again, those slides are available to you. This is a centralized mailbox for you to submit your questions to us, and this will allow us to respond in an accurate way and also a consistent manner with plans, and it also helps us in reviewing bids, because we have a record of our correspondence with the various plans.

And certainly, we want to push the idea that you should participate in user group calls. There are certainly a variety of them throughout the organization. I wanted to talk a little bit about our benefits review goals. First -- you see the first two bullet points that talk about low enrollment and meaningful difference? In the call letter, you'll see meaningful difference referred to as duplicative plans. They're both one and the same as far as the review process. As was mentioned in the talk earlier today, one of the reasons we look at low enrollment and meaningful difference is because there are many areas throughout the country where there's a very large number of plans that are being offered and choices for beneficiaries. So these efforts are an attempt to improve choice for beneficiaries, so that they can differentiate and make clear and good choices.

A couple of the next bullets talks about the review of significant increases in cost-sharing or decreases in benefits. This is referred to as the total beneficiary cost review. This goes back to last year, as part of the Affordable Care Act, and we did this review last year, and this year we're providing you with a great deal more information, since we've had a year to get that under our belt and provide that to you.

Also, we want to ensure that cost-sharing amounts and benefit designs don't discriminate against beneficiaries on the basis of health status, and that's something that we do through our cost-sharing standards. Moving into the exciting part of the presentation, we often get questions about, okay, you guys give us all these standards and tests. Which ones apply to employers, which one applies to non-employer groups? So this slide is attempting to break out the major components that we work on, and also provide you with the ones that are related to non-employers and employer groups. We also have a column here as far as resources, where you can get more information. If you notice, low enrollment, meaningful difference, and total beneficiary cost all apply to non-employer plans, and most of that information can be obtained through the call letter. Also, the HPMS memo that I referred to a few minutes ago, we will be issuing that in the very near future, that will provide more operational guidance, and then also the OOPC model tools are very helpful in those calculations.

The last three rows on this slide talk about the maximum out of pocket, or the MOOP amounts: the actuarial equivalent cost-sharing test and also service category cost-sharing. All three of those types of tests apply to both non-employer as well as employer groups, so it's important to keep that in mind as you're preparing your bids. Low enrollment -- let's focus on that first. Essentially, again, this is focusing on those plans who have insufficient enrollment after a specified period of time, and I think in the call letter, we mentioned it's three years. Just to really break it out for you, as this slide indicates, we're looking at plans that have been in existence in 2009, 2010, and 2011 or longer. So those are the plans that we look at, and we look at those plans, enrollment based on April, enrollment of this year, and you can see that for the non-SNP plans, or special needs plans, we're looking at plans with fewer than 500 enrollees, and for the special needs plans, we're looking at there's plans with fewer than 100 enrollees.

The next thing we do is to look at those plans that we've identified, and we do evaluate the populations that they serve, and also the access or choices that are in that area. So in some cases, we may eliminate or take a plan off the list that we've identified, because we want to make sure there is sufficient choice in those areas.

CMS 2011 Medicare Advantage And Prescription Drug Plan

Once we've identified those plans, we'll send a communication to those parent orgs that have a low enrollment plan that's been identified, and that should be happening in the next few weeks -- it's usually during the April/May timeframe. We try to make it as much in April as possible, and in this communication, the organization will have the opportunity to either agree to consolidate or eliminate their plan, or else to basically submit a business case to CMS, providing a justification as to why it should continue on.

One thing to keep in mind: organizations can consolidate or eliminate their plans in accordance with the CMS renewal and non-renewal guidance that's in the call letter. Just to sort of go back and talk about these justifications, essentially those organizations who receive a communication from us, we will give you instructions, but if you do want to submit a justification, we'll provide you with the instructions, we'll review the business case, and get back to you with a determination.

Moving into meaningful difference, and again, what we're trying to do here is ensure that plans in the same service area within the same organization are meaningfully different, and we're doing this at a county level. So we're looking at each plan at a county level, and the offerings within that contract, if you will. The acceptable difference between each plan is \$20 per member per month, based on the OOPC data, and that is based on Part C and Part D combined, OOPC value. This is the same number that was used last year for the meaningful difference evaluation. In the proposed call letter, we have had a higher number, but based on comments, we've decided to use the \$20 PMPM amount again for 2012.

A couple of things to keep in mind is the fact that premiums are excluded from the OOPC calculation, for purposes of meaningful difference. Provider network or providers are not considered a meaningful difference, and again, organizations can consolidate plans by following CMS guidance.

A couple of things -- the next slide defines how we look at meaningful difference, and if you'd read the call letter, there is -- basically goes through the steps of our evaluation. So for instance, if you're looking at a non-special needs plan or a non-SNP plan, we break out the different plan types. So, for example, HMO and HMO-POS, they're different already. Just the same as HMO and local PPOs, they're different. Same for regional PPOs and private fee for service -- they're different from one another. We also look at the -- whether there's a drug benefit offered with the plan or if there's not a drug benefit offered with the plan, so again, that's meaningful difference. And then once we've gone through that process, we look for a difference of \$20 PM/PM between the plans to determine if that's meaningfully different.

The SNP criteria, or the special needs plan criteria, is very similar to that. There's a little bit of a difference there. For instance, as the example indicates, we do look at chronic care SNPs, and as you're probably aware, there are many different health care conditions that can be different types of chronic care SNPs. So we look at the population served, when we're evaluating meaningful difference there as well. And again, the same dollar amount is used, and that's the \$20 for both Part C and Part D.

Moving in to total beneficiary cost, again, this goes back to evaluating bids for significant changes in basically cost-sharing -- increases in cost-sharing or decreases in benefits from one year to the next. This was something that we performed this past year for 2011. If you recall, TPC is based on the plan-specific premium as well as the OOPC value for that plan, so we're attempting to get the full value of what a beneficiary experiences in cost.

This year, or I should say for 2012 actually, we are going to add a factor that considers Part B premium. That will obviously -- beneficiaries do pay Part B premium, in most cases, but we do have plans who have a buy-down for Part B premium as well, so we're taking that into consideration this year.

Total beneficiary cost represents the financial impact to a beneficiary. So if TBC -- total beneficiary cost -- changes from one year to the next year for that same plan, that's indicative of a change in cost-sharing and/or benefits. So that's how we're using this metric or this measure in our evaluation.

If you've read the call letter for 2012, you've probably seen that we've established the amount at approximately \$36 per member per month, or about ten percent increase as the standard, if you will, as far as when we look at the bids, we're looking at bids to make sure that they're less than this number. Now for this past year, we had a situation where

CMS 2011 Medicare Advantage And Prescription Drug Plan

payments were relatively the same, they were frozen. Between 2011/2012, there are a number of payment changes going on, as you're aware of, and that includes benchmarks, as well as bonus payments. So one thing that we're planning to provide to organizations will be plan-specific adjustment factors that take this into consideration for each specific plan, so that you can make that adjustment. We'll be providing that through an HPMS posting in the next several days or weeks, so that you can be on the lookout for that.

One thing that I need to point out -- again, we're trying to be as transparent as possible, provide you as many requirements upfront. One thing that CMS is reserving the right to do is go back and look at the TBC, and if we see a situation where there are problems for one reason or another, we do have the right to come back and ask plans to make adjustments to their bid, even if they did pass that \$36 PM/PM test.

Just to get into a few operational details here on the next slide, we will provide some more guidance on TBC in a forthcoming HPMS memo. Again, that's coming out in the next several days, or early next week. We'll also be providing to you what CMS has calculated as your 2011 TBC amount -- basically what your premium and what your OOPC value is, and what we view the 2011 TBC amount is. We also are going to give you that adjustment factor I spoke about, for the adjustment related to payments, related to benchmark changes, as well as bonus payments. One thing that we're evaluating now is also whether or not to provide an adjustment factor for changes in OOPC from year to year. One thing that you will learn a little bit later today is if you have the same benefits in 2011 as you do in 2012, your OOPC value may change slightly, based on the -- just changes in the plan/benefit package, or changes in formulary requirements, those types of things. So we are taking a look to see if there will be a second adjustment factor, and we'll communicate whatever the requirements are in this HPMS memo that will be coming out very shortly.

And essentially, we want to give the tools to the plans, or to the organizations, so that you can calculate TBC as you're preparing your bids, and you can evaluate whether or not your bids are meeting our requirements before you submit them. And we do have that expectation.

Another thing to point out is if you're planning to consolidate multiple 2011 bids into a single -- or multiple 2011 plans into a single 2012 plan, we're going to be making that evaluation on a weighted enrollment basis, so you'll need to take that into consideration as you're planning your bids.

Segueing out of TBC and into maximum out of pocket amounts, if you saw the 2012 call letter, the amounts for 2012 are the same as they were for 2011. Regional PPOs are required to follow this guidance for 2012 as well as Vanessa had mentioned this morning. Just to point a few things out about this chart, I don't need to read the numbers off to you specifically, but we do have the mandatory MOOP, which is required by regulation, and that's on the right-hand side of -- the right-hand side of the slide, and you can see the amounts there as far as the requirements. And then we do offer a lower voluntary MOOP amount, and if plans choose to follow the lower voluntary MOOP amount, we provide flexibility and cost-sharing requirements, that you'll see on some of the forthcoming slides.

A couple of other things to point out is at the top of the chart, we sometimes get questions about, well, if I have a MOOP amount of \$3500, am I close enough to a voluntary MOOP, or can you pro-rate? The answer is no. If you look at the heading there, we're trying to illustrate that a mandatory MOOP really ranges from \$3401 to \$6700. So coming close really doesn't help you get a voluntary MOOP; you have to be somewhere between \$0 and \$3400.

Also, point out that in the case of local PPOs and regional PPOs, there is a catastrophic or a combined MOOP amount that's required, and again, that's inclusive of in-network as well as out of network services. The next test is the actuarial equivalent cost-sharing test. This information is taken from the bid pricing tool. Essentially, each plan needs to, on an overall basis, not exceed original Medicare on the basis of actuarial equivalents. And then we take that a step further as well, for certain categories -- the five categories listed on the slide -- inpatient, skilled nursing facility, home health, DME, and Part B drugs. We look at those categories individually, as well on an actuarial equivalence basis.

And again, this information is taken from the bid pricing tool. And actually, if you looked at the 2012 call letter, there's a very complicated chart in there that our friends in the Office of the Actuary has assured us that actuaries do understand, and that you can use as far as meeting this requirement.

CMS 2011 Medicare Advantage And Prescription Drug Plan

Moving in to service category standards, one thing that's listed in Chapter 4 has to do with what a benefit is, and one of the requirements of a benefit is that it can't exceed 50 percent cost-sharing. If it exceeds 50 percent cost-sharing, then it's no longer a benefit. So it's important to keep that in mind. It's also important to keep in mind that CMS also establishes requirements that may be below that 50 percent requirement, and you'll see that in some of the subsequent slides here.

One thing that we do point out is that generally, beneficiaries prefer co-payments over coinsurance, because they are a bit more predictable. So to the extent possible, it would be helpful to have co-payments. In some situations, such as DME and Part B drugs, there's such a wide cost variation that it makes it difficult to come up with one co-payment amount, so we do allow stratified co-payments, which are detailed in Chapter 4, and will actually be detailed further in the forthcoming HPMS guides that we'll be sending out.

I have -- the next three slides deal with a chart that's in the call letter, so I won't really spend a lot of time on this, just to point out some of the highlights. This year, we've identified the PBP section, where we're evaluating these various tests. So there is a column in the call letter, as well as a slide that indicates where we're finding these numbers. We have two types of standards -- one for voluntary MOOP plans, and one for mandatory MOOP plans, and in the case of this first slide, you can see that we have several scenarios for inpatient as well as mental health inpatient, based on days' stay.

And we look at the information that's in your plan benefit package to see how much it costs for an enrollee for an example of a 60-day stay, for a 60-day stay. And we're looking at the service category deductible, we're looking at co-payments and coinsurance, and putting that all together to see how much that would cost a beneficiary. And again, I emphasize that it's service category deductible, and co-payments and coinsurance. In the case of a plan level deductible, that is not considered part of the evaluation.

A couple of things to point out is, in the case of skilled nursing facility, that is broken into two components. One is the first 20 days, and the second is 21 days to 100. CMS requirements do allow some flexibility for cost-sharing in the first 20 days, but the second benefit period, or the 21 to 100 days, it can't exceed fee for service. And another thing to keep in mind on the previous -- one of the previous slides you saw about the actuarial equivalence test, skilled nursing facility is part of that test. So in all likelihood, if you choose to have some cost-sharing during the first 20 days, in all likelihood, you will have to have lower than fee-for-service cost-sharing in the period between 21 days to 100.

Moving on to the next slide, in the call letter, home health was mentioned as TBD -- to be determined -- because the reg hadn't gone final at that point. For this year, for 2012, this is the standard, this will be included in the HPMS memo that will be coming out shortly, and is very similar to last year. Essentially, if you have a mandatory MOOP, there's zero cost-sharing. If you have a voluntary MOOP, you do have some flexibility.

In the case of the next three office visits, for primary care, chiropractic, physician specialist, and outpatient mental health, we have a co-payment limit here. One thing I need to really point out here is this is a limit, and in most cases, plans are well below this number, and we would expect plans to be well below this number, because of beneficiary needs, as well as to be marketable. Quite frankly, these are some of the key measures that are placed on the plan finder, so that beneficiaries can make a choice, and we would expect the co-payments to actually be lower than this, but these are the limits that we're looking at.

We also have therapeutic radiological services at the bottom -- again, 20 percent or the \$60 co-payment. The bottom of the -- well actually, the last slide with this particular chart that's in the call letter, we have durable medical equipment, and you can see if you have a voluntary MOOP, you do have more flexibility because it doesn't apply. I do need to point out again that we have the actuarial equivalents for DME, and we are looking at that on an overall basis, just to make sure that the cost-sharing isn't too far out of line. And I won't read through the various standards here, but you can certainly see them there. One note I should make is with equipment and prosthetics and medical supplies, we just have 20 percent coinsurance there. Most plans, if they have co-payments, do use stratified co-payments for these types of services, because there's such a wide variation of costs. And again, that will be detailed more in the -- it's already in Chapter 4, and we'll be repeating that guidance in the forthcoming HPMS memo.

CMS 2011 Medicare Advantage And Prescription Drug Plan

Discriminatory pattern analysis -- when we receive your bid, we're going to make sure that your bids comply with our standards. We're going to be conducting additional analyses as well, and may be coming back to you with additional changes. Again, we expect that by giving you the requirements upfront, that the bids will be submitted in a way that comply with our requirements.

Couple of quick notes here -- preventative services and ER visits -- preventative services this year are required -- when I say this year I mean 2012. They are required to be zero cost-sharing if they're covered at zero cost-sharing at original Medicare. You'll be hearing from Sarah Silver a little bit later about how the PBP will accommodate this year. It will be a lot easier than last year. Also, one thing that didn't make it into the call letter, because the reg didn't go final until after the call letter, and that was the fact that CMS has the ability to now change the dollar limit for each ER visit. We can specify that amount for each year. Over the past it's been \$50. For 2012, we're moving that up to \$65, and that will be in the HPMS memo as well.

I'm going to hit on the quality bid submissions quickly. Again, we want to make sure that you submit bids that are complete and accurate, and that when you're putting your notes in the PBP, please be sure not to diminish the benefit, or especially if it's a Medicare-covered benefit. In the case of out of network cost-sharing, please make sure that the PBP is filled out correctly. For example, an HMO point of service needs to have at least one out of network service, and also when you're looking at local PPOs as well as regional PPOs, please make sure that the benefits are complete, both in and out of network services.

In terms of the PBP submissions, we're -- a number of us are going through checks to make sure that the plan benefit package and the bid pricing tools match up. So please take the time to make sure you do that before submitting the bids - that will save a lot of time on our end, and also back and forth. From a marketing material standpoint, the bid that you submit is really part of generating marketing materials, and in particular the summary of benefits. So for example, you do have the ability, once you've put your bid into the plan benefit package, to run summary of benefits reports. You need to do that before you submit the bid; that saves a lot of headaches and heartache on the backend.

Certainly actuarial certification is important, and again, communicate and coordinate within your organization. We realize there's a number of different folks who are involved with it, with creating a bid, but it's important to coordinate. Plan correction requests. We really expect this to be a rare event, where there's a plan correction request. If there is one, the last day to submit is October 1. There are no exceptions to that rule.

Again, we take this very seriously, so if there is a plan correction request, it really indicates that there's a problem in submitting complete and accurate information. So in all likelihood, you'll be receiving some sort of compliance letter, and if you've done this in the past, most likely a corrective action plan, because it's important to make sure that the bids are accurate when they're submitted.

Just a couple of quick final thoughts: June 6, important day to submit the bids. I've got the information here, if you have difficulty in uploading your bids. I'm sure Sarah Silver will provide you with the same phone numbers and contact information as far as the HPMS helpdesk, and in terms of if you do have any MA policy questions, this is the mailbox to submit your question to, and certainly appreciate your time.