

MEMO

DATE: February 23, 2011
TO: Clients & Friends
FROM: John Gorman and Jean LeMasurier
SUBJECT: Memo on 45-Day Notice and Draft Call Letter for 2012

On February 18, 2011, CMS issued the Advance Notice of Methodological Changes for CY 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter. Under the Advance Notice, MA rates are estimated to increase 1.6 percent in 2012. The estimate assumes the physician fee cut of 28 percent will take place January 1 and that the expanded quality bonus demonstration will be implemented. It also takes into account adjustments for prior periods.

The rates for 2012 will be determined by blending two rates:

- The “applicable” amount which uses the current payment methodology (greater of the county’s 2012 FFS rate or the prior year MA rate increased by the CY 2012 national per capita MA growth percentage) and
- The “specified” amount which phases in the new methodology from the Affordable Care Act (each county is assigned to a quartile ranging from 95-115 percent of FFS and plans receive a quality bonus based on their star score).

In addition, Indirect Medical Education (IME) Costs will continue to be phased out, however the impact will vary by county. Final rates will be announced on April 4.

CMS included the draft 2012 Call Letter with the 45 day Advance Notice.

45 Day Advance Notice

Part C Payment Methodology

MA National Growth Rate – The preliminary estimate of the National Per Capita MA growth rate is a 0.7 percent increase over 2011 county rates. This reflects a -3.32 percent change in the underlying trend for aged and disabled and adjustments for prior years. This compares to the final 2011 national growth factor of 1.38 percent.

Coding Adjustment – CMS is proposing a 3.41 percent coding pattern adjustment, which is the same as the 2011 adjustment.

Risk Adjustment Normalization Factor – The preliminary Part C normalization factor for the aged and disabled is 1.079. The ESRD factor is 1.012 for dialysis and 1.051 for functioning graft enrollees. The Part D normalization factor is 1.032.

ESRD Rates – CMS fully phases-in revised state capitation rates to determine payment for dialysis and transplant enrollees in 2012. CMS has revised the underlying dialysis rates for 2012 based on FFS costs.

Hierarchical Condition Category (HCC) Risk Adjustment Model – CMS will not implement an updated version of the CMS HCC risk adjustment model that updates data years as discussed in last year's Rate Announcement.

CMS will implement an updated version of the ESRD risk adjustment model in 2012 which recalibrates all components of the ESRD model. The new model modifies the functioning graft codes and increases the Disabled-Disease Interactions from six to seven and the disease interaction codes from four to five.

Medicare Advantage Organizations will submit ICD-9 codes mapped to the payment model HCCs starting January 1, 2011 and may submit for dates of service beginning July 1, 2010 so that they may be included in risk adjustment.

CMS is conducting the ACA mandated evaluation of its risk adjustment system and will publish results in the 2012 Rate Announcement.

ACA Quality Bonus – The Advance Notice states that CMS will use the previously announced demonstration that will expand the quality bonus to MA plans with star ratings with 3 or more stars. For 2012 the bonus will be:

- Less than 3 stars 0%
- 3 stars 3%
- 3.5 stars 3.5%
- 4 stars 4%
- 4.5 stars 4.5%
- 5 stars 5%

For 5-star plans, the bonus will be applied to the full blended rate. CMS states that they are considering applying the bonus to the full blended rate for MA plans with 3-4.5 stars and requests comments on this issue and how to transition plans to the ACA methodology which provides a quality bonus to only MA plans with 4 and 5 stars after the demonstration ends in 2014. They also request comments on how best to incent plans to achieve a 5 star rating.

Qualifying County Quality Bonus – The ACA also provides that the quality bonus will be doubled in “qualifying” counties. These counties have an urban floor rate in 2004, a minimum of 25,000 enrollees, and an average FFS spending that is less than the national average FFS spending for 2012. The Advance Notice states that CMS will use December 2009 enrollment. CMS will publish a list of the qualifying counties in the 2012 final rate announcement.

ACA Transitional Phase In – Each county will be assigned to one of three transitions periods – two, four or six years based on the difference between the county’s Projected 2010 Benchmark Amount and the 2010 Applicable Amount. If the difference is under \$30, the county rate will be blended over two years. If the difference is between \$30 and \$50, the blend will be four years. The blend will be six years if the difference is at least \$50.

Beneficiary Rebate - The ACA changes the beneficiary rebate calculation to link it to the quality bonus in 2012 and phases this change in over three years.

Star Rating	2012	2013	2014
4.5 +Stars	73.33%	71.67%	70%
3.5 – <4.5	71.67%	68.33%	65%
<3.5	66.67%	58.33%	60%

A low enrollment plan is treated as a 4.5 star rated plan and a new plan under a new parent organization is treated as a 3.5 star rated plan.

Under the Advance Notice, CMS is proposing to use the same policies regarding the use of rebate dollars that currently apply, e.g. provision of extra benefits or reduction in cost sharing.

Determination of FFS Costs – CMS is changing the methodology it uses to determine FFS costs in a county to exclude hospice claims and cost plan data over a five year period. This will have a negligible impact on most counties. In addition, the FFS costs in Puerto Rico will be modified. CMS will also modify the methodology for counties with less than 1,000 enrollees, thus avoiding large year to year changes in rural counties.

Medicare Secondary Payer (MSP) Adjustment – CMS has revised the MSP factor for ESRD for 2012 resulting in a lower adjustment of 0.189 (compared to 0.215 in 2011).

IME Adjustment – For 2012, IME costs will be phased out under the MIPPA formula based on the amount of IME included in the FFS rate, up to a maximum of 1.8 percent in a given county. The final announcement will identify the amount of IME for each county rate and will reflect county rates with and without the IME reduction.

Bonus and Incentive Payments – MA plans must pay qualifying non-contracted physicians PQRI and E-prescribing bonuses respectively of 2 percent of Medicare allowed charges under FFS. PFFS plans pay these bonuses to deemed providers.

Clinical Trials – Clinical trials will continue to be paid on a FFS basis.

DOD Adjustment – For 2012, CMS will adjust 138 county rates with at least 10 beneficiaries who are eligible for the Uniformed Services Family Health Plan (USFHP) by approximately \$1.85 (ranging from a decrease of \$0.10 to an increase of \$5.00).

Frailty Adjustor –The new frailty adjustor for PACE plans is fully transitioned in 2012. CMS is planning to implement a frailty adjustor for qualifying Fully Integrated Dual Eligible SNPs in 2012. These DE SNPs must have a capitated state Medicaid contract and a frailty level similar to PACE plans. To make a determination of eligibility, CMS is requiring these plans to field their Health of Senior (HOS) survey at the PBP level in 2011. CMS is requesting comments on the methodology to determine frailty, e.g. using the distribution of ADLs or modeling the relationship of disease scores and the treatment of new and low enrollment DE SNPs.

PFFS Network Areas – In 2012, non-employer PFFS plans that are offered in counties that have two or more network plans open to enrollment must have networks that meet CMS access standards. The counties are listed at: <http://www.cms.hhs.gov/PrivateFeeForServicePlans/>. The list of network areas for 2013 will be included in the final 2012 Rate announcement. CMS will use January 2011 enrollment to identify network areas for plan year 2013.

MSA Demonstration Program – CMS will end the demonstration project that allowed MSA plan designs that more closely resemble private sector high deductible plans.

Employer Group Waiver Plan Bidding – CMS is requesting comments on how to address the discrepancy between bids for EGWPs which are 109 percent of the FFS rate while the average bid for non-EGWP plans is 100 percent of FFS. Further, projected medical costs are higher and the risk scores are lower for EGWP members.

Encounter Data – MA organizations will submit encounter data each time services are provided to enrollees for dates of service beginning January 1, 2012. DME encounter data will begin May 7, 2012. Cost plans will submit encounter data for dates of service after July 1, 2004. Plans will use the HIPAA 5010 format. CMS will continue the current RAS until testing of the Encounter Data Processing System (EDPS) is complete.

Risk Adjustment Processing System – RAPS will be changed to accommodate the ICD-10 system which will use the 5010 transaction standard format January 1, 2012.

RADV Audits – All MA organizations must have systems and telecommunications capability that meet the specified standards.

Part D Payment Methodology

Coverage Gap Discount Program (CGDP) – CMS will determine monthly prospective CGDP payments based on the Part D bid estimates multiplied by the number of non-LIS enrollees. PACE and EGWPs will not receive these payments. CMS is requesting comments on whether the payments should be adjusted to include fill fees.

Gap Coverage – The 2012 coinsurance non-applicable drugs (i.e. generic drugs) will be equal to 86 percent or an actuarially equivalent amount. This is an increase in plan liability and a reduction in enrollee cost sharing. The 14 percent plan liability will not count towards TrOOP.

Rx-HCC Model – The model will be recalibrated to factor in the impact of the Part D benefit. CMS will use a new formula to calculate plan liability for non-LIS beneficiaries. The new denominator is \$1,107.82.

De Minimis Policy – Part D sponsors may not use the de minimis policy to waive Part D premiums for partial subsidy or non-LIS beneficiaries.

Part D Benefit Parameters – The Advance Notice includes the updated Part D and RDS benefit parameters which will be increased by 3.34 percent for 2012 (4.67 annual percentage trend for 2011 adjusted by -1.27 percent for prior year revisions). Due to changes in cost sharing in the coverage gap, there is a different Total Covered Spending at the Out of Pocket Threshold for LIS and non-LIS beneficiaries.

Part D Benefit Parameters	2011	2012
<u>Defined Standard Benefit</u>		
Deductible	\$310	\$320
Initial Coverage Limit	\$2,840	\$2,930
Out-of-Pocket Threshold	\$4,550	\$4,700
Total Spending at Out of Pocket -LIS	\$6447.50	\$6657.50
Total Spending at Out of Pocket – non-LIS	\$6483.72	\$6730.39
Minimum Cost-sharing for Generic/Preferred	\$2.50	\$2.60
Multi-Source Drugs in the Catastrophic Phase		
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	\$6.30	\$6.50
Retiree Drug Subsidy		
Cost Threshold	\$310	\$320
Cost Limit	\$6,300	\$6,500

Draft Call Letter for 2012

Calendar – The calendar includes the earlier Annual Election Period (October 15 - December 7) and thus earlier dates in some instances than in the past. For example the ANOC/EOC documents and LIS rider and formulary must be sent to current members by September 30, 2011.

Quality Improvement Projects and Chronic Care Improvement Programs – MA Organizations must submit QIPs and CCIPs on appropriate templates. Guidance will be sent out separately.

SNP Plans – CMS is seeking comments on an initiative offering plan design flexibility to promote enrollment of duals in fully integrated (i.e. capitated for full array of Medicaid services), high quality SNPs for 2013. Comments are requested on the definition of high quality plans, specific design flexibilities that promote integrated delivery and streamlined administration, incentives that would encourage plan participation (e.g. seamless enrollment transitions), and what additional care coordination or beneficiary protections might be necessary.

Chronic care SNPs must disenroll all members who no longer qualify for the special needs requirements by January 1, 2012. SNPs must notify the members by October 1, 2011. Plans must notify their plan manager of the number of non-special needs beneficiaries that will be disenrolled by June 30, 2011.

Starting in CY 2013, Dual Eligible SNPs must have contracted with the State Medicaid agency in areas where they operate. Existing Dual SNPs that are not expanding can continue to operate without a state contract through December 31, 2012. CMS will coordinate the submission of the contract with the MA contracting process.

Plan Renewal – CMS has authority from the ACA to deny plan bids if there are significant increases in cost sharing or decreases in benefits. CMS has modified some previous options in the HPMS crosswalk. Renewal and Non-renewal guidance is included in the draft Call Letter.

Parent Organization – CMS is increasingly focused on the relationship with Parent Organizations and plans must accurately report their “ultimate” parent which is the top entity in a hierarchy. All changes in parental organizations must be reported to CMS within 30 days.

EGWP Plans – CMS will develop an information collection effort to require EGWPs to submit supplemental benefits negotiated between employers and EGWPs to CMS to assure that plans properly apply the manufacturer coverage discount after the supplemental benefits are applied. Beginning in 2012 Direct EGWPs will be required to report HEDIS, HOS and CAHPS data.

Plan Ratings – The 45 day notice outlines CMS principles for improving plan ratings.

For 2012, CMS proposes to add the following measures:

- All-Cause Readmission rates
- Advising Smoker and Tobacco Users to Quit
- Body Mass Index
- SNP specific measures including the four rates that are part of the Care for Older Adults measure
- Voluntary disenrollment rates
- One or more measures from the Hospital Inpatient Quality Reporting program
- Appropriate Part D transition processes to ensure continuity of care
- Part D Medication Adherence

For 2012 CMS will set 4 star thresholds for measures with at least a two year data history. CMS is also considering the following enhancements for 2012:

- Giving greater weight to clinical outcome measures and less weight to process measures
- Controlling for concentration of providers in an area
- Rewarding contracts for quality improvement
- Reducing ratings for plans with serious compliance issues

For 2013, CMS is considering adding the following measures:

- Adding survey measures of care coordination, care transitions and patient activation to CAHPS
- Case mix adjusted mortality rates
- Preventable hospitalizations
- Serious Reportable Adverse Events including Hospital Acquired Conditions
- Grievances
- Use of highly rated hospitals by plan members
- MTM measures related to comprehensive medication reviews
- Evaluation of CCIP and QIP

Plans with Less than 3 Star Ratings – CMS is strengthening its position that plans with less than a 3 star average summary rating on either Part C or Part D are substantially out of compliance and are on notice that they are to take corrective action to come into compliance. CMS plans to initiate action to terminate their contracts after publicizing the third consecutive summary rating of less than 3 stars and confirming that the data used to calculate the 3 star rating reflects substantial non-compliance.

SEP for Enrollment in a 5 Star Plan – The SEP to enroll in a plan with an overall 5 star rating any time during the year will begin December 8, 2011. Eligible MA plans will have 5 stars as of the 2011 Annual Enrollment. Individuals who are enrolled in another 5 star plan will not be eligible to enroll under this SEP. Individuals who are enrolled in a plan with lower than a 5 star rating can enroll in a 5 star plan offered by the same organization. Beneficiaries enrolled in a PFFS MA only plan will also have a SEP to enroll in a stand-alone PDP. CMS will develop a new SEP indicator to track utilization of this new SEP.

CMS is requesting comments on whether they should create a similar SEP to allow beneficiaries to enroll in a 5 star PDP any time during the year.

Part C Benefits – The Advance Notice references the updated chapter 4 of the manual which includes new policies on benefits, e.g. clarification of items and services that can be classified as supplemental benefits and multi-year benefits.

Part C Duplicative Plans and Plans with Low Enrollment – During April or May 2011 CMS will notify plans with fewer than 500 enrollees (100 enrollees for SNPs) after operating for 3 years and request justification or confirm that the plan will be eliminated or consolidated. CMS will non-renew the plan if there is not a compelling reason for maintaining the low enrollment plan. CMS will recognize legitimate reasons for low enrollment, e.g. service areas without sufficient competing plans of the same type, specific populations or geographic area.

For 2012, CMS will use plan specific out of pocket (OOP) cost estimates that combine Part C and Part D to identify meaningful differences among similar plan types. The plan OOP will be compared to data from the Medicare Current Beneficiary Survey information and will exclude premiums. CMS will evaluate differences among non-employer plan types offered by the same organization in the same county. There must be a total OOPC difference of at least \$22 per member per month between each plan to be considered meaningfully different.

Part C MOOP for 2012 – All plans must include a MOOP (maximum out of pocket) limit in their bid. This includes D-SNPs where states usually pay cost sharing to cover situations where a beneficiary’s eligibility may change mid-year. D-SNPs must track only the beneficiary’s out of pocket costs.

CY 2012 MOOP Amounts	Voluntary	Mandatory
HMO	\$3,400	\$6,700
HMO POS	\$3,400 In-network	\$6,700 In-network
Local PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
Regional PPO	\$3,400 In-network and \$5,100 Catastrophic*	\$6,700 In-network and \$10,000 Catastrophic*
PFFS (full network)	\$3,400 In- and out-of- network	\$6,700 In- and out-of- network
PFFS (partial network)	\$3,400 In- and out-of- network	\$6,700 In- and out-of- network
PFFS (non-network)	\$3,400	\$6,700

*Catastrophic MOOP is inclusive of in- and out-of-network Parts A and B services.

Part C Total Beneficiary Cost (TBC) – CMS will deny the bid if the TBC (premium plus other cost sharing) shows significant cost increases from year to year. For 2012, CMS will include a factor to account for Part B premium buy down as an additional benefit. CMS is requesting comments on two approaches to setting the TBC requirement for 2012: (a) the past method that analyses bids after submission to determine outliers and (b) a method where CMS would establish a TBC change amount based on historical data (approximately \$36 PMPM or a 10% increase in TBC from 2011 to 2012) and scrutinize bids above this amount.

CMS will provide a plan specific adjustment factor to account for geographic and quality bonus payment changes in 2012. This factor will be the projected change in rebate amount from 2011 to 2012.

Discriminatory Cost Sharing – CMS is establishing 3 benefit discrimination assessments for 2012:

- PMPM Actuarially Equivalent Cost Sharing Maximums – amounts may not exceed FFS on an actuarially equivalent basis. Also CMS will apply this separately in 2012 for inpatient hospital, SNF, home health, DME and Part B drugs.
- Service Category Cost Sharing Standards – the Advance Notice includes cost sharing limits for services that may vary based on whether the plan chooses the mandatory MOOP or a lower voluntary MOOP.
- Discriminatory Pattern Analysis – this analysis will consider cost sharing amounts that discriminate against sicker patients or certain disease states.

Multi-Year Benefits – CMS finds that multi-year benefits are confusing to beneficiaries and encourages plans to limit benefits to one contract year. CMS is considering a regulatory change to prohibit multi-year benefits in the future.

Copayment and Coinsurance for the Same Service – CMS is discouraging plans from entering both types of cost sharing for the same service. CMS is considering future rulemaking that will prohibit this practice.

Part D

ESRD Drugs – CMS reminds plans to exclude drug costs related to oral drugs from the Part D bids since these are now included in the bundled PPS system for renal dialysis services.

Prescriber Identifiers – For prescriptions written by foreign prescribers, sponsors should use the license number assigned by the appropriate licensing board in the foreign jurisdiction on the claim with the state license qualifier.

For 2012, Part D sponsors can use the current four prescriber identifiers on claims and PDE records – NPI, DEA, UPIN or state license number. CMS will exclude PDEs with invalid NPIs. Effective January 1, 2012 Part D sponsors must confirm the validity of DEA numbers on Schedule II drug claims or map NPIs on these claims to the prescriber's DEA and must confirm that the controlled substance is within the prescriber's scope of practice. CMS is considering a regulatory change for 2013 that will limit the prescriber identifiers to the individual NPI.

Supplemental Formulary Files – These must be submitted by June 13, 2011.

Hospice Drugs – Part D plan sponsors must ensure that drugs for beneficiaries who elect hospice as identified on the TRR are not submitted under Part D since these are covered under Part A.

Generic Drug Samples – Expenses related to the provision of generic samples in a physician's office may be counted as Part D administrative costs if consistent with a cost effective drug utilization management program. However, these drugs may not be incorporated into step-therapy protocols.

BAE for Home and Community Based Waiver Services – Cost sharing is eliminated for full benefit dual eligible beneficiaries that receive home and community based waiver services. Plans sponsors must follow the best available evidence policies that require a copy of a state document confirming receipt of waiver services.

Transition Policy – Audit findings show that plans have not been following transition policy requirements. CMS will require that plan sponsors provide documentation that their transition policy is properly implemented in their claims system and that beneficiaries are receiving required transition supplies. CMS may require submission of: up to one quarter's worth of denied claims for 2012; test claims for new beneficiaries; documentation of paid claims for transition supplies; or evidence of transition supplies provided across contract years.

MTM and Racial Disparities – CMS is replicating a study that found Hispanic and African American enrollees could have a lower likelihood of meeting MTM eligibility criteria and that there was disparity among beneficiaries with severe health problems. CMS may consider changing eligibility thresholds in future rulemaking. CMS is asking plan sponsors to review their eligibility criteria and submit comments on MTM eligibility criteria.

LIS Reassignment – CMS will reassign auto-enrolled beneficiaries when their plan is above the LIS benchmark. Plans that volunteer to waive the de minimis amount of the premium will no longer lose LIS beneficiaries. Organizations under sanction will not receive reassignments.

Low Enrollment PDPs – CMS will review the lowest quintile (20%) of 2011 plans ranked by enrollment. CMS encourages plan sponsors to withdraw or consolidate plans with less than 1,000 enrollees. Before non-renewing a plan, CMS will consider whether the plan has less than 3 years in the program, whether it is a basic plan necessary to offer an enhanced plan; the total number of plans in an area; whether the premium is below the LIS benchmark; and whether it is a national plan.

COB User Fee – The Part D COB user fee will be increased to \$1.62 per enrollee per year for 2012.

Part D Benefit Design – CMS will continue to use the cost sharing out of pocket amounts (OOPC) to establish meaningful differences between basic and enhanced plans and between low and high value enhanced plans. The 2012 minimum monthly threshold between basic and enhanced plans will remain at \$22. CMS will also use the median monthly cost sharing OOPC difference of \$16 between 2 enhanced plans in the same service area. CMS will provide the OOPC model on their website and encourages plans to run their plan benefit structures through the model before submission. Plan sponsors can only submit 1 basic offering and at most 2 enhanced plans. The second enhanced plan will have a higher value and at least some brand name coverage (10-65% of formulary drugs labeled as brand) in the gap.

Co-Pay Thresholds – CMS will use the 95th percentile across all bids consisting of 3 or more tiers to identify outliers for 2012. The following thresholds were used in the 2011 discrimination review; tier 1 over \$10; tier 2 over \$45; and tier 3 over \$95. CMS will also increase scrutiny of coinsurance tiers. If a sponsor submits coinsurance values for its non-specialty formulary tiers that are greater than the standard benefit of 25%, CMS may request documentation of expected prices of medications.

Tier Labeling and Hierarchy – For 2012 there will continue to be a maximum of 6 drug tiers however a 6th tier will be accepted only if it is an excluded drug only tier or a tier that provides a meaningful benefit such as a \$0 vaccine-only tier, a low or \$0 cost sharing tier for SNP plans targeting specific conditions or an injectable drug tier with cost sharing that is at or below cost sharing in the other tiers.

CMS is adopting tier labels and hierarchy consistent with industry standards. The tier hierarchy is included in the Advance Notice.

Gap Coverage – The basic package includes 14 percent generic drug coverage in the gap for 2012. CMS will evaluate plans that provide gap coverage at or below 30% of the cost of generic drugs or coinsurance higher than 70 percent to ensure substantial differences.

Specialty Tier Threshold – For 2012, the Part D specialty tier threshold will remain at \$600. Plans should have claims data that demonstrates that the majority of fills exceed the specialty tier cost criteria.

If you have specific questions regarding the content of this memo, please contact us at ghg@gormanhealthgroup.com.