CLIENT ALERT

CMS Re-Issues Draft 2010 Medicare Advantage, Prescription Drug Plan and Health Plan Call Letter

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On February 23, 2009, the Centers for Medicare & Medicaid Services (CMS) re-issued the Draft 2010 Call Letter for Medicare Advantage organizations (MAOs) and Part D sponsors (Revised Draft Call Letter). MAOs and Part D sponsors have been awaiting this guidance since CMS withdrew the original Draft 2010 Call Letter on January 22, 2009 (Original Draft Call Letter).

CMS states in the cover memo to the Revised Draft Call Letter that it is considering publishing plans' medical loss ratios. CMS explains that stakeholders have expressed an interest in receiving this data. CMS requests comments on how the medical loss ratio should be calculated.

Below is a summary of the key changes from the Original Draft Call Letter. Comments on the Revised Draft Call Letter are due by March 6, 2009. Comments regarding the Original Draft Call Letter, if still applicable, should be resubmitted.

MA, MA-PD, and Cost Plans

Multiple Plans. The Original Draft Call Letter suggested that MAOs eliminate plans that are substantially duplicative in cost sharing, provider network, and benefit design. CMS explained that multiple plan choices may lead to beneficiary confusion. In the Revised Draft Call Letter, CMS more emphatically encourages MAOs to "ensure plan differences are transparent, readily discernable to beneficiaries and meant to provide the highest value at the lowest cost."[1] Two examples of meaningful differences are plans with and without the Part D benefit and plans with and without specific supplemental benefit options. CMS is considering issuing new rules that will limit the number of plan benefit designs for a single MAO in a service area. CMS requests comments on this proposal.

***Benefit Design*.** CMS expands upon the benefit design and cost-sharing guidance provided in the Original Draft Call Letter. The new guidance provides that CMS will not likely consider an MA plan's coinsurance to be discriminatory if the: (i) overall out-of-pocket maximum is no more than $3,400; (ii) coinsurance for renal dialysis, Part B drugs, psychiatric hospitalization, and skilled nursing facility services do not exceed the original Medicare coinsurance; and (iii) out-of-pocket maximum does not exclude any Parts A and B services. CMS requests comments on this proposal.

The Revised Draft Call Letter also provides details on how CMS will evaluate MA plans that do not impose coinsurance but may have out-of-pocket maximum limits. CMS requests comments on how benefit design and cost sharing rules can be revised to provide "transparent, high value, low cost, non-discriminatory plan offerings."[2]

Medicare Health Outcomes Survey Administration. A new section provides that the current year HEDIS reporting requirement to report Medicare Health Outcomes Survey (HOS) results apply to: (i) all coordinated care contractors with at least 500 members with six months of continuous enrollment that had a contract with CMS on or before January 1 of the preceding year; and (ii) MA contracts with exclusively Special Needs Plan benefit packages. Beginning in 2010, MAOs that offer Private Fee-for-Service Plans (PFFS) that meet certain requirements must also report HOS. In addition, the Minnesota Senior Health Options,

Minnesota Disability Health Options, Wisconsin Partnership Programs, and Massachusetts MassHealth Senior Care Options plans will be required to report HOS and will no longer participate in the HOS-Modified survey. PACE programs with contracts in effect on or before January of the previous year are required to administer the HOS-Modified survey for current year HEDIS reporting.

Special Needs Plans. The Medicare Improvements for Patients and Providers Act of 2008[3] and January 12, 2009 final rule[4] (January Rule) require substantial changes to Special Needs Plans' (SNPs) operations, including several changes that will likely limit the number and types of SNPs offered in 2010. As a result, the Revised Draft Call Letter provides guidance on how SNP enrollees should be transitioned in 2010. In addition, CMS modifies its position from the Initial Draft Call Letter.

As an example, the Original Draft Call Letter provided that MAOs must disenroll enrollees who do not have the special needs status required to remain enrolled in a 2010 Chronic Condition SNP (C-SNP). The Revised Draft Call Letter provides that MAOs must permit these enrollees to remain enrolled, consistent with the January Rule's preamble. CMS will also consider establishing a special election period to permit these enrollees to move to another plan before 2010. CMS requests comments on this issue.

The Revised Call Letter also includes several additional provisions regarding C-SNPs. CMS reminds MAOs offering C-SNPs that they must verify the members' chronic condition. CMS expects to conduct focused audits in 2010 to determine MAOs' compliance with this requirement.

Confirming member eligibility is particularly important since effective March 13, 2009, as a result of the January Rule, C-SNPs may only enroll beneficiaries who have the targeted chronic condition. Therefore, CMS provides a general reminder about the special enrollment periods for C-SNPs as provided in Section 30.4.4 of Chapter 2 of the Medicare Managed Care Manual. CMS requests comments on the existing special enrollment period rules.

The Revised Draft Call Letter also adds important new provisions for Dual SNPs (D-SNPs). If a dual eligible beneficiary loses Medicaid eligibility following a required grace period, the individual may elect another MA plan or Prescription Drug plan. CMS will consider approving proposals to move these enrollees to another MA plan offered by the MAO that CMS finds better meets the beneficiary's needs.

Private Fee-for-Service Plans. CMS reminds MAOs offering Private Fee-for-Service (PFFS) plans that they must pay deemed providers at no less than the original Medicare payment rates and consistent with the plan's terms and conditions. CMS has received numerous complaints that MAOs are not paying at the original Medicare rates. CMS also expects MAOs to cooperate with the PFFS reimbursement adjudication independent review entity.

The Revised Draft Call Letter adds a new section to enhance and clarify CMS's previously published guidance that prohibits prior authorization by MAOs offering PFFS plans. MAOs are prohibited from imposing prior authorization or referral requirements for PFFS plan enrollees. Voluntary prior notification is permissible, although in general CMS "discourages provisions that provide incentives for prior notification."[5] This new section provides that MAOs requesting voluntary prior notification for PFFS plans in exchange for reduced cost sharing must: (i) clearly advise enrollees that they may obtain service at the cost sharing level that applies in the absence of voluntary prior notification; (ii) pass a CMS review of all cost sharing to ensure non-discrimination and actuarial soundness; and (iii) cover any medically necessary service if the enrollee does not voluntarily notify the MAO. CMS is soliciting comments on whether benefit structures that include lower cost sharing when the enrollee obtains prior notification should be prohibited.

Prescription Drug Plans

Formulary Reference Files. A new section is added on formulary reference files (FRF). In CY 2010, the FRF will be based on the National Library of Medicine's standardized nomenclature for drugs, RxNorm. As a result, certain drug records contained in the CY 2009 FRF will be absent from the CY 2010 file. These deletions eliminate duplicate codes.

Transition Requirements for Formulary Changes. A new section is added that clarifies a Part D sponsor's obligation to implement an appropriate and meaningful transition for enrollees whose drugs are no longer on the formulary in a subsequent contract year. The transition requirements are currently described in Prescription Drug Benefit Manual.[6] These transition requirements will also apply to drugs that will be subject to new prior authorization or step therapy requirements.

Beneficiary Understanding of Part D Benefits and Labeling of Part D Benefit Designs. CMS describes its efforts to convey meaningful and understandable Part D plan design information to beneficiaries. CMS's efforts included a new labeling process to describe gap coverage in the CY 2009 Medicare & You health plan charts. Beginning in 2010, Part D sponsors must identify gap coverage offerings for generic and brand drugs in plan benefit package software using CMS-defined standardized thresholds. CMS solicits comments regarding potential improvements in labeling and describing plan designs and features in pre-enrollment tools.

CMS states that it is equally important for beneficiaries to understand their plan's benefits. The Revised Draft Call Letter describes CMS's changes to the model explanation of benefits (EOB). CMS solicits comments regarding how plan benefits can best be conveyed to enrollees.

Marketing/Beneficiary Communications

CMS has added several new paragraphs concerning MAO and Part D sponsors' marketing practices.

CMS Oversight. CMS states that despite its oversight efforts, certain MAOs and Part D sponsors, and related third-party entities "attempt to find ways to circumvent our rules and guidelines."[7] CMS "will take very strong action against any entity attempting to circumvent our rules."[8]

Payment of Agents for Enrollments in 2009. In 2009 MAOs and Part D sponsors are required to pay agents and brokers at the renewal commission rates unless the enrollee is newly entitled or enrolled from original Medicare. In the preamble to the November 14, 2008 interim final rule, CMS stated that it will run a report identifying those beneficiaries enrolled in an MA or Prescription Drug plan who were newly entitled or enrolled from original Medicare to determine which agents are entitled to the initial compensation amount.[9] CMS has received questions concerning whether MAOs and Part D sponsors may withhold payments to agents and brokers until this report is released. MAOs and Part D sponsors are not required to withhold payment and CMS suggests that MAOs and Part D sponsors make preliminary payments and then adjust payments as necessary.

Payment of Referral Fees to Agents. CMS has learned that certain MAOs and Part D sponsors have implemented "exorbitant" referral fees in addition to the compensation paid to the agent that ultimately enrolls the beneficiary. In some cases the referral fees exceed the total compensation that can be paid to agents. The amount paid to the agent enrolling the beneficiary, when combined with the referral fee, may not exceed the CMS limits. Per CMS, payments for referrals are "finder's fees" and are

considered compensation under the compensation rule. CMS states that MAOs and Part D sponsors should immediately cease practices that result in compensation exceeding CMS standards.

CMS Surveillance of Marketing Activities. CMS describes its recent surveillance activities. CMS has attended over 1000 secret "shopping marketing" events and has focused increased resources on high risk geographic areas and particular MAOs and Part D sponsors. CMS also implemented several additional surveillance activities, including: scanning local advertisements to assess content and whether the event was reported to CMS; implementing secret shopping call centers; making outbound calls to recently enrolled beneficiaries to confirm that enrollments were conducted properly; reviewing recorded enrollment calls; reviewing data for potential evidence of marketing violations, such as data contained in CMS's complaint tracking module; conducting online readiness assessments to determine MAOs' and Part D sponsors' ability to implement the new marketing requirements; and implementing Regional Office surveillance. As a result, CMS issued over 40 compliance letters at the end of the Annual Election Period. CMS expects to continue to devote considerable resources to these types of surveillance activities in the future.

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1. Revised Draft Call Letter, p. 12.
2. Revised Draft Call Letter, p. 14.
3. Pub. L. 110-275.
4. 74 Fed. Reg. 1493 (Jan. 12, 2009).
5. Revised Draft Call Letter, p. 41.
6. Prescription Drug Benefit Manual, Ch. 6 § 30.4.5.
7. Revised Draft Call Letter, p. 77.
8. Id.
9. 73 Fed. Reg. 67406, 67408 (Nov. 14, 2008).

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.