Medicare Advantage and Part D

They’re Not For the Faint of Heart

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Introduction

- Changes to the Medicare Advantage and Part D programs may make participation less attractive to plans
  - Increased obligations/government scrutiny/penalties under PPACA and April 15th final rule
  - PPACA froze MA payments for 2011 and implements new blended benchmark payment methodology
- Plans still dealing with MIPPA implementation
  - E.g., MIPPA's network requirements for PFFS plans are effective for 2011 plan year

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PPACA's Changes to Medicare Advantage

- Froze 2011 payments at 2010 levels
- Created blended benchmark payment methodology starting in 2012 that includes bonus adjustments based on quality ratings
- Changed beneficiary rebate requirements
- Established minimum medical loss ratio

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MA Payment Changes

- PPACA froze 2011 MA payment rates at 2010 levels
  - However, for 2011, CMS will apply a 3.41% reduction to each Part C beneficiary's risk score
  - Risk score reduction unrelated to PPACA

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MA Blended Benchmark Methodology

- **Beginning in 2012, MA benchmark based on ½ of the "applicable amount" and ½ of "base payment amount" multiplied by "applicable percentage"**
  - Applicable amount = amount for the area for previous year increased by national per capita MA growth percentage
  - Base payment amount = 100% of fee-for-service costs for 2012. For subsequent years, calculated by increasing previous year's base amount and increasing it by national per capita MA growth percentage taking into account phase out of IME

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MA Blended Benchmark (cont'd)

- **Applicable percentage =**
  - 95% for MA plans in highest quartile ranking of payments for previous year;
  - 100% for MA plans in second highest quartile ranking of payments for previous year;
  - 107.5% for MA plans in third highest quartile ranking of payments for previous year; and
  - 115% for MA plans in fourth highest quartile ranking of payments for previous year.

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MA Blended Benchmark (cont'd)

- **Applicable percentage increase for quality care**
  - Applicable percentage will be increased by 1.5% in 2012, 3% in 2013, and 5% in 2014, for MA plans that in 2012 have a quality rating of 4 stars or higher
- **Low enrollment and new MA plans also eligible for quality increase**
- **Quality rating based on 5 star system**
  - Rating based on data collected by CMS
  - Failure to report data will result in fewer than 3.5 stars rating

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Enrollee Rebates

- Phase-in of the new rebate percentages starts in plan year 2012
- Rebate is sum of product of “old phase-in proportion” and 75%, and product of “new phase-in proportion” for the year and the final applicable percentage rebate

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Enrollee Rebates (cont'd)

- **For 2012**
  - Old phase-in proportion is 2/3
  - New phase-in proportion is 1/3
- **For 2013**
  - Old phase-in proportion is 1/3
  - New phase-in proportion is 2/3
- **For 2014 and after**
  - Phase phase-in proportion is 0
  - New phase-in proportion is 1
- **Final applicable rebate percentages**
  - 70% for MA plan with at least 4.5 stars
  - 65% for MA plan with at least 3.5 and less than 4.5 stars
  - 50% for MA plan with less than 3.5 stars

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Limitations on Cost-Sharing

- For plan years beginning on or after January 1, 2011, cost-sharing under MA plans may not exceed Part A and Part B cost-sharing amounts for:
  - chemotherapy administration services
  - renal dialysis services
  - skilled nursing care
  - such other services that CMS determines appropriate

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Minimum Medical Loss Ratio

- Effective in 2014, MA plans must have a medical loss ratio (MLR) of at least 85%
- MA plans that fail to satisfy minimum MLR requirement will be required to remit to CMS an amount equal to the plan's total revenue for the applicable contract year and the difference between 85% MLR and the plan's actual MLR
- Plans that fail to meet the minimum MLR for three consecutive years will be prohibited from enrolling new beneficiaries for the second succeeding contract year
- The Secretary is required to terminate the MA contracts of plans that fail to meet the minimum MLR for five consecutive years

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Change in MA and Part D Election Periods

- PPACA changed annual, coordinated election period for MA and Part D starting for 2012 to October 15 through December 7
- PPACA eliminated the MA open enrollment period
  - Starting in 2011, MA plan enrollees can choose during the first 45 days of the year to disenroll from their MA plan and return to traditional Medicare
  - Such enrollees may also elect to enroll in standalone PDP

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PPACA Changes to Part D

- Eventual closing of donut hole/coverage gap
  - $250 rebate in 2010
  - Manufacturer discounts
  - Phase down of cost sharing requirements
- Created Medicare coverage gap discount program
- Voluntary *de minimis* policy for LIS eligibles
- Increased authority of CMS to establish formulary requirements
- Improved PDP and MA-PD complaint system
- Uniform exceptions and appeals process

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April 15th Final Rule – 75 FR 19678 Part C Changes

Risk Adjustment Data Validation (RADV)

- Before rule, no process for appealing overpayments resulting from CMS' risk adjustment data validation activities referenced in §422.310(e)
- Proposed Rule [74 FR 54634 (Oct. 22, 2009)] - New 42 C.F.R. §422.311
  - Process for submitting provider attestations for outpatient medical records with missing or illegible signature and/or credentials
  - Process for disputing errors arising from operational processing of medical records
  - Process for contract-level RADV payment error calculations
  - Added RADV audit and appeal-related definitions to 42 C.F.R. §422.2
- Final Rule
  - Finalized proposals
  - Added process for disputing medical record review determinations
  - Effective beginning contract year January 1, 2011

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April 15th Final Rule – 75 FR 19678
Compliance Programs Under Parts C and D

Significant revisions to 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

- CMS concerned about "paper" compliance programs
- Provide the "minimum" amount of information CMS expects to see in an "effective" compliance program
- Not intended to be "prescriptive" as to choice of processes or procedures
- Effective June 7, 2010

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Compliance Programs Under Parts C and D

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

(vi) Adopt and implement an effective compliance [plan] program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements as well as measures [to] that prevent, detect, and correct [and prevent] fraud, waste, and abuse. The compliance program must, at a minimum [shall,] include the following [elements] core requirements:

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Compliance Programs Under Parts C and D

(A) Written policies, procedures, and standards of conduct that—

(1) Articulate the organization's commitment to comply with all applicable Federal and State standards[.];

(2) Describe compliance expectations as embodied in the standards of conduct,

(3) Implement the operation of the compliance program;

(4) Provide guidance to employees and others on dealing with potential compliance issues;

(5) Identify how to communicate compliance issues to appropriate compliance personnel;

(6) Describe how potential compliance issues are investigated and resolved by the organization; and

(7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

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Compliance Programs Under Parts C and D

(B) The designation of a compliance officer and compliance committee [that] who report directly and are accountable to the organization's chief executive or other senior management.

(1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the MA organization, parent organization or corporate affiliate. The compliance officer may not be an employee of the MA organization's first tier, downstream or related entity.

(2) The compliance officer and the compliance committee must periodically report directly to the governing body of the MA organization on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

(3) The governing body of the MA organization must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness ofthe compliance programs.

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Compliance Programs Under Parts C and D

MA Organizations

(C) (1) Each MA organization must establish and implement effective training and education between the compliance officer and [the MA] organization['s] employees, the MA organization's chief executive or other senior administrator, managers and [directors] governing body members, and the MA organization's first tier, downstream, and related entities. Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member.

(2) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.

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Compliance Programs Under Parts C and D

Part D Plans

(C)(1) Each Part D plan must establish, implement and provide effective training and education [between the compliance officer and the Part D plan sponsor's] for its employees including, the chief executive [managers], and [directors] senior administrators or managers; governing body members; and [the Part D plan sponsor's] first tier, downstream, and related entities.

(2) The training and education must occur at least annually and be a part of the orientation for new employees including, the chief executive and senior administrators or managers; governing body members; and first tier, downstream, and related entities.

(3) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.

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(D) Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the MA organization's employees, managers and [directors] governing body, and the MA organization's first tier, downstream, and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

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(E)[Enforcement of standards through w] Well-publicized disciplinary [guidelines] standards through implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. These standards must include policies that —

(1) Articulate expectations for reporting compliance issues and assist in their resolution;

(2) Identify non-compliance or unethical behavior; and

(3) Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined.

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MA Organizations

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include [Procedures for] internal monitoring and audits[ing] and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

Part D Plans

(F) [Procedures for] Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits[ing.] and, as appropriate, external audits, to evaluate the Part D plan sponsors, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

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Compliance Programs Under Parts C and D

(G) Establishment and implementation of [P]procedures and a system for [ensuring] promptly [response to detected offenses and development of corrective action initiatives relating to the organization's MA contract] responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

MA Organizations

(7) Not have terminated a contract by mutual consent under which, as a condition of the consent, the MA organization agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per §422.508(c) of this subpart.

Part D Plans

(6) Not have terminated a contract by mutual consent under which, as a condition of the consent, the Part D plan sponsor agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per § 423.508(e) of this subpart.

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Compliance Programs Under Parts C and D

- Implementation Issues
  - Timing and cost
  - MA Organizations should become familiar with Chapter 9 of Prescription Drug Benefit Manual
  - Waiting on sub-regulatory guidance from CMS on training of first tier, downstream, and related entities (how to provide, content)

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