Introduction to Medicare Parts C and D

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Agenda

• Overview of Part C (Medicare Advantage or MA) and Part D Programs and Benefits
• Introduction to Bidding and Payment
• Highlight Regulatory Requirements of Critical Plan Functions
• Describe Oversight by CMS
Tip of the Iceberg

- Tutorial is an introduction to provide context
- Voluminous legal, regulatory, and sub-regulatory requirements apply to MA and Part D plans
- Heavy reliance on sub-regulatory guidance
## Key Resources

### MA
- 42 C.F.R. Part 422
- CMS Medicare Managed Care Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors

### Part D
- 42 C.F.R. Part 423
- CMS Medicare Prescription Drug Benefit Manual
- Additional CMS guidance, including HPMS memos sent to plan sponsors
Medicare Part C
Medicare Part C

- **Medicare Advantage**
- **Formerly Medicare+Choice**
- Private entities, called plan sponsors, contract with the federal government to offer Medicare medical benefits
- Centers for Medicare & Medicaid Services (CMS) pays plan sponsors on a capitated (per member, per month) risk basis to manage Original Medicare (Parts A and B) benefits
Why Every Health Lawyer Needs to Know About Medicare Advantage

What percentage of Medicare beneficiaries are covered under Medicare Advantage plans?
Percentage of Medicare Beneficiaries in Medicare Advantage

27%

- As of September 2012, 13.7 million beneficiaries were enrolled in Medicare Advantage.

Primary Types of Medicare Advantage Plans

Coordinated Care Plans

- **Health Maintenance Organization (HMO)** – care through contracted network of providers
- **Preferred Provider Organization (PPO)** – contracted network plus out-of-network benefits
- **Special Needs Plan (SNP)** – for individuals with special needs such as nursing home residents, people with chronic or disabling conditions, or Medicaid eligibles
Primary Types of Medicare Advantage Plans

Private Fee for Service (PFFS) Plans

- Pays providers on a fee-for-service basis through contracts or “deeming” that providers accept fees and terms
- From 2011, individual PFFS plans in a service area with two or more network MA plans must have a contracted provider network
Medicare Advantage Plan Benefits

- Must cover all services covered under Original Medicare
- Can design own benefit structure with co-payments, coinsurance, deductibles or no deductibles
- May offer supplemental benefits
- Follow National and Local Medicare Coverage Determinations and Coverage Guidelines
- May employ utilization management
- Generally must have quality improvement and chronic care management programs
- Mandated out-of-pocket maximum for year
Medicare Advantage Bidding

- MA plan sponsors submit bids by the first Monday in June
- CMS has authority to negotiate with plan sponsors before accepting or rejecting a bid
- Plans submit bids with a standard bid amount that will be adjusted for enrollee risk factors or “case mix”
Reimbursement of MA Plans

• Affordable Care Act
  • Made substantial changes to MA reimbursement framework
  • Changes to payment methodology beginning 2012

• Regulations have been updated to incorporate changes

• CMS issued a Final Rule on April 15, 2011 implementing new requirements
Benchmarks and Bids

- CMS sets MA benchmark rates taking into account each county’s per capita FFS (Original Medicare) spending.

- Affordable Care Act requires counties to be divided into quartiles based on per capita FFS spending, with benchmark adjustments to be phased in between 2012 and 2017.

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Benchmark Percentage</th>
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<tbody>
<tr>
<td>4 (highest)</td>
<td>95% of county’s FFS spending</td>
</tr>
<tr>
<td>3</td>
<td>100% of county’s FFS spending</td>
</tr>
<tr>
<td>2</td>
<td>107.5% of county’s FFS spending</td>
</tr>
<tr>
<td>1 (lowest)</td>
<td>115% of county’s FFS spending</td>
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Rewarding Quality:  
5-Star Rating System

- MA plans are assigned a star rating posted on Medicare.gov based on measures in 5 categories:
  - Staying Healthy: Screenings, Tests and Vaccines
  - Managing Chronic (Long Term) Conditions
  - Member Experience with Health Plan
  - Member Complaints, Problems Getting Services, and Improvement in the Health Plan’s Performance
  - Health Plan Customer Service

- Beginning 2012, quality bonuses will be added to applicable benchmark for higher rated plans

- 2012-2014 CMS Medicare Advantage Quality Bonus Payment Demonstration - bonuses range from 3% for 3-Star plans up to 5% for 5-Star plans

- Beginning 2015, ACA methodology – must earn 4 stars to receive a quality bonus payment
Relationship of Bid to Benchmark

Plan’s aggregate bid amount − Benchmark = Rebate (if negative) or Member Premium (if positive)
Rebates or Member Premium

If bid falls below benchmark

- No member premium for medical benefits and percent of the difference is a “rebate” can be used to:
  - Fund supplemental benefits
  - Offset Part D premium in an MA-PD plan
  - Credit to members’ Part B premium

If bid higher than benchmark

- Enrollees pay difference as premium
- Member premium for MA plan
- Enrollees also pay Part B premium
Rewarding Quality: Ratings and Rebates

- Through 2011, all MA plans were able to use 75% of rebate to supplement benefits or offset Part D or B premium
- Beginning in 2012, plan’s Star Rating determines the rebate percentage a plan can use

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>4.5+ Stars</td>
<td>73.33%</td>
<td>71.67%</td>
<td>70%</td>
</tr>
<tr>
<td>3.5 to &lt;4.5 Stars</td>
<td>71.67%</td>
<td>68.33%</td>
<td>65%</td>
</tr>
<tr>
<td>&lt;3.5 stars</td>
<td>66.67%</td>
<td>58.33%</td>
<td>50%</td>
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Eligibility for Medicare Advantage

- Entitled to Part A and Enrolled in Part B
- Does not have end stage renal disease (ESRD) unless an exception applies
- Resides in plan service area
- Not enrolled in another plan
MA Election Periods

Initial Election Period (IEP)
- 7 month period beginning 3 months before eligible for Parts A and B and ending 3 months after month of eligibility

Annual Election Period (AEP)
- Fall Open Enrollment
- October 15 through December 7

Special Election Periods (SEPs)
- Based on numerous special circumstances such as change in residence or plan termination
- Ongoing SEP for Medicaid eligibles
- For 2012, ongoing SEP to enroll in 5-Star plans
# MA Election Periods

## Open Enrollment Period for Institutionalized Individuals
- Continuous open enrollment period
- Unlimited number of MA enrollment changes or disenrollment

## SEP Age 65
- If elected an MA plan during IEP around 65\textsuperscript{th} birthday
- 12 months to disenroll into Original Medicare

## Medicare Advantage Disenrollment Period (ADP)
- Can disenroll from MA plan into Original Medicare between Jan. 1 and Feb. 14
- Not an opportunity to switch plans
MA Enrollment Process

• Election may be through paper enrollment form, online enrollment, telephone enrollment, or through [www.medicare.gov](http://www.medicare.gov)

• Specific timeframes and notice requirements for every step, for example
  • 7 days to submit enrollment to CMS
  • 10 days after receipt of CMS’ Transaction Reply Report (TRR) to send written notice of decision to applicant
MA Plan Disenrollment

- Generally, enrollee can only disenroll during an election or special election period
- In some circumstances, plan sponsor involuntarily disenrolls members
  - Required – e.g., move out of service area
  - Permitted – e.g., non-payment of member premium
- Notice and grace periods apply
Organization Determinations

- Organization determinations – plan decisions about the benefits an enrollee is entitled to and the level of cost sharing

- Types of organization determinations
  - Requests for service
    - Standard
    - Expedited (when standard timeframe could jeopardize health)
  - Request for payment
Timeframes for MA Plan Organization Determinations

**Standard Request for Service**
- As expeditiously as health condition requires but no later than 14 calendar days

**Request for Payment**
- Subject to prompt pay requirement of 95% of “clean claims” from members and non-contracted providers paid within 30 days

**Expedited Request for Service**
- As expeditiously as health condition requires but no later than 72 hours
Reconsiderations and Appeals

- Reconsiderations – first level of appeal of an MA plan’s organization determination, handled internally
- If decision on reconsideration adverse to enrollee, plan automatically forwards case to Independent Review Entity (IRE)
- Additional levels of external review available
Timeframes for Reconsiderations

- **Standard Request for Service Reconsideration**: As expeditiously as health condition requires but no later than 30 calendar days.
- **Request for Payment Reconsideration**: No later than 60 calendar days.
- **Expedited Request for Service Reconsideration**: As expeditiously as health condition requires but no later than 72 hours.
External Levels of Appellate Review

- Independent Review Entity (IRE)
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MAC)
- Judicial Review
Grievances

- Complaints about the plan that are not organization determinations or appeals of organization determinations
  - E.g. generally dissatisfied with copayment amount, billing issue, provider or customer service rep was rude, don’t like hold time music

- Grievance process must provide notice to enrollee no later than 30 days after receipt of grievance
Provider Network

- MA plans must maintain a network that meets care access requirements
- Need written provider agreements that contain provisions required by regulations
- Regulated credentialing process – initial and re-credentialing at least every three years
- “Non-interference clause” – government is not involved in rate negotiations or disputes between plan sponsors and providers
Medicare Part D
Medicare Part D

- Prescription Drug Benefit
- Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Commenced January 1, 2006
- Private entities contract with the federal government to offer prescription drug benefits
- CMS makes capitated (per member, per month) payments to the plan sponsor to manage drug benefits
Part D Benefits

- MA plan sponsors must offer an MA-PD option
- Part D plan sponsors must offer a standard plan or its actuarial equivalent
- May also offer enhanced benefit packages
- Common enhancements
  - No deductible
  - Generic drugs in coverage gap with a copayment
Plan Formulary

- CMS reviews plan formularies (lists of covered drugs)
- Certain drugs excluded by statute (e.g. non-prescription drugs, agents used for weight loss or gain)
- Formulary must include all or substantially all drugs in six protected classes:
  - Immunosuppressant (post transplant)
  - Antidepressant
  - Antipsychotic
  - Anti-convulsant
  - Anti-retroviral
  - Antineoplastic
Part D Standard Benefit for 2013

**Deductible**
- Member pays 100%
- Set at $325

**Initial Coverage Phase**
- Plan pays 75%
- Member pays 25%
- Up to $2,970 in total drug costs

**Coverage Gap**
- Member pays 47.5% for brand, 79% generic
- Plan pays 2.5% for brand, 21% for generic
- Up to $4750 in Member’s total True Out of Pocket Cost (TrOOP)

**Catastrophic Coverage**
- Government reinsures 80%
- Plan pays 15%
- Member pays 5% (or small copay)
Closing the Coverage Gap
Brand Drugs

- Affordable Care Act gradually reduces the coverage gap from 100% to 25% enrollee coinsurance between 2011 and 2020

- Brand name drug manufacturers will reimburse plans for 50% of the cost of their drugs in the coverage gap, and members had 50% coinsurance

- For 2013 and 2014, the plan will pay 2.5%, and the member will be responsible for 47.5%

- Plan share grows gradually to 25% in 2020

- Member cost-sharing will phase down to 25% in 2020
Closing the Coverage Gap
Generic Drugs

• Plan’s cost share increases
• No manufacturer discount
• In 2011, plan paid 7% for generics
• Plan share increases by 7% per year to maximum of 25% in 2020
• Plan pays 21% in 2013
• By 2020, coverage gap will combine with initial coverage phase in terms of member cost sharing
Part D Bidding

- Submit bids by the first Monday in June – same as for MA
- After bids are submitted, CMS announces a national average monthly bid amount and base beneficiary premium
Part D Plan Reimbursement

- Prospective payments to plans per member, per month based on plan’s approved standardized bid amount, adjusted for:
  - Members’ health status and risk (case mix)
  - Reduced by amount of member’s premium
- Reinsurance payments for 80% of drug costs in catastrophic phase
- Reconciliation to compare prospective payments against actual experience
- Risk corridors – limit plan potential for profit or loss beyond set thresholds
Eligibility for Part D

- Entitled to Part A or Enrolled in Part B
- Resides in Plan Service Area
- Not Enrolled in Another Part D Plan
Part D Election Periods

**Initial Enrollment Period (IEP)**
- 7 month period beginning 3 months before eligible for Parts A and B and ending 3 months after month of eligibility

**Annual Coordinated Election Period (ACEP)**
- Fall Open Enrollment
- October 15 through December 7

**Special Enrollment Periods (SEPs)**
- Based on numerous special circumstances such as change in residence or plan termination
- Ongoing SEP for LIS eligibles
- For 2012, ongoing SEP to enroll in 5-Star plans
Part D Enrollment and Disenrollment

- Like MA enrollment, regulated down to minute level of detail
- Election may be through paper enrollment form, online enrollment, telephone enrollment, or through [www.medicare.gov](http://www.medicare.gov)
- Specific timeframes and notice requirements for every step
- Disenrollment only during election periods
- Limited bases for involuntary disenrollment by plan
Low Income Subsidy (LIS) and Low Income Cost Sharing (LICS)

- Qualified based on income and asset requirements
- 4 levels of LIS premium subsidy
  - 100% subsidy for Full Benefit Dual Eligibles and others below 135 federal poverty level
  - Also 75%, 50%, and 25% subsidy levels
  - Subsidy based on national low-income benchmark premium
- 3 levels of LICS
  - Different cost sharing (copay) levels for each
  - Means plan sponsor administers 4 benefit packages for each plan
  - Retroactive determinations common
Coverage Determinations

- Decisions about the prescription drug coverage a Part D enrollee is entitled to and the level of cost sharing, such as
  - Requests for exceptions to plan formulary
    - Non-formulary drug
    - Tiering exception
  - Requests for prior approval

- Plan must maintain standard and expedited procedures for coverage determinations
Timeframes for Part D Coverage Determinations

- **Standard Request for Drug Benefit**: As expeditiously as health condition requires but no later than 72 hours.

- **Request for Payment**: Notify and make payment no later than 14 calendar days.

- **Expedited Request for Drug Benefit**: As expeditiously as health condition requires but no later than 24 hours.
Redeterminations and Appeals

- Redeterminations are first level appeals to a Part D plan following an adverse coverage decision.

- If decision on reconsideration is adverse to enrollee, then enrollee has the option to appeal to Independent Review Entity (IRE):
  - Not automatically forwarded as with MA.

- Additional levels of external appeal:
  - IRE
  - ALJ
  - Medicare Appeals Council (MAC)
  - Judicial review.
Transition Process

- Part D plan must provide a transition supply of non-formulary medications to –
  - New enrollees
  - Enrollees affected by formulary change

- Includes drugs not on formulary as well as those subject to prior authorization or step therapy

- Members are entitled to a temporary supply of their medication during the first 90 days of their enrollment
Timeframes for Redeterminations

Standard Request for Redetermination

• As expeditiously as health condition requires but no later than 7 days

Expedited Request for Redetermination

• As expeditiously as health condition requires but no later than 72 hours
Grievances

- Complaints about the plan that are not coverage determinations or appeals of coverage determinations
  - E.g. provider access, billing issue, customer service rep was rude, don’t like hold time music

- Grievance process must provide for notice to enrollee no later than 30 days after receipt of grievance
Marketing of Medicare Advantage and Part D Plans
Marketing = High Risk Area

- Risk of abuse of beneficiaries
- Concern with external sales agents
- Misleading about product rules
- Confusion about MA as a Medicare replacement product, not a supplement
- All aspects of sales and marketing tightly regulated
A Sampling of Sales Requirements and Prohibitions

**Requirements**
- Conduct outbound calls to new enrollees to confirm understanding of plan rules
- Document “scope of appointment” before any face-to-face meetings
- All marketing materials must be filed with CMS for approval

**Prohibitions**
- Outbound calls to Medigap members to market MA or Part D
- Sales activities in healthcare settings except in common areas
- Unsolicited contacts – email, telephone, or in-person
Providers and Marketing

- Providers may not
  - attempt to induce or steer beneficiaries to a particular plan or plans
  - accept enrollment forms
  - accept compensation directly or indirectly from plan for enrollment activities

- Providers may
  - provide names of plans with which they contract
  - distribute plan marketing materials (not in an exam room setting and not including enrollment applications) for a subset of contracted plans if option available to all contracted plans
  - refer patients to medicare.gov plan comparison tool and print information
Gifts and Promotional Activities

- Nominal value limit of $15 aggregate retail value
- Available to all eligible to enroll, regardless of whether they do
- No cash, rebates, or gift cards readily convertible to cash
- No meals, just snacks
Agents and Brokers

- Must be trained on compliance and product specifics and receive 85% or higher on exam

- Compensation tightly regulated
  - CMS sets regional fair market value caps
  - Initial year compensation and 5 years of renewal compensation

- Must recover commission for rapid disenrollments
Oversight by CMS
Compliance Program Requirements

- Emphasis on **effectiveness**, as demonstrated by compliant operational results

- CMS Final Rule April 15, 2010 added specificity to the traditional seven compliance plan requirements
  - e.g. Orientation and annual general compliance training for employees, senior management, board members, subcontractors
  - e.g. Anonymous hotline must be available to subcontractors

- Oversight of subcontractors (first tier, downstream, and related entities) is critical to controlling compliance risk
  - Sales agents
  - Administrative contractors (e.g. utilization management)
  - Providers (included in CMS definition of “first tier entities”)
CMS’ Approach - Traditional vs. Data Driven Monitoring and Oversight

Routine Triennial Audits
- Data Driven Targeting
- High Risk Plans Audited

Focus on Policies and Procedures
- Focus on Outcomes Reported and Monitored
- Prompt Detection and Correction of Issues

On-site Audit Sample Gathering or Complaints
- Multiple Real-Time Sources of Data on Plans
- Plan Reporting IRE, CTM Secret Shoppers
Types of Audits

Audits of plans include the following:

- Financial Audits
- Operational audits
- Compliance Program Effectiveness Audits
- Risk Adjustment Data Validation (RADV) audits
  - Routine (small sampling of diagnoses)
  - Ad hoc (very resource intensive)
- Reporting Requirements Data Validation Audits
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