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2020 Medicare Advantage

Summary of Advance Rate Notice Part 2

February 7, 2019

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Executive Summary

On January 30, 2019, CMS released the payment year (PY) 2020 Advance Notice Part 2 and Call Letter (the Notice). The comment deadline is March 1, 2019.

The CY2020 fee-for-service (FFS) growth rate, which is now the major driver of Part C benchmark rates, is 4.52%. This is 66 basis points higher than the November 27, 2018 estimate in the CMS early preview of growth rates.

As noted in Part 1 of the Advance Notice, released December 20, 2018, a new Part C risk adjustment model was proposed that reflects a new variable for the count of payment conditions. This model is the same as that proposed in the previous year's Advance Notice Part 1; although it was not adopted for Payment Year (PY) 2019. CMS estimates that the impact of the new model and a change in the weighting of RAPS- and EDS-based scores on average risk scores nationwide is small at +0.22%; however, the impact can vary substantially by plan. Medicare Advantage Organizations (MAOs) can see their plan-specific impact by downloading risk scores in HPMS.

CMS is continuing to observe a significant increase in Part C FFS risk scores for 2018, as was the case with 2016 and 2017 data. The proposed PY2020 FFS normalization factors are 1.075/1.069 for RAPS and the new EDS PCC models, respectively. The RAPS FFS normalization factor was 1.040 for PY2019, which implies a reduction in RAPS scores of 3.2%, assuming no trend in MAO coding. Since the EDS model is new, there is no comparable normalization factor from PY2019. The EDS model in place for PY2019 had a FFS normalization factor of 1.038.

Following is a brief summary of the key changes and proposals in the PY2020 Notice:

Part C Payment Methodology

- Non-ESRD FFS growth rate percentage for CY2020 is 4.52%.

Risk Scores

- CMS is introducing a new "Payment Condition Count (PCC)" risk model that will be blended with the existing RAPS-based 2017 HCC model. The blend is 50%/50% 2017 HCC/EDS with PCC model.
- The FFS Normalization factor for PY2020 is proposed to be a 50%/50% blend of 1.075 and 1.069, which relate to the 2017 HCC model and the new EDS PCC model, respectively.
- CMS is proposing a change to the RxHCC model for PY2020. Two models are proposed: one based on a calibration using 2014/2015 data, and the other based on calibration using 2015/2016. The RxHCC FFS normalization factor is proposed to be

1.043 and 1.035 for each of these calibrations, respectively. The PY2019 normalization factor was 1.020.
- The PY2020 blend of EDS/RAPS risk scores is proposed to be 50%/50%, which is in line with the proposed schedule presented in the PY2019 Final Announcement. The EDS based risk scores under the HCC PCC model use diagnosis data from encounter submissions as well as RAPS based on diagnoses from inpatient services.
- The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with PY2019.

EGWPs

- Plans will not need to file EGWP bid pricing tools (BPTs) for PY2020, as was the case in PY2019.
- CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual plan data and then re-weighted with EGWP enrollment.

Benefit Changes

- Cost sharing standards were updated for MA and PD benefits. Most thresholds stayed the same; however, the maximum allowed cost sharing for inpatient acute and psychiatric stays increased substantially, and the Skilled Nursing Facility maximum copay for days 21 through 100 increased from $172/day to $178/day.
- The voluntary and mandatory MOOP amounts did not change. Looking ahead to 2021, CMS noted that they are considering a third, higher MOOP limit of $10,000.
- Part D parameters were updated, including a significant increase in the TrOOP ($6,350 for PY2020 versus $5,100 in PY2019), and decreased member coinsurance in the gap for generic drugs to 25% (was 37% in PY2019).

TBC Thresholds

- The TBC requirements are the same as last year, including the standard threshold amount of $36.00.
- Benefits and cost sharing reductions offered as part of Part C uniformity flexibility or the VBID model will be excluded from the TBC calculation.

Star Rating Changes

- The quality bonus payment (QBP) for a cross-walked contract will now be determined by the enrollment weighted average of what would have been the QBPs of both contracts using November enrollment from the year the Star Ratings were released. In prior years, the star rating would be determined entirely by the surviving contract, with no consideration for the terminated contract. This can be a major impact for national carriers or plans operating in multiple regions.
- CMS is proposing to continue adjusting 2020 Star Ratings to take into account the effects of natural disasters (Hurricanes Harvey, Irma, and Maria, and the wildfires in California) that occurred during the performance period. Subject to specific criteria,

CMS is proposing to use the higher of the 2019 or 2020 Star Ratings for each CAHPS or HEDIS measure, as well as allowances related to HOS adjustments.

Part D Tier Placement of Generics and Brand Drugs

- CMS is considering (though not yet proposing) discouraging or disallowing a mix of generic and brand products on the same tier. FDA-approved therapeutically equivalent generics would automatically be placed on the generic tier.

Overall MA Payment Impact

Wakely estimates that, on average, PY2020 Part C standardized benchmarks will increase 4.55% over PY2019 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e. quartile rankings). We also estimate that the change in CMS revenue for PY2020 versus PY2019 is expected to be +1.45%. This takes into account changes in the FFS normalization factor.

Plans should be aware that the changes in the benchmarks can be considerably different (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore, a change in the benchmark will impact plans differently based on the disparity of the plan's bid compared to the benchmark (i.e. the "savings") and the star-based percentage of the savings retained by the plan (i.e. Part C "rebate").

Our analysis of county specific benchmarks and plan revenue was aggregated using January 2019 CMS published MA enrollment and star ratings for PY2020.

Details regarding our calculations and assumptions are described in Appendix A at the end of this summary.

The remainder of this summary includes many details discussed at length in the Notice.

Attachment I: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY2020

Section A. MA Growth Percentage

Preliminary estimates of the MA growth rates were announced as +4.84% (last year the rate was +5.93%).

Section B FFS Growth Percentage.

Fee-for-service growth rate estimated at +4.52% (last year rate was +5.11%).

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2019 to 2020 will be 4.55% and the nationwide average change in the blended risk adjusted benchmark will be 1.45%. See Appendix A at the end of this summary for additional detail.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. The table below shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, and benchmark cap).

Table 2

States with Highest and Lowest Benchmark Change

Rank	State	Change
1	DC	11.4%
2	HI	7.0%
3	ID	6.4%
4	MS	5.7%
5	LA	5.6%
49	NH	3.0%
50	KS	2.4%
51	NE	2.2%
52	NJ	2.0%
53	OK	1.2%

Attachment II: Changes in the Part C Payment Methodology for CY2020

Section A. MA Benchmark, Quality Bonus Payments and Rebate

CMS intends to rebase county FFS rates in 2020 (which is the basis of the "Specified Amount").

County benchmark rates are capped at the Applicable Amount (defined below). CMS interprets that the comparison occurs after the Quality Bonus Payment Percentage ("QBP") has been included. Like in last year's notice, CMS states that they share stakeholder concerns about a rate-setting mechanism (i.e. the benchmark cap) that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries.

Below are the key components of the Part C benchmark calculation:

- **2020 "Applicable Amount" (pre-ACA amount)**: The greater of a county's 2020 FFS cost and the 2019 Applicable Amount increased by the 2020 National Per Capita MA Growth Percentage.
- **2020 "Specified Amount" (FFS benchmark)**: 2020 FFS Cost less IME phase-out amount multiplied by the "Applicable Percentage" plus the QBP **"Applicable Percentage"** varies by county and is based on the county's rank of 2018 per capita FFS rate, assigned by quartiles per below:

  FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95.0%
3rd	100.0%
2nd	107.5%
1st (lowest)	115.0%

  If a county's quartile changed from last year, the Applicable Percentage is the average of the current and prior year's applicable percentage.

- **Quality Bonus Percentage (QBP), or "applicable % quality increase":** The QBP is 5% for 4, 4.5 and 5 star MAOs, and is 0% for plans with a star rating below 4. For new plans under a new parent and low enrollment plans, a 3.5% QBP applies.

  Contract year 2020 will be the first year the new contract consolidation rule for calculating star ratings becomes effective. For consolidations of two or more contracts of the same plan type and legal entity approved on or after January 1, 2019, the QHP rating for the

first year following consolidation is determined by the enrollment weighted average of what would have been the QBPs of both contracts using November enrollment from the year the Star Ratings were released. *Example:* for two contracts consolidating for January 2021, the 2021 QBP rating is based on 2020 Star Ratings released in 2019, using November 2019 enrollment of the two contracts.

Double QBP percentages are awarded to "qualifying plans" located in qualifying or "double bonus" counties. Double bonus counties must:

1. Have a population of over 250,000 (as of 2004).
2. Have at least 25% of MA-eligible beneficiaries enrolled in MA plans (as of December 2009).
3. Have 2020 per capita FFS spending lower than the national average.

The final 2020 rate notice will contain a list of all double bonus counties, as the third criterion above is not yet known.

- **Rebates**. Rebate levels are based on plan Star Ratings as follows:

MA Rebate Percentages

Star Rating	2020
4.5+ Stars	70%
3.5 to < 4.5 Stars	65%
< 3.5 Stars	50%

The percentage is applied to the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. New plans are treated as having 3.5 Stars; CMS intends to treat low enrollment plans the same way.

Section B. Calculation of Fee for Service Cost

2020 FFS County Cost = [(National FFS Cost) or (US Per Capita Cost)] x [County-level Geographic Index aka AGA].

- With the Advance Notice, CMS is releasing county-level 2017 FFS cost data used to develop 2020 rates:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html

  AGA Development Overview:

- A five-year average of FFS costs from 2013 to 2017 is initially calculated (last year was 2012 to 2016), and is then adjusted.
- Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans are not auto-enrolled into Part B, they must opt in). An adjustment is made to reflect Puerto Rico's high proportion of no-claim members to the national average. CMS is seeking comment regarding treatment of Puerto Rico claim experience.
- CMS will re-price the 2013 to 2017 to the most current wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.
- Adjustments are made for shared savings and losses from programs like the MSSP, Pioneer and NextGen ACO programs
- GME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries in Veteran Affairs and/or the Department of Defense health programs.
- VA and DoD adjustments are proposed to be applied concurrently for 2020, which was proposed in 2018, but not enacted until 2019.

Section C. IME Phase Out

IME is being phased out from MA capitation rates. For 2020, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2020 is 6.6% of the FFS rate. As in prior years, CMS will publish rates with and without the 2020 IME reduction.

Section D. ESRD Rates

ESRD Rates = [2017 FFS ESRD dialysis USPCC] x [trend to 2020] x [State AGA] x [GME and IME removal factor].

- State AGA is the weighted average of state ESRD FFS dialysis costs for 2013 to 2017 divided by the national average for the same timeframe normalized for risk score.
- CMS proposes to reprice historical inpatient, outpatient and SNF claims for 2013 to 2017 to reflect the most recent wage indices (in this case FY2019), and reprice physician claims with the most recent Geographic Practice Cost Indices (CY2019). This is a continuation of an enhancement introduced last year.
- CMS is also proposing to reprice ESRD PPS dialysis claims for 2014 to 2017 (2014 is the first year the dialysis PPS was fully phased in).
- CMS will also adjust historical FFS claims for ESRD beneficiaries to account for legislative and regulatory changes.

Section E. Location of Network Areas for PFFS Plans in Plan Year 2020

Non-employer MA PFFS plans offered in a network area must meet certain access standards. Network area is defined as an area that the Secretary identifies as having at least two network-based plans. CMS will include the list of network areas for plan year 2020 in the Final Announcement.

Section F. MA Employer Group Waiver Plans

For 2020, CMS will continue to waive bid pricing tool requirements.

CMS is also proposing to continue the payment methodology implemented for MA EGWPs finalized in the 2019 Rate Announcement.

The steps of the EGWP payment rate calculations are outlined below:

- The bid to benchmark (B2B) ratio **within each quartile** is calculated as follows using February 2019 individual market MA enrollment for weighting:

$$2019\ individual\ market\ B2B\ ratio = \frac{Weighted\ avg\ of\ ISAR\ adjusted\ 2019}{Weighted\ avg\ of\ county\ standardized\ benchmarks}$$

ISAR = Intra-Service Area Rate Adjustment

- The 2019 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types.
- B2Bs for PPOs and HMOs will be weighted by the total proportion of EGWP PPO and HMO plan type enrollment, respectively, to result in the final B2B ratios for 2020 by quartile.
- The EGWP Part C Base payment rate is calculated as follows, with the MA county benchmark reflecting the published 5.0%, 3.5%, and 0.0% bonus county rate book rates (vary based on star rating, including adjustments for qualifying double bonus counties):

$$EGWP\ Base\ Rate = B2B\ Ratio\ for\ Applicable\ Quartile * MA\ County\ Benchmark$$

$$EGWP\ Rebate\ Rate = Rebate\ \% \times (MA\ County\ Benchmark - EGWP\ Base\ Rate)$$

$$EGWP\ Total\ Payment = (EGWP\ Base\ Rate + EGWP\ Rebate\ Rate) \times Risk\ Score$$

Regional PPO (RPPO) EGWP rates will be derived as follows:

$$RPPO\ EGWP\ Base\ Rate = B2B\ Ratio \times 2019\ Monthly\ Capitation\ Rate$$

$$RPPO\ EGWP\ Regional\ Rebate = (1 - B2B\ Ratio) \times 2019\ Regional\ Rate \times Rebate\ \%$$

Regional PPO EGWP Total Payment= (RPPO Base Rate+Regional Rebate Rate) ×Risk Score

- For 2020, CMS is proposing to reverse its prohibition against MA EGWPs using a portion of Part C payment to buy down enrollee Part B premium (this prohibition was in effect between 2017 and 2019).
- CMS is proposing to collect Part B premium buy-down amounts in the EGWP PBP submission.
- EGWPs that choose to use a portion of their payment to buy-down Part B premium will have that amount reduced from their capitated payment.
- Similarly, the Part B buy-down amount cannot vary among beneficiaries within a plan.

Section G. CMS-HCC Risk Adjustment Model for CY2020

CMS published for public comment the proposed Part C risk adjustment model in Part 1 of the Advance Notice, released December 20, 2018. The proposed model is the same as the Payment Condition Count (PCC) model first introduced in the December 27, 2017 Advance Notice Part 1. CMS also proposed "for consideration" an alternative PCC model that adds the following HCCs:

- HCC 51 Dementia with Complications
- HCC 52 Dementia without Complication
- HCC 159 Pressure Ulcer of Skin with Partial Thickness Skin Loss

Section H. ESRD Risk Adjustment Model for CY2019

CMS is proposing a revised CMS-HCC ESRD risk adjustment model (2020 ESRD model) calibrated with diagnoses filtered using the same approach currently used to filter encounter data records to calculate EDS risk scores for MA plans. This change in filtering is the same change that was made for the CY 2019 CMS-HCC risk adjustment model.

- The recalibrated ESRD model uses similar HCCs as the other CMS risk adjustment models, but is calibrated on the FFS ESRD population to reflect cost and disease patterns of this subgroup.
- The 2020 ESRD model will be calibrated using the same underlying data years and Medicaid factors as the 2019 ESRD model. As has been the case since 2005, separate coefficients will be maintained for dialysis, transplant, and post-graft beneficiaries.
- Two key model updates: diagnoses codes selected with EDS filtering logic applied, and adjustments made to the coefficients for dialysis new enrollee, post-graft new enrollee, and post graft Long-Term Institutionalized (LTI) segments.

Section I. CMS-HCC Risk Adjustment Model Used for PACE Organizations in CY 2020

- CMS is proposing to change the model used to pay PACE organizations for non-ESRD enrollees in CY 2020. PACE risk scores will be calculated using the 2017 CMS-HCC model instead of the PACE CMS-HCC model that has been in place since CY 2012.

- The 2017 CMS-HCC model has a similar impact on the average PACE risk score as would an updated recalibrated version of the current PACE CMS-HCC model. CMS evaluated the impact of the model change on CY 2016 risk scores for PACE enrollees by comparing PACE risk scores under two models:
    1. A recalibrated PACE model with 2014 diagnoses predicting 2015 costs, and
    2. The 2017 CMS-HCC model
- When comparing the risk scores, CMS measured only a 0.25% difference in average risk scores between the two models.
- In a February 4, 2019 "Stakeholders" call, CMS noted that the RAPS/EDS blend would remain the same as in past years.

Section J. Frailty Adjustment for PACE organizations and FIDE SNPs

- CMS is permitted to make additional payment adjustments to take into account the frailty of Fully Integrated Dual Eligible (FIDE) Special Needs Plans (SNP) if the FIDE SNP has similar average levels of frailty as the PACE program. CMS has also provided an alternative Payment Condition Count (APCC) model for consideration for CY 2020, and separate frailty factors for this model.
- Since CMS is proposing a new "Payment Condition Count" model for 2020, CMS is also proposing to calculate PACE frailty scores with the frailty factors associated with the 2017 CMS-HCC model.

Proposed FIDE SNP Frailty Factors for CY2020

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.078	-0.141
1-2	0.161	0.021
3-4	0.303	0.151
5-6	0.303	0.371

Proposed FIDE SNP Frailty Factors for the CY 2020 APCC model

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.078	-0.134
1-2	0.161	0.025
3-4	0.293	0.155
5-6	0.293	0.370

Current Frailty Factors associated with the 2017 CMS-HCC model

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section K. Medicare Advantage Coding Pattern Adjustment.

The coding pattern adjustment for Payment Year (PY) 2020 is the statutory minimum of 5.90%. This is the same adjustment used for PY2019.

Section L. Normalization factors

Proposed Normalization Factors for PY2020:

Model	2019 Payment Year	2020 Payment Year	Year-to-Year Impact
2017 CMS-HCC Model	1.041	1.075	-3.20%
CMS Payment Condition Count Model[1]	NA	1.069	NA
Blended 50% 2017 Model /50% Payment Condition Model (illustration of approximate impact)	NA	1.072	NA
PACE	1.082	1.075	0.70%
ESRD Dialysis	1.033	1.059	-2.50%
ESRD Functioning Graft	1.048	1.084	-3.30%
RxHCC Calibrated on 2014/2015 Data[2]	1.02	1.043	-2.20%
RxHCC Calibrated on 2015/2016 Data[2]	1.02	1.035	-1.40%

[1]Model change in PY 2020
[2]Model recalibration in PY 2020

For the CMS-HCC model used for PY 2020, normalization factor (1.075) is higher than the 2019 HCC factor of 1.041. This will reduce revenue for any MA-PD plans that do not keep pace in terms of their coding trend. Note that for 2020, CMS proposes to blend the 2017 HCC model (50% weight) with the newly established Payment Condition Count Model (50%).

Two separate RxHCC normalization factors have been proposed, based on two different calibration periods. Depending on the final factor chosen by CMS, the RxHCC model

normalization factor (1.020) will drive either a 2.2% decrease (calibrated on 2014/2015 data) or a 1.4% decrease (calibrated on 2015/2016 data) to Part D risk scores from 2019 to 2020.

For payment year 2020, CMS is proposing to maintain the same linear slope projection method as was used in payment year 2019 to calculate the normalization factor.

Section M. Medical Loss Ratio Credibility Adjustment.

No changes for 2020.

Section N. Encounter Data as a Diagnosis Source for 2020

CMS is proposing the following EDS/RAPS mix:

- 50% EDS (supplemented with RAPS inpatient data) and FFS.
- 50% RAPS and FFS.
- EDS Part C risk scores will be calculated with the PCC CMS-HCC model, while ESRD dialysis and functioning graft risk scores will be calculated using the updated 2020 ESRD model.
- RAPS Part C risk scores will be calculated with the 2017 CMS-HCC model, while ESRD dialysis and functioning graft risk scores will be calculated using the 2019 ESRD model.

Attachment III – Changes in the Payment Methodology for Medicare Part D for CY2020

Section A. Update of the RxHCC Model

Following are the changes to the RxHCC model for 2020:

Re-Calibration for 2020 Benefit Structure: Updated to reflect gap plan liability for non-LIS beneficiaries will be 75% for generics and 5% for brand scripts – this increases plan liability for non-LIS beneficiaries relative to LIS beneficiaries.

CMS is considering recalibration of the model under two different data sets:

- 2014 diagnoses and 2015 PDE data: Note that this is the same as the current model. Updating the model to include 2015 diagnoses and 2016 PDE data would have reflected a mixture of ICD-9 and ICD-10 data; therefore, CMS decided not to push the diagnoses and PDE data forward one year.
- 2015 diagnoses and 2016 PDE: Since RxHCCs are determined based on ICD-9 codes, ICD-10 codes submitted during the last quarter of 2015 were mapped to associated RxHCCs based on a standard crosswalk between ICD-9 and ICD-10.

For payment year 2020, the model was recalibrated using diagnoses from FFS and MA-PD beneficiaries enrolled in a Part D plan. Diagnoses from the prior year PDE data were used to predict PDE expenditures.

Comments were requested in relation to the data set that will be used for model recalibration. Quantification of the changes was not provided.

Section B. Encounter Data as a Diagnosis Source for 2020

Consistent with the approach used for PY2019, CMS proposes calculation of PY2020 risk score based on diagnoses with CY2019 dates of service from two separate data sources:

1. Risk Adjustment Processing System (RAPS) and Fee-for-Service (FFS) data
2. Encounter Data System (EDS) and FFS data

The final risk score will be a blend of the above two risk scores with 50% weight on the first and 50% on the second. For PACE, CMS proposes to continue the same method for CY2020 that has been in place since CY2015.

Section C. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for 2020.

Section D. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit

PY2020 Part D Defined Standard benefit changes:

- $435 deductible ($415 in 2019)
- $4,020 ICL ($3,820 in 2019)
- $6,350 TrOOP ($5,100 in 2019)
- $1.30/$3.90 copays for full subsidy full benefit duals ($1.25/$3.80in 2019)

It is important to note that the value of the TrOOP is increasing significantly for PY2020. This is the direct result of Section 1860D-2(b)(4) of the Social Security Act, which modified the out-of-pocket threshold growth rate for 2014 through 2019. More specifically, for 2014 and 2015, the Act required that the out-of-pocket threshold be updated by the API[1] minus 0.25%, while for

[1] API is defined as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify"

contract years 2016 through 2019 the Act required that the out-of-pocket threshold be updated from the previous year by the lesser of (1) the API or (2) two percentage points plus the annual percentage increase in the Consumer Price Index (CPI).

For 2020, the out-of-pocket threshold must be calculated as if the calculation of the out-of-pocket threshold for years 2014 through 2019 had not be modified (i.e., as if the thresholds for each of years 2014 through 2019 had been updated using the API). For 2021 and future years, the TrOOP increase will increase the prior year's value by the API.

See table below for detail of all Part D defined standard parameters.

Part D Benefit Parameters	2019	2020
Standard Benefit		
Deductible	$415	$435
Initial Coverage Limit	$3,820	$4,020
Out-of-Pocket Threshold	$5,100	$6,350
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$7,653.75	$9,038.75
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$8,906.55	$9,719.38
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.40	$3.60
Other	$8.50	$8.95
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services [category code 3]	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.25	$1.30
Other (6)	$3.80	$3.90
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.40	$3.60
Other	$8.50	$8.95
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 135% FPL and resources ≤ $8,890 (individuals) or ≤ $14,090 (couples) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.40	$3.60
Other	$8.50	$8.95
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00

Part D Benefit Parameters, cont.	2019	2020
Partial Subsidy		
Applied and income below 150% FPL and resources below $13,820 (individual) or $27,600 (couples) [category code 4]		
Deductible	$85.00	$89.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.40	$3.60
Other	$8.50	$8.95
Retiree Drug Subsidy Amounts		
Cost Threshold	$415.00	$435.00
Cost Limit	$8,500.00	$8,950.00

Section E. Reduced Coinsurance for Applicable Beneficiaries in the Coverage Gap

Phase-in of reduced non-LIS cost sharing in the gap continues, with ultimate levels (95% for brand drugs and 25% for generic drugs) to be accomplished by PY2020. The non-LIS gap cost sharing for 2020 is as follows:

- Non-LIS 25% coinsurance for non-applicable drugs (mainly generics) in the gap (was 37% in 2019).
- Non-LIS 95% coinsurance for non-applicable drugs (mainly brand) in the gap (versus 85% in 2019). Note that member liability is approximately 25% after 70% manufacturer discount. This is the same cost sharing scheme used in PY2019.

Reductions in non-LIS coinsurance will result in lower TrOOP, which will be reflected in the 2020 bids.

Section F. Dispensing Fees and Vaccine Administration Fees for Applicable Drugs in the Coverage Gap

Consistent with the gap cost sharing reductions discussed above, beneficiary/plan liability will be 25%/75%, respectively, for dispensing fees and vaccine administration fees related to applicable drugs in the gap.

Section G. Part D Calendar Year Employer Group Waiver Plans

Beginning in 2017, CMS began making prospective payments for Part D federal reinsurance for calendar year Employer Group Waiver Plans (EGWPs) offering Part D, due to rising specialty drug costs. Consistent with Part D non-EGWPs, the prospective payment will be reconciled with actual expenses several months after the conclusion of the plan year.

For 2020, CMS proposes to continue making prospective reinsurance payments to calendar year Part D EGWPs. The payment will be based on the average reinsurance amount paid to CY2017 EGWPs. This amount is $40.77 PMPM (versus $36.10 PMPM in 2019).

Consistent with 2019 and prior years, non-calendar year EGWPs are excluded from the Part D federal reinsurance program.

Attachment IV – Medicare Part D Parameters for the Defined Standard Benefit Annual Adjustments for 2020

Attachment IV contains detailed calculations of the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop the 2020 benefit parameters: the annual percentage increase (API) and the annual Consumer Price Index (CPI) increase. These adjustments are described below. The API is applied to all Part D parameters, except for copayments that apply to full benefit dual-eligible enrollees with incomes up to or at 100% FPL, which increase based on CPI.

Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

The API is defined as the annual percentage increase in the average per capita expenditures for Part D for the 12-month period ending in July of the previous year.

Section B. Annual Percentage Increase in Consumer Price Index (CPI)

The CPI is defined as the annual percentage increase in the CPI, All Urban Consumers (all items, U.S. city average) as of September of the previous year.

Section C. Calculation Methodology

The API uses prescription drug event (PDE) data to calculate the per capita Part D costs from August 2018 to July 2019 divided by the per capita Part D costs from August 2017 to July 2018. Since PDE data are not yet available for 2019, the per capita costs for this time period are estimated using August 2018 to December 2018 PDE data. This calculation results in an estimated 5.25% annual increase in per capita costs. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -0.04%, primarily driven by an update to last year's API. This results in a total 2020 API of 5.21%.

The CPI increase is based on the projected September 2019 CPI divided by actual September 2018 CPI, which results in an estimated increase of 2.27%. This increase is further adjusted

based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is 0.32%. In total, this produces a 2019 CPI increase of 2.59%.

Section D. Retiree Drug Subsidy Amounts

The Part D parameters, including the retiree drug subsidy amount, are each multiplied by the appropriate increase (CPI or annual percentage increase). For 2020, the retiree subsidy cost threshold is $435 (was $415 in 2019) and the cost limit is $8,950 (was $8,500 in 2019).

Section E. Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries

The 2019 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is calculated to be $9,719.38 ($8,906.55 for 2019). This amount is calculated as the ICL plus 100 percent beneficiary cost sharing in the coverage gap divided by the weighted gap coinsurance factor. Further detail on these calculations and inputs is provided in the Advance Notice.

Attachment VI. Draft CY2020 Call Letter

Section I – Parts C and D

ANNUAL CALENDAR: KEY UPCOMING DATES

The following bullet points contain major/key items for 2020 bid submission. The full detailed list can be found on pages 101-106 of the Advance Notice.

- February 13, 2019: Initial and Service Area Expansion Application due to HPMS by 8:00PM EST.
- Mid-late March 2019: Release of CY2020 Formulary Reference File (FRF).
- March/April 2019: CMS works with MAOs and PDPs to resolve low enrollment issues for 2020.
- Early April 2019: CY2020 OOPC Model and OOPC estimates for each plan made available.
- April 1, 2019: 2020 Final Announcement of MA Capitation Rates and MA/Part D Payment Policies released along with Final Call Letter.
- April 5, 2019: Release of the CY2020 Plan Creation Module, PBP, and BPT software in HPMS.
- April 10, 2019: Deadline for MAOs to submit requests for full contract consolidations for CY 2019.
- Mid-April 2019: Release of HPMS Memo: Contract Year 2020 MA Bid Review and Operations Guidance.
- Late April 2019: TBC data for CY2020 released.

- May 2019: Final ANOC/EOC, LIS rider, formularies, provider directory and other items for CY2020 available.
- Early May 2019: MA/MA-PD/PDP plans to notify CMS of its intention to non-renew county(ies) for individuals, but continue the county(ies) for "800 series" EGWP members, or reduce its service area at the contract level.
- May 4, 2019: Release of the CY2020 Bid Upload Functionality in HPMS.
- May 14, 2019: Release of CY2020 Formulary Submission Module in HPMS.
- May 17, 2019: Release of CY2020 Actuarial Certification Module in HPMS.
- June 3, 2019:
    - Deadline for submission of CY2020 bids for all MA/MAPD/PDP plans.
    - Deadline for submission of CY2020 Formularies.
    - Deadline for submission of a CY2020 contract non-renewal, service area reduction notice to CMS from MA/MAPD/PDP plans.
- June 2019: CMS Conducts Network Adequacy Reviews.
- Late July/Early August 2019: CMS releases the 2020 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, the MA regional PPO benchmarks, and the de minimis amount.
- Late July/Early August 2019: Rebate reallocation period begins after release of the above bid amounts.
- Late August/Early September 2019: Plan preview period of Star Ratings in HPMS.
- October 1, 2019: Tentative date for 2020 plan and drug benefit data to be displayed on Medicare Plan Finder on Medicare.gov.
- October 9, 2019: Star Ratings go live on medicare.gov.
- October 15, 2019: 2020 Annual Election Period (AEP) begins.
- December 7, 2019: End of AEP.

ENHANCEMENTS TO THE 2020 STAR RATINGS AND FUTURE MEASUREMENT CONCEPTS

Unless noted below, CMS does not anticipate methodology changing from the 2019 Star Ratings. For reference, a list of measures and methodology included in the 2019 Star Ratings is described in the Technical Notes: **http://go.cms.gov/partcanddstarratings**

Changes to Measures for 2020

Improvement Measures (Part C & D) – A detailed list of the measures proposed to calculate 2020 improvement measures is included on pages 110-111.

Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D) – Continue to exclude beneficiaries from the MTM program who did not receive a CMR within 60 days of enrollment of the program; do however include the beneficiaries in the denominator and the numerator if they received a CMR within that 60 day time frame.

Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D) – CMS is proposing to exclude beneficiaries who elected to receive hospice care at any time in the measurement period for CY 2020 Star Ratings instead of applying a Proportion of Days (PDC). Statin Use in Persons with Diabetes (SUPD) (Part D) – SUPD measurement was added with a weight of 1 for CY 2019. In 2020 and beyond, this measure will be weighted at three.

Statin Use in Persons with Diabetes (SUPD) (Part D) – SUPD measurement was added with a weight of 1 for CY 2019. In 2020 and beyond, this measure will be weighted at three.

Temporary Removal of Measures from Star Ratings

Controlling High Blood Pressure (Part C) – CMS is proposing to move the "controlling high blood pressure" measure to 2022 given that the target for HEDIS 2019 will be revised to <140/90 mmHg and to incorporate some structural changes to the measurement:

- Allowing two outpatient encounters to identify the denominator and remove the medical record confirmation for hypertension;
    - Allowing the use of telehealth services for one of the outpatient encounters in the denominator, adding an administrative approach that utilizes CPT category II codes for the numerator;
    - Allowing remote monitoring device readings for the numerator.

2020 Star Ratings Program and the Categorical Adjustment Index

The Categorical Adjustment Index (CAI) values and abridged details of the methodology are provided in the annual Medicare Part C & D Star Ratings Technical Notes available on the CMS webpage at https://go.cms.gov/partcanddstarratings. The CAI was implemented to address the within-contract disparity in performance associated with a contract's percentages of beneficiaries with low income subsidy and dual eligible (LIS/DE) and disability.

The PQA examined their medication adherence measures, which are currently used in the Star Ratings Program, for potential risk adjustment (i.e., adjustment for socioeconomic status, aka SES, and demographic factors). Beginning in 2018, the PQA included in the 2018 PQA Measure Manual draft recommendations on risk adjustment of the three medication adherence measures: Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension, and Medication Adherence for Cholesterol. The draft recommendations are as follows:

- All three adherence measures should be risk adjusted for sociodemographic status (SDS) characteristics to adequately reflect differences in patient populations.
- The measures should be adjusted for the following beneficiary-level SDS characteristics:
- Age
- Gender
- Dual eligibility/LIS status, and
- Disability status

- The three adherence measures should be stratified by the beneficiary-level SDS characteristics listed above to allow health plans to identify disparities and understand how their patient population mix is affecting their measure rates.

CMS is proposing to expand the adjusted measure set for the determination of the 2020 CAI values. The proposed methodology for the 2020 Star Ratings is the same methodology that has been finalized for the 2021 Star Ratings in the Contract Year 2019 Final Rule. For the 2020 CAI adjusted measure set, CMS is proposing that all measures identified as candidate measures will be included in the determination of the 2020 CAI values.

A measure will be included as a candidate measure if it remains after applying the following four bases for exclusions:

- The measure is already case-mix adjusted for SES (for example, CAHPS and HOS outcome measures);
- The focus of the measurement is not a beneficiary-level issue but rather a plan or provider-level issue (for example, appeals, call center, Part D price accuracy measures);
- The measure is scheduled to be retired or revised during the Star Rating yin which the CAI is being applied; or
- The measure is applicable to only Special Needs Plans (SNPs) (for example, SNP Care Management, Care for Older Adults measures).

The candidate measure set for the 2020 CAI is as follows:

- Adult BMI Assessment
- Annual Flu Vaccine
- Breast Cancer Screening
- Colorectal Cancer Screening
- Diabetes Care – Blood Sugar Controlled
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Improving Bladder Control
- Medication Reconciliation Post-Discharge
- MTM Program Completion Rate for CMR
- Monitoring Physical Activity
- Osteoporosis Management in Women who had a Fracture
- Plan All-Cause Readmissions
- Reducing the Risk of Falling
- Rheumatoid Arthritis Management
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension
- Medication Adherence for Cholesterol
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Use in Persons with Diabetes
- 2020 Categorical Adjustment Index (CAI) Values

MA contracts have up to three mutually exclusive and independent adjustments – one for the overall Star Rating and one for each of the summary ratings (Part C and Part D). PDPs have one adjustment for the Part D summary rating. Tables 4 – 13 on pages 115 through 119 in the Advance Notice provide the rating-specific categories for classification of contracts based on the percentage of LIS/DE and disabled beneficiaries along with the final adjustment categories.

Extreme and Uncontrollable Circumstances Policy

CMS is proposing to adjust the 2020 Star Ratings to take into account the effects of extreme and uncontrollable circumstances that occurred during the performance period using a similar methodology to the one adopted for the 2019 Star Ratings in the CY 2019 Call Letter. This policy is largely the same as that described in the final 2019 Call Letter and used for 2019 Star Ratings, with two substantive exceptions:

- Eliminating the difference-in-differences adjustment for survey data. The difference-in-differences adjustment showed no consistent, negative impact of extreme and uncontrollable circumstances on the 2019 Star Ratings; therefore, CMs is proposing to eliminate this adjustment to simplify the methodology.

- Clarifying the rules around measures with missing or biased data in the prior or current year.

Identification of Affected Contracts

CMS proposes a policy to identify MA and Part D contracts affected by extreme and uncontrollable circumstances that may impact their performance on Star Ratings measures and/or may impact their ability to collect necessary measure-level data. Contracts must meet all of the following criteria:

- The service area is within an “emergency area” during an “emergency period” as defined in Section 1135(g) of the Act.

- The service area is within a county or county-equivalent entity designated in a major disaster declaration under the Stafford Act that served as a condition precedent for the Secretary’s exercise of authority under Section 1135 of the Act based on the same triggering event(s).

- Certain minimum percentage (25% measure adjustment or 60% for exclusion from cut point calculations) of the enrollees under the contract must reside in a FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance.

CMS proposes that the policy be tailored to the specific areas experiencing the extreme and uncontrollable circumstances. For purposes of this policy, a narrower geographic scope than the full emergency area would ensure that the Star Ratings adjustments are focused on the specific geographic areas that experienced the greatest adverse effects of the extreme and uncontrollable circumstances and are not applied to areas sustaining little or no adverse effects. Tables 14 and 15 on page 121 show the list of Section 1135 waivers issues and the Individual Assistance counties from FAMA major disaster declarations, respectively.

To further narrow the scope of this policy to ensure it is applied to those contracts most likely to have experienced the greatest adverse effects, CMS proposes to limit to Individual Assistance disaster declarations. To determine whether a contract was impacted (such as that it would be an "affected contract" eligible for adjustments), CMS proposes to compare the number of enrollees in the Individual Assistance area at the time of the extreme and uncontrollable circumstance compared to the number of enrollees outside the Individual Assistance area.

The Hurricanes Florence and Michael, Typhoon Yutu, and the California wildfires trigger the extreme and uncontrollable circumstances policy. CMS proposes to limit adjustments to the star ratings to affected contract for these major disasters.

Contracts that do not meet the definition of an "affected contract" or the parameters discussed below would not be eligible for any adjustments to the 2020 Star Ratings under this policy.

CAHPS Adjustments
For CAHPS, CMS is proposing to take into account the effects of these extreme and uncontrollable circumstances in the following two ways for affected contracts:

- For all contracts, the MA organization would be required to administer the 2019 CAHPS survey unless the contract requested and CMS approved an exception because a substantial number of their enrollees have been displaced due to a FEMA-designated disaster in 2018 and it would be practically impossible to contact the required sample for the survey. CMS proposes to make the exception available only to affected contracts that can demonstrate meeting this standard.

- CMS' proposed adjustment is for affected contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance. These would receive the higher of the 2019 or 2020 Star Rating/corresponding measure for each CAHPS measure.

For all adjustments, if the Star Rating is the same in both years, CMS would use the Star Rating and measure score from the most recent year.

HOS Adjustments
For the HOS survey, CMS proposed to follow similar procedures as CAHPS but the adjustment for 2017 disasters (listed in Tables 15 and 16 on page 121 and 136, respectively of the final CY 2019 Call Letter) will apply to 2020 Star Ratings, and the adjustment for 2018 disasters (listed in Tables 14 and 15 of this CY 2020 Call Letter) will apply to 2021 Star Ratings.

For all contracts, the MA organization would be required to administer the 2019 HOS survey unless the contract requested and CMS approved an exception because a substantial number of their enrollees have been displaced due to a FEMA-designated disaster in 2018 and it would be practically impossible to contact the required sample for the survey. CMS proposes to make the exception available only to affected contracts that can demonstrate meeting this standard.

CMS' proposed adjustment is for affected contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable

circumstance. These affected contracts would receive the higher of the 2021 or 2020 Star Rating/corresponding measure for each HOS outcome measure and HEDIS-HOS measure in the 2021 Star Ratings.

For all adjustments, if the Star Rating is the same in both years, CMS would use the Star Rating and measure score from the most recent year.

HEDIS Adjustments
For HEDIS, all affected contracts would be required to report HEDIS data to CMS unless the MA organization of an affected contract requests and receives from CMS and exception because the MA organization cannot obtain both administrative and medical record data necessary for HEDIS. All contracts in disaster areas can work with NCQA to request modifications to the samples for measures that require medical record review. For affected contracts with more than 25% of beneficiaries in a FEMA designated Individual Assistance area at the time of the disaster, CMS would take the higher of the 2019 or 2020 Star Ratings (and corresponding measure rating) for each HEDIS measure.

In contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas that were affected by disasters in 2017 and 2018, CMS proposes they receive the higher of the 2020 Star Rating or what the 2019 Star Rating would have been in the absence of any adjustment that took into account the effects of the 2017 disaster for each measure.

For all adjustments, if the Star Rating is the same in both years, CMS would use the Star Rating and measure score from the most recent year.

Other Star Ratings Measure Adjustments
CMS proposes that for all other measures for affected contracts with at least 25% of beneficiaries in a FEMA-designated Individual Assistance area at the time of the disaster, CMS would take the higher of the 2019 or 2020 measure Star Rating (and corresponding measure rating).

In contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas that were affected by disasters in 2017 and 2018, CMS proposes that they will receive the higher of the 2020 Star Rating or what the 2019 Star Rating would have been in the absence of any adjustment that took into account the effects of the 2017 disaster for each measure.

For all adjustments, if the Star Rating is the same in both years, CMS would use the Star Rating and measure score from the most recent year.

CMS proposes to exclude from this adjustment policy the following measures: Part C Call Center – Foreign Language Interpreter and TTY Availability and Part D Call Center – Foreign Language Interpreter and TTY Availability.

Improvement Measure(s) and Missing Data Rules:
Currently, contracts must have data for at least half of the attainment measures used to calculate the Part C or Part D improvement measures to be eligible to receive a rating in each improvement measure. For affected contracts that revert back to the underlying 2019 Star Rating for a particular measure, CMS proposes to exclude that measure in the measure count

for determination of whether the contract has at least half of the measures needed to calculate the relevant improvement measure for the 2020 and 2021 Star Ratings. CMS would follow their usual rule where a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C or D improvement measures to receive a Star Rating in the improvement measures.

Except in cases of a granted exception, CMS proposes that the final measure rating would come from the current year for all measures eligible for an extreme and uncontrollable circumstance adjustment, when an affected contract has missing data in either their current or previous year.

Cut Points for Non-CAHPS Measures
Currently, the Star Rating for each non-CAHPS measure is determined by applying a clustering algorithm to all the measures' numeric value scores from all contracts required to submit the measure. The cut points are derived from this clustering algorithm. CMS proposes to exclude the numeric values for affected contracts with 60% or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance.

Similarly, CMS proposes that affected contracts with 60% or more of their enrollees impacted would also be excluded from the determination of the performance summary and variance thresholds for the Reward Factor. However, these contracts would still be eligible for the Reward Factor based on the mean and variance calculations of other contracts.

2020 Star Ratings Measures
Members Choosing to Leave the Plan (Parts C & D): CMS proposes to use additional data to identify beneficiaries leaving a contract due to a move out of the contract service area since a move out of the service area is considered an involuntary disenrollment. This proposal would exclude from the numerator dis-enrollees for which the new contract service area does not overlap with the old contract service area.

2020 CMS Display Measures
Display measures on CMS.gov are not part of the Star Ratings. CMS will continue to solicit feedback on new and updated measures through the draft Call Letter, as well as continue to provide advance notice regarding measures considered for implementation as future Star Ratings measures.

New 2020 Display Measures
- Transitions of Care (Part C)
- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C)
- MPF Price Accuracy (Part D)

Display Measures Being Retired
- Transition Monitoring Program Analysis (TMPA) and Formulary Administration Analysis (FAA) (Part D)

Changes to existing 2020 display measures
- Use of Opioids at High Dosage and from Multiple Providers (OHDMP) and Antipsychotic Use in Persons with Dementia (APD) (Part D)

- Problems Getting Information and Help from the Plan and Problems with Prescription Drug Benefits and Coverage Disenrollment Reasons Survey composite measures (Part D)

Forecasting to 2021 and Beyond

Potential changes to existing measures:

-Health Outcomes Survey (HOS)
-Plan All-Cause Readmissions (Part C)
-Medication Reconciliation (Part C)
-Osteoporosis Measures (Part C)
-Care for Older Adults – Functional Status Assessment Indicator (Part C)
-Hospitalization for Potentially Preventable Complications (Part C)
-Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for -Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D)
-Antipsychotic Use in Persons with Dementia (APD) and Statin Use in Persons with Diabetes (SUPD) (Part D)
-Concurrent Use of Opioids and Benzodiazepines (COB), Polypharmacy Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH), and Polypharmacy Use of -Multiple Central Nervous System (CNS) – Active Medications in Older Adults (Poly-CNS) (Part D)
-Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D)
-High Risk Medication (HRM) and Diabetes Medication Dosing (DMD) (Part D)

Potential new measures concepts

-Cross-Cutting Topic – Measure Digitalization (Part C)
-Cross-Cutting Topic – Exclusions for Advanced Illness (Part C)
-Physician/Plan Interactions (Part C & D)
-Interoperability Measures (Part C)
-Patient-Reported Outcome Measures (Part C)
-Adherence to Antipsychotic Medications for Individuals with Schizophrenia (Part C)
-Antibiotic Utilization Measures (Part C)
-Diabetes Overtreatment (Part C)

Removal of Measures from 2022 Star Ratings

-Adult BMI Assessment (Part C)
-Appeals Auto-Forward (Part D), Appeals Upheld (Part D)

Measurement and Methodological Enhancements Under Construction

-CMS is exploring the feasibility of testing web options for some existing beneficiary survey and are interested in receiving feedback from plans.

INCOMPLETE AND INACCURATE BID SUBMISSIONS

The following components—where applicable—are required to constitute a complete bid submission:
-PBP and BPT
-Service Area Verification
-Plan Crosswalk (if applicable)
-Cross-Sharing Justification (if applicable)
-Formulary Submission (for plans offering PD coverage with a formulary)
-Formulary Crosswalk (for plans offering PD coverage with a formulary)
-Substantiation (supporting docs)

If any of the above components are not submitted by the deadline, the bid submission will be considered incomplete and not accepted.

Inaccurate Submissions
CMS will only approve a Part D bid if the organization offering the plan's bid complies with all applicable Part D requirements. All Part C bids must be complete, timely, and accurate so that CMS may use its authority to impose sanctions or may choose not to renew the contracts.

Organizations that submit inaccurate bids that fail to meet Part C and D requirements and established thresholds will receive a compliance notice in the form of a letter or a corrective action plan.

Plan Corrections
The plan correction window will be open from early September to late September 2019. The only changes to the PBP that will be allowed during the plan correction period are those that modify the PBP data to align with the BPT. No changes to the BPT are permitted during this time.

In advance of the bid submission deadline, CMS will provide organizations and sponsors the guidance and tools necessary for a complete and accurate bid submission. These tools include a Medicare Plan Finder (MPF) summary table that will be released in HPMS in May. Organizations and sponsors submitting plan corrections will receive a compliance action and will be suppressed in MPF until the first update in November. In addition, CMS may issue more severe compliance actions.

Innovations in Health Plan Design
The CMS Innovation Center is responsible for developing and testing new payment and service delivery models that will lower costs while preserving or enhancing quality of care for beneficiaries. CMS began the Medicare Advantage Value-Based Insurance Design (MA-VBID) and the Part D Enhanced Medication Therapy Management (MTM) Model tests on January 1, 2017.

Value-Based Insurance Design (VBID) Model Test
In CY 2019, the VBID model is testing whether the additional flexibilities provided under the model allow and incentivize plans to develop and offer interventions that improve health outcomes and lower expenditures for Medicare enrollees. For CY2020, MA plans that meet model eligibility

criteria may apply for participation in the VBID model for one or more VBID component(s). The application deadline is March 1, 2019.

Part D Enhanced MTM Model
The Part D Enhanced MTM model tests whether providing Part D sponsors with additional payment incentives and regulatory flexibilities will engender enhancements in the MTM program, leading to improved therapeutic outcomes, while reducing net Medicare expenditures. Six Part D Sponsors, encompassing 22 PBPs are participating in the CMS Innovations Center's Part D Enhanced MTM model for 2018. All other Part D plans, including any ineligible plans offered by the PDP sponsors of participating plans, will remain subject to the current regulatory requirements for MTM programs.

Section II – Part C

OVERVIEW OF CY2020 BENEFITS AND BID REVIEW

Any organization whose bid fails the Part C Service Category Cost Sharing, PMPM Actuarial Equivalent Cost Sharing, Meaningful Difference (if applicable, see below), Total Beneficiary Cost (TBC), and/or Optional Supplemental Benefit requirements at any time prior to final approval will receive a compliance notice, even if the organization is allowed to correct the deficiency. The severity of compliance notice may depend on the type and/or severity of error(s).

Plan Types and Applicable Bid Review Criteria

Bid Review Criteria	Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)	Applies to Non-Employer Dual Eligible SNPs	Applies to 1876 Cost Plans	Applies to Employer Plans
Low Enrollment	Yes	Yes	No	No
Total Beneficiary Cost	Yes	No	No	No
Maximum Out-of-Pocket (MOOP) Limits	Yes	Yes	No	Yes
PMPM Actuarial Equivalent Cost Sharing	Yes	Yes	No	Yes
Service Category Cost Sharing	Yes	Yes	Yes[1]	Yes
Part C Optional Supplemental Benefits	Yes	Yes	No	No

[1] Section 1876 Cost Plans and MA plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 C.F.R. §§417.454(e) and 422.100(j)).

PLANS WITH LOW ENROLLMENT

At the end of March, CMS will send affected MAOs a list of non-SNP plans that have fewer than 500 enrollees or of SNP plans that have fewer than 100 enrollees and that have been in existence for three or more years [as of March 2019 (three annual election periods)]. Plans with low enrollment located in service areas that do not have a sufficient number of competing options of the same plan type (such that the low enrollment plan still represents a viable plan option for beneficiaries), as determined by CMS, will not receive this notification.

TOTAL BENEFICIARY COST (TBC)

The methodology for developing the CY2020 out-of-pocket costs (OOPC) model is consistent with last year's methodology.

MA plans offering Part C uniformity flexibility and/or participating in the Value-Based Insurance Design (VBID) model test will be subject to the TBC evaluation for CY2020; however, benefits and cost sharing reductions (entered in Section B-19 of the PBP) that are offered as part of Part C uniformity flexibility or the VBID model test will be excluded from the TBC calculation. This approach allows CMS to readily evaluate changes in cost sharing and benefits that are provided to all enrollees in a plan.

CMS is proposing to maintain the TBC change threshold, for most plans, at $36.00 PMPM in CY 2020. For CY2020, the TBC change evaluation will be treated differently for the following specific situations:

1. Plans with an increase in quality bonus payment and/or rebate percentage, and an overall payment adjustment amount greater than $36.00 PMPM will have a TBC change threshold of $0.00 PMPM (i.e., −1 times the TBC change limit of $36 PMPM) plus applicable technical adjustments.
2. Plans with a decrease in quality bonus payments and/or rebate percentage, and an overall payment adjustment amount less than -$36.00 PMPM will have a TBC change threshold of $72.00 PMPM (i.e., 2 times TBC change limit of $36.00 PMPM) plus applicable technical adjustments. That is, plans are not be allowed to make changes that result in greater than $72.00 worth of decreased benefits or increased premiums.
3. Plans with a star rating below 3.0 and an overall payment adjustment amount less than −$36.00 PMPM will have a TBC change threshold of $72.00 PMPM (i.e., 2 times TBC change limit of $36.00) plus applicable technical adjustments.

Plans not accounted for in the three specific situations above are evaluated at the $36 PMPM limit, similar to CY2019.

If CMS provides an opportunity to correct CY2020 TBC issues following the submission deadline, the MAO cannot change its formulary (e.g., adding drugs etc.) as a means to satisfy this requirement.

MAXIMUM OUT-OF-POCKET (MOOP) LIMITS

CY2020 Voluntary and Mandatory MOOP Range Amounts by Plan Type

Plan Type	Voluntary	Mandatory
HMO	$0 - $3,400	$3,401 - $6,700
HMO POS	$0 - $3,400 In-network	$3,401 - $6,700 In-network
Local PPO	$0 - $3,400 In-network and $0 - $5,100 Combined	$3,401 - $6,700 In-network and $3,401 - $10,000 Combined
Regional PPO	$0 - $3,400 In-network and $0 - $5,100 Combined	$3,401 - $6,700 In-network and $3,401 - $10,000 Combined
PFFS (full network)	$0 - $3,400 Combined	$3,401 - $6,700 Combined
PFFS (partial network)	$0 - $3,400 Combined	$3,401 - $6,700 Combined
PFFS (non-network)	$0 - $3,400	$3,401 - $6,700

PMPM ACTUARIAL EQUIVALENT (AE) COST SHARING LIMITS

See table below for an Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing.

	1	2	3	4	5	6	
BPT Benefit Category	PMPM Plan Cost Sharing (Parts A&B) (BPT Col. l)	Original Medicare Allowed (BPT Col. m)	Original Medicare AE Cost sharing (BPT Col. n) 1	Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on FFS data)	Comparison Amount (#3 x #4)	Excess Cost Sharing (#1 – #5, min of $0)	Pass/Fail
Inpatient	$ 33.49	$ 331.06	$ 25.30	1.39	$ 35.18	$ -	Pass
SNF	$ 10.83	$ 58.19	$ 9.89	1.068	$ 10.57	$ 0.26	Fail
DME	$ 3.00	$ 11.37	$ 2.65	1	$ 2.65	$ 0.35	Fail
Part B-Rx	$ 0.06	$ 1.42	$ 0.33	1	$ 0.33	$ -	Pass

[1] PMPM values in column 3 for Inpatient and Skilled Nursing Facility only reflect Part A fee-for-service actuarial equivalent cost sharing for that service category.

PART C COST SHARING STANDARDS

The cost sharing standards in the table below apply to in-network services.

CMS is planning to add cost sharing standards in section B-3 of the PBP for cardiac rehabilitation, intensive cardiac rehabilitation, pulmonary rehabilitation, and supervised exercise therapy (SET) for peripheral artery disease (PAD) services for CY 2020. CMS intends to have a separate PBP data entry for SET and PAD for CY 2020.

If a plan uses a copayment method of cost sharing, then the copayment for an in-network Original Medicare service category cannot exceed 50% of the average contracted rate of that service.

CY2020 In-Network Service Category Cost Sharing Requirements

Service Category	PBP Section B data entry field	Voluntary MOOP	Mandatory MOOP
Inpatient Hospital--Acute-60 days	1a	N/A	$4,777
Inpatient Hospital--Acute-10 days	1a	$2,721	$2,177
Inpatient Hospital--Acute-6 days	1a	$2,461	$1,969
Inpatient Hospital Psychiatric - 60 days	1b	$3,048	$2,438
Inpatient Hospital Psychiatric -15 days	1b	$2,204	$1,763
Skilled Nursing Facility - First 20 Days[1,2]	2	$20/day	$0/day
Skilled Nursing Facility - Days 21 through 100[1,2]	2	$178/day	$178/day
Intensive Cardiac Rehabilitation Services	3	$100	$100
Cardiac Rehabilitation	3	$50	$50
Pulmonary Rehabilitation	3	$30	$30
Supervised exercise therapy (SET) for Symptomatic peripheral artery disease (PAD)	3	$30	$30
Emergency Care/Post Stabilization Care[3]	4a	$120	$90
Urgently Needed Services[3]	4b	$65	$65
Partial Hospitalization	5	$55/day	$55/day
Home Health	6a	20% or $35	$0
Primary Care Physician	7a	$35	$35
Chiropractic Care	7b	$20	$20
Occupational Therapy	7c	$40	$40
Physician Specialist	7d	$50	$50
Psychiatric and Mental Health Specialty Services	7e and 7h	$40	$40
Physical Therapy and Speech-language Pathology	7i	$40	$40
Therapeutic Radiological Services	8b	20% or $60	20% or $60
DME-Equipment	11a	N/A	20%
DME-Prosthetics	11b	N/A	20%
DME-Medical Supplies	11b	N/A	20%
DME-Diabetes Monitoring Supplies	11c	N/A	20% or $10
DME-Diabetic Shoes or Inserts	11c	N/A	20% or $10
Dialysis Services[1]	12	20% or $30	20% or $30
Part B Drugs-Chemotherapy[1,4]	15	20% or $75	20% or $75
Part B Drugs-Other	15	20% or $50	20% or $50

1 MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration including chemotherapy drugs and radiation therapy integral to the treatment regimen, skilled nursing care, and renal dialysis services (42 CFR §§417.454(e) and 422.100(j)).

2 MA plans that establish a voluntary MOOP may have cost sharing for the first 20 days of a SNF stay. The per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount. Total cost sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost sharing in Original Medicare, pursuant to §1852(a)(1)(B).

3 Emergency Care and Urgently Needed Care benefits are not subject to plan level deductible amount and/or out-of-network providers. The dollar amount included in the table represents the maximum cost sharing permitted per visit (copayment or coinsurance).

4 Part B Drugs - Chemotherapy cost sharing displayed is for services provided on an outpatient basis and includes administration services.

If a plan uses a copayment method of cost sharing, then the copayment for an in-network Original Medicare service category cannot exceed 50% of the average contracted rate of that service.

PART C OPTIONAL SUPPLEMENTAL BENEFITS

CMS will continue to consider a plan to be non-discriminatory when the total value of all optional supplemental benefits offered to non-employer plans under each contract meets the following thresholds:

(a) the enrollment-weighted contract-level projected gain/loss margin, as measured by a percent of premium, is no greater than 15% and

(b) the sum of the enrollment-weighted contract-level projected gain/loss margin and non-benefit expenses, as measured by a percent of premium, is no greater than 30%.

MEDICARE-COVERED OPIOID TREATMENT PROGRAM SERVICES BEGINNING IN CY2020

Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Public Law No. 115-271) establishes opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a Medicare Part B service beginning in 2020.

Opioid use disorder treatment services include:

- FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications,
- substance use counseling,
- individual and group therapy,
- toxicology testing, and
- other items and services that CMS determines appropriate (excluding meals and transportation).
- Medicare Health plans and PACE organizations will be required to provide OTP services as a Medicare-covered benefit and must enter cost sharing for OTP services in PBP service category B7k as appropriate.

NON-OPIOID PAIN MANAGEMENT SUPPLEMENTAL BENEFITS

CMS encourages MA organizations to consider Part C benefit designs for supplemental benefits that address medically-approved non-opioid pain management and complementary and integrative treatments.

For purposes of completing the PBP, peer support services and/or psychosocial services/cognitive behavioral therapy can be included in counseling services (PBP 14c). In addition, non-Medicare covered chiropractic services (PBP 7b), acupuncture (PBP 13a), and therapeutic massage (PBP B14c) furnished by a state licensed massage therapist, may also be incorporated into plan designs.

“Massage” should not be singled out as a particular aspect of other coverage (e.g., chiropractic care or occupational therapy) and must be ordered by a physician or medical professional in order to be considered primarily health related and not primarily for the comfort or relaxation of the enrollee.

The non-opioid pain management item or service must treat or ameliorate the impact of an injury or illness (e.g., pain, stiffness, loss of range of motion).

POTENTIAL CHANGES TO MOOP AND COST SHARING STANDARDS FOR CY2021

For CY 2021, CMS is considering whether to establish a third MOOP limit (referred to as the intermediate MOOP limit) that would be the approximate numeric midpoint between the mandatory and voluntary MOOP limits for the applicable year (i.e., mandatory MOOP limit, less approximately 50% of the numeric difference between the mandatory and voluntary MOOP amounts).

The table below illustrates the three MOOP limits (using current information to provide examples) that CMS is considering:

Proposed CY2021 MOOP Limits and Examples

MOOP Limit	Approximate Original Medicare Percentile	Examples Based on Current MOOP Limits	
		In Network	Combined In & Out-of-Network
Mandatory	95th	$5,001 to $6,700	$7,501 to $10,000
Intermediate	Approximate numeric midpoint*	$3,401 to $5,000	$5,101 to $10,000
Lower	85th	$0 to $3,400	$0 to $5,100

CMS is also considering additional flexibilities for the service category cost sharing standards described below for MA plans that elect to use the intermediate MOOP or the lower MOOP. These changes would afford such MA plans that adopt the lower or intermediate MOOP limits greater flexibility in establishing Parts A and B cost sharing than is available to MA plans that adopt the higher, mandatory MOOP limit. Flexibilities under consideration include:

- Adding one or two additional inpatient length of stay scenarios for both acute and psychiatric care. The cost sharing standard for mandatory and lower voluntary MOOP limits would continue to be based on 100% and 125% of estimated Medicare FFS cost sharing, respectively. The intermediate MOOP limit cost sharing standard would be based on the approximate mid-point between the mandatory and lower voluntary cost sharing limits.
- Establishing nominal cost sharing limits during the first 20 days of a SNF stay for both lower and intermediate voluntary MOOP limits. Per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount, and total cost sharing for the overall SNF benefit must be no higher than the actuarially equivalent cost sharing in Original Medicare, pursuant to §1852(a)(1)(B). For example, the per-day cost sharing limit during the first 20 days of a SNF stay could be $0 for mandatory, $10 for intermediate, and $20 for the lower MOOP limits, so long as the overall actuarial equivalence for the SNF benefit is met.
- Varying cost sharing limits across all three proposed MOOP limits for emergency care/post stabilization care (PBP B4a), home health services (PBP B6a), and physician specialist services (PBP B7d). CMS intends to include varying cost sharing across additional services in future years as part of this flexibility.
- Introducing new cost sharing limits for observation services (PBP B9a) and ambulance services (PBP B10a) that would use the same cost sharing across all three MOOP limits for CY 2021.

SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)

In the 2019 Call Letter, CMS expanded its interpretation of how a benefit may be a “health care benefit” that is approvable as a supplemental benefit offered by an MA plan. CMS has historically interpreted the statute as requiring a supplemental benefit to (1) not be covered by Original Medicare, (2) be primarily health related, and (3) require the MA plan to incur a non-zero direct medical cost. Specifically, CMS expanded its definition of “primarily health related” to consider items or services used to “diagnose, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”

Special Supplemental Benefits for the Chronically Ill (SSBCI) include supplemental benefits that are not primarily health related and/or offered non-uniformly to eligible chronically ill enrollees. CMS believes the intended purpose of the new category of supplemental benefits is to enable MA plans to better tailor benefit offerings for the chronically ill population, address gaps in care, and improve specific health outcomes.

CMS defines a chronically ill enrollee as an individual who

- Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
- Has a high risk of hospitalization or other adverse health outcomes; and
- Requires intensive care coordination

MA plans do not have to submit the processes by which they identify chronically ill individuals that meet this definition. However, all three criteria must be met for an enrollee to be considered chronically ill, and thus eligible for the SSBCI. CMS expects MA plans to develop and document mechanisms to identify chronically ill enrollees based on the definition above.

Beginning CY 2020, CMS does not require supplemental benefits to be primarily health related when they are provided to chronically ill enrollees if certain conditions are met. MA plans will have the ability to offer a "non-primarily health related" item or service to chronically ill enrollees if the SSBCI has *a reasonable expectation of improving or maintaining the health or overall function of the enrollee* as it relates to the chronic disease.

PROVIDER DIRECTORIES

CMS recently concluded the third year of online provider directory review by checking the accuracy of a least one online provider directory from virtually every parent organization with a MA contract.

CMS has published a report of their findings on the CMS website.

PHYSICAL EXAM SUPPLEMENTAL BENEFIT FOR SPECIAL NEEDS PLANS (SNPS)

Beginning in CY2020, SNPs may offer the Physical Exam supplemental benefit that is currently available to Non-SNP MA plans.

The physical exam supplemental benefit would provide services beyond what is required as part of the SNP's regular care coordination and disease management responsibilities.

D-SNP ADMINISTRATIVE ALIGNMENT OPPORTUNITIES

CMS is currently working with Massachusetts, Minnesota, and New Jersey to update or develop new state-specific models of integrated materials for fully integrated dual eligible SNP (FIDE SNP).

Through the Medicare-Medicaid Coordination Office, CMS provides state Medicaid agencies with technical assistance and information on plan performance and audit results of their contracted D-SNPs so that the quality of Medicare services delivered by those D-SNPs can inform state contracting strategies. CMS also provided states the opportunity to ensure that

state expectations for the delivery of managed long-term services and supports and behavioral health services are integrated into the model of care employed by the D-SNPs that deliver those benefits.

CMS is seeking comments from stakeholders on D-SNP initiatives, including the operational challenges that MA organizations or states may face in accessing these mechanisms for Medicare-Medicaid integration and any requests to clarify relevant policies in CMS guidance. In addition, CMS is seeking suggestions for additional administrative alignment initiatives the CMS could pursue either through rulemaking or through sub-regulatory guidance.

D-SNP "LOOK-ALIKES"

CMS has received a number of anecdotal reports from multiple sources across multiple states about misleading marketing and training materials for agents and brokers that misrepresent the characteristics of such look-alike plans and describe them as designed specifically for dually eligible beneficiaries. Marketing of such D-SNP look-alike plans to full benefit dually eligible beneficiaries may undermine state efforts to integrate Medicare and Medicaid benefits through their contracted D-SNPs or MMPs.

CMS reminds MA organizations that section 30.7 of the 2019 Medicare Communications and Marketing Guidelines clarifies that MA plans that are not D-SNPs may not:

> (i) imply that their plan is designed for dually eligible beneficiaries;
>
> (ii) claim that they have a relationship with the state Medicaid agency, unless the MA plan (or its parent organization) has contracted with the state to coordinate Medicaid services, and the contract is specific to that MA plan (not for a separate D-SNP or MMP); or
>
> (iii) target their marketing efforts exclusively to dually eligible beneficiaries.

CMS plans to monitor D-SNP look-alike marketing, including through in-field surveillance, and is considering additional regulatory, sub-regulatory, and compliance steps to ensure that plans' marketing to dually eligible beneficiaries is compliant with CMS rules. Plans found to be out of compliance may be subject to compliance action.

PARTS A AND B COST-SHARING FOR INDIVIDUALS ENROLLED IN THE QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

All MA providers, suppliers, and pharmacies must refrain from collecting Medicare cost-sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program.

To reinforce billing requirements, simplify compliance, and prevent improper billing, CMS has strongly encouraged organizations to affirmatively inform providers if member cost-sharing liability is zero dollars.

Prior to claims submission, MA plans can provide real-time information and indicators through automated eligibility-verification systems, online provider portals and phone query mechanisms; plans can also provide QMB status on member ID cards so that information is available when an individual presents the card at the pharmacy counter.

A new method exists for plans to notify pharmacies of a member's QMB status for Part B drugs claims at the point of sale. The National Council for Prescription Drug Plans (NCPDP) developed a new Benefit State Qualifier (BSQ) Value 51 to indicate to pharmacy providers that the individual is a QMB and cannot be liable for cost-sharing for Part B drugs.

> -The NCPDP description for BSQ value 51 is as follows: Not paid under Part D, paid under Part C benefit (for MA-PD plan). Beneficiary is a Qualified Medicare Beneficiary - pharmacy should not attempt to collect cost-share, but instead should attempt to bill COB to Medicaid coverage.

CMS encourages MA-PDs to implement BSQ value 51 for additional protection for the QMB individual and to inform pharmacy providers and assist them in proper billing for this population.

MEDICARE ADVANTAGE ORGANIZATIONS CROSSING CLAIMS OVER TO MEDICAID AGENCIES

CMS automatically forwards claims under Medicare FFS to state Medicaid agencies and other secondary payers to process for covering Medicare part A and B cost sharing. CMS requires that certain Medicaid managed care plans, including Medicaid managed care organizations and prepaid health plans, be responsible for Medicare cost sharing for dually eligible individuals enroll in Medicare's automated crossover process.

In the recently published Notice of Proposed Rulemaking (see 83 FR 57264), CMS proposed to modify the requirement so that the state's contract with a Medicaid managed care plan must ensure the plan receives Medicare crossover claims, but provides states the flexibility to determine on how to do so.

CMS is seeking comments on ways to promote MA plans automatically crossing over cost-sharing claims to state Medicaid agencies and Medicaid managed care plans for dually eligible individuals.

INTEROPERABILITY AND PRIOR AUTHORIZATION COORDINATION

In 2018, CMS began participating in the Da Vinci project, a private-sector initiative led by Health Level 7 (HL7), a standards development organization.

CMS encourages all payers, including but not limited to Medicare Advantage organizations and Part D plan sponsors, to follow CMS's example and align with the Da Vinci Project's Coverage Requirements and Documentation Rules Discovery work by: (1) developing a similar lookup service; (2) populating it with their list of items/services for which prior authorization is required; and (3) populating it with the documentation rules for, at least, oxygen and CPAP.

REQUEST FOR INFORMATION – BARRIERS FOR MA PLANS OR PROVIDERS IN USING RISK BASED ARRANGEMENTS FOR PHARMACY BENEFITS

CMS is soliciting comment on the potential use of risk based arrangements for pharmacy benefits in contracts between MA plans and contracted providers. CMS respectfully requests information on the barriers, feasibility, and benefits/drawbacks for these types of arrangements between MA plans and contracted providers.

Section III – Part D

FORMULARY SUBMISSIONS

The CY2020 formulary submission window is May 13, 2019 through June 3, 2019. A limited update window will be provided in August 2019 where drugs new to the Formulary Reference File (FRF) may be added; negative changes are allowed if replaced by an equivalent generic or therapeutically similar drug.

CMS is expecting to release the CY2020 FRF in March 2019 with an update prior to the June 3, 2019 formulary submission deadline. Newly added drugs on the May release of the CY2020 FRF will not be included in the 2020 OOPC model.

To reduce Part D sponsor burdens and CMS review efforts, CMS will now provide plans with an Excluded Drug reference file for CY2020 in a format that mirrors the FRF.

IMPROVING ACCESS TO OPIOD-REVERSAL AGENTS

In an effort to combat the opioid crisis, CMS wants to ensure appropriate access to potentially lifesavings interventions such as naloxone. To ensure access, Part D sponsors are strongly encouraged to place naloxone products on their generic tier(s) or lowest-cost sharing tiers. Benefit designs that inappropriately restrict access to naloxone products will not be approved.

Consistent with CDC Guideline recommendations, CMS encourages co-prescribing naloxone with opioid prescriptions. Part D sponsors can also consider innovative approaches, such as patient-specific pharmacy messaging to alert pharmacists or targeted education of prescribers.

ACCESS TO MEDICATION-ASSISTED TREATMENT

CMS will closely monitor formulary and benefit submissions to ensure that beneficiaries have access to medication-assisted treatment (MAT). Part D sponsors are expected to include products in preferred formulary tiers and non-brand tiers for MATs. MAT products will not be approved if PA criteria duplicates requirements set forth in the FDA Risk Evaluation and Mitigation Strategies and Drug Addiction Treatment Act of 2000.

PART D PBP MRX ENHANCEMENTS

References to the coverage gap phase of the benefit will remain unchanged in PBP and in references noted for the Part D Benefit Parameters section of the Call Letter.

MEDICATION THERAPY MANAGEMENT (MTM) ANNUAL COST THRESHOLD

The 2020 annual threshold will be finalized in the 2020 Call Letter, and will be the 2019 annual cost threshold adjusted for the annual percentage increase.

COMPREHENSIVE MEDICATION REVIEW SUMMARY STANDARDIZED FORMAT

CMS will propose revisions to the standardized Comprehensive Medication Review (CMR) summary by Part D sponsors. The revisions will be available for comment through the Paperwork Reduction Act (PRA) process before submission to Office of Management and Budget (OMB) for approval in 2020.

PART D BENEFIT PARAMETES FOR NON-DEFINED STANDARD PLANS

Benefit Parameters for CY2020 Threshold Values	CY2020 Threshold Values
Minimum Meaningful Differences (PDP Cost-Sharing OOPC)	
Enhanced Alternative Plan vs. Basic Plan	$22
Maximum Copay: Pre-ICL and Additional Cost-Sharing Reductions in the Gap	Standard Retail Cost Sharing
Preferred Generic Tier	<$20
Generic Tier	$20
Preferred Brand/Brand Tier	$47
Non-Preferred Drug Tier	$100
Non-Preferred Brand Tier	$100
Injectable Tier	$100
Select Care/Diabetic Tiers	$11
Vaccine Tier	$0

Benefit Parameters for CY2020 Threshold Values	CY2020 Threshold Values
Maximum Coinsurance: Pre-ICL (3 or more tiers)	Standard Retail Cost Sharing
Preferred Generic Tier	25%
Generic Tier	25%
Preferred Brand/Brand Tier	25%
Non-Preferred Drug Tier	50%
Non-Preferred Brand Tier	50%
Injectable Tier	33%
Select Care/Diabetic Tiers	15%
Vaccine Tier	0%
Maximum Coinsurance: Additional Cost-Sharing Reductions in the Gap for Applicable Beneficiaries (all tier designs)	Standard Retail Cost Sharing
Preferred Generic Tier	15%
Generic Tier	15%
Preferred Brand/Brand Tier	50%
Non-Preferred Drug Tier	50%
Non-Preferred Brand Tier	50%
Injectable Tier	50%
Select Care/Diabetic Tiers	50%
Vaccine Tier	0%
Minimum Specialty Tier Eligibility	
1-month supply at in-network retail pharmacy	$670

As part of the 2019 final rule, CMS eliminated the PDP enhanced alternative (EA) to EA meaningful difference requirement. Meaningful differences will still be required between basic and enhanced plans. An amount of $22 is being proposed for 2020.

BENEFIT REVIEW

As a discriminatory test, CMS will be comparing the effective copays of coinsurance values greater than 25% on non-specialty tiers against the established copay thresholds in the table above. For example, if a plan has a 30% coinsurance on a preferred brand tier, CMS will be checking that the effective copayment as listed in the PBP for that preferred brand tier is not greater than $47, as listed in the table above.

SPECIALTY TIERS

CMS is proposing to maintain the $670 threshold for specialty drugs in CY2020.

TIER COMPOSITION

As in the past, plan sponsors can select either a non-preferred brand tier or a non-preferred drug tier, but not both. Similar to CY2019, CMS is proposing non-preferred brand tier have a maximum threshold of 25% generic composition. CMS prefers coinsurance for non-preferred drug tier, ad will continue to conduct outlier tests for copays on no-preferred drug tiers.

IMPROVING ACCESS TO PART D VACCINES

CMS is encouraging plan sponsors to cover vaccines for $0 or to place vaccines on a formulary tier with low cost-sharing.

IMPROVING ACCESS TO GENERIC AND BIOSIMILAR MEDICINES

As an alternative to the tier composition policy, CMS is considering discouraging or prohibiting the placement of generics on brand formulary tiers, brand drugs on generic tiers, and the non-preferred drug tier entirely. Drug tiers would no longer include a mix of generic and brand products, but instead, generics would be on the generic tier and brands would be on the brand tier. FDA-approved therapeutically equivalent generics would automatically be placed on the generic tier.

LOW ENROLLMENT PLANS (STAND-ALONE PDPS ONLY)

The definition and treatment of low enrollment plans is unchanged. CMS is continuing to review low enrollment plans, and is proposing that if the plan is identified as a low enrollment plan for two consecutive years, CMS can exercise its authority to non-renew the plan. Low enrollment plans will be notified by April 2019 of available options.

PDP NON-RENEWAL POLICY CLARIFCATIONS

PDP sponsors who non-renew Part D contracts are prohibited from re-entering a new stand-alone PDP contract for two years. This rule is applicable at the PDP Region basis, meaning a non-renewal in a given region would result in the two-year ban, even if the sponsor is still serving other regions. The ban does not impact a sponsor's ability to expand its service area to other regions.

IMPROVING DRUG UTILIZATION REVIEW CONTROLS IN MEDICARE PART D

CMS seeks to strengthen and broaden initiatives from the 2019 initiatives with the following policies and initiatives continuing into 2020:

- The Comprehensive Addiction and Recovery Act (CARA) finalized the drug management programs sponsors may implement for beneficiaries at risk of misusing or abusing frequently abused drugs.

- Part D sponsors are expected to implement a care coordination safety edit at the time of dispensing to educate patients and subscribers about overdose risks.
- CMS released guidance available on the Improving Drug Utilization Review Controls in Part D webpage.
- Improved access to potentially lifesaving interventions and treatments.
- Reminding MA organizations that medically-approved non-opioid pain management can be offered as Part C supplemental benefits.

CMS is proposing to implement revised PQA opioid overuse measures.

Sponsors with drug management programs must review beneficiaries who meet the minimum OMS criteria and may review beneficiaries who meet supplemental OMS criteria. The criteria are defined in more detail in the Call Letter, beginning on page 189.

CMS continues to research potentiator drugs that increase an individual's risk of opioid overdose. Part D sponsors are encouraged to offer MTM services to individuals in such situations.

COORDINATION OF BENEFITS (COB) USER FEES

A COB user fee of $0.087 PMPM ($0.1166 per month for 9 months) will be collected in 2019 and should be accounted for when developing 2019 bids.

PART D MAIL ORDER AUTO-SHIP MODIFICATIONS

For 2020 CMS is proposing to allow interested Part D sponsors to offer an opt-in voluntary auto-ship program for refills of established therapies. This replaces the current affirmative prior consent step required for sending refills. The proposed rule would require minimum communications ahead of any shipments to provide sufficient time for the beneficiary to make any modifications. Confirmation or consent from the pharmacies is expected to be gathered annually. Sponsors offering a plan would be expected to provide a full refund to any refills the beneficiary reports as unwanted.

Section IV – Medicare-Medicaid Plans

Additional guidance will be forthcoming regarding applicability of Call Letter provisions to Medicare-Medicaid Plans (MMPs). The annual submission timelines for formularies, MTM programs, and PBPs are aligned with the standard MA and Part D schedule. Additionally, MMPs must submit:

- Provider and pharmacy adequacy information (due third Tuesday in September)
- The Additional Demonstration Drug containing non-Part D drugs (due June 7, 2019)

Similar to other MA/PD plans, MMPs must submit:

- PBPs that accurately describe the coverage and cost-sharing for all Medicare, Medicaid, and demonstration-specific benefits
- Service area verification
- Plan crosswalks
- Formulary crosswalks

Note that MMPs have some flexibility with respect to subsequent PBP revisions, including changes during rebate reallocation and rate related PBP corrections in September. Other corrections may be considered plan error and subject to compliance action.

Appendix A - Wakely Estimated Impact of Growth Rates

CHANGE IN BENCHMARK RATES

Wakely estimates that, on a nationwide average basis, and as compared with 2019, nationwide average 2020 Part C benchmarks will:

- Increase by 4.55 % on a standardized (i.e. 1.00) risk score basis.
- Increase by 1.45% on a risk-adjusted basis.

The Wakely estimate of 1.45% is comparable to the CMS estimate of 1.59%, which is before the adjustment for changes due to VA and DoD factors, star rating and double bonus status, applicable percentage and benchmark cap. The Wakely estimate also does not include any changes for risk model revision, and encounter data transition.

The Wakely risk-adjusted estimate is based on the following components:

- Change in 1.00 benchmarks
- Impact of change in fee-for-service normalization factor
- Assumption of no trend in raw risk scores

Table A1 shows our estimates of the components that make up this change:

Table A1	
Change in Blended	
Risk-Adjusted Benchmarks [1]	
2018 to 2019	
Growth Rate	4.51%
Applicable %	0.14%
Star Rating/Quality Bonus	-0.22%
Benchmark Cap	0.12%
Total Benchmark Change	**4.55%**
FFS Normalization	-2.96%
MA Coding Pattern	0.00%
Total Risk Score Change	**-2.96%**
TOTAL	**1.45%**
[1] Based on January 2019 MA enrollment and Fall 2018 Star Ratings	

Below is a brief definition of each of the elements in Table A1.

Growth Rate. This is the impact of the FFS (+4.52%) growth rate. Please note there are still a handful of counties impacted by the IME phase out which produces an effective growth rate less than 4.52%.

Applicable %. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county.

Star Rating/Quality Bonus. Difference in quality bonus impact on benchmarks between 2019 and 2020. This can be due to star rating improvements for MA plans from 2019 to 2020 as well as changing enrollment mix by MA plan.

Benchmark Cap. The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend.

Part C Fee-for-Service (FFS) Normalization Factor. The 2019 Part C FFS normalization factor was a 75%/25% blend of the 2017 RAPS CMS-HCC model (1.041) and the CMS Payment Condition Count model (1.038). For 2020, the FFS normalization factor is proposed to be a 50%/50% blend of the 2017 RAPS CMS-HCC model (1.075) and the CMS Payment Condition Count model (1.069). Calculating the change between the blended 2019 factor and the proposed blended 2020 factor, the impact is (1/1.0403)/(1/1.0720) - 1 = -2.96%

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2020 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2019.

CHANGE IN BID AND REBATE AMOUNTS

In order to properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the change in risk-adjusted benchmarks to be +1.45%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is +1.41%. This estimate is based on the following assumptions:

- Plans bid at 90% of the benchmark in 2020
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 64.4% in 2019 and 64.0% for 2020.
- No consideration for sequestration or insurer fee

Table A2 shows the calculations underlying our estimates.

Table A2			
Item	**2019**	**2020**	**2020/2019**
1.0 MA Benchmark [1]	$924.43	$966.47	4.55%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
FFS Normalization	1.0403	1.0720	-2.96%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.9046	0.8778	-2.96%
Risk-Adjusted Benchmark	$836.23	$848.36	1.45%
Assumed Risk-Adjusted Bid [3]	**$752.61**	**$763.53**	1.45%
Savings (Benchmark less bid)	$83.62	$84.84	1.45%
Rebate (64.4% for 2019, 64.0% for 2020)	**$53.85**	**$54.33**	0.89%
Risk-Adjusted Bid + Rebate	**$806.46**	**$817.86**	**1.41%**
[1] Based on nationwide average MA enrollment by county as of January 2019			
[2] Assumed no trend in risk scores			
[3] Bid set at 90% of risk-adjusted benchmark			

As in past years, CMS did not release county-specific benchmarks that reflect re-basing. The re-basing that CMS intends to perform prior to the Final Rate Announcement may result in dramatically difference changes in FFS benchmarks by county.