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Summary of 2019 Final Rate Notice & Call Letter

Medicare Advantage

April 6, 2018

Wakely Consulting Group, LLC

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CMS released the 2019 Final Rate Notice and Call Letter on April 2, 2018. This summary provides a high level description of the information included in the Notice. It contains the material Wakely views as important and should not be viewed as an all-inclusive summary. It has been written for those who are familiar with MA/PD programs and methods and condensed in order to keep it brief. The document in its entirety can be found at the following location:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

It should be noted that there are still several outstanding proposed policy, guidance and instructions changes that will be released before the June 4, 2018 bid submission deadline. The 2019 Final Policy and Technical Changes Rule was released April 2, 2018 and we expect that the final BPT instructions will be released on Friday, April 6, 2018.

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Executive Summary

The CMS 2019 Final Announcement and Call Letter (the Notice) was released April 2, 2018.

CMS largely maintained the recommendations in the Advance Notice; however, there were several notable changes.

The most significant change from the February 1, 2018 Advance Notice is that the CY2019 fee-for-service (FFS) growth rate is 5.11%, an increase of more than 100 basis points above the 4.08% initial estimate. Similar to recent years, rebased benchmark rates were released with the Final Announcement with varying results by county. Nationwide, Wakely projects the average impact of rebasing to be -0.1% for individual MA plans, which is lower than the +0.49% increase projected by CMS.

Both the HCC and RxHCC model implementations were altered from that proposed in the Advance Notice.

The Notice incorporated the acceleration of the brand drug coverage gap closure as mandated by the Bipartisan Budget Act (BBA) of 2018. The BBA increased the mandated drug manufacturer coverage gap discount, which will mean significantly lower plan liability for brand name drugs in the coverage gap in 2019.

Following is a brief summary of the key changes and proposals in the 2019 Notice:

Part C Payment Methodology

- Non-ESRD FFS growth rate percentage for CY2019 is 5.11%.

Risk Scores

- CMS chose to use a new EDS-driven HCC model that does not reflect a count of conditions, but does continue to append EDS diagnoses with RAPS diagnoses from inpatient services. The blend of RAPS and EDS models is 75% 2017 HCC/ 25% Updated HCC no count model.

- Two separate FFS Normalization factors will be used in 2019 for the RAPS and EDS models. The normalization factors will be 1.041 and 1.038, which relate to the 2017 HCC model and the Updated HCC model, respectively.

- The RxHCC model will not be changed, so the 2018 RxHCC will continue to be used for 2019. The RxHCC FFS normalization factor is proposed to be 1.019,

which will drive a 1.4% decrease in Part D risk scores from 2018 to 2019, assuming no coding trend.

- The coding pattern adjustment was kept at the statutory minimum of 5.90%.

EGWPs

- Plans will not need to file EGWP bid pricing tools (BPTs) for 2019, as was the case in 2018.

- 2019 EGWP Payments will be fully transitioned to be based only on bid-to-benchmark ratios from individual bids. In addition, the bid-to-benchmark ratios are calculated separately for individual HMO and PPO plans, and then blended into a single ratio for each quartile based on the EGWP distribution of HMO and PPO enrollment.

Special Needs Plans

- The Notice noted that the BBA permanently reauthorized SNPs. The BBA also mandated the integration of dual eligible beneficiaries into SNPs; although further guidance will be needed.

Benefit Changes

- Per the April 2, 2018 Final Rule, MA plans have the option to vary benefits (e.g. reduce cost sharing) for beneficiaries that meet certain medical criteria. The Notice only indicated that further guidance on implementation of this rule would be published prior to CY2019 submissions.

- Beginning in CY2019, D-SNPs and I-SNPs may offer the EDM supplemental benefit that is currently available to Non-SNP MA plans.

- The maximum allowed copay for emergency room services was held at $120/$90 for voluntary/mandatory MOOP, respectively. The 2018 maximum was $100/$80.

- Part D parameters were updated to be consistent with the BBA. The BBA accelerated the closure of beneficiary cost sharing in the gap by one year, and increased the coverage gap discount obligation of drug manufacturers. Brand drug coinsurance in the gap will be 70%/25%/5% drug manufacturer/beneficiary/plan for 2019.

Meaningful Difference and TBC Thresholds

- The Final Rule waives the meaningful difference thresholds for MA-PD plans and between enhanced alternative Part D offerings for CY2019. The Notice only indicated that further guidance on implementation of this rule would be published prior to CY2019 submissions. The threshold for meaningful difference between defined standard and enhanced alternative Part D offerings will be $22 for CY2019, as proposed in the Advance Notice.

- TBC requirements are the same as 2018, but the threshold has increased to $36.00 from $34.00. This is the same as proposed in the Advance Notice.

Star Rating Changes

- CMS upheld the key provisions modifying the calculation of 2019 and 2020 Star Ratings for the impacts of Hurricanes Harvey, Irma, and Maria, and the California wildfires that occurred in the 2017 performance period.

- The quality bonus payment (QBP) for cross-walked contracts will continue to be based on the star rating of the surviving contract. The Final Rule has established that cross-walked contracts in 2020 and beyond will 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.

MACRA

- For 2019, CMS is implementing an additional way for clinicians to become qualifying APM participants (QPs) that considers not only Advanced APM participation but also other innovative payment arrangements through Medicaid, MA, and commercial payers – called an “All Payer Combination Option.”

Part D Medication Therapy Management Model

- Plans can earn a fixed $2.00 PMPM incentive payment under the MTM model by achieving a 2% reduction in Medicare costs of care along with successful data and quality reporting. In the Final Notice, CMS determined that it will not be in a position to consider these premium reductions when determining 2019 low income premium subsidy amounts.

Overall MA Payment Impact

Wakely estimates that, on average, 2019 Part C standardized benchmarks will increase 5.50% over 2018 nationwide. This reflects the impact of the growth rate, change in star ratings, changes to applicable percentages (i.e. quartile rankings), and the impact of county rebasing. We also estimate that the change in CMS revenue for 2019 versus 2018 is expected to be +3.42%. This takes into account changes in Part C risk scores, including the FFS normalization factor and the MA Coding Pattern adjustment.

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, an increase in the benchmark will impact plans differently based on the disparity of the plan's bid compared with 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 March 2018 CMS published MA enrollment and star ratings for payment year 2019.

Details regarding our calculations and assumptions are provided 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: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2019 MA Growth Percentage (also known as NPCMAGP)

The MA growth rate was announced as +5.93% (Advance Notice growth rate was +5.44%).

FFS Growth Percentage

The Fee-for-service growth rate was announced as +5.11% (Advance Notice growth rate was +4.08%).

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2018 to 2019 will be +5.50% and the nationwide average change in the blended risk-adjusted benchmark will be +3.42%. 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.

States with Highest and Lowest Benchmark Change		
Rank	**State**	**Change**
1	LA	9.00%
2	NM	7.62%
3	MA	7.49%
4	OK	7.30%
5	NH	7.27%
47	MD	4.39%
48	ID	3.87%
49	IN	3.68%
50	NV	3.37%
51	AZ	3.05%

Attachment II and III: Key Assumptions, Financial Information and Responses to Public Comments

Section A. Final Estimate of the National Per Capita Growth Percentage and the Fee-for-Service (FFS) Growth Percentage for Calendar Year 2019

The MA growth rate for 2019 is +5.93% and the FFS growth rate was announced as +5.11%. The calculation methodology is similar to past years.

Section B. MA Benchmark, Quality Bonus Payments and Rebate

There are no changes to the methodology for calculating these amounts for 2019.

Section C. Calculation of Fee for Service Cost

The methodology for calculation of Fee for Service Cost is similar to last year's methodology, as follows:

2019 FFS County Cost = [(National FFS Cost) or (US Per Capita Cost)] x [County-level Geo Index, aka AGA].

The AGA basis is being updated to include a five year average of FFS costs from 2012 to 2016, an update of one year from last year's five-year period spanning 2011 to 2015.

CMS released the county-level 2016 FFS cost data used to develop 2019 rates with the Advance Notice:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html

As part of the Final Notice, CMS is releasing other elements of the AGA calculation, such as county-level wage indices and other adjustments applied to the FFS cost.

As in past years, CMS will adjust Puerto Rico's FFS experience to reflect nationwide prevalence of zero-dollar beneficiaries, rather than Puerto Rico's own high proportion of zero-dollar beneficiaries. This resulted in an approximate increase of 4.5% to Puerto Rico's FFS costs for 2012 to 2016.

The VA and DoD adjustments will be applied concurrently for 2019. CMS intended to apply these adjustments concurrently in 2018, but this didn't happen due to time constraints. CMS published the county-level VA/DoD adjustments with the Advance Notice.

Many commenters advocated that CMS calculate FFS spending using beneficiaries enrolled in both Parts A and B (instead of the current practice that includes beneficiaries enrolled in *either* Part A *or* Part B). This would be similar to CMS's approach for Puerto Rico FFS beneficiaries, who unlike beneficiaries on the mainland, must opt in to Part B coverage. CMS will not make a change to their methodology for 2019 bids, but has indicated that this change will be considered in future years.

Section D. IME Phase Out

IME is continuing to be phased out from MA capitation rates. For 2019, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2019 is 6.0% of the FFS rate. Only seven counties (two in Minnesota, one in Massachusetts, one in Puerto Rico and three in New York – three of New York City's five counties) hit the 6% maximum.

Section E. ESRD Rates

CMS will calculate ESRD benchmarks similarly to prior years. However, CMS has made a few enhancements to their methodology.

- CMS will reprice historical inpatient, outpatient and SNF claims for 2012 to 2016 to reflect the most recent wage indices, and reprice physician claims with the most recent Geographic Practice Cost Indices.

- CMS will reprice ESRD PPS dialysis claims for 2014 to 2016 (2014 is the first year the dialysis PPS was fully phased in).

- An adjustment is applied to FY2012 and FY2013 inpatient claims to replace 75% of the Disproportionate Share Hospital (DSH) payments with the Uncompensated Care Payments (UCP C).

Section F. MA Employer Group Waiver Plans

For 2019, CMS will continue to waive bid pricing tool filing requirements. CMS will fully transition bid to benchmark ratios (B2B) to be calculated only on individual plans as the basis for 2019 EGWP payment rates. However, the individual B2B ratios will be adjusted to account for the difference in enrollment by plan type between EGWPs and individual market MA plans. EGWP payment rates in 2018 reflected a 50-50 blend of individual market and EGWP B2B ratios.

See table below for the B2B ratios used to derive 2019 payment rates.

2018 Bid-to-Benchmark Ratios
Applied in Calculating 2019 MA EGWP Payment Rates

Applicable Percentage	Ratio
0.950	86.1%
1.000	88.7%
1.075	88.5%
1.150	88.5%

Section G. Medicare Advantage Coding Pattern Adjustment.

The coding pattern adjustment for CY2019 has been finalized at the statutory minimum of 5.90%. CMS stated they will continue to consider alternative methodologies for calculating the factor for future years, when the statutory minimum will continue to be 5.9%. The 2019 coding pattern adjustment represents virtually no change from the 2018 factor of 5.91%.

Section H. CMS-HCC Risk Adjustment Model for CY2019

The 2019 CMS-HCC model will reflect a 75%/25% blend of the existing 2017 CMS-HCC Model based on RAPS diagnoses and an updated HCC model using EDS diagnoses appended by RAPS diagnoses derived from inpatient services.

The updated HCC model is being implemented as a response to requirements established in the 21st Century Cures Act. It adds four new HCCs for mental health, substance use disorder, and chronic kidney disease conditions.

CMS elected not to add a "Payment Condition Count" variable to the updated model, as was proposed in the Advance Notice. CMS has indicated that they intend to begin implementing the previously proposed Payment Condition Count model for payment year 2020.

Section I. ESRD Risk Adjustment Model for CY2019

- CMS has used the same ESRD risk adjustment model since 2012, but will implement a recalibrated model for 2019.
- The two key model updates are (1) update data years underlying the model and (2) update Medicaid factors to be concurrent.

- The 21st Century Cures Act allows all Medicare beneficiaries with ESRD to enroll in MA plans starting in 2021, so CMS is expecting an increase in MA ESRD enrollment. 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.

- As has been the case since 2005, separate coefficients will be maintained for dialysis, transplant, and post-graft beneficiaries.

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.

The published frailty factors for 2019 are calculated based on the CMS-HCC model without count variables.

The table below shows the final recalibrated FIDE SNP Frailty Factors for CY2019.

ADL	Non-Medicaid	Medicaid
0	-0.077	-0.138
1-2	0.160	0.019
3-4	0.302	0.146
5-6	0.302	0.367

Section K. Normalization factors

Consistent with the risk model changes above, CMS has finalized the following normalization factors for payment year 2019:

Model	2018 Payment Year	2019 Payment Year	Year-to-Year Impact
CMS-HCC Model used for 2017/2018	1.017	1.041	-2.3%
CMS-HCC model without count variable for 2019	NA	1.038	NA
Blended	1.017	1.040	-2.2%
PACE	1.082	1.159	-6.6%
ESRD Dialysis	1.015	1.033	-1.7%
ESRD Functioning Graft	1.082	1.048	3.2%
RxHCC	1.005	1.019	-1.4%

Section L. Encounter Data as a Diagnosis Source for 2019

CMS is finalizing the following EDS/RAPS mix:

- 25% EDS (supplemented with RAPS inpatient data) and FFS
- 75% RAPS and FFS

Section M. Quality Payment Program

The Quality Payment Program was enacted by MACRA with the goal of promoting greater value in Part B payments to Medicare clinicians. Physicians choose from two reimbursement paths:

1. Merit-Based Incentive System (MIPS), or
2. Advanced Alternative Payment Models (Advanced APMs)

Advanced APMs meet certain criteria including use of certified EHR technology, pay based on MIPS-comparable quality measures, and taking downside financial risk (or qualifying under Medical Home Model).

Clinicians can become APM qualifying participants (QPs) by meeting threshold levels (total Part B payments or patient counts) of participation in Advanced APMs. QPs may earn a lump sum 5% APM incentive payment and are excluded from MIPS reporting requirement.

As proposed in the 2019 Advance Notice, CMS is implementing an additional way for clinicians to become QPs that considers not only Advanced APM participation but also other innovative payment arrangements through Medicaid, MA, and commercial payers – called an "All Payer Combination Option." This effectively gives clinicians credit (on Medicare payments) for participation in Advanced APMs on other lines of business.

Payers and clinicians may voluntarily submit information on payment arrangements they believe qualify as Other Payer Advanced APMs. CMS will collect data and announce which payment arrangements qualify in advance of 2019.

As part of 2019 bid submission, MAOs may submit applications to determine if payment arrangements quality as Other Payer Advanced APMs.

Attachment IV – Responses to Public Comments on Part D Payment Policy

Section A. Update of the RxHCC Model

Based on the amount of time required to update the RxHCC model to include the changes described in the Bipartisan Budget Act, CMS will not be implementing the updated 2019 RxHCC model discussed in the 2019 Rate Announcement. Instead, for PY2019, CMS will continue to utilize the 2018 RxHCC model.

Section B. Encounter Data as a Diagnosis Source for 2019

Consistent with CY2018, CMS proposes calculation of the 2019 risk score based on diagnoses with CY2018 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), supplemented with RAPS inpatient data, and FFS data

The final risk score will be a blend of the above two risk scores with 75% weight on the first and 25% on the second. For PACE, CMS proposes to continue the same method for CY2019 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 2019.

Section D. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2019

Part D Defined Standard benefit changes:

- $415 deductible ($405 in 2018)
- $3,820 ICL ($3,750 in 2018)
- $5,100 TrOOP ($5,000 in 2018)
- $1.25/$3.80 copays for full subsidy full benefit duals ($1.25/$3.70in 2018)

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

Part D Benefit Parameters	2018	2019
Standard Benefit		
Deductible	$405	$415
Initial Coverage Limit	$3,750	$3,820
Out-of-Pocket Threshold	$5,000	$5,100
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries	$7,508.75	$7,653.75
Estimated Total Covered Part D Spending for Applicable Beneficiaries	$8,417.60	$8,139.54
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$3.35	$3.40
Other	$8.35	$8.50
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	$1.25
Other	$3.70	$3.80
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	$3.35	$3.40
Other	$8.35	$8.50
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI, income at or below 135% FPL and resources ≤ $9,060 (individuals 2018) or ≤ $14,340 (couples 2018) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.35	$3.50
Other	$8.35	$8.50
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $14,100 (individual, 2018) or $ 28,150 (couples, 2018) [category code 4]		
Deductible	$83.00	$85.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$3.35	$3.40
Other	$8.25	$8.50
Retiree Drug Subsidy Amounts		
Cost Threshold	$405.00	$415.00
Cost Limit	$8,350.00	$8,500.00

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

Non-LIS coinsurances in the coverage gap for 2019 will be as follows:

Drug Type	Beneficiary Coinsurance	Plan Liability	Manufacturer Discount
Applicable Drugs	25%	5%	70%
Non-Applicable Drugs	37%	63%	0%

This change was the result of the 2018 Bipartisan Budget Act, and represents a departure from the original schedule and provisions in the Affordable Care Act.

The coverage gap will be fully closed in 2020; therefore, Non-LIS cost sharing will be as follows for future years:

Drug Type	Beneficiary Coinsurance	Plan Liability	Manufacturer Discount
Applicable Drugs	25%	5%	70%
Non-Applicable Drugs	25%	75%	0%

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

Consistent with the gap cost sharing reductions discussed above, member liability is 37%/25% (generic/brand) and plan liability is 63%/75% (generic/brand) for dispensing fees and vaccine administration fees 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 2019, 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 CY2016 EGWPs. This amount is $36.10 PMPM (versus $32.00 PMPM in 2018).

Consistent with 2018 and prior years, non-calendar year EGWPs are excluded from the Part D federal reinsurance program.

Section H. Enhanced Medication Therapy Management (MTM) Model

CMS will be offering an Enhanced Medication Therapy Management (MTM) Model for PY2019. Plans can earn a fixed $2.00 PMPM incentive payment by achieving a 2% reduction in Medicare costs of care and successful data and quality reporting. The $2.00 PMPM amount is consistent with the level of recent LIS benchmark de minimis amounts. Plans will receive this payment through an increase to the direct subsidy; therefore, the plan will still be receiving the total payment specified in its bid (not an additional add-on payment). However, the government portion revenue would increase, while the beneficiary portion would decrease (offsetting).

In the Final Notice, CMS indicated that the premium reductions will not be considered when determining the 2019 low income premium subsidy amounts.

Attachment V – Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Attachment V contains detailed calculations of the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop the 2019 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 2017 to July 2018 divided by the per capita Part D costs from August 2016 to July 2017. Since PDE data are not yet available for 2018, the per capita costs for this time period are estimated using August 2017 to December 2017 PDE data. This calculation results in an estimated 3.96% 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 -1.95%, primarily driven by an update to last year's API. This results in a total 2019 API of 1.94%.

The CPI increase is based on the projected September 2018 CPI divided by actual September 2017 CPI, which results in an estimated increase of 1.95%. This increase is further adjusted based on revisions to prior years' estimates. The cumulative adjustment for prior year revisions is -0.17%. In total, this produces a 2019 CPI increase of 1.78%.

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 2019, the retiree subsidy cost threshold is $415 ($405 in 2018) and the cost limit is $8,500 ($8,350 in 2018).

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 $8,139.54 ($8,417.60 for 2018). 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 Rate Announcement.

Attachment VI. CMS-HCC and ESRD Risk Adjustment Factors

Attachment VI includes the final risk adjustment factors for the CMS-HCC and ESRD risk models. Please see the Notice for details.

Attachment VII. CY2019 Final Call Letter

Section I – Parts C and D

ANNUAL CALENDAR: KEY UPCOMING DATES

The following bullet points contain major/key items for 2019 bid submission. The full detailed list can be found on pages 114-121 of the Announcement.

- February 14, 2018: Initial and Service Area Expansion Application due to HPMS by 8:00PM EST.
- Mid-late March 2018: Release of CY2019 Formulary Reference File (FRF).
- Early April 2018: CY2019 OOPC Model and OOPC estimates for each plan made available.
- April 2, 2018: 2019 Final Announcement of MA Capitation Rates and MA/Part D Payment Policies released along with Final Call Letter.
- April 6, 2018: Release of the 2019 Plan Creation Module, PBP, and BPT software in HPMS.
- April 10, 2018: Deadline for MAOs to submit requests for full contract consolidations for CY 2019.
- Mid-April 2018: Release of HPMS Memo: Contract Year 2019 MA Bid Review and Operations Guidance.
- Late April 2018: TBC data for CY2019 released.
- May 2018: Final ANOC/EOC, LIS rider, formularies, provider directory and other items for CY2019 available.
- Early May 2018: 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, 2018: Release of the 2019 Bid Upload Functionality in HPMS.
- May 14, 2018: Release of 2019 Formulary Submission Module in HPMS.
- May 18, 2018: Release of 2019 Actuarial Certification Module in HPMS.
- June 4, 2018:

  Deadline for submission of CY2019 bids for all MA/MAPD/PDP plans.

  Deadline for submission of CY2019 Formularies.

  Deadline for submission of a CY2019 contract non-renewal, service area reduction notice to CMS from MA/MAPD/PDP plans.

- Late July/Early August 2018: CMS releases the 2019 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 2018: Rebate reallocation period begins after release of the above bid amounts.
- Late August/Early September 2018: Plan preview period of Star Ratings in HPMS.
- October 1, 2018: Tentative date for 2019 plan and drug benefit data to be displayed on Medicare Plan Finder on Medicare.gov.
- October 11, 2018: Star Ratings go live on medicare.gov.
- October 15, 2018: 2019 Annual Election Period (AEP) begins.
- December 7, 2018: End of AEP.

ENHANCEMENTS TO THE 2019 STAR RATINGS AND FUTURE MEASUREMENT CONCEPTS

Unless noted below, CMS does not anticipate methodology changing from the 2018 Star Ratings. For reference, a list of measures and methodology included in the 2018 Star Ratings is described in the Technical Notes:

https://go.cms.gov/partcanddstarratings

New Measures for 2019 Star Ratings

Statin Use in Persons with Diabetes (SUPD) (Part D) – CMS will add this SUPD measure to the 2019 Star Ratings (based on 2017 data) with a weight of 1 for the first year and with a weight of 3 in subsequent years.

Statin Therapy for Patients with Cardiovascular Disease (Part C) – CMS will include this measure in the 2019 Star Ratings as a process measure with a weight of 1.

Changes to Measures for 2019

Improvement Measures (Part C & D) – A detailed list of the measures used to calculate 2019 improvement measures is included on pages 123-125.

Changes are being made to the following measures:

- Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications (Part D)
- Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D)
- MPF Price Accuracy (Part D)
- Members Choosing to Leave the Plan (Parts C & D)
- Reducing the Risk of Falling (Part C) – CMS proposed removing the measure from the 2019 and 2020 Star Ratings, but after reviewing comments this measure will be maintained in the 2019 and 2020 Star Ratings.

Removal of Measures from Star Ratings

The following measure is being removed: *Beneficiary Access and Performance Problems (BAPP) (Part C & D)*

Scaled Reductions for Appeals IRE Data Completeness Issues

CMS is finalizing its proposal for statistical criteria to reduce a contract's Star Rating for data that are not complete or lack integrity using TMP data or audit. They recognize that there are varying degrees of data issues and as such, have developed a methodology for reductions that

reflects the degree of the data accuracy issue for a contract instead of a one-size-fits-all approach. Details can be found on pages 130-133.

2019 Star Ratings Program and the Categorical Adjustment Index

For the 2019 Star Ratings Program, CMS is proposing to continue the use of the interim analytical adjustment to address within-contract disparity in performance based on the plan's percentage of low income subsidy, dual eligible, and disabled status, the Categorical Adjustment Index (CAI). The overall methodology will remain unchanged for 2019. The 2019 CAI values are determined using data from the 2018 Star Ratings. For MA (MA-only, MA-PD) and 1876 contracts, the Part C measures selected for adjustment for the 2019 Star Ratings include: Annual Flu Vaccine, Breast Cancer Screening, Diabetes Care – Blood Sugar Controlled, Medication Reconciliation Post-Discharge, Osteoporosis Management in Women who had a Fracture, Reducing the Risk of Falling, and Plan All-Cause Readmissions. For MA-PDs and PDPs, the two Part D measures selected for adjustment for the 2019 Star Ratings include: Part D Medication Adherence for Hypertension and MTM Program Completion Rate for CMR.

2019 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 3 – 14 in the 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.

Additional Adjustment to Address Lack of an LIS Indicator for Enrollees in Puerto Rico

CMS applies an additional adjustment factor to contracts only in Puerto Rico to reflect that Puerto Rican beneficiaries are not eligible for LIS. In addition, Star Ratings weights for adherence to medication have been adjusted to reflect the challenge posed by the lack of LIS status.

Disaster Implications

CMS is adjusting the calculation of 2019 and 2020 Star Ratings due to the impacts of Hurricanes Harvey, Irma, and Maria, and the California wildfires that occurred in the 2017 performance period.

Identification of Affected Contracts

In the Final Notice, CMS defines how to identify the affected contracts that will be included in the Star Rating adjustments due to natural disasters.

CAHPS Adjustments

The 2018 CAHPS survey will be optional for Puerto Rico plans and any other plans with an approved exception due to the 2017 natural disasters. Affected contracts with at least 25% of beneficiaries in the affected areas will also have the higher of the 2018 or adjusted 2019 Star Rating for each CAHPS measure.

HOS Adjustments

The HOS survey will be adjusted similar to the CAHPS survey, with the impact being made to the 2020 Star Ratings due to the lagged data collection.

HEDIS Adjustments

Puerto Rico only plans, or any plan with an exception from CMS, will be able to answer “NA” for HEDIS reporting that covers 2019 Star Ratings. Affected contracts with at least 25% of beneficiaries in the affected areas will also have the higher of the 2018 or adjusted 2019 Star Rating for each HEDIS measure.

Other Star Ratings Measure Adjustments

For all other measures, 25% of beneficiaries in an affected area will trigger CMS taking the higher of the 2018 or 2019 measure Star Rating. Certain measures are excluded; please see the Final Notice for full details. Based on comments following the Advance Notice, appeals data will no longer be excluded and new Star Ratings measures will also be adjusted to not harm plans.

Cut Points for Non-CAHPS Measures

CMS will exclude affected contracts with 60% or more enrollees in disaster areas from the clustering algorithm for defining cut points and from the determination of the performance summary and variance thresholds for the Reward factor. The cut points derived from other plans data will still apply to affected contracts.

2019 CMS Display Measures

New 2019 Display measure:

- Plan Makes Timely Decisions About Appeals (Part C)

Existing Display Measures that will change:

- Hospitalizations for Potentially Preventable Complications (Part C)
- High Risk Medication (Part D)
- Drug-Drug Interactions (DDI) (Part D)
- Antipsychotic Use in Persons with Dementia (APD) (Part D)
- Use of Opioids from Multiple Providers and/or at a High Dosage in Persons without Cancer (Part D)
    - Measure 1: Use of Opioids at High Dosage in Persons without Cancer (OHD)
    - Measure 2: Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
    - Measure 3: Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP)
- Transition Monitoring (Part D)
- Formulary Administration Analysis measure (Part D)
- Timely Effectuation of Appeals (Part D)

Display measures being retired:

- Enrollment Timeliness (Part C and D)
- Appropriate Monitoring of Patients Taking Long-term Medications and Asthma Medication Ratio (Part C)

Forecasting to 2020 and Beyond

Existing measures where there may be changes

- Controlling High Blood Pressure (Part C)
- Plan All-Cause Readmissions (Part C)
- Initiation and Engagement in AOD Treatment (Part C)
- Telehealth and Remote Access Technologies (Part C)
- Cross-Cutting Exclusions for Advanced Illnesses (Part C)
- Medication Adherence (ADH) for Cholesterol (Statins) (Part D)
- Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D)
- MPF Price Accuracy (Part D)
- Center for Medicare and Medicaid Innovation Model Tests

Potential new measures for 2020 and beyond

- Transitions of Care (Part C)
- Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C)
- Care Coordination Measures (Part C)
- Opioid Overuse (Part C)
- Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C)
- Depression Screening and Follow-Up for Adolescents and Adults (Part C)
- Unhealthy Alcohol Use Screening and Follow-Up (Part C)
- Readmissions from Post-Acute Care (Part C)
- Adult Immunization Measures (Part C)
- Anxiety (Part C)
- Polypharmacy Measures (Part D)

- Polypharmacy: Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)
- Polypharmacy: Use of Multiple Central Nervous Systems (CNS)-Active Medications in Older Adults (Poly-CNS)
- Concurrent Use of Opioids and Benzodiazepines

- Additional PQA Medication Adherence Measures (Part D)
  - Adherence to Non-Warfarin Oral Anticoagulants (ADH-NWOA)
  - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (ADH-MS)

INCOMPLETE AND INACCURATE BID SUBMISSIONS

Incomplete Submissions

CMS requires the following components—where applicable—for a bid to be considered complete and to be accepted at the bid deadline:

- PBP and BPT
- Service Area Verification
- Plan Crosswalk (if applicable)
- Cost Sharing Justification (if applicable)
- Formulary Submission and Crosswalk (for plans offering PD coverage with a formulary)
- Substantiation (supporting docs)

Inaccurate Submissions

CMS will only approve a Part C or Part D bid if the bid complies with all prescribed requirements, with sanctions possible for bids with inaccurate information or that fail to meet established thresholds.

Plan Corrections

The plan correction window to change the PBP to match the BPT will be open from early September to late September 2018.

Validation Audits

CMS requires sponsoring organizations who have been audited and found to have deficiencies to undergo a validation audit to ensure correction.

CMS has finalized the following changes to the audit process based on feedback from the Advance Notice and a July 2017 listening session.

Threshold for Requiring an Independent Validation Audit

CMS will exclude Compliance Program Effectiveness (CPE) conditions when calculating if a sponsoring organization will be required to hire independent validation auditors as a result of 2019 program audits.

Conflict of Interest Limitations on Independent Auditing Firms

Sponsoring organizations are allowed to select the same independent auditing firm that is used for their annual external CPE audit for an independent validation audit, as long as the firm has not provided assistance with the correction of audit findings.

Required use of CMS Validation Audit Work Plan Template

CMS is creating a draft validation work plan template that will be included in the upcoming Federal Register proposed information collection.

Timeframe to Complete Validation Audits

Sponsoring organizations will have 180 days from the date that CMS accepts their program audit Corrective Action Plan to undergo a validation audit and submit the independent audit report to CMS for review, up from the previous requirement of 150 days.

Submitting Independent Audit Report to CMS

Sponsoring organizations must copy the independent auditor on the submission of the independent auditing firm's validation report to CMS.

PLAN FINDER CIVIL MONEY PENALTY (CMP) ICON OR OTHER TYPE OF NOTICE

CMS will not display an icon or other notice on Plan Finder regarding an organization receiving a CMP based on feedback from the Advance Notice.

ENFORCEMENT ACTIONS FOR PROVIDER DIRECTORIES

Civil Money Penalties (CMPs) and other enforcement actions may be imposed against MAOs that have received a compliance notice or notices for violations that have gone uncorrected. Also, CMS has the discretion to take enforcement actions when egregious instances of non-compliance are discovered.

AUDIT OF THE SPONSORING ORGANIZATION'S COMPLIANCE PROGRAM EFFECTIVENESS

Sponsoring organizations are no longer required to conduct an internal compliance program effectiveness (CPE) audit in the calendar year following a CMS program audit being initiated.

INNOVATIONS IN HEALTH PLAN DESIGN

CMS is continuing to conduct model tests on the Medicare Advantage Value-Based Insurance Design (MA-VBID) and the Part D Enhanced Medication Therapy Management (MTM) models.

Medicare Advantage Value-Based Insurance Design Model Test

The MA-VBID model is an opportunity for MAO's to offer supplemental benefits or reduced cost sharing to enrollees with CMS approved chronic conditions, focused on the services that are of highest clinical value to them. The model will be revised to be consistent with the Bipartisan Budget Act of 2018.

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.

NEW MEDICARE CARD PROJECT (FORMERLY THE SOCIAL SECURITY NUMBER REMOVAL INITIATIVE, SSNRI)

Beginning in April 2018, the current Social Security Number based HICN has been replaced with a new Medicare number, the Medicare Beneficiary Identifier (MBI). A transition period will

take place from April 1, 2018 through December 31, 2019 where Medicare plans can use HICN or MBI to exchange data with CMS.

Section II – Part C

SPECIAL NEEDS PLANS (SNP) PERMANANTLY REAUTHORIZED

On February 9, 2018 via the Bipartisan Budget Act of 2018, Congress permanently reauthorized SNPs.

EXPANDING USE OF ELECTRONIC HEALTH DATA FOR MA ENROLLEES

In March 2018, CMS launched Blue Button 2.0, which enables beneficiaries to connect their data to applications, services, and research programs they trust. CMS recommends and encourages plans to adapt data release platforms that meet or exceed the capabilities of CMS's Blue Button 2.0. Although it's not a requirement for current plans, CMS is considering future rulemaking to require the adoption of such platforms by MA plans beginning in CY 2020. For more information, visit the Blue Button website at https://bluebutton.cms.gov/developers/

OVERVIEW OF CY2019 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).

The table below indicates the application of each bid review criteria to each plan type.

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
Meaningful Difference	Yes	No	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 sent affected MAOs a list of non-SNP plans that have fewer than 500 enrollees or SNP plans that have fewer than 100 enrollees and that have been in existence for three or more years [as of March 2018 (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.

Be aware of additional guidance included in the CMS notification.

MEANINGFUL DIFFERENCE (SUBSTANTIALLY DUPLICATIVE PLAN OFFERINGS)

The Final Rule eliminated the meaningful difference requirement for MA plans in CY2019.

TOTAL BENEFICIARY COST (TBC)

The methodology for developing the CY2019 out-of-pocket costs (OOPC) model is consistent with last year's methodology. CMS has adapted all proposed changes to the TBC change evaluation from the Advanced Notice (summarized below).

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 CY2019; 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 increased the TBC change threshold, for most plans, from $34.00 PMPM to $36.00 PMPM in CY2019 to provide flexibility in addressing medical and pharmacy inflation and benefit design and formulary changes.

For CY2019, CMS will continue to use the same application of the TBC evaluation for the following specific situations:

- 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.

- 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 will not be allowed to make changes that result in greater than $72.00 worth of decreased benefits or increased premiums.

- 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 CY2018.

If CMS provides an opportunity to correct CY2019 TBC issues following the submission deadline, the MAO cannot change its formulary (e.g., adding drugs etc.) as a means to satisfy this requirement.

CMS is considering the elimination of the current TBC evaluation in future years, subject to statutory and regulatory limitations or changes.

MAXIMUM OUT-OF-POCKET (MOOP) LIMITS

The CY2019 MOOP limits remain unchanged from the CY2018 limits.

CY2019 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

Certain services have cost sharing limits that must be satisfied. Below is a table showing an illustrative comparison of service-level actuarial equivalent costs to identify excessive cost sharing.

BPT Benefit Category	PMPM Plan Cost Sharing (Parts A & B) *(BPT Col. 1)*	Original Medicare Allowed *(BPT Col. m)*	Original Medicare AE Cost Sharing *(BPT Col. N)* [1]	Part B Adj. 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	1.395	$35.30	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.066	$10.54	$0.29	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	$0.00	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

For CY2019, the voluntary MOOP Emergency Care/Post Stabilization Care copay amount increased from $100 to $120, while the mandatory MOOP amount increased from $80 to $90. Cost sharing limits also increased for Inpatient Hospital (both acute and psychiatric) and SNF for days 21-100 under both voluntary and mandatory MOOPs.

CY2019 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	$4,314
Inpatient Hospital--Acute-10 days	1a	$2,552	$2,042
Inpatient Hospital--Acute-6 days	1a	$2,325	$1,860
Inpatient Hospital Psychiatric - 60 days	1b	$2,737	$2,190
Inpatient Hospital Psychiatric -15 days	1b	$2,075	$1,660
Skilled Nursing Facility - First 20 Days[1,2]	2	$20/day	$0/day
Skilled Nursing Facility - Days 21 through 100[1,2]	2	$172/day	$172/day
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 Services	7b	$20	$20
Occupational Therapy Services	7c	$40	$40
Physician Specialist Services	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-Diabetic Supplies and Services	11c	N/A	20% or $10
DME-Diabetic Therapeutic 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%.

EMPLOYER GROUP WAIVER PLANS

Beginning in 2017, CMS waived the requirement for MA employer plans to submit a MA or Part D Bid Pricing Tool (BPT), but employer plans must complete and submit the MA portion of the Plan Benefit Package (PBP) in accordance with CMS requirements.

Organizations should make a good faith effort in projecting CY2019 member months for each plan and place the amount in Section A-2 of the PBP.

TIERED COST SHARING OF MEDICAL BENEFITS

For 2019, tiered cost sharing of medical benefits must satisfy the following standards:

- The plan fully discloses tiered cost sharing amounts and requirements to enrollees and plan providers;

- The services at each tier of cost sharing are available to all enrollees;
- Enrollees may not be limited to obtaining services from providers/suppliers assigned to a particular tier;
- All enrollees are charged the same amount for the same service provided by the same provider; and
- Deductibles, MOOP, and out-of-network benefits are not to be tiered.

The following examples of "differential cost sharing" are allowable, and not considered to be "tiering" of medical benefits:

- Facility settings for furnishing some services, such as diagnostic imaging services; and
- In-network versus out-of-network services.

OUTPATIENT OBSERVATION SERVICES

In an effort to make the cost sharing for observation services more transparent, CMS will distinguish the cost sharing for observation services from other outpatient hospital services by modifying PBP category B9a to include separate cost sharing data entries.

COVERAGE OF SUPERVISED EXERCISE THERAPY (SET) FOR SYMPTOMATIC PERIPHERAL ARTERY DISEASE (PAD)

CMS has determined that the National Coverage Determination (NCD) requiring coverage of supervised exercise therapy (SET) for symptomatic peripheral artery disease (PAD) is considered a significant cost under 42 C.F.R. § 422.109(a)(2). As a result, for CY2018 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans. (See HPMS email, Subject titled "MAO Coverage of Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)" sent on August 12, 2017).

For CY2019, MAOs should account for these items and services in their bids as a basic benefit, and should not include these Medicare-covered items and services as supplemental benefits. MA Plans should include Medicare-covered SET for PAD in the cardiac and pulmonary rehabilitation services PBP service category B3 "Medicare-covered Pulmonary Rehabilitation Services" and include a range of cost sharing.

HEALTH RELATED SUPPLEMENTAL BENEFITS

CMS has previously disallowed an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance. The final Call Letter includes a revised definition for what CMS considers a supplemental benefit to include some daily maintenance benefits that would diminish the impact of injuries/health conditions and reduce avoidable utilization (e.g. fall prevention devices). For additional information, see pages 207-209 of the final Call Letter.

ENHANCED DISEASE MANAGEMENT (EDM) FOR DUAL ELIGIBLE SPECIAL NEEDS PLANS (D-SNPS) AND INSTITUTIONAL SPECIAL NEEDS PLANS (I-SNPS)

Beginning in CY2019, D-SNPs and I-SNPs may offer the EDM supplemental benefit that is currently available to Non-SNP MA plans.

Services in a supplemental EDM benefit would include qualified case managers with specialized knowledge about the target disease(s)/condition(s), educational activities that are focused on the target disease(s)/condition(s), and routine monitoring applicable to the target disease(s)/condition(s). The benefit may be proposed as a supplemental benefit in an MA plan's bid and submitted plan benefit package.

C-SNPs are excluded, as C-SNPs are already required to offer comprehensive targeted disease management elements.

MEDICARE ADVANTAGE (MA) UNIFORMITY FLEXIBILITY

CMS relaxed its uniformity rule, allowing MAOs to vary benefits by health status within a PBP. The flexibility will apply only to Part C benefits and not to Part D.

Targeted supplemental benefits can be offered through a benefit package that ensures equal treatment of enrollees with the same clinical conditions for whom such services and benefits are useful.

In identifying eligible enrollees, the MA plan must use medical criteria that are objective and measurable, and the enrollee must be diagnosed by a plan provider.

Prior to 2019 bid submissions, CMS will issue detailed guidance for MAOs as they consider upcoming plan offerings.

MEDICARE ADVANTAGE (MA) SEGMENTED SERVICE AREA OPTIONS

CMS reviewed section 1854(h) of the Social Security Act (the Act) and MA regulations governing plan segments and has determined that it has the authority to allow MA plans to vary supplemental benefits, in addition to premium and cost sharing, by segment, as long as the benefits, premium, and cost sharing are uniform within each segment of an MA plan's service area.

MA plans can segment Part C benefits; however, if an MA plan offers Part D it must offer the Part D benefit uniformly within the plans service area including any segments the MA plan may have.

MEDICARE DIABETES PREVENTION PROGRAM (MDPP) SERVICES CLARIFICATION

MDPP services consist of structured health behavior change sessions that are furnished under the MDPP expanded model with the goal of preventing diabetes among Medicare beneficiaries with prediabetes, and that follow a CDC-approved curriculum.

CMS wants to ensure that MA plans are aware that while they must cover MDPP services in accordance with the MDPP regulations, they may also offer additional MDPP-like services as a supplemental benefit.

The similar supplemental benefit does not count as the Part B covered service, but may still be offered by the plan.

SPECIAL NEEDS PLAN (SNP)-SPECIFIC NETWORKS RESEARCH AND DEVELOPMENT

In the CY2018 Final Call Letter, CMS announced plans to move forward on developing SNP-specific network adequacy evaluations. CMS believes that the current network adequacy criteria and exception request process account for the unique healthcare needs and delivery patterns for SNP plans.

CMS may re-examine this issue once they gain experience with improved network adequacy processes described in their February 2018 guidance on network adequacy.

REWARDS AND INCENTIVES FOR COMPLETION OF A HEALTH RISK ASSESSMENT (HRA)

Regulations at §422.134 allow MA plans to create Rewards and Incentives (RI) Programs that provide rewards and incentives to enrollees for participation in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of healthcare resources.

CMS has previously included HRAs in this exclusion because of §422.112 and §422.101.

For CY2019, MA plans may include the completion of an HRA as a permitted health-related activity in an RI Program. An RI Program is not a benefit but it must be included in the bid as a non-benefit expense. See section 100 of Chapter 4 of the Medicare Managed Care Manual for more information about rewards and incentives.

COST PLAN TRANSITION TO MA UNDER MACRA

Cost Plan entities must complete the transition to MA by contract year 2019 in order to deem their cost enrollees into an affiliated MA plan offered by the organization under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) cost transition requirements.

Any plan wishing to deem enrollees from its cost plan to one of its MA plans under the MACRA provisions must notify CMS of that intention via the HPMS crosswalk process. This may be completed as early as May of 2018 for enrollments in 2019, the final contract year for deeming enrollment from a non-renewing cost plan to an affiliated MA plan. All crosswalks must be completed by the time the bid is due, unless a plan qualifies to submit a crosswalk during the exceptions window. Plans are responsible for following all contracting, enrollment, and other transition guidance released by CMS.

CMS has released guidance on the requirements of the cost plan transition which is available at the following link:

https://www.cms.gov/Medicare/Health-Plans/MedicareCostPlans/index.html

COST PLAN COMPETITION REQUIREMENTS

Plan competition requirements will first be effective in 2019, that is, cost plans affected by these requirements will first be unable to offer a cost plan in a service area or portion of a service area in contract year 2019.

CMS will non-renew any portion of a cost plan's service area if there are at least two competing MA local or two MA regional coordinated care plans with a minimum of 5,000 enrollees (urban areas) or 1,500 enrollees (non-urban areas) for the entire year prior to the non-renewal. CMS used 2017 enrollment data to determine the cost plans subject to non-renewal. CMS provided the results of the competition analysis to each cost contract in December 2017.

IMPROVING BENEFICIARY COMMUNICATIONS AND REDUCING BURDEN FOR INTEGRATED D-SNPS

CMS continues to seek opportunities to maximize the potential for D-SNPs to align benefits and improve coordination for Medicare-Medicaid enrollees.

CMS has identified the following specific areas in which administrative alignment for integrated D-SNPs is currently feasible within existing statutory, regulatory, and operational constraints:

- **Oversight**: Improving CMS-state communication and information sharing as permitted by applicable law to improve oversight and administration of D-SNP contracts.
- **Integrated model materials**: Collaborating with states to develop a set of model materials with integrated benefit information for use by integrated D-SNPs. In response to previous stakeholder comments on this topic, the following materials were prioritized:
    - ***Summary of Benefits***. Starting with the CY2017 cycle, integrated D-SNPs have had flexibility to display integrated Medicare and Medicaid benefits, as applicable, in their SBs.
    - ***Annual Notice of Change (ANOC)/Evidence of Coverage (EOC)***. Starting with the CY2018 cycle, the standardized ANOC and EOC models for D-SNPs include new opportunities for integrating Medicare and Medicaid benefit descriptions similar to those available in the SB guidance.
    - ***Provider and Pharmacy Directory***. CMS believes that inclusion of all available providers – including those offering services only covered through Medicaid – in a single document will facilitate beneficiary understanding of both their Medicare and Medicaid provider choices and streamline health plan processes.
    - ***Formulary.*** Similar to directories, CMS believes integration of Part D and Medicaid-covered prescription and over-the-counter drug/product information in one document is beneficial to both plan enrollees and to health plans.
- **Non-Renewals**: Coordinating state and CMS communications and processes for D-SNP non-renewals, including working with states and plans to develop state-specific integrated non-renewal notices that include information about changes in the delivery of Medicaid benefits that will accompany the non-renewal of an integrated D-SNP.
- **Model of Care:** Providing technical assistance to states on the implementation of more robust D-SNP model of care (MOC) submissions that incorporate information about the integration of Medicare and Medicaid Managed Long Term Services and Supports (MLTSS).

- **Appeals and Grievances and Integration Standards:** CMS invites stakeholders to submit comments to help inform CMS' next steps related to unified D-SNP grievance and appeals processes and new integration standards by April 12, 2018. More information is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DSNPBBA2018.html.

- **Member Materials Review:** CMS received industry feedback in support of an integrated CMS-state process for review and approval of member materials in order to streamline and coordinate the multiple levels of review these materials undergo in some states. CMS stated that there remain both operational and statutory obstacles to extending these processes in absence of a demonstration waiver.

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

The QMB Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans.

CMS also encourages plans to educate providers about the QMB billing requirements for Medicare Parts A/B deductibles and coinsurance.

Plans may want to leverage CMS information for providers and plans on CMS's QMB webpage at:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html

ENCOUNTER DATA LISTENING FORUMS, MONITORING AND COMPLIANCE ACTIVITIES

Under 42 C.F.R. § 422.310, MA organizations are required to submit encounter data records for each item and service provided to an MA plan enrollee.

In order to assist organizations in meeting requirements for submitting complete and accurate data, CMS conducts a range of activities aimed at providing feedback and technical assistance to, and soliciting input from, stakeholders.

Listening Forums. CMS has also initiated a series of listening forums with MA organizations.

CMS's framework for monitoring and compliance activity was categorized into three performance areas:

- Operational Performance: Refers to submitters' performance related to encounter data submission requirements such as certification to submit, non-submission, and frequency of submission.

- Completeness Performance: Refers to both the overall volume of encounter data records (e.g., whether encounter data records are being submitted for all services rendered) as well as to the completeness of data within an encounter data record (e.g., whether key fields are populated as expected).

- Accuracy Performance: Refers to the reasonableness of ED patterns. Measures addressing the reasonableness of specific data elements or reasonable patterns in submitted data would be considered.

TRANSPARENCY & TIMELINESS WITH PRIOR AUTHORIZATION PROCESSES

CMS notes it is aware of stakeholder concerns about the burdens imposed by coverage restrictions such as prior authorizations (PA) in the Part C program.

Section III – Part D

FORMULARY SUBMISSIONS

CY2019 Formulary submission window is May 14-June 4.

CMS is analyzing utilization of current Formulary Reference File (FRF) drugs and has proposed to delete 376 RXCUIs. The most recent CY2019 FRF, which was published in March 27, 2018, will be used for the OOPC tool. Further changes to FRF will not be reflected in OOPC tool. There will be a summer formulary update window ahead of which CMS will publish an update to the FRF. The summer window will allow for adding drugs new to the FRF and submission of negative changes on brand drugs.

CMS is implementing the following changes for CY2019 Formulary Submissions:

- CMS will make the validation file for the Additional Demonstration Drug (ADD) file, which is for Medicare-Medicaid plans and includes all non-Part D drugs required by the state, available in advance of the ADD submission deadline.

- CMS is eliminating the Non-Extended Day Supply (NDS) supplemental file for CY2019.

- CMS is proposing to provide an OTC reference file with a proxy code (e.g. RXCUI) to enable plans to refine list of OTCs that will be accepted.

EXPANDING THE PART D OTC PROGRAM

CMS is not expanding the OTC program at this time.

MEDICATION THERAPY MANAGEMENT (MTM) ANNUAL COST THRESHOLD

The 2019 annual threshold is $4,044, up from $3,967 for 2018.

PART D BENEFIT – CHANGE IN THE COVERAGE GAP DISCOUNT PROGRAM

The Bipartisan Budget Act, enacted on February 9, 2018, made two modifications to the Medicare Part D Coverage Gap Discount Program. Cost sharing values were changed as shown in the following table. Beginning in January 2019, biosimilars are no longer excluded from the definition of applicable drugs, and will be subject to a 70 percent manufacturer discount and must be covered under a CMS CGDP agreement in order to be covered by Medicare Part D.

Year	Applicable Drugs			Non Applicable Drugs		
	Manufacturer Discount	*Beneficiary Cost Sharing*	*Plan Cost Sharing*	*Manufacturer Discount*	*Beneficiary Cost Sharing*	*Plan Cost Sharing*
2018	50%	35%	15%	N/A	44%	56%
2019	70%	25%	5%		37%	63%
2020 and Beyond	70%	25%	5%		25%	75%

PART D BENEFIT PARAMETERS FOR NON-DEFINED STANDARD PLANS

CY2019 benefit parameters are set as shown in table below.

Benefit Parameters for CY 2019 Threshold Values CY 2019 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 (3 or more tiers)	
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
Maximum Coinsurance: Pre-ICL (3 or more tiers)	
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)	
Preferred Generic Tier	17%
Generic Tier	17%
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

For CY2019, the minimum OOPC difference between basic and enhanced PDPs is $22.

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.

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. A non-preferred brand tier can have a maximum threshold of 25% generic drugs.

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.

SPECIALTY TIERS

CMS will maintain the $670 threshold for specialty drugs in CY2019.

LOW ENROLLMENT PLANS (STAND-ALONE PDPS ONLY)

Definition and treatment of low enrollment plans is unchanged. CMS is continuing to review low enrollment plans, and intends to non-renew a plan that is identified as a low enrollment plan for two consecutive years. Low enrollment plans will be notified by April 2018 of available options.

IMPROVING DRUG UTILIZATION REVIEW CONTROLS

The Part D Opioid Overutilization Policies for 2019 are the following.

- Implement a hard days supply limit of 7 days for initial fills of opioids (for opioid naïve patients).
- Enhance the Overutilization Management System (OMS) to include additional flags for high risk opioid users.
- Real time safety edits at the time of dispensing for chronic opioid users.

- Implement opioid care coordination edit at 90 MME per day.
- Implement revisions to the PQA quality measures and add a new measure.
- All sponsors are expected to implement additional soft point of sale safety edits.

COORDINATION OF BENEFITS (COB) USER FEES

A COB user fee of $1.05 per enrollee per year ($0.1166 per month for 9 months) will be collected in 2019 and should be accounted for when developing 2019 bids.

LIS COST-SHARING FOR OUT-OF-NETWORK PART D DRUGS

CMS is reminding plans of their obligations to LIS enrollees regarding reimbursement for out of network cost-sharing of part D Drugs. No changes are being made.

TIMELY UPDATES TO LIS STATUS BASED ON BEST AVAILABLE EVIDENCE (BAE)

CMS is reminding plans to comply with the BAE policy when updating and applying LIS status. No changes are being made.

PART B VS PART D COVERAGE DETERMINATIONS

CMS is launching a new web portal that will provide Medicare-covered transplant data to assist in identifying whether immunosuppressants and inhalation DME Supply drugs should be considered under Part B or Part D.

PART D MAIL-ORDER REFILL

Further refinement is still being considered for patient consent requirements prior to delivery for mail-order new and refill prescriptions.

Section IV – Medicare-Medicaid Plans

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 8, 2018)

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.

Appendix A - Wakely Estimated Impact of Growth Rates

CHANGE IN BENCHMARK RATES

Wakely estimates that, on a nationwide average basis, and as compared with 2018, nationwide average 2019 Part C benchmarks will:

- Increase by 5.50% on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, county rebasing and re-pricing, average change in star ratings and quality bonus, and the impact of the benchmark cap.

- Increase by 3.42% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors and the MA Coding Pattern adjustment and the risk model revision. The Wakely estimate does not include changes for encounter data transition and employer group waiver plan payment policy.

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
- Change in coding pattern difference adjustment
- Assumption of no trend in raw risk scores
- Average change in star ratings based on March 2018 MA enrollment
- Risk Model Revision

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	5.51%
Rebasing/Re-pricing	-0.13%
Applicable %	0.43%
Star Rating/Quality Bonus	-0.35%
Benchmark Cap	0.01%
Total Benchmark Change	**5.50%**
FFS Normalization	-2.26%
MA Coding Pattern	0.01%
Risk Model Revision [2]	0.28%
Total Risk Score Change	**-1.98%**
TOTAL	**3.42%**
[1] Based on March 2018 MA enrollment and Fall 2017 Star Ratings *[2] CMS estimate in the April 2, 2018 Fact Sheet*	

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

Growth Rate. This is the combined impact of the FFS (+5.11%) growth rate, the change to using concurrent VA and DoD factors, and changes in the GME factors from 2018 to 2019.

Applicable %. This is the average nationwide change in applicable percentage based on the March 2018 enrollment by Medicare Advantage contract and county.

Star Rating/Quality Bonus. This displays the difference in quality bonus impact on benchmarks between 2018 and 2019. This can be due to star rating changes for MA plans from 2018 to 2019 as well as changing enrollment mix by MA plan. Our estimate is based on 2019 star ratings with March 2018 individual MA plan enrollment.

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 change 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 2018 Part C FFS normalization factor was 1.0170. For 2019, two FFS normalization factors will be used. The RAPS 2017

CMS-HCC model factor will be 1.041 and the EDS Updated HCC model factor will be 1.038. CMS estimates the impact of the change in FFS normalization factors to be -2.26%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2019 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. This represents a reduction of 0.01% as compared with 2018.

CHANGE IN BID AND REBATE AMOUNTS

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on plan star rating, counties served, risk score trends, population changes, and many other factors.

If we assume that both 2018 and 2019 bids are 85% of the benchmark then we estimate the change in Part C payments from 2018 to 2019 to be an increase of +3.42% (see Table A2).

In order to properly estimate the impact of the various MA payment components addressed in the Final Announcement, 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 +3.42%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is nearly the same, at +3.38%. This estimate is based on the following assumptions:

- Plans bid at 85% of the benchmark in 2019 (this is consistent with bid to benchmark ratios used for 2019 EGWP payment calculations).
- Annual risk score coding trend is 0% for a static population.
- Nationwide average star ratings, which result in an average rebate percentage of 65.9% in 2018 and 65.7% for 2019.
- No consideration for sequestration or insurer fee.

Table A2 shows the calculations underlying our estimates.

Table A2			
Item	**2018**	**2019**	**2019/2018**
1.0 MA Benchmark [1]	$873.81	$921.90	5.50%
Raw Risk Adjustment Factor [2]	1.000	1.000	0.00%
FFS Normalization	1.017	1.041	-2.26%
MA Coding Pattern Adjustment	0.941	0.941	0.01%
Risk Model Revision	1.000	1.003	0.28%
RAF after FFS Norm & Coding Pattern	0.925	0.907	-1.98%
Risk-Adjusted Benchmark	$808.13	$835.75	3.42%
Assumed Risk-Adjusted Bid [3]	**$686.91**	**$710.39**	**3.42%**
Savings (Benchmark less bid)	$121.22	$125.36	3.42%
Rebate (64.1% for 2018, 64.2% for 2019)	**$79.94**	**$82.35**	**3.01%**
Risk-Adjusted Bid + Rebate	**$766.85**	**$792.74**	**3.38%**
[1] Based on nationwide average MA enrollment by county as of March 2018			
[2] Assumed no trend in risk scores			
[3] Bid set at 85% of risk-adjusted benchmark			