American Hospital Association

Special Bulletin

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# CMS Proposes Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and Part-D Prescription Drug Programs

The Centers for Medicare & Medicaid Services (CMS) on Nov. 16 issued a proposed rule that would update Medicare Advantage (MA) and the Part D prescription drug program. CMS estimates that its proposed changes would result in $195 million in savings over five years for the Medicare program. The rule's proposed changes are based on ideas shared with CMS through its spring 2017 request for information on how to transform the MA and Part D programs. In addition, CMS proposes to implement certain provisions of the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act. Major provisions of the rule are summarized below.

## Major Provisions for the MA and Part D Programs

**Transparency of Star Rating:** Beginning in calendar year (CY) 2019, CMS proposes to codify the current MA and Part D programs Quality Star Rating System – its uses, methodology, measures and data collection. The rule also proposes changes in how contract consolidations affect Star ratings.

**MA Plan Variety:** CMS proposes to eliminate the "meaningfully different" standard that MA organizations must meet if they offer multiple MA plans in the same county. The standard currently requires organizations offering MA enhanced plans and basic plans, in the same county, to identify meaningful differences in value. CMS states that eliminating the "meaningfully different" standard would allow plans to innovate and improve plan options.

**Flexibility in MA Cost-sharing and Premium Uniformity Requirements:** The proposed rule would allow MA organizations the option to reduce cost-sharing for certain covered benefits, offer specific supplemental benefits, and offer different deductibles for beneficiaries that meet specific medical criteria beginning in CY 2019.

**Maximum Out-of-Pocket (MOOP) and Cost-sharing Limits:** CMS proposes to revise its existing methodology that ties maximum MOOP limits to Medicare fee-for-service spending. In addition, CMS proposes to add additional flexibility to allow plans to offer differing levels of MOOP limits.

**Default and Passive Enrollment and Special Enrollment Periods (SEP:** CMS proposes to allow an MA organization to provide continuation of coverage for newly eligible MA individuals who are currently enrolled in non-Medicare health plans offered by that organization, including Medicaid commercial plans. CMS also would allow passive enrollment for enrollees dually eligible for Medicare and Medicaid if they are currently enrolled in a "dual eligible special needs plan" (D-SNP) that is non-renewing as along as the passive enrollment is into a comparable D-SNP. In addition, CMS proposes to limit the Part D SEP for dually eligible and low-income-subsidy (LIS) individuals. However, CMS proposes that a separate SEP be established for potentially at-risk or at risk dual or LIS individuals.

**MA Open Enrollment Period:** The proposed rule codifies the 21st Century Cures Act change in the annual open enrollment period for MA plans. Effective CY 2019, the open enrollment period will be from Jan. 1 through March 31.

**MA and Part D Medical Loss Ratio (MLR) Reporting:** Part D and MA plans are required to meet an MLR of 85 percent standard. CMS proposes the following changes to the MLR, which measures how much of the premium dollars goes toward health care services: 1.) allow plans to count fraud reduction activities and Medication Therapy Management programs in their MLR and; 2.) significantly reduce the amount of MLR information and data plans are required to report to CMS.

**Removal of Quality Improvement Project:** MA plans are required to have quality improvement programs that include quality improvement projects (QIPs) and a Chronic Care Improvement Program (CCIP). CMS proposes to eliminate the QIP requirement, which CMS believes would allow MA plans to concentrate their efforts on management of chronic conditions through CCIPs.

**Substitutions of Generics and Treatment of Biological Products:** CMS proposes to allow Part D plans to substitute, immediately, newly released equivalent generics for brand name drugs at the same or lower cost sharing. The proposed rule would require that plans advise enrollees that substitutions may occur without advance notice. In addition, CMS proposes to classify biosimilar products as generics for purposes of cost sharing for certain low-income Part D enrollees.

**Part D Manufacturer Rebates and Drug Price Concessions:** The proposed rule solicits comments on how Part D plan sponsors, through their pharmacy benefit managers (PBMs), negotiate drug price concessions from drug manufacturers, network pharmacies and other entities. Specifically, CMS is interested in learning if Part D plans and their PBMs are lowering premiums and cost sharing for beneficiaries because of the savings generated from price concessions. CMS also is interested in learning how much of the drug discounts PBMs keep and whether they are incentivized to favor expensive drugs over cheaper alternatives on their formularies.

**Implementation of CARA:** CARA requires CMS, beginning in CY 2019, to establish a framework for Part D plan sponsors to implement drug management programs that limit "at risk" beneficiaries' access to controlled substances. The rule proposes to designate opioids (with limited exceptions) as frequently abused drugs and tie the definition of an "at risk" beneficiary to the protocols in CMS's current Part D Opioid Drug Utilization Review Policy Overutilization Monitoring System. The rule also proposes to limit SEPs for any dually eligible or LIS individuals identified as "at risk" for prescription drug abuse.

## NEXT STEPS

Comments on the proposed rule are due Jan. 16. If you have further questions, contact Molly Smith, AHA vice president for coverage and states issues, at mollysmith@aha.org or Molly Collins Offner, AHA director of policy development, at mcollins@aha.org.