# 2019 Changes to Medicare Advantage and Part D

The 2018 *Balanced Budget Act* (BBA), Centers for Medicare & Medicaid Services (CMS) Call Letter, and Part C and D Final Rule and Revised Regulations made significant programmatic changes to Medicare for the coming year. This fact sheet provides an overview of the Medicare Advantage (MA) and Part D program changes that will impact Medicare beneficiaries effective January 1, 2019.[1]

## Pricing and Coverage Changes

### *Expanded MA health related supplemental benefits*

In 2019, MA plans may offer supplemental benefits if they are used to "diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization."

Supplemental benefits must be medically appropriate and recommended by a licensed provider as part of a care plan. Supplemental benefits are not items or services solely to induce enrollment. Examples of newly allowable benefits include adult day care services, home and bathroom safety devices, transportation, and home-based palliative care.

This expanded benefits guidance is separate from the CY2020 waiver of uniformity requirement for the chronically ill.

*In the past, MA supplemental benefits were required to be "primarily health related" and typically related to dental, hearing or vision benefits.*

### *Elimination of meaningful difference for MA plans*

CMS will no longer limit the variety of plans an MA organization can offer in the same service area.

*Previously, CMS only approved MA bids for multiple plans within a service area if the plan benefit packages were substantially different in premiums, cost-sharing, or benefits offered.*

[1] Be advised that this fact sheet is based on current CMS guidance as of September 2018, which is subject to ongoing re-interpretation. NCOA will update the fact sheet in accordance with revised or reinterpreted CMS regulations. Please contact ann.kayrish@ncoa.org with any updates or questions.

### *Elimination of meaningful difference between Part D enhanced alternatives*

In 2019, the meaningful difference requirement for prescription drug plan (PDP) Enhanced Alternative (EA) benefit designs offered by the same organization in the same region has been removed. Part D plans are still limited to two enhanced and one basic plan in each service area. No changes have been made to the meaningful difference requirements between PDP basic and enhanced plans.

*Previously, EA drug plans offered in the same service were required to be appreciably different in premium, cost-sharing, or benefits.*

### *Tiering of Medicare Part C benefits*

MA plans may choose to tier the cost-sharing for contracted providers as an incentive to encourage enrollees to seek care from specific providers. Plans that utilize tiered cost-sharing must disclose tiered cost-sharing amounts and requirements to enrollees and plan providers, ensure that services at each tier of cost-sharing are available to all enrollees, and ensure that all enrollees are charged the same amount for the same service provided by the same provider. Additionally, plans may not require enrollees to obtain services from a designated provider group or tier. Maximum out-of-pocket (MOOP) and out-of-network benefits are **not** to be tiered.

*Previously, MA plans were required to offer all enrollees in a plan in a service area access to the same benefits at the same level of cost-sharing.*

### *Step therapy for Part B drugs*

Medicare Advantage plans now have the option of applying step therapy for physician-administered and other Part B drugs. Step therapy requires enrollees to try one or more similar, lower cost drugs to treat their condition before the plan covers a higher priced medication. Plans requiring step therapy must offer enrollees drug management care coordination programs. Incentives such as gift cards may be offered to enrollees to encourage participation in beneficiary engagement programs. See the CMS bulletin under the Resource portion of this fact sheet, which describes the new step therapy authority and information on the exceptions process.

*Previously, physician-administered and other Part B drugs were not subject to step therapy requirements. Additionally, incentives or rewards were not utilized to encourage participation in care coordination programs*

### *Income Related Medicare Adjustment Amount (IRMAA) update*

Beginning in 2019, a sixth tier has been added to the Medicare Part B and Part D IRMAA brackets for beneficiaries with incomes of $500,000 (for individuals) and $750,000 (for married couples) or more. The new tier requires these high earners to cover 85% of Medicare premiums.

*Previously individuals and married couples earning above the $500,000 and $750,000 respectively were included in the 5th tier, which required coverage of 80% of the Medicare program costs.*

### *Coverage gap changes*

The Part D coverage gap for brand name drugs will close in 2019 as the beneficiary coinsurance is reduced to 25%. To make up for the reduction in the beneficiary's responsibility, the pharmaceutical manufacturer's discount will increase to 70% and the Part D plan's discount will be 5%. The 2019 generic drug donut hole discount has not changed; it remains at 63% of retail price. Beneficiaries will pay 37% of the generic drug cost.

*In 2018, the pharmaceutical manufacturer discount was 50%, the Part D plan discount was 15%, and beneficiaries paid 35% of the brand name drug cost. The coverage gap was not scheduled to close until 2020.*

### *Changes to biosimilar drugs under Part D*

In 2019, biosimilars will be subject to the 70% manufacturer's rebate in the Part D coverage gap. CMS will lower copays for biosimilars to the generic cost-sharing amounts for LIS beneficiaries in all phases of the Part D benefit.

*Previously, biosimilar copays for LIS enrollees were set at the brand name rate.*

### *Part D tiering exceptions*

In seeking to standardize the tiering exceptions process, CMS has determined that tiering exceptions requests should be granted to the lowest applicable cost-sharing for the tier containing the preferred alternative drugs (that treat the enrollee's health condition). For example, brands are assigned to the lowest cost-sharing tier associated with brand alternatives and generics are assigned to the lowest cost-sharing tier associated with generic alternatives.

*Previously, Part D plans were permitted to exclude the generic tier from the exception process.*

### *Changes to Part D transition supply*

CMS is reducing the transitional supply provided in a long-term care setting to 30 days, to conform with the transitional supply provided in the outpatient setting. The 30-day transition supply is being changed to a to "an approved month's supply."

*Previously, the transitional supply in LTC was 90 days.*

### *Lengthening adjudication timeframes for Part D payment redeterminations and Independent Review Entity (IRE) reconsiderations*

The timeframe for issuing decisions on payment redeterminations will be 14 calendar days from the date the plan sponsor receives the request. The change provides additional time to adjudicate payment requests in situations where beneficiaries have already obtained the requested medications.

*Previously, the maximum adjudication timeframe for decisions on payment appeals was 7 days.*

### *Introduction of Medicare Diabetes Prevention Program (began April 1, 2018) in Original Medicare*

The Medicare Diabetes Prevention Program is a lifestyle change program that is designed to prevent the development of diabetes in pre-diabetic Medicare beneficiaries. The program provides at least 16 core group sessions over a 6-month period which are designed to promote and maintain healthy lifestyles, including increasing exercise and controlling/losing weight. Pre-diabetic beneficiaries may join a program at no out-of-pocket cost and without a doctor's referral.

*This is a new program that has not been offered previously under Original Medicare.*

## Changes to Plan Disclosure and Notification Policies

### *Changes to EOC method of disclosure and delivery date*

CMS has separated the delivery of the Annual Notice of Change (ANOC) and the Evidence of Coverage (EOC). The ANOC delivery date has not changed. CMS continues to require that the ANOC be mailed 15 days prior to the Annual Election Period (AEP) for receipt by September 30.

Meanwhile, the delivery date of the EOC has been moved from 15 days prior to the start of the AEP to the first day of the AEP, October 15. Additionally, plans are no longer required to provide enrollees a hard copy version of the Evidence of Coverage. Instead, plans fulfill Medicare's disclosure requirements by posting the EOC on their plan website (by October 15) and mailing a notice to all enrollees. The Notification of Electronic Materials explains how to obtain a hard copy of plan materials routinely available on the plan's website (EOC, provider directories, and formularies). The notice must include a plan phone number, URL address, and the date the documents will be available on the website.

*Previously, plans were required to provide plan members with hard copies of both the ANOC and EOC prior to the start of the AEP. Additionally, plan provider directories and formularies are currently available to enrollees online. Each year enrollees receive a printed notification explaining how to obtain hard copies of these plan documents.*

### *Mid-year formulary notification*

In 2019, plans may immediately substitute therapeutically equivalent generics for brand name drugs on the same or lower cost-sharing tier, without prior drug specific beneficiary notification. Instead, plans are permitted to use a general notification which advises enrollees beforehand that mid-year generic substitutions can occur and affected beneficiaries will be notified after the fact.

Beneficiaries affected by a formulary change are entitled to either a 30-day advance notice or a one-month brand refill upon request. The expedited substitution does not change a beneficiary's ability to seek a formulary exception.

*Currently, if a plan formulary replaces a brand name drug with a new generic drug, the plan must provide either a 60-day advance notice or a 60-day brand name refill.*

### *IRE level of appeal forwarding notification requirement*

CMS is removing the current requirement that Medicare Advantage plans send a notice to a beneficiary when his/her appeal case file is forwarded to Medicare's Part C Independent Review Entity (IRE). The Part C IRE (MAXIMUS) will continue to notify MA enrollees of forwarded cases.

*Currently an enrollee receives a notice when an appeal is forwarded to the IRE from both the plan and the IRE.*

## Changes Impacting Beneficiary Access

### *Cost-sharing and benefit variability*

Under a more relaxed interpretation of uniformity, MA organizations may now reduce cost-sharing for certain benefits and offer tailored supplemental benefits for enrollees that meet specific medical criteria (if any do). The benefit package must be medically related to the specific condition or health status of the eligible enrollees.

Each customized benefit offering must satisfy two key criteria:

1) The target population for customized benefits must be objectively identified based on health status, disease state, or clinical condition, and

2) A reduction in cost-sharing or offering a non-Medicare supplemental service must be medically related to the target condition.

Allowable target populations include individuals with: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), stroke history, hypertension, coronary artery disease, tobacco use, opioid addiction, and hypercholesterolemia.

The flexibility will apply only to Part C benefits and not to Part D.

*Previously, MA plans were required to offer all enrollees in a plan in a service area access to the same benefits at the same level of cost-sharing.*

### *Restoration of the Medicare Advantage Open Enrollment Period (MA OEP)*

2019 will mark the return of an annual MA-OEP running January 1 - March 31 each year. The new MA-OEP allows individuals enrolled in an MA plan as of January 1 to make a one-time election to another MA plan or return to original Medicare and a stand-alone Medicare Part D plan. This enrollment period does not allow for Part D changes for individuals enrolled in Original Medicare. Marketing to MA enrollees during the MA OEP is prohibited.

Additionally, new Medicare beneficiaries who enroll in an MA plan during the first three months they have Medicare may elect to enroll in another MA plan or return to Original Medicare and a stand-alone Medicare Part D plan.

*The Medicare Advantage OEP replaces the Medicare Advantage Disenrollment Period, which ran from January 1 to February 14. The Medicare Advantage OEP provides beneficiaries the opportunity to switch from one MA plan to another, which was not a provision of the Medicare Advantage Disenrollment Period (MAPD).*

### *Limitation of the Part D Special Enrollment Period for LIS and dual eligibles*

The new rule converts the Special Enrollment Period (SEP) for dual eligibles and Part D Low Income Subsidy (LIS) beneficiaries from an open ended monthly SEP to one that must be used only once per calendar quarter during the first nine months of the year. In the last quarter the SEP will not be available. The final rule also allows for separate SEPs for: (1) a CMS or state-initiated enrollment; and (2) a change to an individual's LIS or Medicaid status. Dual eligible and LIS recipients retain the right to switch plans during other times that apply to all Part D enrollees, such as the annual open enrollment period and SEPs for events (such as permanently moving to a new residence).

*Previously, dual eligibles and other beneficiaries who received LIS were entitled to a SEP that allowed them to switch Part D plans, which include MA plans that offer Part D coverage, monthly.*

### *Opioid prescription limitations & checks for all Part D enrollees*

Part D sponsors are required to limit initial opioid prescription fills for the treatment of acute pain to no more than a 7 days' supply, as part of the implementation of the *Comprehensive Addiction and Recovery Act of 2016* (CARA).

Additionally, Part D sponsors must implement a flag at 90 MME (morphine milligram equivalent). When a beneficiary's cumulative MME per day across their opioid prescriptions reaches or exceeds 90 MME, the pharmacist must consult with the prescriber, document the discussion, and if the prescriber confirms intent, use an override code that specifically states that the prescriber has been consulted.

*Neither the 7-day initial supply nor the 90 MME dispensing limit check were in place in 2018.*

### *Limitations on Part D enrollees considered "at risk" for prescription drug abuse*

Part D plan sponsors must establish a drug management program for beneficiaries deemed at risk for prescription drug abuse. "At-risk beneficiaries" are identified as those that take a specific dosage of opioids and/or obtain them from multiple prescribers and multiple pharmacies. At-risk determinations will be subject to the existing beneficiary appeals process.

Plans may utilize a "lock in" provision to limit at-risk beneficiaries' access to coverage of frequently abused drugs to a selected prescriber(s) and/pharmacy(ies) after case management with the prescribers and beneficiaries. Beneficiaries can submit prescriber and pharmacy preferences to the plan.

Plans can also limit the use of the special enrollment period (SEP) for dually or other low-income subsidy (LIS)-eligible beneficiaries who are identified as at-risk or potentially at-risk for prescription drug abuse.

CMS exempts beneficiaries from drug management programs who are being treated for active cancer-related pain, are receiving palliative or end-of-life care, or are in hospice or long-term care.

*Lock in and LIS SEP enrollment provisions were not previously incorporated into the Part D benefit.*

### *Transition of Medicare cost plans to MA plans*

CMS will not renew any portion of a Medicare cost plan's service area if there are at least two competing MA 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. Many cost plan contracts will not be renewed for 2019 and enrollees will need to enroll into an MA plan or return to Original Medicare. Some MA plans are seeking to deem enrollees from their cost plan to their MA plans.

Copies of the CMS scripts that answer questions raised by cost plan non-renewal can be found in the resource section of this fact sheet.

*Previously, Medicare cost plans remained a viable enrollment option for many Medicare beneficiaries.*

### *Passive default enrollment for non-renewing D-SNPs*

CMS is allowing passive enrollment for full benefit duals where integrated care is being disrupted by changes in health plan participation. Full benefit duals enrolled in a non-renewing integrated Dual Eligible Special Needs Plan (D-SNP) may be passively enrolled into another comparable plan after consulting with the state Medicaid agency. Passively enrolled beneficiaries must receive proper notification and have a SEP to opt out of the new plan.

*Previously, non-renewing D-SNPs required affected beneficiaries to "opt into" a new plan.*

### *Default/seamless enrollment from non-MA plan to MA plan*

CMS is permitting default enrollment only for Medicaid managed care enrollees who are newly eligible for Medicare and who are enrolled into a D-SNP or a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) administered by an MA organization (under the same parent organization that operates the Medicaid managed care plan). MA

organizations must get approval from CMS before implementing the default enrollment. The MA organization must send a notice at least 60 days before the default enrollment effective date to the enrollee.

*New applications for seamless enrollment have been suspended since 2016.*

## Resources

The CMS final policy and change document in its entirety can be found here: 2019 Call Letter and Final Rule

The CMS Fact Sheet summarizing the final policy changes can be found here: CMS 2019 Final Rule and Call Letter Fact Sheet

The CMS bulletin introducing Step Therapy for Part B drugs can be found here**:** Step Therapy for Part B drugs

For your reference:

- The 2019 Medicare Communication and Marketing Guidelines
- Sample cost plan non-renewal letters for enrollees affected by cost plan not-renewal
- Medicare Managed Care Manual. Chapter 2 provides information on Medicare Advantage enrollment and disenrollment