



# 2019 SMP/SHIP NATIONAL CONFERENCE

## Medicare Advantage

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July 22–25, 2019 • San Diego, CA

# 2019 – A Year of Growth

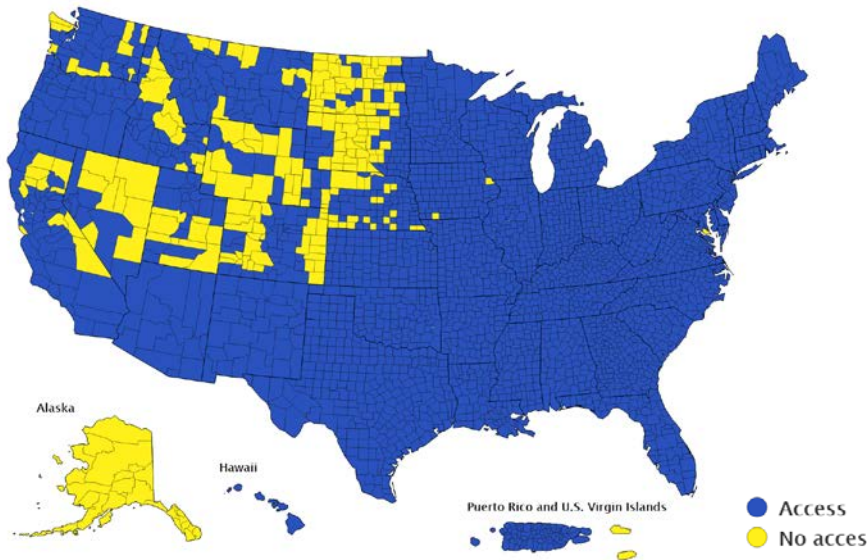
- Access to Medicare Advantage remains strong and stable
- Enrollment is growing
- Premiums continue to decrease
- More benefits are available

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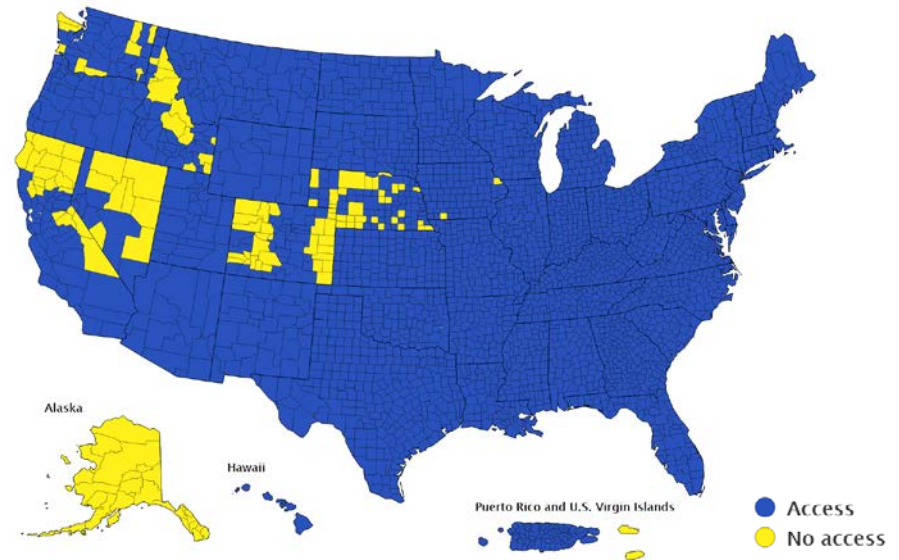
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# Access Remains Strong

2018



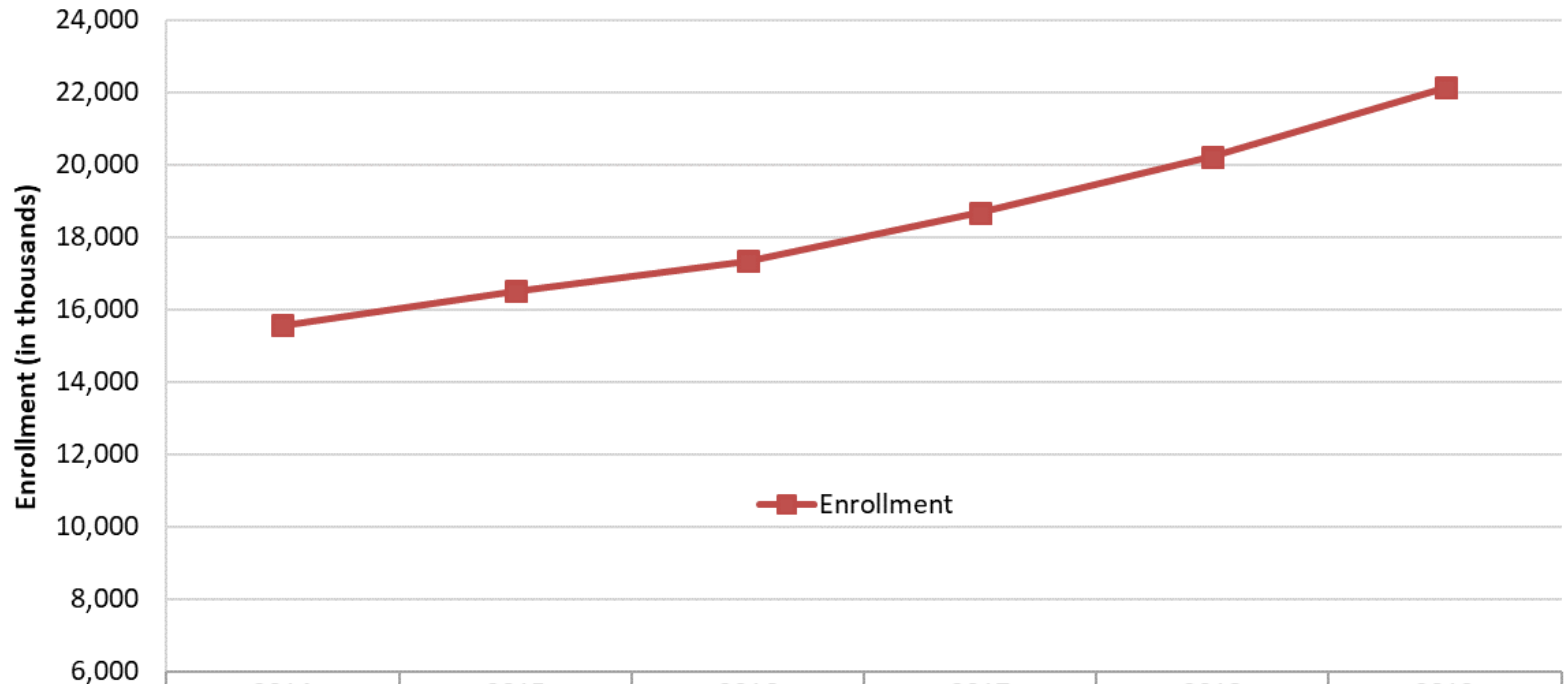
2019



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# Enrollment Continues to Grow



	2014	2015	2016	2017	2018	2019
Enrollment	15,572	16,521	17,338	18,689	20,241	22,150
Growth Percentage	8.72%	6.10%	4.94%	7.79%	8.30%	9.43%

Note: July enrollment of the plan year is used for 2013-2018 and June enrollment of the plan year is used for 2019.

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# New Supplemental Benefit Options

In 2019 plans can offer benefits tailored to a specific disease or illness and can now provide benefits they were previously not allowed to offer

- Reduced cost sharing for specific benefits (e.g., lower copay for specialist or acupuncture)
- Tailored supplemental benefit offerings tied to one or more disease state (e.g., therapeutic massage)
- MA plans may require enrollees to participate in a care management program or use high value providers as a condition of reduced cost sharing or additional benefits

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# Special Supplemental Benefits for the Chronically Ill

Beginning 2020 MA plans can offer Special Supplemental Benefits for the Chronically Ill for certain chronically ill enrollees.

- MA plans can choose to only offer these benefits for one or more specific chronic condition
- Reduced cost sharing for specific benefits (e.g., lower copay for specialist or acupuncture)
- Standard supplemental benefits offered only to the chronically ill enrollees (e.g., therapeutic massage)
- Non-health related supplemental benefits (e.g., transportation for non-medical needs, food and produce)

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# Special Supplemental Benefits for the Chronically Ill

- New laws define a chronically ill enrollee as an individual who:
  - Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
  - Has a high risk of hospitalization or other adverse health outcomes; and
  - Requires intensive care coordination
- MA plans may offer a benefit to a chronically ill enrollee if it has a reasonable expectation of improving or maintaining their health or overall function

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# Special Supplemental Benefits for the Chronically Ill

Enrollees with one or more of the conditions below will meet the standard for medically complex chronic conditions (MMCM, Chapter 16b, Section 20.1.2)

Chronic Condition
Cardiovascular disorders
Diabetes mellitus
Chronic lung disorders
Neurologic disorders
Chronic heart failure
Chronic and disabling mental health conditions
Cancer, excluding pre-cancer conditions or in-situ status
Dementia
Chronic alcohol and other drug dependence
Autoimmune disorders
Stroke
End-stage renal disease (ESRD) requiring dialysis
Severe hematologic disorders
End-stage liver disease
HIV/AIDS

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# Additional Telehealth Benefits

Recent law allows MA plans to provide “additional telehealth benefits” (**ATBs**) to enrollees starting in **2020**.

- ATBs are services that are available under Medicare Part B but which are not already payable under original Medicare
- MA plans may decide which Part B services are clinically appropriate to provide as ATBs and enrollees must have the option to receive the service through an in-person visit or through telehealth.
- Cost sharing may vary for the specified service furnished in-person vs. telehealth
- ATBs must be listed in MA plans’ Evidence of Coverage and Provider Directory

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# Step Therapy for Part B Drugs

MA plans may use step therapy for Part B drugs as a recognized utilization management tool and must disclose that Part B drugs may be subject to step therapy requirements in the plan's Annual Notice of Change and Evidence of Coverage documents

- MA plans must cover all medically necessary Part B drugs;
- Beneficiaries can request a coverage decision (“organization determination”) if they need direct access to a drug that would otherwise only be available after trying an alternative drug
- Shorter adjudication timeframes for organization determinations and appeals: 72 hours for standard requests, 24 hours for expedited requests
- Step therapy requirements only apply to new starts of medication (not taken within the past 365 days) and must be reviewed and approved by the plan's pharmacy and therapeutics committee
- The beneficiary can appeal the plan's decision

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# Agent/Broker Prohibited Behaviors

## Agents and Brokers:

- May not state they are from Medicare or use the term “Medicare” in a misleading manner
- May not solicit door-to-door, via text message, or via cold-calling (including leaving voicemail)
- May not approach beneficiaries in public – beneficiaries must approach the agent/broker at public events/healthcare settings

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# Agent/Broker Permitted Actions

- May call or visit a beneficiary with permission
- May call an existing beneficiary (i.e., client of the agent/broker) to discuss plan business

## Examples:

- Calling a PDP beneficiary about MA plans
  - Calling a commercial member who is aging into Medicare
- Must obtain a scope of appointment (SOA) prior to any meeting or change in meeting topics (e.g., adding MA to a PDP meeting)

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# Electronic Documents

CMS permits plans to provide members with certain materials electronically (via email, link to website, member portal, or phone app)

- Beneficiaries who have “opted-in” can receive all documents electronically
- Plans/Part D Sponsors may choose to make available certain documents, such as the Evidence of Coverage or Formularies, electronically (by default) to all beneficiaries
  - Members will receive a hard copy notice of how to access the documents
  - Members can request a hard copy to be mailed

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# Gifts

- Plans/Part D Sponsors may offer nominal gifts to beneficiaries at meetings provided the gift is worth \$15 or less and is offered regardless of whether the beneficiary enrolls
- The annual limit for Plans/Part D Sponsors providing gifts to any beneficiary is \$75 a year
- Plans/Part D Sponsors may not offer gifts in the form of cash or other monetary rebates, even if their worth is \$15 or less

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# Star Ratings

- CMS requires Plans/Part D Sponsors to include the CMS Star Rating template with enrollment forms
- Star ratings are out of five (5) stars
- CMS issues star ratings on a calendar year basis; Plans/Part D sponsors must indicate the year in which the star rating applies
- Plans/Part D Sponsors must not present a star rating for individual measures (e.g., customer service) and imply that the rating is its overall star rating.
- If a Plan/Part D Sponsor provides a star rating for an individual measure, it must also provide its overall star rating.

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