DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

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TO: Medicare Advantage Organizations and Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Director

SUBJECT: Reinterpretation of the Uniformity Requirement

In the contract year (CY) 2019 Call Letter, issued on April 2, 2018, CMS announced the reinterpretation of the uniformity requirement in the Medicare Advantage (MA) regulations at §422.100(d). This uniformity reinterpretation was also detailed in the preamble of CMS-4182-F. The purpose of this memorandum is to provide MA organizations and Section 1876 cost plans with guidance for preparing their 2019 plan bids. This guidance will be incorporated into the Medicare Managed Care Manual, Chapter 4.

Under this reinterpretation, CMS determined that providing access to services (or reductions in specific cost sharing and/or deductibles for services or items) that are tied to health status or disease state in a manner that ensures that similarly situated individuals are treated uniformly is consistent with the uniformity requirement in the MA regulations at §422.100(d). These targeted benefits must provide for equal treatment of enrollees with the same health status or disease state for whom such services and benefits are useful and consistent with equal access and anti-discrimination provisions in section 1852 of the Act. The requirement for uniform bids and premiums in section 1854(c) of the Act remains applicable, and therefore, plan premium and Part B premium buy-down amounts must be the same for all enrollees in the plan or plan segment. CMS's reinterpretation of the uniformity requirements applies only to Part C benefits.

Please note that MAOs may vary premium, cost sharing, and supplemental benefits within each segment of an MA plan's service area. Plan segments are defined in the MA regulations at §422.262(c)(2). Although an MA plan may segment Part C benefits, if the plan offers Part D it must offer the Part D benefit uniformly within the plan's service area including any segments.

Separately, CMS continues to test value based insurance design (VBID) through the use of our demonstration authority under Section 1115A of the Act (42 U.S.C. 1315a, added by Section 3021 of the Affordable Care Act), which includes some of the elements discussed in this memo. The MA-VBID demonstration is testing whether the flexibility to offer clinically-nuanced VBID elements in MA plan benefit designs will lead to improved health outcomes and lower expenditures for MA enrollees. There are features of the MA-VBID demonstration that are unique to the demonstration test, such as the ability to lower cost sharing or design interventions

for Part D benefits. In addition, the MA-VBID demonstration has additional model requirements including an application prior to bid submission, geographic limitations for plan offerings in CY 2019, and requiring three years' experience prior to participation in the demonstration. The reinterpretation of uniformity discussed in this memorandum is not subject to VBID demonstration requirements and plans must reflect benefit costs as described in MA bidding guidance issued annually by the Office of the Actuary.

Coverage requests from enrollees and providers related to targeted benefits, as discussed below, should not be treated differently from requests for other benefits furnished by an MA plan. If a request concerning coverage of an item or service submitted to a plan fits within one of the actions defined as an organization determination under 42 CFR §422.566(b), then the MA plan must treat the request as an organization determination. If a request is an organization determination under 42 CFR §422.566(b), then the coverage decision is subject to the Subpart M appeals process.

Consistent with other benefits, CMS expects plans to follow Medicare marketing guidelines in communicating these benefits to potential enrollees. For example, plans may include these benefits in the Summary of Benefits. Specific instructions related to uniformity flexibility have been included in the Annual Notice of Changes/Evidence of Coverage (ANOC/EOC) model materials to summarize information in the benefits chart. This will serve as the required communication of targeted benefits to potential enrollees.

Organizations are responsible for clearly identifying what supplemental benefits will be covered in the plan's EOC. Any limitations on coverage also should be clearly noted in the EOC. Plans must include the objective criteria used to identify eligible enrollees in written policies and must clearly communicate these policies to enrollees (such as in the EOC and other plan documents). This is necessary to ensure that plans do not provide targeted benefits in a discriminatory fashion and that the overall benefit package is uniform.

The cost sharing and benefit flexibility must be furnished uniformly to plan enrollees that are similarly situated (that is, all plan enrollees who are diagnosed with the identified, specified health status or disease state(s) are treated the same and enjoy the same access to these targeted benefits). Section 1852(b)(1)(A) prohibits an MA plan from denying, limiting, or conditioning the coverage or provision of a service or benefit based on health-status related factors. MA regulations (e.g., §§422.100(f)(2) and 422.110(a)) reiterate and implement this non-discrimination requirement. In interpreting these obligations to protect against discrimination, CMS has historically indicated that the purpose of the requirements is to protect high-acuity beneficiaries from adverse treatment on the basis of their higher cost health conditions. (79 FR 29843; 76 FR 21432; and 74 FR 54634.)

As organizations consider implementation of flexibility in the uniformity requirement, they must ensure compliance with non-discrimination rules and regulations. Organizations that exercise this flexibility must ensure that the cost sharing reductions and targeted supplemental benefits only apply to healthcare services that are medically related to each health status or disease state. CMS will not permit cost sharing reductions across *all* benefits for an enrollee; cost sharing reductions must be for specific benefits or services related to a specific health status or disease state. In addition, CMS will be concerned about potential discrimination if a plan is targeting

cost sharing reductions and additional supplemental benefits for a large number of disease states, while excluding other conditions, particularly higher-cost conditions. CMS will review benefit designs to make sure that the overall impact of the benefit design is non-discriminatory and that higher acuity, higher cost enrollees are not being excluded from these targeted benefits in favor of healthier populations. CMS may not approve benefit offerings that may pose an undue risk of enrollee harm or confusion, are determined to be discriminatory, or have the potential to impose excessive costs on the Medicare program. CMS reserves the right to take enforcement or compliance action should discriminatory activities or factors related to plan designs later become apparent in the organization's implementation, administration, or provision of these benefits.

Targeted Benefits and Enrollee Eligibility

Organizations offering targeted benefits are responsible for clearly identifying the clinical categories selected by an organization, and must briefly describe them in section B19 of the PBP, which is used to collect information about VBID and/or MA Uniformity Flexibility benefit designs. The International Statistical Classification of Diseases and Related Health Problems, also known as ICD-10 codes, must be used to formally define the targeted conditions, or a subset of diagnoses within the targeted conditions. Plans are encouraged to select ICD-10 codes that map to the CMS Hierarchical Condition Category (HCC) risk-adjustment model when defining the targeted conditions. Plans are expected to briefly describe their criteria in the PBP in the general notes field at the end of section B19a and/or 19b (i.e., no need to include CMS-HCC or ICD-10 codes), as well as maintain detailed internal documentation necessary to address potential beneficiary appeals, complaints, and/or general oversight activities performed by CMS.

Examples of disease states/clinical conditions in the PBP from which organizations may choose to target benefits include: Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Patient with Past Stroke, Hypertension, and Coronary Artery Disease. Plans that target benefits for the disease states identified in the PBP are not required to cover all ICD-10 codes associated with the disease, but may offer targeted benefits to a subset of diagnoses within the targeted condition.

Plans may also offer targeted benefits for other disease states/clinical conditions not identified above, (e.g., lower back pain, kidney disease, obesity, pre-diabetes, asthma, tobacco use, hypercholesterolemia) as long as the conditions can be objectively identified by ICD-10 codes and the benefits are medically related to each health status or disease state. Also, we encourage organizations to consider offering targeted benefits for treating opioid addiction by reducing cost-sharing for mental health care services. Social determinants may not be used as a means to target benefits, even those benefits related to health (e.g., homelessness, food insecurity).

Organizations also may identify combinations of clinical conditions and establish targeted benefits for each group. For example, a plan could identify enrollees diagnosed with two specific diseases as medically in need of certain benefits and services, such as both diabetes and congestive heart failure, so long as they align with those diseases.

Plans must use objective measureable medical criteria to identify eligible enrollees, and the enrollees must be diagnosed by a plan physician/medical professional or have their existing

diagnosis certified or affirmed by a plan physician/medical professional. Eligible enrollees cannot be required to opt-in, unless there is a prerequisite for participation in a wellness or care management program.

Types of Targeted Benefit Enhancements

Organizations may select from two types of targeted benefit offerings: reduced cost sharing and additional supplemental benefits. An organization may vary benefits from one target population to another and from one PBP to another. However, organizations may not reduce benefits or increase cost sharing for targeted enrollees, as compared to the base benefits offered to all enrollees in the plan year.

Reduced Cost Sharing

Organizations can choose to reduce or eliminate cost sharing or deductible requirements for items or services for the target population. Organizations have flexibility to choose the items or services that are eligible for cost sharing reductions. The items or services must be clearly identified and defined in the bid, and reductions in cost sharing must be available to all enrollees within the target population. Reductions in cost sharing could include elimination or reduction of copays, coinsurance, deductibles, and/or exemption of a given service from the plan or service category deductible. If the targeted cost sharing benefit structure differs from the base plan benefit structure (e.g. the base benefit is coinsurance but the targeted benefit is copay), the organization must apply the cost sharing benefit that results in the lowest out-of-pocket cost to the enrollee.

Examples of targeted benefits might include the elimination of copays for endocrinologist visits for enrollees with diabetes or offering diabetic enrollees a lower deductible. Under this example, non-diabetic enrollees would not have access to the reduced cost sharing; however, any enrollee that develops diabetes would then have access to these benefits. In cases where the enrollee has multiple diseases that cross multiple targeted benefit packages, the enrollee should receive the benefit that offers them the lowest cost sharing for that service.

Organizations may process the reduced cost sharing for targeted enrollees through retroactive reimbursement. For example, an enrollee who receives care from a provider for which cost sharing should be less than the base plan would pay the base plan cost sharing to the provider and be retroactively reimbursed by the plan for the reduced cost sharing.

Consistent with Chapter 4, plans may not use different cost sharing amounts that are based on the cumulative number of visits (e.g., cost sharing of $5 for visits 1-5 and cost sharing of $10 for visits 6 and greater); however, plans are permitted to limit the maximum aggregate dollar amount of reduced cost sharing.

Additional Supplemental Benefits (Does <u>not</u> apply to 1876 Cost Plans)

Organizations may offer certain supplemental benefits to targeted populations only, so long as the benefits are consistent with existing rules for supplemental benefits. Examples might

include: nonemergency transportation to primary care visits for enrollees with CHF, and additional sessions of tobacco use cessation counseling for enrollees with COPD (See Managed Care Manual, Ch. 4, section 30 for additional guidance on supplemental benefits). Targeted supplemental benefits must be health care items or services that are medically related to the health status or disease state of the targeted enrollees.

These benefits will be treated as mandatory supplemental benefits and are subject to the same rules as any other benefit in that service category. Although these benefits are available only to certain clinically-targeted enrollees, they are funded by rebate and/or premium dollars from all PBP enrollees. In this respect, the benefits would be similar to existing enhanced disease management programs, which are only available to enrollees with a targeted health status or disease state. Plans need not use uniformity flexibility to offer enhanced disease management, medical nutrition therapy (MNT), and health education to enrollees with a targeted health status or disease state as mandatory supplemental benefits.

Prerequisites for Targeted Benefits

Organizations have the option of limiting targeted benefits to enrollees who agree to participate in a plan-sponsored wellness, care management, or similar program as long as there is equal access to the disease management program based on objective criteria related to the health status or disease state. A plan-sponsored program could include participation in an enhanced disease management program, offered by the organization as a supplemental benefit, or it could refer to specific activities that are offered or recommended as part of a plan's care coordination activities.

Organizations using this approach can condition cost sharing reductions or access to targeted supplemental benefits on enrollees meeting certain milestones based on participation. For example, a plan may require that enrollees meet with a case manager at a defined regular interval in order to qualify. This prerequisite may not be structured in a discriminatory manner, and all applicable targeted enrollees must have the opportunity to enroll in the program and/or participate in the activities in question (or an alternative), regardless of health status, location or disability. However, plans cannot make cost sharing reductions or access to targeted supplemental benefits conditional on achieving any specific clinical goals. For example, a plan cannot condition cost sharing reductions on enrollees achieving certain thresholds in Hba1c levels or body-mass index.

Examples of targeted benefits with this prerequisite might include elimination of primary care copays for diabetic patients who meet regularly with a case manager or reduction of primary care copays for patients with heart disease who regularly monitor and report their blood pressure.

Organizations also may choose to offer targeted benefits to enrollees when they visit providers identified by the plan as being high-value. For example, a plan may reduce or eliminate cost sharing for seeing identified providers, regardless of the specific service provided to a targeted enrollee. Or a plan may reduce or eliminate cost sharing only when a high-value provider delivers a specific service, or services, to a targeted enrollee. Plans also may vary their approach by target population, provider type, or certain services.

Organizations may identify high-value network providers across one or more Medicare provider types (e.g., physicians and medical practices, hospitals, skilled-nursing facilities, home health agencies, and ambulatory surgical centers). CMS encourages organizations to rely on efficiency and quality data when determining whether a provider is high-value.

Plans do not need to meet any specific network adequacy standards for the subset of high-value network providers selected as part of this approach. However, all high-value providers must be available and accessible to applicable targeted enrollees. Notwithstanding the targeted benefits offered under uniformity flexibility, plans must still meet all standard applicable network adequacy requirements (see 42 C.F.R. 422.112 and Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance). All plan enrollees, including targeted enrollees, retain the right to see any provider in network at any time (at base plan benefit package levels of cost sharing), without penalty or restriction.

When a plan offers a cost sharing reduction for a specific high-value service only, organizations are encouraged to make sure that related services in the episode of care are not subject to variable or unanticipated cost to the enrollee based on the provider's choice of coding, facility fees, or non-discounted services from other providers. In addition, we encourage plans to educate beneficiaries about the total cost of episodic care to limit beneficiary confusion.

Examples of targeted benefits with this prerequisite might include reducing cost sharing for diabetics who see a physician who historically has achieved strong results in controlling his or her patients' Hba1c levels, or eliminating cost sharing for heart disease patients who elect to receive nonemergency surgeries at cardiac centers of excellence (potentially including centers geographically remote from the PBP's service area, for which additional safeguards may be necessary, such as travel and accommodation requirements).

Plan Benefit Package (PBP) Submission

Targeted benefits offered under MA Uniformity Flexibility should be entered in PBP service category B19 VBID/MA Uniformity Flexibility. Plans have the option to create up to 15 separate disease state packages under B19a Reduced Cost Sharing for VBID/MA Uniformity Flexibility, and also under B19b Additional Benefits for VBID/MA Uniformity Flexibility. Plans may choose from the list of disease states identified, or may select "other" and clearly describe up to five additional disease states for which the plan chooses to offer targeted benefits. Plans must identify in PBP B19 if there is a prerequisite for each disease package, must enter the reduced cost sharing and/or additional supplemental benefits being offered for the appropriate service categories, must specify if the plan is offering retroactive reimbursement for the benefit, and must clearly describe the targeted benefits in the notes field.

PPO plans offering additional supplemental benefits must offer the benefits both in and out of network, though higher cost sharing for out-of-network benefits is permitted. As previously noted, plans can reduce cost sharing and deductible requirements for enrollees diagnosed with a targeted health status or disease state. However, PPO plans are not required to extend the reduction in cost sharing to out of network benefits.

Employer Group Waiver Plans (EGWP) may offer benefits under this new flexibility, but are not required to enter information into PBP Section B19. EGWPs continue to be subject to all requirements, unless waived, regardless of whether they are affirmatively evaluated as part of benefits review or in connection with other oversight.

Additional instructions for completing the PBP section B19 can be found in the Bid Submission User Manual for Contract Year 2019, Chapter 4.

Policy questions related to the information in this memorandum, may be submitted at: https://dpap.lmi.org/dpapmailbox/. If you have any operational and/or PBP related questions about the information outlined in this memorandum, please submit your question to https://mabenefitsmailbox.lmi.org/.