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CMS Proposes Key Changes to the Medicare Advantage Program

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On November 16, 2017, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule to revise regulations and clarify requirements for the Medicare Advantage (MA) and Medicare Prescription Drug Benefit (Part D) programs.[1] CMS will accept comments on the proposed rule through January 16, 2018.

In a separate, earlier alert, we summarized key proposed changes to the Part D program.[2] This summary focuses on select proposed MA program changes that, if adopted, would affect Medicare Advantage Organizations (MAOs), health care providers, Medicare beneficiaries, and various other individuals and entities.

Compliance Program Changes

CMS proposes various changes to MA compliance program requirements. CMS proposes to reduce compliance training obligations with respect to first tier, downstream, and related entities (FDRs) by eliminating the requirements that MAOs be responsible for providing compliance training to their FDRs and that FDRs complete a series of CMS-developed, web-based compliance program training modules.[3]

CMS also proposes to eliminate the requirement that providers and suppliers be enrolled in Medicare in order to provide health care items or services to an MA beneficiary. The agency expressed concerns that the existing Medicare enrollment requirement may impose a burden on and limit beneficiary access to MA providers and suppliers. Accordingly, CMS proposes an alternative rule, under which an MA organization would not be permitted to make payment for any item or service furnished by an individual or entity included on a defined "preclusion list."[4]

Modifications to the Star Ratings System

CMS proposes to codify the existing MA and Part D Star Ratings System, with certain modifications, beginning with the measurement periods in CY 2019.[5] This would create a longer lead time for new Star Ratings measures and substantive changes to existing Star Ratings

[1] Display copy available here.
[2] See Hogan Lovells, CMS Releases Major MA/Part D Proposed Rule.
[3] Display copy at 345-46.
[4] *Id.* at 413-14.
[5] *Id.* at 169.

measures. These changes would first be announced through the annual Notice and Call Letter Process and then be proposed and considered through formal rulemaking.

CMS also proposes changes to the manner in which Star Ratings are assigned to consolidated MA contracts.[6] Currently, CMS permits MAOs to assign the surviving contract the Star Rating that the contract would have earned without regard to whether a consolidation took place. In contrast, CMS now proposes to assign the consolidated contract a Star Rating that reflects the enrollment-weighted mean of the Star Rating scores of all surviving and consumed contracts.[7]

Changes to Medical Loss Ratio Reporting

MAOs are required annually to report a medical loss ratio (MLR), which reflects in the numerator how much of a MA plan's total revenue is spent on medical services claims and other qualifying expenses like quality improvement activities. CMS subjects plans to financial and other penalties if they fail to achieve and report an MLR of at least 85 percent. In the proposed rule, CMS proposes to reduce the amount of MLR data that MAOs would report to the agency. Specifically, an MAO would report only the MLR percentage and the amount of remittances owed to CMS (if any) for each of the MAO's contracts.[8] CMS also proposes to permit MAOs to include, in the numerator of the MLR, expenditures related to fraud prevention, detection, and recovery activities and Part D Medication Therapy Management programs – a regulatory change that MAOs had long sought.[9]

Revisions to Marketing Requirements

CMS proposes changes to the Medicare regulations regarding marketing activities in order to lessen the burden on MAOs and focus the agency's review on materials that present the greatest risk of negatively affecting MA plan beneficiary experiences. Specifically, CMS proposes to redefine and narrow the term "marketing" to mean materials and activities that aim to influence beneficiary enrollment decisions. Only materials that fall within this definition would be subject to more rigorous agency review.[10] CMS proposes to apply less stringent review standards to certain other materials and activities, which would be referred to as "communications" and "communications materials."[11]

Benefit and Cost-Sharing Changes

CMS proposes to revise its interpretation of the MA uniformity requirements, which currently require that MAOs offer MA plans to all Medicare beneficiaries in a particular service area at a uniform premium, with uniform benefits and cost-sharing amounts. Under the proposed rule, MAOs would have flexibility to offer certain groups of similarly situated individuals tailored supplemental benefits and/or cost-sharing amounts, so long as all individuals within a particular group have access to the same benefits with the same cost-sharing requirements.[12] CMS indicated that it may issue additional guidance clarifying the manner in which MA plans would be permitted to offer such additional, tailored supplemental benefits to particular groups.[13]

Enrollment-Related Changes

CMS also proposes changes to MA enrollment-related requirements. For instance, CMS proposes a default enrollment process for certain categories of beneficiaries. Under this process, an

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[6] *Id.* at 187-93.
[7] *Id. at 188.*
[8] *Id. at 456.*
[9] *Id. at 450-54.*
[10] *Id. at 361-64.*
[11] *Id. at 360-61.*
[12] *Id. at 106.*
[13] *Id. at 108.*

individual who is newly-eligible for Medicare and is currently enrolled in a non-MA plan offered by an MAO may be deemed to have elected an MA plan offered by the MAO if he or she does not elect to receive Medicare coverage in another manner.[14]

CMS also proposes changes to current plan requirements regarding the delivery of beneficiary documents. CMS proposes to separate the delivery date of the Annual Notice of Change (ANOC) from that of the Evidence of Coverage (EOC) and other plan documents.[15] Under the proposed rule, plans would still be required to send the ANOC to beneficiaries at least fifteen days prior to the open enrollment period. However, they could send the EOC and other materials by the first day of the annual open enrollment period. In proposing this change, CMS noted that it has found, through consumer testing, that the EOC is often an overwhelming and confusing document for beneficiaries, and, in contrast, the ANOC provides beneficiaries with a clearer summary of relevant plan information.[16] CMS hopes that, with the benefit of an additional two weeks to prepare the EOC, MAOs will prepare documents with fewer errors. CMS also proposes to allow plans to post certain benefit documents, including the EOC, electronically and to provide hardcopy materials only upon request, given the increasing number of beneficiaries who use the internet.[17]

Elimination of Quality Improvement Project Requirements

Currently, in addition to other quality improvement activities, CMS requires plans to implement quality improvement projects (QIPs) in particular focus areas identified by CMS. In the proposed rule, CMS acknowledges that the QIPs do not add significant value and are often duplicative of activities MAOs are already pursuing to meet other plan needs and requirements.[18] Therefore, CMS proposes to eliminate regulatory requirements regarding QIPs. CMS clarifies that the MA requirements with respect to Chronic Care Improvement Programs and other Quality Improvement Program components would remain in place, as is required under Section 1852(e) of the Social Security Act.[19]

[14] *Id.* at 126-28.
[15] *Id.* at 353.
[16] *Id.* at 352.
[17] *Id.* at 355-57.
[18] *Id.* at 440.
[19] *Id.* at 441-42.

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