COSMOS
Navigate the Compliance Universe

Compliance Today - March 2021
Back to the future: Medicare Advantage compliance policies and processes that the Biden administration may revisit

By Michael S. Adelberg and Kristin B. Rodriguez

Michael S. Adelberg (michael.adelberg@faegredrinker.com) is Principal at Faegre Drinker Consulting in Washington, DC, and **Kristin B. Rodriguez** (kristin.rodriguez@healthplanalliance.org) is Chief Operating Officer at Health Plan Alliance located in Dallas, TX.

- linkedin.com/in/kbrodriguez/
- linkedin.com/in/michael-adelberg-77799b2b/

Years from now we will remember this time period as the good old days of Medicare Advantage (MA). The program is growing rapidly, nearly 10% annually, and some prognosticators expect enrollment to reach 70% of Medicare beneficiaries by 2040.[1] Despite the rapid growth, member satisfaction is at a record high—94% per a recent survey.[2] Medicare beneficiaries choose managed care plans for the same reason that state governments and employers select managed care for Medicaid and employees respectively—managed care delivers more benefits and services for a fixed cost than unmanaged care. MA plans offer Medicare beneficiaries a compelling value proposition: lower total out-of-pocket costs, catastrophic protection, care coordination, and supplemental benefits unavailable in original Medicare. This value proposition is discussed favorably in Centers for Medicare & Medicaid Services (CMS) information channels: the "Medicare & You" handbook, medicare.gov, and 1-800-MEDICARE. Some consumer advocacy groups have accused CMS of pro-MA bias.[3]

Without question, the Trump administration policies have contributed to the growth of Medicare Advantage. In addition to greater annual payment updates than experienced during the Obama administration (e.g., 4.1% for Plan Year 2022),[4] a short list of Trump administration policy changes that facilitated growth in the MA program include:

- **Benefits**: CMS loosened longstanding uniformity and primarily health-related supplemental benefit rules[5] (recently codified in regulation)[6] and rolled out, per section 50322 of the Bipartisan Budget Act, additional special supplemental benefit flexibilities, as well as other benefit flexibilities under its multiyear value-based insurance design model.[7]
- **Meaningful difference:** CMS ended "meaningful difference" reviews, permitting MA plan sponsors to offer more plans within a given market.[8]
- **Marketing**: CMS loosened its marketing rules in a number of important ways, such as excluding "communications" materials from its marketing review process and permitting providers to support plan marketing in new ways.[9]
- **Network adequacy**: CMS eased provider network adequacy standards by clarifying network adequacy exceptions and introducing a network adequacy credit for telehealth providers.[10]

- **Drugs**: CMS introduced prior authorization for Part B drugs,[11] indications-based formulary flexibilities, and other formulary management flexibilities.[12]
- **Telehealth**: CMS permitted MA plan sponsors to consider telehealth Part B benefit rather than a supplemental benefit, making telehealth more affordable in plan bids.[13] It then introduced several new virtual health services flexibilities in response to the COVID-19 public health emergency.[14] (As the public health emergency had been extended to the end of January, it will fall to the new Biden administration to determine when these flexibilities might sunset.)
- **CMS application and contract award**: CMS moved provider network submission and network adequacy review for contract applications and, while maintaining the requirement for applicants to obtain a state license by February, without an explicit policy change, extended the window during which applicants can secure a state license from spring into early summer. CMS first removed provider network adequacy reviews from CMS's 2019 "Part C -Medicare Advantage and 1876 Cost Plan Expansion Application."[15] The application maintains provider network requirements for Special Needs Plan Models of Care.[16]