7/29/04

MEDICARE ADVANTAGE REFORM AND BURDEN REDUCTION

One of the principal goals of the Medicare Advantage (MA) program is to reform and expand the current Medicare+Choice (M+C) program and provide the kinds of reliable coverage choices available to those in the Federal Employees Health Benefits Program (FEHBP). Participation of additional plans will provide beneficiaries choices like those in the FEHBP everywhere in the nation. Expanding plan participation requires not only creation of new alternatives, but also reforms in the processes and requirements previously imposed under M+C. That program was unnecessarily burdensome in some ways, and was designed around an HMO model unsuited for PPO and HMO point-of-service (POS) plans.

The table below shows some of the important similarities between a newly reformed Medicare Advantage program and FEHBP. Medicare Advantage will become a competitive, consumer-driven system that enables beneficiaries to join the plans best suited to their needs.

Program Characteristics	FEHBP	Medicare Advantage	Comment
Annual Open Season to choose plan	Yes	Yes	This focuses enrollees on their opportunity for choice.
Multiple plans available in all areas of the country	Yes	Yes	One third of beneficiaries currently have no M+C plan available; new MA regional plans should eliminate this gap.
Plans compete based on premium, benefits, service, and provider networks	Yes	Yes	Competition pressures plans to improve performance.
Plans have comprehensive hospital, doctor, drug benefits	Yes	Yes	Previously, many M+C plans offered minimal drug benefits.
Plans have flexibility to design own options – no “one-size-fits all” single plan design.	Yes	Yes	Although plan flexibility is expanded, MA core benefits must equal those of traditional Medicare.
Information comparing plan quality and benefits	Yes	Yes	Enables enrollees to make informed choices.
Quality improvement emphasis	Yes	Yes	Plans focus on real problems and solutions
Minimum red tape and barriers to flexibility imposed on plans	Yes	Yes	Numerous reductions in regulatory burden under MA, moving closer to the FEHBP model.
Multiple plan types allowed (HMO, PPO, POS, MSA)	Yes	Yes	MA tailored to participation of new plan types
Plans "at risk" for profits or losses	Partial	Yes	Most FEHBP enrollment is in "experience rated" plans that can recover some losses. Cost plans phased out under MA.
Detailed risk adjustment mechanism to ameliorate adverse selection	No	Yes	Creates level playing field for plan competition.

Achieving this parallelism required not only new statutory authority (e.g., for regional PPO plans), but also a substantial focus on reducing regulatory barriers and burdens in the M+C program. Some of these have long been obvious, and during the last several years a number of reforms were made under the old statute.

Recently Completed Burden Reduction Initiatives

CMS has already undertaken a series of initiatives to reduce the unnecessary administrative burden faced by health plans during their participation in the M+C program. Many of these were brought to our attention by the industry and CMS has worked collaboratively with the health plans to ensure smooth implementation of these improvements by:

- Automating the rate submission and review process to make it more simple and efficient for plans to submit their proposals each year.

- Allowing plans to use marketing materials to inform beneficiaries without waiting for CMS review. (The statute requires CMS to review plan marketing materials and we still require plans to file these materials.) This "file and use" system is similar to the FEHBP approach, where information is assumed to be accurate and intervention is on a by exception basis.

- Developing and implementing an outcomes-focused performance review system to reward high-performing health plans. This also parallels the FEHBP practice.

- Reducing reporting, paperwork, and record-keeping requirements in a number of ways, including:
    - Developing and implementing a risk adjustment data collection system that minimizes burden on plans.
    - Modifying provider re-credentialing requirements to every three years (rather than every two years) – which is comparable to standard, non-governmental industry practices.
    - Reducing reporting of physician incentive program data by plans.
    - Modifying our standard contract with health plans to eliminate imposition of new, mid-year requirements, which were neither known nor built into rates when they were submitted to CMS.
    - Using an outside contract to manage the retroactive payment requests submitted by the health plans, thereby significantly increasing the accuracy, consistency and timeliness of the processing.

- Encouraging waivers that allow health plans and employers to establish plans for use by the employer's retirees.

Planned Reforms to Provide Tailored Assistance to Medicare Beneficiaries and Reduce Burdens on Plans

The Medicare Advantage proposed rules are based, in large part, on the existing M+C program platform. The improvements and efficiencies recently achieved in that program will be carried over into these rules. In addition, additional initiatives to tailor information and benefits for specific beneficiaries and reduce burden or reform procedures are proposed in the rules.

- Further reducing unnecessary paperwork by:
    - Eliminating requirements that each Medicare Advantage plan provide information on competing plans that duplicates information already provided to beneficiaries by CMS. This reform reflects the substantial expansion of information dissemination in recent years in order to improve the availability of consistent, useful information. The innovations include a plan comparison tool on the Medicare.gov web site and the toll-free 1-800-MEDICARE phone line, as well as information in the *Medicare & You* handbook. This way, we can give each beneficiary personalized information about the options in their area and assistance in making good choices while removing an unnecessary plan burden.
    - Eliminating requirements that practitioners provide unnecessary notices to enrollees at each encounter regarding any decision to deny services, e.g., eliminating the requirement for a written notice when a favorable determination is made orally. This will eliminate a confusing notice for beneficiaries while reducing plan burden.
- Targeting our new access to care requirements to deal with the special problems faced by regional Medicare Advantage plans, and to give plans flexibility in how they meet network requirements (e.g., by holding enrollees financially harmless if they need to use a non-network provider).
- Taking advantage of modern technology to help plans in program administration.
    - We propose to make it easier for beneficiaries to enroll in Medicare Advantage plans by allowing additional mechanisms (other than paper) for enrollment applications that take advantage of modern technology for an efficient and simplified process for all parties.
    - We propose to allow plans more options than traditional mailings to notify enrollees of important changes as a way to ensure that beneficiaries get this information as quickly as possible.
    - To make plan information more easily available for beneficiaries, we will encourage (and may require) plans to use up-to-date and easily

searchable Web sites to provide important information such as provider lists and drug formularies. Almost all FEHBP plans use Web sites to provide such information to enrollees.

- Allowing Medicare Advantage organizations more flexibility in responding to problems:

  - Plans may submit requests to restrict enrollment when capacity problems arise, rather than just at the time the ACR is submitted prior to the beginning of a contract year.

  - Plans will have more flexibility in developing rules related to disenrolling individuals who fail to pay premiums. Proper notice and demonstrated reasonable efforts to collect premiums continue to apply to protect beneficiaries.

  - Mitigating requirements regarding the information plans provide to enrollees about participating providers. Medicare Advantage organizations must only provide information on contracting providers that a beneficiary may "reasonably be expected" to use, such as providers in his area, rather than our current standard that requires disclosure of all contracting providers, wherever located. Of course, plans must still provide information to beneficiaries on providers outside their service area upon request.

- Changing "Quality Assurance" to "Quality Improvement" – to emphasize the organic and ongoing nature of the process. Various reforms, consistent with a "quality improvement" approach to quality standards, are made to encourage plans to focus on real problems as identified by the plans rather than on ritualistic documentation. This will improve care for Medicare Advantage enrollees as plans focus their improvement efforts on the health needs of their enrollees.

- Tailoring all substantive and administrative requirements to the unique characteristics of each type of plan. PPOs will not have to meet all HMO requirements, and FFS and MSA plans will not have to meet requirements appropriate only to coordinated care plans.

- Finding additional flexibilities in the use of waivers to facilitate employer participation and to accommodate unique situations involving a plan's retirees. Under the new rules, Medicare will be able to contract directly with employers or unions to provide care for their retirees. This way, these individuals won't have to change plans just because they become Medicare-eligible – they can have seamless coverage as they transition to Medicare.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecomments