Overview

The Centers for Medicare and Medicaid Services ("CMS") recently released a proposed rule outlining Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program. In the wide-ranging 713-page document, CMS details proposed policy updates focused on “promoting innovation and empowering MA and Part D sponsors with new tools to improve quality of care and provide more plan choices for MA and Part D enrollees.” In this summary we provide highlights of the proposed policy updates as well as a more detailed outline that follows the sequence of the CMS document. Our summary emphasizes the material that Wakely views as most relevant to product design and MA/PD bid preparation, and should not be viewed as all-inclusive. It has been written for those who are familiar with MA/PD programs and methods.

The proposed policy and technical change document in its entirety can be found here:


The CMS Fact Sheet summarizing the proposed policy changes can be found here:


Comments to the proposed rule are due January 16, 2018. We strongly encourage plan sponsors to utilize this summary to identify and prioritize proposed changes that are most relevant to plan offerings and operations.
The Highlights

The CMS proposed policy and technical changes comprise a broad array of product design, operational, quality, and compliance matters for Medicare Advantage Organization (MAO) and Part D plan sponsors. Below we briefly summarize a few of the highlights. Refer to the Detailed Outline section for a more robust summary of proposal provisions.

Pharmacy Point of Sale Rebates and Price Concessions - Request for Information

The proposed rule includes a Request for Information (RFI) exploring the concept of pharmacy price concessions at the point of sale (POS). Currently, manufacturer rebates and pharmacy price concessions are rarely captured at the POS. Therefore, while such rebates/concessions do drive lower member premiums, they do not necessarily drive lower member cost sharing at the point of sale. CMS highlights that the variation in market treatment of rebates/concessions at the POS leads to drug pricing that is not transparent. In the RFI CMS is requesting information from plan sponsors on how to effectively capture rebates/concessions at the POS to be included in the negotiated price.

In the RFI CMS discusses a few options for applying rebates at the POS, with the parameters that government expenditures do not increase and manufacturer payments under the coverage gap discount program are not reduced. The various options floated are described in our detailed outline. Based on our current understanding of the options we see the potential for cost shifting: lower member cost sharing and government low income cost sharing subsidies; increased member premium and government direct subsidies; lower coverage gap discount amounts and decreased federal reinsurance. This is assuming that plans renegotiate contracts with pharmacy benefit managers (PBMs) to roughly equate to current discounts and rebates. It will be important for plans to evaluate the impact of any revised PBM contract terms on Part D member premiums, cost sharing, and plan revenue. At this juncture, it does not appear that CMS has explored the impact to administrative costs of operationalizing such POS changes and its downstream impact on member premium.

Star Ratings - Proposed Changes

As noted in MedPAC’s March 2016 Report to Congress, over the past number of years there has been a steady increase in the number of enrollees being moved (“cross-walked” or “consolidated”) from lower Star Rating Contracts that do not receive a Quality Bonus Payment (“QBP”) to higher Star Rating Contracts that do receive a QBP. CMS sees this practice as potentially masking lower quality plans under higher rated surviving contracts. CMS is proposing to modify the Star Rating treatment of contract consolidations to be based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts (whereas current policy only considers the surviving contract performance). CMS also proposes to codify key elements of the Star Rating program, including its approach to modifying measures and calculation methodologies, with an eye toward improving visibility for MAOs around future measure modifications and weight changes. More specifically, CMS is proposing that any new performance measures be reflected on the display page for at least two years before influencing star rating calculations.
Minimum Medical Loss Ratio (MLR) - Proposed Changes

CMS is proposing to expand the definition of MLR Quality Improvement Activity ("QIA") to include all fraud reduction activities and Medication Therapy Management ("MTM") program expenses. The proposed changes serve to increase the numerator of the MLR calculation. CMS is also proposing to drastically reduce the breadth of the minimum MLR reporting requirements to only include four data fields (organization name, contract number, adjusted MLR, remittance amount). CMS still reserves the right to audit MAO data and MLR calculations.

Plan Design Flexibility – Proposed Changes

CMS proposes to remove meaningful difference requirements for MA plans. CMS also proposes that MA plans may vary supplemental benefits by segment (in addition to segment-level variation by premium and cost sharing, which is already permitted). CMS also proposes that MA organizations have the ability to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that satisfy specific clinical criteria. Finally, CMS proposes to eliminate Enhanced Alternative ("EA") meaningful difference requirements for plans offered by the same organization in the same region.

Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) – Proposed Changes

The proposed rule implements CARA and includes new authority for Part D drug management programs effective January 1, 2019. CMS proposes a framework for Part D plan sponsors to establish a drug management program for beneficiaries at risk for prescription drug abuse. Under the proposal Part D sponsors may limit “at-risk” beneficiaries’ access to coverage of frequently abused drugs to a selected prescriber(s) and/or network pharmacies.

Enrollment Provisions – Proposed Changes

There are a number of enrollment operational provisions in the proposal. CMS is proposing to codify specific limits on default enrollments for "seamless continuation of coverage" which allow MAOs to transition its Medicaid managed care plan members into MA Dual Special Needs Plans (D-SNP) upon initial Medicare eligibility. In order to promote continuity of care, CMS is also proposing to allow passive enrollment for Full Benefit Dual Eligible Beneficiaries from non-renewing integrated D-SNPs to another comparable plan (in consultation with a State Medicaid agency and various conditions must be met).

CMS is proposing to limit the current open-ended Special Election Period (SEP) for dual-eligible and Low Income Subsidy (LIS) beneficiaries. So long as the beneficiary has not been flagged as “at-risk” by pharmacy management programs, such individuals would be eligible to change plans once per year (or within two months of certain eligibility status changes).

Finally, beginning in 2019, CMS proposes to establish a new Open Enrollment Period ("OEP") per the 21st Century Cures Act. The OEP would run from January 1st through March 31st each year and allow enrollees in an MA plan to make a one-time election to join another MA plan or original Medicare.
Contents

Overview................................................................................................................................................... 1
The Highlights........................................................................................................................................ 2
Detailed Outline of Proposed Policy & Technical Changes ................................................................. 4
I. Executive Summary .................................................................................................................... 6
   A. Purpose................................................................................................................................... 6
   B. Summary of Major Provisions ................................................................................................. 6
      1. Implementation of the Comprehensive Addiction and Recovery Act of 2016 (“CARA”).... 6
      2. Updating the Part D E-Prescribing Standards............................................................... 6
      3. Revisions to Timing and Method of Disclosure Requirements ........................................... 6
      4. Preclusion List .................................................................................................................. 6
II. Provisions of the Proposed Regulation ........................................................................................ 7
   A. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability..... 7
      1. Implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) Provisions ............................................................................................................................. 7
      2. Flexibility in the Medicare Advantage Uniformity Requirements ........................................ 7
      3. Segment Benefits Flexibility .............................................................................................. 8
      4. Maximum Out-of-Pocket (MOOP) Limit for Medicare Parts A and B Services .................. 8
      5. Cost Sharing Limits for Medicare Parts A and B Services .................................................. 8
      6. Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review ........... 8
      7. Coordination of Enrollment and Disenrollment Through MA Organizations ....................... 8
      8. Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Duals .......... 9
      9. Part D Tiering Exceptions ................................................................................................ 10
     10. Establishing Limitations for the Part D Special Election Period (SEP) for Duals ............... 10
     12. Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy....... 14
     13. Changes to the Days’ Supply Required by the Part D Transition Process ......................... 15
     14. Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes ....... 15
     15. Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic ........... 15
16. Eliminating the Requirement to Provide PDP Enhanced Alternative (EA) to EA Plan Offerings with Meaningful Differences.......................................................................................................................... 15

17. Request for Information Regarding the Application of Manufacturer Rebates and Rx Price Concessions at the Point of Sale (POS) ........................................................................................................ 15

B. Improving the CMS Customer Experience ........................................................................................................ 19
   1. Restoration of the Medicare Advantage Open Enrollment Period .............................................. 19
   2. Reducing the Burden of the Compliance Program Training Requirements .............................. 19
   3. Medicare Advantage Plan Minimum Enrollment Waiver ............................................................ 19
   4. Revisions to Timing and Method of Disclosure Requirements .................................................. 20
   5. Revisions to Communication/Marketing Materials and Activities .......................................... 20
   6. Lengthening Adjudication Timeframes for Part D Payment Redeterminations and IRE Reconsiderations ...................................................................................................................... 20
   7. Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE ........................ 20
   8. E-Prescribing and the Part D Prescription Drug Program; Updating Part D Prescribing Standards .................................................................................................................................. 20
   9. Reduction of Past Performance Review Period for Applications Submitted by Current ...... 21
   10. Part D Prescriber Preclusion List ............................................................................................ 21
   11. Part C/Medicare Advantage Cost Plan and PACE Preclusion List ......................................... 21
   12. Removal of Quality Improvement Project for Medicare Advantage Organizations ................ 22
   13. Reducing Provider Burden – Comment Solicitation ................................................................. 22

C. Implementing Other Changes .......................................................................................................................... 22
   1. Reducing the Burden of the Medicare Part C and Part D Medical Loss Ratio Requirement 22
   3. Late Contract Non-Renewal ...................................................................................................... 23
   4. Contract Request for a Hearing .................................................................................................. 23
   5. Physician Incentive Plans - Update Stop-Loss Protection Requirements ................................. 23
   6. Changes to the Agent/Broker Compensation Requirements .................................................... 24
   7. Changes to the Agent/Broker Requirements ............................................................................ 24
   8. Codification of Certain Medicare Premium Adjustments as Initial Determinations ............... 24
   9. Eliminate Use of the Term “Non-renewal” to Refer to a CMS-Initiated Termination ............ 24
I. Executive Summary
   A. Purpose
      1. Purpose of the proposed changes
         • Support innovative approaches to improving quality, accessibility, and affordability
         • Improve the CMS customer experience.
         • Implement other changes.
         • Mitigate the increase in prescription drug prices.
   B. Summary of Major Provisions
      1. Implementation of the Comprehensive Addiction and Recovery Act of 2016 ("CARA")
         • The proposed rule implements CARA and includes new authority for Part D drug
           management programs effective January 1, 2019.
         • CMS proposes a framework for Part D plan sponsors to establish a drug
           management program for beneficiaries at risk for prescription drug abuse.
           a. Part D sponsors may limit at-risk beneficiaries’ access to coverage of frequently
              abused drugs to a selected prescriber(s) and/or network pharmacies.
         • Codifies current Part D Opioid Drug Utilization Review (DUR) Policy and
           Overutilization Monitoring System (OMS)
      2. Updating the Part D E-Prescribing Standards
         • The National Council for Prescription Drug Programs (NCPDP) SCRIPT standards
           are used to exchange information electronically between prescribers, dispensers,
           intermediaries and Part D plans. The proposed changes include the adoption of the
           NDPDP SCRIPT Standard Version 201701 and retirement of the current NCPDP
           SCRIPT Version 10.6 (effective January 1, 2019).
      3. Revisions to Timing and Method of Disclosure Requirements
         • CMS is proposing to allow plans to submit documents electronically (which were
           formally required to be submitted via hard copy) such as Evidence of Coverage
           (EOC) forms.
         • CMS is proposing to change the deadline for EOC document submissions to be the
           first day of the Annual Election Period (AEP). Previously, the deadline was 15 days
           prior to AEP.
      4. Preclusion List
         • Part D
           a. Currently, physicians must enroll in or validly opt-out of Medicare in order for a
              drug that they prescribe to be covered.
           b. The proposed rule would support covering prescribed drugs unless the
              prescribing physician is on a "preclusion list."
         • Part C
           a. Currently, physicians must be enrolled in Medicare in order to provide health
              care items/services to an MA enrollee.
           b. The proposed rule would support covering health care items/services furnished
              by individuals/entities not on the "preclusion list."
C. Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability


   - The proposed rule implements CARA and includes new authority for Part D drug management programs effective January 1, 2019.
   - Implements CARA Part D drug management provisions by integrating them with the current Part D Opioid Drug Utilization Review (DUR) Policy and Overutilization Monitoring System (OMS).
   - CMS proposes a framework for Part D plan sponsors to voluntarily establish a drug management program for beneficiaries at risk for prescription drug abuse.
     a. Part D sponsors may limit at-risk beneficiaries’ access to coverage of frequently abused drugs to a selected prescriber (“prescriber lock in”) and/or network pharmacies (“pharmacy lock-in”).
     b. Part D sponsors may limit access to opioids through point-of-sale (POS) claim edits or by requiring beneficiaries to obtain opioids from selected pharmacies or prescribers (after case management and notice provided to beneficiary).
   - Limits use of the Special Enrollment Period (SEP) for low income subsidy (LIS)-eligible beneficiaries who are identified as potential at-risk beneficiaries.
   - Clinical guidelines must be met to substantiate that the beneficiary is taking a high-risk dose of opioids over a sustained time period, and obtaining opioids from multiple prescribers and multiple pharmacies.
     a. Part D sponsors may evaluate enrollees for overutilization management more frequently than current CMS policy (quarterly review with 6-month lookback).
   - CMS expects that all Part D plan sponsors will implement such drug management plans.
   - CMS will publish a list of frequently abused drugs for purposes of Part D drug management programs (to be included in future Call Letters).
   - Beneficiaries with cancer, in hospice, or in long-term care would be exempt.
   - CMS details the operational parameters and requirements of drug management programs focused on opioid abuse, including prescriber and beneficiary notification requirements.

2. Flexibility in the Medicare Advantage Uniformity Requirements

   - CMS proposes to allow MA organizations to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees (that is, all enrollees who meet the identified criteria) are treated equitably.
     a. For example, reduced cost sharing flexibility would allow an MA plan to offer diabetic enrollees $0 cost sharing for endocrinologist visits along with a lower deductible.
• This new interpretation is not without limits as MA regulations still require non-discrimination in terms of limits based on health-status related factors
• CMS's updated interpretation of protecting against discrimination is to protect high-acuity enrollees from adverse treatment, and CMS will review benefit designs to ensure this is not happening.
• Targeted cost-sharing reductions and supplemental benefits should be for services related to the disease conditions.
• This flexibility would only apply to Part C (and not Part D).

3. **Segment Benefits Flexibility**
   - CMS proposes that MA plans may vary supplemental benefits by segment (in addition to segment-level variation by premium and cost sharing, which is already permitted).

4. **Maximum Out-of-Pocket (MOOP) Limit for Medicare Parts A and B Services**
   - CMS proposes to maintain its methodology for how it calculates the mandatory and voluntary MOOP limits for now, but seeks additional flexibility in how it is allowed to establish annual MOOP limits.

5. **Cost Sharing Limits for Medicare Parts A and B Services**
   - CMS proposes to use FFS data as well as MA utilization encounter data to inform patient utilization scenarios used to help identify MA plan cost sharing standards and thresholds that are not discriminatory.

6. **Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review**
   - CMS proposes to eliminate meaningful difference rules for MA plans (stand-alone PDP plans would still be subject to meaningful difference requirements).
     a. This proposal is aimed to increase competition as well as innovation.
        i. CMS notes that the average number of plans per county has fallen from about 30 in 2010 to 18 in 2017 (primarily driven by a tremendous decrease in PFFS plans).
        ii. CMS also notes that current methodology makes it difficult to objectively measure meaningful differences between plans.
        iii. CMS suggests that current methodology may force MA organizations to design benefit packages to meet CMS standards rather than beneficiary needs.
     b. CMS expects that eliminating the meaningful difference requirement will improve the plan options available for beneficiaries. However, CMS does not believe the number of similar plan options offered by the same MA organization in each county will necessarily increase significantly or create confusion in beneficiary decision-making.
     c. CMS will maintain requirements that:
        i. Allow it to discontinue plans that fail to attract sufficient membership over a sustained period
        ii. Forbid plans from misleading beneficiaries in their communication materials

7. **Coordination of Enrollment and Disenrollment through MA Organizations**
   - CMS is proposing to establish limits on default enrollments for "seamless continuation of coverage"
a. Seamless continuation is an optional process MA plans can establish where an enrollee is automatically enrolled in an MA product offered by the MCO upon initial Medicare eligibility (i.e. age-in, disability) provided the MCO covered the enrollee in a non-MA product (Commercial, Medicaid) offered by the same parent company.

- CMS is proposing to permit default enrollment only for Medicaid managed care enrollees who are newly eligible for Medicare and who are enrolled into a D-SNP administered by an MA organization (under the same parent organization that operates the Medicaid managed care plan).

- Five conditions for default enrollment:
  a. Beneficiary is dual eligible and is enrolled in an affiliated plan
  b. Default enrollment process is approved by the State, which also provides membership information to the plans
  c. Beneficiary does not opt out of default enrollment
  d. Plan provides notice to the beneficiary
  e. CMS approves the MA plan's process (approval can occur only if State approves).

- MA organization must issue a notice at least 60 days before the default enrollment effective date to the enrollee.

- CMS may rescind approval at any time if it is determined that the plan is not following requirements.

- CMS proposes to establish a simplified “opt-in” election process that would be available to all MA organizations (not just those offering D-SNPs) for the MA enrollment of their commercial, Medicaid or other non-Medicare plan members.

- Proposing to add text clarifying that seamless continuations of coverage are available to an individual who requests enrollment during his or her Initial Coverage Election Period

- When a Medicaid managed care member becomes eligible for Medicare, qualification for enrollment in a D-SNP is contingent on the following:
  a. State support for the default enrollment process
  b. Organization’s ability to identify such members >=90 days in advance of Medicare eligibility.
  c. Organization’s ability to issue written notification of enrollment at least 60 days in advance.

8. Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Duals

- CMS is proposing a limited expansion of passive enrollment for certain duals in instances where integrated care coverage would otherwise be disrupted.

- Adds authority to passively enroll full-benefit duals who are currently enrolled in an integrated D-SNP into another integrated D-SNP under certain circumstances.

- Permitted only when ALL of the following conditions are met:
  a. When necessary to promote integrated care and continuity of care
  b. Action is taken in consultation with the State Medicaid agency
c. MCO receiving passive enrollment contracts with the State to provide Medicaid coverage
d. Certain conditions are met regarding quality and continuity of care
   • Qualifying individuals will get a 2-month special enrollment period.
   • Examples where this rule could apply:
     a. MCO no longer contracts with State, but maintains MA contract. CMS could passively enroll members into a different contract that is integrated across Medicare & Medicaid
     b. If an MCO non-renews its D-SNP contract, but maintains Medicaid contract with the State, CMS could passively enroll duals into a different integrated MCO.
   • In order to receive passive enrollments, MA plans must be highly integrated (so MA plans that operate as a FIDE SNP or highly integrated D-SNP).
   • Plans newly receiving passive enrollees would be required to have substantially similar networks as plans from which passive enrollees came
   • Plans receiving new enrollment would be required to have at least a 3.0 Star Rating.
   • CMS would continue to encourage, but not require, a second notice or additional outreach to impacted individuals.

9. Part D Tiering Exceptions
   • Significant changes in the prescription drug landscape have led to increased use by plan sponsors of two generic-labeled drug tiers and mixed drug tiers that include brand and generic products on the same tiers.
   • The proposed rule would revise and clarify requirements for how tiering exceptions are to be adjudicated and effectuated.
   • The changes are intended to ensure that eligibility for tiering exceptions is based on the lowest applicable cost sharing for the tier containing the preferred alternative drug(s) for treatment of the enrollee's health condition (as compared to cost sharing for the requested, higher-cost drug).

10. Establishing Limitations for the Part D Special Election Period (SEP) for Duals
    • CMS has observed that few duals/LIS enrollees use the special enrollment period
    • CMS believes it may be disadvantageous for dual enrollees to change plans once or multiple times.
    • CMS proposing to make the SEP for Full Benefit Dual Eligibles (FBDE) and other subsidy-eligible individuals available only in certain circumstances:
      a. Eligible beneficiaries could use the SEP once a year
      b. Eligible beneficiaries assigned by CMS or the State could use SEP before auto-assign and up to two months after enrollment
      c. Beneficiaries with a change in Medicaid or LIS status would have a SEP for 2 months after the change.

11. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System
    • In this section CMS details the current process for measuring quality at the contract level for MA only, MA-PD, and PDP contracts. The following summary touches on each of the changes proposed, but will not provide a rigorous review of current CMS methodologies.
• Star Ratings for Contract Consolidations
  a. As noted in MedPAC's March 2016 Report to Congress, there has been a steady increase in the number of enrollees being moved from lower Star Rating Contracts that do not receive a Quality Bonus Payment ("QBP") to higher Star Rating Contracts that do receive a QBP. This practice is seen as masking the low quality plans under higher rated surviving contracts.
  b. CMS is proposing to assign and display on Medicare Plan Finder Star Ratings based on the enrollment-weighted mean of the measure scores of the surviving and consumed contracts.
  c. Enrollment-weighted means will be used for the first and second year after a contract consolidates. By the third year, the measure data being collected will be based off the combination of contracts.
    i. CMS will use July enrollment of the measurement period for each contract measure being averaged.
  d. QBPs in the first year after consolidation will also be based on the enrollment-weighted average of the combining contracts' QBP ratings.
    i. This qualification is specifically for two or more contracts consolidating that are under the same parent organization and are of the same product type.
    ii. The calculation uses contract enrollment from November of the year the Star Ratings were released.
  e. CMS Estimates that with the change in how QBP are paid to consolidated contracts there will be fewer Quality Bonus Payments paid out in future years.
    i. CMS estimates that this will lead to $32M in Net Savings in 2019, increasing each year to $44M in net savings in 2023.
  f. See below for table describing how consolidations would be handled each year for two contracts consolidating on January 1st, 2019:
g. **A more stringent and clear process for adding, updating and removing measures each year.** The goal here is to lessen the year over year changes in quality measures to allow plans more stability to organize multi-year initiatives.

i. MAOs will know in advance when new measures will be added.

ii. Because the process is now more mature, there should be less need for extensive changes each year.

iii. Proposed changes will begin for measure data collected starting in 2019

iv. CMS will request feedback on potential changes to quality measures via the Call Letter each year.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>QBP is determined based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2020</td>
<td>2017 (IS NOT COMBINED YET)</td>
<td>2018 (IS NOT COMBINED YET)</td>
<td>November 2018 enrollment-weighted average of surviving and consumed overall (rounded) contract Star Ratings</td>
</tr>
<tr>
<td>2020</td>
<td>2021</td>
<td>2018 and will need to be weighted together at the individual measure level using July 2018 contract-level enrollment weights</td>
<td>2019 and will need to be weighted together at the individual measure level using contract-level enrollment weights (at the time of sample pulls)</td>
<td>Combined Star Rating</td>
</tr>
<tr>
<td>2021</td>
<td>2022</td>
<td>2019 and will need to be weighted together at the individual measure level using July 2019 contract-level enrollment weights</td>
<td>2020 as reported/collection (since contracts were already consolidated as of 1/1/2020)</td>
<td>Combined Star Rating</td>
</tr>
</tbody>
</table>
v. New performance measures will be incorporated into the display page for at least two years before they are built into the Star Rating Calculation.

h. Changes to Star Rating Measures to be collected in 2019 for calendar year 2021 contracts impacting payment year 2022:
   i. Removed measures:
      1. Beneficiary Access and Performance Problems-Removed as both a Part C and Part D Measure
   ii. Added measures:
      1. Statin Therapy for Patients with Cardiovascular Disease (SPC)- Added as a Part C Measure
      2. MTM Program Completion Rate for Comprehensive Medication Reviews (CMR)- Added as a Part D Measure
      3. Statin Use in Persons with Diabetes (SUPD) - Added as a Part D Measure
   iii. Changed Weights
      1. Patient experience/complaints and access measures will be increased from a weight of 1.0 to between 1.5 and 3.
   i. CMS has proposed new rules for reducing measure Star Ratings in instances of incomplete, inaccurate, or biased data.
      i. HEDIS measures will be reduced to 1 Star if through an audit, the data is deemed "biased" by the auditor.
      ii. HEDIS measures will be reduced to 1 Star if MAOs choose not to submit data and an audit deems that they should have submitted data (on the specified measure).
      iii. HEDIS measures will be reduced to 1 Star if MAO does not score at least 95% on data validation. This would require plans to be not sufficiently accurate, impartial, or complete.
   iv. CMS is also introducing a scaled measure level reduction where data completion issues are identified. If an MAO is deemed to have failed to submit data to an Independent Review Entity (IRE), it may be subject to a reduction in the measure level star rating in the instance of:
      1. Failure to submit at least 20% of potential total data records applicable to a measure
      2. Failure to submit at least 10 cases in a 3-month period
      3. The Star reduction will vary from 1-4 depending on the assumed percent of total cases not submitted.
   j. CMS is requesting feedback on the following topics (not yet formal proposals):
      i. Additional opportunities to improve measures
      ii. Whether the current cut-point process can be simplified
      iii. How CMS should measure overall improvement across Star Rating measures
      iv. Additional geographic/market specific adjustments that could be incorporated
v. Opportunities for CMS to put new entrants on a level playing field with renewing plans
vi. Adding measures that evaluate quality from the perspective of adopting new technology
vii. Adding survey measures of physician experiences
viii. Whether plan level reporting could be considered rather than contract level reporting

12. Any Willing Pharmacy Standards Terms and Conditions and Better Define Pharmacy

- This section is intended to clarify or modify CMS interpretation of the existing regulations to ensure that MAOs can continue to develop and maintain preferred networks while fully complying with the any willing pharmacy requirement.

- Any Willing Pharmacy Required for All Pharmacy Business Models
  a. Although Part D sponsors may continue to tailor their standard terms and conditions to various types of pharmacies, Part D plan sponsors may not exclude pharmacies with unique or innovative business or care delivery models from participating in their contracted pharmacy network on the basis of not fitting in the correct pharmacy type classification.
  b. In particular, CMS considers "similarly situated" pharmacies to include any pharmacy that has the capability of complying with standard terms and conditions for a pharmacy type, even if the pharmacy does not operate exclusively as that type of pharmacy.

- Revise the Definition of Retail Pharmacy and Add a Definition of Mail-Order Pharmacy
  a. To clarify what a mail-order pharmacy is, CMS proposes to define mail-order pharmacy as a licensed pharmacy that dispenses and delivers extended days' supplies of covered Part D drugs via common carrier at mail-order cost sharing.
  b. CMS proposes to revise the definition of retail pharmacy to "any licensed pharmacy that is open to dispense prescription drugs to the walk-in general public from which Part D enrollees could purchase a covered Part D drug at retail cost sharing without being required to receive medical services from a provider or institution affiliated with that pharmacy."

- Treatment of Accreditation and Other Similar Any Willing Pharmacy Requirements in Standard Terms and Conditions
  a. Consistent with longstanding policy, CMS expects Part D plan sponsors to limit dispensing of certain drugs or drugs for certain disease states to a subset of network pharmacies, except when necessary to meet FDA-mandated limited dispensing requirements

- Timing of Contracting Requirements
  a. CMS proposes to establish deadlines by which Part D plan sponsors must furnish their standard terms and conditions to requesting pharmacies (within two business days of request, documents must be ready as of September 15th for succeeding year).
13. Changes to the Days’ Supply Required by the Part D Transition Process
   - CMS proposes to shorten the required transition days’ supply in the long-term care (LTC) setting from up to "at least 91 days and may be up to 98 days" to the same supply currently required in the outpatient setting.
   - CMS proposes a technical change to the current required days' transition supply in the outpatient setting from "at least 30 days of medication" to one month's supply.

14. Expedited Substitutions of Certain Generics and Other Midyear Formulary Changes
   - CMS proposes to provide Part D sponsors with more flexibility to implement generic substitutions as follows:
     a. Permit Part D sponsors to immediately remove brand name drugs (or to make changes in their preferred or tiered cost-sharing status), when replaced with therapeutically equivalent newly approved generics--rather than having to wait for direct request/formulary change requirements.
        i. Generic drug must be offered at the same or a lower cost sharing and with the same or less restrictive utilization management criteria originally applied to the brand name drug.
     b. Allow sponsors to make specified generic substitutions at any time of the year rather than waiting for them to take effect two months after the start of the plan year.
     c. Decrease notice requirement from 60 to 30 days when drug removal and changes in cost sharing will affect enrollees (excluding generic substitution and drugs deemed unsafe or withdrawn from the market).
     d. CMS does not believe that significant savings will necessarily result from these proposed provisions, because historically Part D sponsors have been able to anticipate the generic launches well and migrate the brand scripts to generics smoothly once the generic drugs become available.

15. Treatment of Follow-On Biological Products as Generics for Non-LIS Catastrophic
   - CMS proposes to revise the definition of generic drug to include certain follow-on biological products.
   - CMS believes this will reduce costs to Part D enrollees and generate savings for the Part D program. Specifically, OACT estimates this proposal will provide a modest savings of $10 million in 2019, with savings increasing by approximately $1 million each year through 2028.

16. Eliminating the Requirement to Provide PDP Enhanced Alternative (EA) to EA Plan Offerings with Meaningful Differences
   - Effective for Contract Year 2019, CMS proposes to eliminate the PDP EA to EA meaningful difference requirement, while maintaining the requirement that enhanced plans be meaningfully different from the basic plan offered by a plan sponsor in a service area.

17. Request for Information Regarding the Application of Manufacturer Rebates and Rx Price Concessions at the Point of Sale (POS)
   - Introduction:
a. Through analysis of Direct and Indirect Remuneration (DIR) reports submitted by MAPD and PDP plans, CMS has observed significant growth in manufacturer rebates and pharmacy price concessions.

b. CMS recognizes that while these amounts do lower member premium, for the most part, these amounts are not captured at point of sale and the result is that beneficiaries do not benefit from lower cost sharing.

c. CMS explains that the variation in treatment of these amounts in the market results in point of sale drug prices that are less transparent.

d. CMS requests information from plan sponsors on how to effectively capture these amounts at point of sale to be included in the negotiated price.

- Background
  
a. Point-of-sale (POS) negotiated price is key determinant of member, plan, manufacturer (coverage gap) and government (subsidies and federal reinsurance) liability.

b. Under current law, plan sponsors are not required to reflect all price concessions at point of sale (very rarely are rebates and pharmacy price concessions captured at point of sale).

  i. Premium and Plan Benefits
     1. A primary benefit to reflect rebates and pharmacy price concessions as DIR is that plan liability is lowered, which results in lower plan premiums and government subsidies.
     2. Per CMS, the majority of excess DIR not captured in the bid is retained as plan sponsor profits
     3. Per CMS, this approach to capture these amounts as DIR results in higher negotiated point of sale prices and a cost shift from plan liability to higher member cost sharing (for members that use higher cost drugs) and to government subsidies.

  ii. Cost-Shifting
     1. Members that utilize the high cost drugs incur higher overall costs after adjusting for lower member premiums. For LI members, this cost is borne by the government.
     2. CMS recognizes the advantage of lower premiums must be weighed against reduced access from higher cost sharing.
     3. Per CMS, this phenomenon pushes members through the four coverage phases into catastrophic at a quicker pace and results in higher federal reinsurance expenditures.

  iii. Transparency and Differential Treatment
     1. True cost of drug is not known at point of sale as rebates and pharmacy price concessions are not captured until DIR. This hurts the ability of the consumer to effectively compare prices.
     2. To the extent plan sponsors do reflect these amounts at the point of sale and others do not, an inconsistency of point of sale pricing definition is created. Further, plans that report these amounts as DIR will have lower member premium and a market advantage.
• Manufacturer Rebates at Point of Sale
  a. CMS seeks comments on different methodologies to capture rebates at point of sale subject to the following parameters: no increase in government expenditures and no reduction in manufacturer payments under the coverage gap discount program.
  b. The methodologies seek to define a point of sale rebate with any variances to actual rebates captured as DIR.
  c. Specified Minimum Percentage
     i. CMS is considering to specify a minimum percent of rebates (less than 100%) to be captured at point of sale - this would not vary drug category or class.
     ii. The outcome of this change would lower cost sharing for some beneficiaries but increase premiums for all beneficiaries. CMS seeks a minimum threshold that balances the two expected outcomes.
  d. Applicable Average Rebate Amount
     i. Rebate Year: Point of sale rebates be based on expected rebates to be received and not historical amounts with consideration that some PBM contracts have contingencies and not all rebates are known in advance.
     ii. Rebated Drugs: CMS is considering only applying the point of sale rebates to drugs that are rebated and that amounts are calculated at the eleven digit NDC code.
     iii. Plan Level Average: CMS is considering that the average point of sale rebate amount be specific to each benefit package or PBP. This is consistent with bid development, PDE reporting and DIR reporting.
     iv. Drug Category or Class: CMS is considering that the average amount be calculated at the drug category or class level. This would protect confidential information relative to an individual drug amount calculation.
     v. Weighting: CMS is considering that the average point of sale rebate amount within a drug category or class be weighted based on utilization across the category or class and updated periodically based on emerging experience.
     vi. Timing: CMS seeks comment on how often point of sale rebates should be calculated with consideration to both improved transparency and plan sponsor administrative burden.
  e. Point-of-Sale Rebate Drugs
     i. CMS is considering application to only rebated drugs but providing flexibility to plans to apply more broadly.
     ii. CMS is considering limiting application to only specific drug categories or classes that most directly contribute to rising costs in the catastrophic phase
  f. Additional Considerations
     i. The plan sponsor will be responsible to administer point-of-sale rebates. The amount will be captured on the PDE and any differences between
amounts captured point-of-sale and actual receivables will be on the DIR report.

ii. CMS is considering adding language to the PDE & DIR data accuracy certification to include point-of-sale rebate estimates.

g. Impacts of Applying Rebates at the Point of Sale

i. The result would be a cost shift: lower member cost sharing and government LI cost sharing subsidies, increased member premium and government direct subsidies, lower coverage gap discount amounts and decreased federal reinsurance.

ii. It does not appear that CMS considered the impact to administrative costs and its downstream impact on member premium.

• Pharmacy Price Concessions Point of Sale

a. Part D Sponsors and Pharmacies have engaged in contracts that adjust the pharmacy's reimbursement after point-of-sale based on specific measures to be obtained by the pharmacy.

b. The growing trend is that the plans recoup far more dollars then they pay to pharmacies.

c. Because the measure outcomes are not known at point-of-sale, Part D Sponsors have deemed these price concessions cannot be reasonably determined, and therefore, are DIR.

d. All Pharmacy Price Concessions

i. CMS is considering to remove the "reasonably determined" exception from regulations and require all concessions to be reflected point of sale regardless of whether or not contingencies are in place.

ii. CMS is considering to require all (not some like rebates) pharmacy concessions to be reflected point of sale.

e. Lowest Possible Reimbursement

i. CMS is considering requiring the negotiated price at point of sale to reflect the lowest possible reimbursement that could be received from a Part D sponsor.

ii. That is, if a performance-based payment arrangement exists between a plan sponsor and a network pharmacy, the lowest possible reimbursement is defined as the cost assuming the pharmacy is assigned the lowest possible performance score.

iii. To the extent the pharmacy performed better than the lowest score, the difference would be included in DIR.

iv. CMS is considering that all contingent incentive payments be excluded at point-of-sale to ensure drug prices do not appear to be higher at a "higher performing" pharmacy than a lower performer.

f. Additional Considerations

i. CMS would leverage existing reporting fields on the PDEs and DIR to capture these amounts. Price concessions would be included in the point-of-sale rebate column.

g. Impacts of Applying Pharmacy Price Concessions at Point of Sale
i. The result would be a cost shift: lower member cost sharing and government LI cost sharing subsidies, increased member premium and government direct subsidies, lower coverage gap discount amounts and decreased federal reinsurance.

ii. It does not appear that CMS considered the impact to administrative costs and its downstream impact on member premium.

D. Improving the CMS Customer Experience

1. **Restoration of the Medicare Advantage Open Enrollment Period**
   - CMS proposes to establish "new Open Enrollment Period" (OEP), per 21st Century Cures Act.
   - Beginning in 2019, the "new OEP" will be January 1 through March 31 each year.
   - Allows enrollees in an MA plan to make a one-time election to join another MA plan or original Medicare. Part D coverage can change. Allows:
     a. MA-Only to MA-Only
     b. MA-Only to MA-PD
     c. MA-PD to MA-Only
     d. MA-PD to MA-PD
     e. MA-Only or MA-PD to Original Medicare without PDP
     f. MA-Only or MA-PD to Original Medicare with PDP
   - Beneficiaries in original Medicare cannot use the new OEP, regardless of Part D coverage.
   - MA Plan can choose to not accept OEP requests.
   - CMS estimates that increasing the amount of time MA enrollees are given to switch plans will lead to slightly more beneficiaries selecting plans that receive Quality Bonus Payments.

2. **Reducing the Burden of the Compliance Program Training Requirements**
   - CMS continues to hear complaints from first-tier downstream and related entities (FDRs) who have not utilized the new compliance training module and CMS has concluded that their standard compliance training module has not fulfilled its intended purpose (i.e. removing the burden on FDRs). Therefore, CMS is proposing to end their compliance training model for FDRs and hold sponsors accountable for their FDRs' compliance.

3. **Medicare Advantage Plan Minimum Enrollment Waiver**
   - CMS is proposing to review and approve minimum enrollment waivers as part of the initial MA application process rather than reviewing annual requests from MA plans in each of the first three years.
   - Reminder regarding minimum enrollment requests:
     a. MA Organizations in urbanized area: 5,000 members by year three
     b. Provider Sponsored Organizations (PSO) in urbanized area: 1,500 members by year three
     c. MA Organizations outside urbanized area: 1,500 members by year three
     d. PSOs outside urbanized area: 500 members by year three
4. **Revisions to Timing and Method of Disclosure Requirements**
   • CMS is proposing to revise regulations to include language that requires sponsors to provide EOC, provider network information, formulary, pharmacy directory, etc. (information required to be posted on their website) in hard-copy format to enrollees "upon request."
   • CMS will allow an additional two weeks to the current deadline for plans to prepare these documents

5. **Revisions to Communication/Marketing Materials and Activities**
   • CMS proposes to narrow the definition of "Marketing" for purposes of what materials CMS must review. In CMS's view, "marketing" has been too broadly defined in the past.
     a. CMS will now differentiate between "Marketing" and "Communication" materials.
     b. Communications materials will be subject to less stringent requirements than marketing materials.
     c. Items such as membership communication materials, subscriber agreements, member handbooks and wallet card instructions to enrollees will no longer be considered marketing materials, but instead are "member communications".
        i. All advertisements remaining "marketing".
     d. CMS's proposed definition for "marketing" will focus on materials and activities that aim to influence enrollment decisions (vs. providing information about benefits or the sponsor). This definition is informed by CMS's review of what materials have the greatest opportunity to confuse or mislead beneficiaries.

6. **Lengthening Adjudication Timeframes for Part D Payment Redeterminations and Independent Review Entity (IRE) Reconsiderations**
   • CMS is proposing to change the timeframe for issuing decisions on payment redeterminations from seven calendar days from the date the plan sponsor receives the request to 14 calendar days.
     a. 14-day timeframe would also apply to the IRE reconsideration.

7. **Elimination of Medicare Advantage Plan Notice for Cases Sent to the IRE**
   • Current regulations provide MA enrollees with the right to request reconsideration of a health plan's initial decision to deny Medicare coverage. When the MA plan upholds initial payment or service denials, in whole or in part, it must forward the member's case files to an Independent Review Entity (IRE).
   • CMS is proposing that the IRE would be responsible for notifying enrollees upon forwarding all cases - including both standard and expedited cases.
   • CMS has proposed changes that would result in a slight reduction of burden to Part C plans by no longer requiring a Notice of Appeal Status for each case file forwarded to the IRE.

8. **E-Prescribing and the Part D Prescription Drug Program; Updating Part D Prescribing Standards**
   • CMS reviewed the specifications for NCPDP SCRIPT Standard Version 2017071 and found that this version would allow users substantial improvements in efficiency. Specifically, Version 2017071 supports communications regarding multi-
ingredient compounds, thereby allowing compounded medication to be prescribed electronically.

- CMS proposes to require use of NCPDP SCRPT 2017071 for nine distinct transaction types.
- CMS would identify the standards that will be in effect on or after January 1, 2019, for those that conduct e-prescribing for part D covered drugs for Part D eligible beneficiaries. If finalized, those individuals and entities would be required to use NCPDP SCRIPT 2017071 to convey prescriptions and prescription-related information for 24 distinct transaction types.

9. **Reduction of Past Performance Review Period for Applications Submitted by Current**

- In April 2010, CMS clarified their authority to deny contract qualification applications from organizations that have failed to comply with the requirements of a Medicare Advantage or Part D plan sponsor contract they currently hold.
- CMS has a policy to review the applicant’s previous 14 months’ performance when considering approval of the contract’s application. CMS is proposing to change the prior review period from 14 months to 12 months.

10. **Part D Prescriber Preclusion List**

- Currently, physicians must enroll in or validly opt-out of Medicare in order for a drug that they prescribe to be covered.
- Several provider organizations have expressed concerns about the enrollment requirements.
- In order to reduce burden for providers without compromising the payment safeguard, CMS will focus on preventing payment for Part D drugs prescribed by demonstrably problematic prescribers by creating a preclusion list.
- These problematic prescribers will be defined as those who have engaged in behavior for which CMS:
  a. Has revoked their enrollment, or
  b. Could have revoked their enrollment if he or she had been enrolled in Medicare.
- Part D plan sponsors must reject a pharmacy claim for a Part D drug prescribed by an individual on the preclusion list.
- The preclusion list would be updated on a monthly basis.

11. **Part C/Medicare Advantage Cost Plan and PACE Preclusion List**

- CMS proposes to eliminate the current "enrollment" required for MA providers and suppliers.
  a. This is intended to minimize the burden on MA providers and suppliers while allowing CMS to concentrate their efforts on preventing MA payments to providers and suppliers that pose an "elevated risk".
  b. CMS will focus on individuals and entities that are currently revoked from Medicare (or would be if they participated).
- As part of the preclusion proposal, CMS proposes to amend existing data submission requirements for risk adjustment to require MA organizations to include provider NPIs as part of encounter data submissions. This is because CMS intends to use the NPI data to identify individuals and entities that may be included on the preclusion list.
12. **Removal of Quality Improvement Project for Medicare Advantage Organizations**

- In the years following the 2003 Medicare Modernization and Improvement Act, CMS created and refined requirements for all Medicare Advantage Organizations to have defined Quality Improvement Programs and Chronic Care Improvement Programs. CMS suggests that these strict requirements and data reporting requirements have created duplicative efforts for MAOs that were already performing their own quality improvement either for general care management or for the benefit of Quality Star Ratings.
- Because of this, CMS has removed some QIP and CCIP requirements and related reporting requirements as they have found they do not add significant value.
- Remaining Quality Improvement and Chronic Care Improvement requirements should ensure no reduction in the quality of care patients receive, but this change should at least lessen the reporting burden MAOs and CMS face.

13. **Reducing Provider Burden – Comment Solicitation**

- CMS is soliciting comments from providers (in particular, solo providers) regarding the burden to comply with medical records documentation required under current law.
  - Mainly in relation to risk adjustment audits. CMS has listed specific examples of the feedback they are requesting (see page 444).

E. **Implementing Other Changes**

1. **Reducing the Burden of the Medicare Part C and Part D Medical Loss Ratio Requirement**

- CMS is proposing changes to MLR Quality Improvement Activity ("QIA") reporting requirements.
- CMS is hoping that these changes will encourage plans to invest more in fraud prevention activities and Medication Therapy Management (MTM) programs.
- CMS’s ultimate goal is to save the Medicare Trust Fund money and/or permit additional supplemental benefits to beneficiaries by reducing claims expenses either through fraud reduction or improved medication compliance.

  - **Fraud Prevention Expenses**
    - Remove the current exclusion of fraud prevention activities from Quality Improvement Activities (QIA).
    - Expand the definition of QIA to include all fraud reduction activities, including fraud prevention, fraud detection, and fraud recovery.
    - Exclude the amount of claims payments recovered through fraud reduction efforts up to the amount of fraud reduction expenses in incurred claims.

  - **MTM Expenses**
    - Include all Medication Therapy Management (MTM) programs that are offered by Part D sponsors (including MA-PD sponsors) as QIA in the MLR calculation that:
      - Improve health quality;
      - Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results;
iii. Are directed toward individual enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and 
iv. Are grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

- Reduced Reporting Requirements - to reduce the complexity of reporting and reduce administrative costs both for the MAO and for CMS
  a. Reduce the Medicare MLR reporting requirements to include only the following fields:
     i. Organization Name
     ii. Contract Number
     iii. Adjusted MLR (which would be populated with Not Applicable or N/A for non-credible contracts)
     iv. Remittance Amount
   - CMS is not proposing to change its authority to conduct selected audit reviews of the reported data and the accuracy of calculations.


- Minor regulation wording changes to correct for inconsistencies within the regulations

3. Late Contract Non-Renewal

- Current regulations state that contract non-renewals effective at the end of the 1-year contract term must be submitted to CMS in writing by the first Monday in June.
- CMS is proposing to clarify its operational policy that any request to terminate a contract after the first Monday in June is considered a request for termination by mutual consent.

4. Contract Request for a Hearing

- There is an inconsistency in regulations regarding the date by which an MA organization must receive a decision from CMS on an appeal (September 1 vs. July 15th). The regulations have been revised to specify September 1st is the correct date.

5. Physician Incentive Plans - Update Stop-Loss Protection Requirements

- Current regulations state that MA organizations must provide adequate and appropriate stop-loss insurance to all physicians or physician groups that are at substantial financial risk under the MA organization's physician incentive plan (PIP).
- Under the current regulation, an MA organization that operates a PIP must provide stop loss protection for 90 percent of actual costs of referral services that exceed the per patient deductible limit to all physicians and physician groups at financial risk under the PIP. The stop loss protection may be per patient or aggregate
- CMS is proposing the following changes:
  a. Update the stop-loss deductible limits and codify the methodology that CMS would use to update the stop-loss deductible limits in the future to account for changes in medical cost and utilization.
b. Authorize MA organizations to use actuarially equivalent arrangements to protect against substantial financial loss under the PIP due to the risks associated with serving particular groups of patients.

c. Allow non-risk patient equivalents (NPEs), such as Medicare Fee-For-Service patients (FFS), who obtain some services from the physician or physician group to be included when determining the deductible.

- CMS is seeking comment on whether the definitions of "substantial financial risk" and "risk threshold" contained in the current regulation should be revisited, including whether the current identification of 25 percent of potential payments remains appropriate as the standard in light of changes in medical costs.

- For physician groups who assume risk through capitation, CMS is proposing to replace the current insurance schedule in the regulation with updated stop-loss insurance requirements that would allow insurance with higher deductibles. The new schedule would result in a significant reduction to the cost of obtaining stop-loss insurance. See page 533 for details.

6. Changes to the Agent/Broker Compensation Requirements

- CMS is proposing a minor update to remove regulatory language that is no longer relevant after a 2014 rule update to agent/broker compensation requirements.

  a. Since a 2014 rule update, agent/broker compensation rates for renewal enrollments have been tied to fair market value versus the prior (pre-2014) rule which tied renewal compensation to a percentage of initial enrollment compensation rates.

  b. The language to be removed refers to the payment associated with initial enrollment, which is no longer relevant (and has created confusion among plan staff and brokers).

7. Changes to the Agent/Broker Requirements

- CMS is proposing eliminate provisions that limit what MA organizations and Part D sponsors can do when they have discovered that a previously licensed agent/broker has become unlicensed.

8. Codification of Certain Medicare Premium Adjustments as Initial Determinations

- CMS is proposing to change the current regulations regarding premium adjustments. This proposed change seeks only to codify existing processes related to premium adjustments, and not to alter existing processes or procedures, it applies only to Part A and Part B late enrollment and reenrollment penalties.

9. Eliminate Use of the Term “Non-renewal” to Refer to a CMS-Initiated Termination

- CMS is proposing to add provisions to require that enrollees receive notice no later than 90 days prior to the December 31 effective date of a contract termination when CMS makes such determination on or before August 1 of the same year.

Please contact Tim Courtney at timc@wakely.com or your Wakely client manager with any questions or comments. Thank you to the following Wakely consultants who contributed to the development of this summary document: Nate Baehr, Dani Beierle, Brad Davis, Julia Lambert, Bob Moné, Tim Murray, Dave Neiman, Tyson Reed, Kelsey Stevens