# NCHA Financial Feature

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## CMS Proposes Select Calendar Year 2020 Medicare Advantage and Part D Changes

The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would revise certain aspects of the Medicare Advantage (MA) program (Part C), the Prescription Drug Benefit program (Part D); implement certain provisions of the ***Bipartisan Budget Act of 2018***; improve quality and accessibility; clarify certain program integrity policies; and implement other technical changes regarding quality improvement. The proposed rule would also revise the appeals and grievances requirements for Medicaid managed care and MA special needs plans for dually eligible individuals.

The rule is available at: https://bit.ly/2SGmtCE. A 60-day comment period is provided. CMS says that the proposal, if finalized, would save $4.5 billion over 10 years.

**Summary of Major Provisions**

*1. Requirements for Medicare Advantage Plans Offering Additional Telehealth Benefits (§§ 422.100, 422.135, 422.252, 422.254, and 422.264)*

Section 50323 of the ***Bipartisan Budget Act*** created a new section 1852(m) of the Social Security Act, which allows MA plans to provide "additional telehealth benefits" to enrollees starting in plan year 2020 and treat them as basic benefits for purposes of bid submission and payment by CMS.

The original Medicare telehealth benefit is narrowly defined and includes restrictions on where beneficiaries receiving care via telehealth can be located. Changes would allow greater ability for Medicare Advantage enrollees to receive telehealth from places including their homes, rather than requiring them to go to a health care facility to receive telehealth services. Plans would also have greater flexibility to offer clinically-appropriate telehealth benefits that are not otherwise available to Medicare beneficiaries.

Further, CMS proposes to establish regulatory requirements that would allow MA plans to cover Part B benefits furnished through electronic exchange as "additional telehealth benefits" – and as part of the basic benefits defined in § 422.101 – instead of separate supplemental benefits.

*2. Dual Eligible Special Needs Plans Provisions (D-SNPs) (§§ 422.2, 422.60, 422.102, 422.107, 422.111, 422.560 through 422.562, 422.566, 422.629 through 422.634, 422.752, 438.210, 438.400, and 438.402)*

Section 50311(b) of the ***Bipartisan Budget Act*** requires integration of the Medicare and Medicaid benefits provided to enrollees in Dual Eligible Special Needs Plans (D-SNPs). In particular, the statute requires: (1) development of unified grievance and appeals processes for D-SNPs; and (2) establishment of new standards for integration of Medicare and Medicaid benefits for D-SNPs.

CMS is proposing to establish new minimum criteria for Medicare and Medicaid integration in D-SNPs for Contract Year 2021 and subsequent years. CMS proposes to require that D-SNPs meet the integration criteria either by (1) covering Medicaid long-term services and supports and/or behavioral health services through a capitated payment from a state Medicaid agency; or (2) notifying the state Medicaid agency (or its designee) of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, as determined by the state Medicaid agency.

CMS is proposing rules to unify Medicare and Medicaid grievance and appeals processes for certain D-SNPs and affiliated Medicaid managed care plans. The processes would apply to D-SNPs with fully aligned enrollment and the affiliated Medicaid managed care organization, where one organization is responsible for managing Medicare and Medicaid benefits for all enrollees. In such, CMS argues, D-SNPs, enrollees will have simpler, more straightforward grievance and appeals processes.

*3. Proposal for Prescription Drug Plan Sponsors' Access to Medicare Parts A and B Claims Data Extracts (§ 423.153)*

This proposed element sets forth the manner in which CMS proposes to implement section 50354 of the ***Bipartisan Budget Act***. Section 50354 amends section 1860D-4(c) by adding a new paragraph (6) entitled *"Providing Prescription Drug Plans with Parts A and B Claims Data to Promote the Appropriate Use of Medications and Improve Health Outcomes"*. Specifically, section 1860D–4(c)(6)(A), provides that the Secretary shall establish a process under which the sponsor of a Prescription Drug Plan (PDP) that provides prescription drug benefits under Medicare Part D may request, beginning in plan year 2020, that the Secretary provide on a periodic basis and in an electronic format standardized extracts of Medicare claims data about its plan enrollees. Such extracts would contain a subset of Medicare Parts A and B claims data as determined

*4. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System (§§ 422.162(a) and 423.182(a), §§ 422.166(a) and 423.186(a), §§ 422.164 and 423.184, and §§ 422.166(i)(1) and 423.186(i)(1))*

CMS is proposing enhancements to the "cut point" methodology for non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. CMS is also proposing substantive updates to the specifications for a few measures for the 2022 and 2023 Star Ratings, and rules for calculating Star Ratings in the case of extreme and uncontrollable circumstances. Unless otherwise stated, data would be collected and performance measured using these proposed rules and regulations for the 2020 measurement period and the 2022 Star Ratings.

CMS is proposing to modify the following existing measures:

- Controlling High Blood Pressure (Part C) to align with new clinical guidelines related to hypertension.
- Medicare Plan Finder Price Accuracy (Part D) to better measure the reliability of a contract's advertised prices.
- Plan All-Cause Readmissions (Part C) to include observation stays and remove individuals with high frequency hospitalizations.
- Improvement measures (Part C and D) to exclude from the improvement calculation any measure that receives a measure-level Star Rating reduction for data integrity concerns for either the current or prior year.

**Proposed Updates to Individual Star Rating Measures for Performance Periods Beginning On or After January 1, 2021**

| Measure | Measure Description | Domain | Measure Category and Weight | Data Source | Measurement Period | NQF Endorsement | Statistical Method for Assigning Star Ratings | Reporting Requirements (Contract Type) |
|---|---|---|---|---|---|---|---|---|
| **Part C Measure** | | | | | | | | |
| Controlling Blood Pressure (CBP) | Percent of plan members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90). | Managing Chronic (Long Term) Conditions | Intermediate Outcome Measure Weight of 3 | HEDIS | The calendar year 2 years prior to the Star Ratings year | #0018 | Clustering | MA-PD and MA-only |
| **Part D Measure** | | | | | | | | |
| MPF Price Accuracy | A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for the Medicare Plan Finder website. | Drug Safety and Accuracy of Drug Pricing | Process Measure Weight of 1 | PDE data, MPF Pricing Files | The calendar year 2 years prior to the Star Ratings year | Not Applicable | Clustering | MA-PD and PDP |
| **Part C Measure** | | | | | | | | |
| Plan All- Cause Readmissions (PCR) | Percent of acute inpatient stays that were followed by an unplanned acute readmission or an observation stay for any diagnosis within 30 days, for members ages 18 and over. Rates are risk adjusted. | Managing Chronic (Long Term) Conditions | Intermediate Outcome Measure Weight of 3 | HEDIS | The calendar year 2 years prior to the Star Ratings year | #1768 | Clustering | MA-PD and MA-only, except for 1876 Cost Plans |

*5. Preclusion List Requirements for Prescribers in Part D and Individuals and Entities in MA, Cost Plans, and PACE (§§ 422.222 and 423.120(c)(6))*

The proposal would make several revisions and additions to the preclusion list provisions CMS finalized in its April 2018 final rule. CMS says it believes that these changes would help clarify for stakeholders CMS's expectations with respect to the preclusion list.

CMS is proposing to revise the following requirements:

- Length of time on the preclusion list for providers or prescribers with a felony conviction;
- Consolidation of the appeals process;
- Effective date for the consolidation of appeals;

- Timeframe for the addition to the preclusion list;
- Beneficiary appeals;
- Beneficiary held harmless;
- Beneficiary notification;

*6. Medicare Advantage Risk Adjustment Data Validation (RADV) Provisions (§§ 422.300, 422.310(e), and 422.311(a))*

CMS is proposing the following:

- To establish use of extrapolation in RADV contract-level audits and that the extrapolation authority would apply to the payment year 2011 contract-level audits and all subsequent audits.

- Not to apply a fee-for-service (FFS) Adjuster to audit findings.

**Final Comment**

The material presented above is but a very brief outline of the material contained in the proposal. Those involved in MA organizations and Prescription Drug Plans need to review the information in detail to understand the changes being proposed.

It is interesting that while CMS says many of the changes are intended to reduce burdens, one needs to remember that CMS is claiming the changes will also result in significant savings to the program. A question is where savings are accruing from—MA plans, PDPs or providers.

Our Washington liaison, Larry Goldberg of Larry Goldberg Consulting, has provided us with this summary. Please contact either Jeff Weegar, NCHA, at 919-677-4231, jweegar@ncha.org or Ronnie Cook, NCHA, at 919-4225, rcook@ncha.org if you have questions.