Wynne Health Group

Memorandum

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CMS Releases CY 2020 Policy and Technical Changes Proposed Rule for Medicare Advantage and Part D Plans; Telehealth Benefits, RADV Extrapolation, Duals Integration Addressed

Today, the Centers for Medicare and Medicaid Services (CMS) released a **proposed rule** (**release**; **fact sheet**) **on policy and technical changes to Medicare Advantage (MA) and Part D for Contract Years (CYs) 2020 and 2021**.

- **What it is.** CMS proposes to implement several Chronic Care-driven sections of the Bipartisan Budget Act (BBA) passed earlier this year. No drug pricing-related proposals, such as modifications to the six protected classes in Medicare Part D, are addressed in the proposed rule. However, CMS includes a comment in the preamble to the proposed rule that it "plans to release a proposed Medicare rule in the near future to further the President's agenda of reducing drug costs" (see p. 4).

- **Why it is important for you.** CMS proposes to implement BBA authority allowing MA plans to cover Part B benefits furnished through electronic exchange as "additional telehealth benefits," which allows plans to go beyond Medicare-covered telehealth services as part of the basic benefit package. The agency also proposes to implement an approach to extrapolating risk adjustment data validation findings for the 2011 payment year and subsequent years. CMS estimates $1 billion in savings to the Medicare Trust Fund in 2020 because of "collections from industry of money improperly paid." The agency projects that the agency would save $381 million annually in each subsequent year because of avoided improper payments.

  The proposed rule also addresses Dual Special Needs Plans integration requirements, MA and Part D Quality Rating, and the process for Part D plans to request Medicare Parts A and B data, among other issues.

- **Potential next steps**. Comments on the proposed rule are due by **Dec. 31, 2018**.

Highlights of today's proposed rule follow:

- **Medicare Advantage Plans Offering Additional Telehealth Benefits** – The proposed rule would codify Sec. 50323 of the BBA allowing MA plans to cover Part B benefits furnished through electronic exchange as "additional telehealth benefits" instead of separate supplemental benefits starting in plan year 2020. On p. 16, CMS notes that "while MA plans have always been able to offer more telehealth services than are currently payable under original Medicare through supplemental benefits, this change in how such additional telehealth benefits are financed (that is, accounted for in the capitated payment) makes it more likely that MA plans will offer them and that more enrollees will use the benefit." The agency elaborates that "under this proposal, MA plans

will be permitted to offer, as part of the basic benefit package, additional telehealth benefits beyond what is currently allowable under the Medicare telehealth benefit."

CMS proposes to define additional telehealth benefits as services that "(1) are furnished by an MA plan for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act [relating to Medicare payment for telehealth]; and (2) have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange." The agency notes that its proposed definition provides that "it is the MA plan (not CMS) that identifies the appropriate services for the applicable year," adding that it "believe[s] that MA plans are in the best position to identify each year whether additional telehealth benefits are clinically appropriate to furnish through electronic exchange" (p. 18). CMS notes that behavioral health is a "prime" example of a service that could be "provided remotely through MA plans' providing of additional telehealth benefits under this proposal" (p. 21-22) and cites applications in substance abuse treatment as well.

CMS proposes to define electronic exchange as "electronic information and telecommunications technology." While it does not propose regulation text with specific examples, it notes that examples "may include, but are not limited to, the following: secure messaging, store and forward technologies, telephone, videoconferencing, other internet-enabled technologies, and other evolving technologies as appropriate for non-face-to-face communication." Comments are sought on whether any limits should be imposed on "what types of Part B items and services (for example, primary care visits, routine and/or specialty consultations, dermatological examinations, behavior health counseling, etc.) can be additional telehealth benefits provided under this authority."

CMS also proposes to continue authority for MA plans to offer supplemental benefits via remote access technologies and/or telemonitoring for those services that do not meet the requirements for "additional telehealth benefits." The agency solicits comment on how to implement the statutory provision that if an MA plan covers a Part B service as an additional telehealth benefit, then the MA plan must also provide the enrollee access to such service through an in-person visit. CMS proposes codifying the statutory requirement that would "require that the enrollee must have the option to receive a service that the MA plan would cover as an additional telehealth benefit either through an in-person visit or through electronic exchange."

CMS proposes to "allow MA plans to maintain different cost sharing for the specified Part B service(s) furnished through an in-person visit and the specified Part B service(s) furnished through electronic exchange." Additionally, CMS proposes that MA plans offering additional telehealth benefits "comply with [applicable] provider selection and credentialing requirements" and "ensure through its contract with the provider that the provider meet and comply with applicable state licensing requirements and other applicable laws for the state in which the enrollee is located and receiving the service." See further discussion on p. 23-24. Furthermore, CMS proposes to require that MA plans furnishing additional telehealth benefits may only do so using contracted providers, regarding which comments are requested on p. 25.

CMS solicits comments in several additional areas, including on what impact, if any, additional telehealth benefits should have on MA network adequacy policies (see p. 23); and whether to impose additional requirements for qualifications of providers of additional telehealth benefits, and if so, what those requirements should be (p. 25-26). For proposals to amend MA bidding regulations, see the discussion beginning on p. 28.

- **Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs) –** Beginning on p. 30, the rule proposes to establish new minimum criteria for Medicare and Medicaid integration in D-SNPs for CY 2021 forward. Pursuant to the BBA, 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 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.

- **Medicare Advantage Risk Adjustment Data Validation Extrapolation –** CMS cites a 2012 white paper in which it "informed MA and Part D sponsors of its intention to extrapolate audit recovery findings starting with payment year 2011 contract-level audits." CMS says even though it conducted 2011, 2012, and 2013 audits accordingly, "contract-level recoveries have not yet been sought."

  In the proposed rule, the agency "would, based on longstanding case law and best practices from HHS and other federal agencies, establish that extrapolation may be utilized as a valid part of audit authority in Part C, as it has been historically a normal part of auditing practice throughout the Medicare program." The agency says that "in addition to the contract-level methodology described earlier, we have identified other potential methodologies for sampling and extrapolation, which would calculate improper payments made on the audited MA contract for a particular sub-cohort or sub-cohorts in a given payment year, and the agency may also use such a methodology to calculate improper payments made to the audited MA contract."

  CMS proposes to apply its the finalized RADV payment error methodology (or methodologies) to payment year 2011 and all subsequent years. It seeks comment on whether it would need to engage in retroactive rulemaking to accomplish this. It notes it does not anticipate using the sub-cohort methodology for any payment year before 2014. Comments are sought on the contract-level and sub-cohort methodology and scenarios in which one would be preferable. CMS says it is considering expanding MA plans' appeal rights, "particularly in light of the upcoming auditing and recoveries in the MA program."

  CMS says that "because it appears that diagnosis error in FFS claims data does not lead to systematic payment error in the MA program, we propose not to include an FFS Adjuster in any final RADV payment error methodology." The agency also says that adding a FFS adjuster would "introduce inequities between audited and unaudited plans, by only correcting the payments made to audited plans." See p. 209-210.

- **Unified Grievance and Appeals Procedures for D-SNPs –** Driven by BBA requirements, CMS proposes to "unify Medicare and Medicaid grievance and appeals processes for certain D-SNPs and affiliated Medicaid managed care plans." CMS notes that the proposal would "allow enrollees to follow one resolution pathway at the plan level when filing a complaint or contesting an adverse coverage determination with their plan regardless of whether the matter involves a Medicare or Medicaid covered service." Under the BBA, compliance is required beginning in CY 2021 and CMS estimates the cost impact at $0.2 million in that and subsequent years.

  The agency discusses its interpretation of the statutory implementation timeline on p. 64, noting the "statute does not, however, explicitly rule out the possibility of implementing such unified processes prior to 2021." CMS adds "we interpret the statute as permitting a state to adopt unified grievance and appeals processes for integrated D-SNPs and Medicaid plans in that state consistent

with our final regulations on this topic starting as soon as the regulations establishing such procedures are final."

- **Medicare Advantage and Part D Prescription Drug Plan Quality Rating System** – The proposal includes several measure specification updates, adjustments for extreme and uncontrollable circumstances, and enhanced cut point methodology. CMS notes that the changes "are routine and do not have a significant impact on the ratings of contracts." They are aimed at improving the methodology for the determination of cut points, adjust the methodology for Star Ratings for affected Medicare Advantage and Part D plans. See p. 127.

- **Preclusion List Requirements for Prescribers in Part D and Individuals and Entities in MA, Cost Plans, and Programs of All-Inclusive Care for the Elderly (PACE)** – In April 2018, CMS "announced that the agency would prohibit payment for Part D drugs and MA items or services that are prescribed or furnished by prescribers and providers on a 'preclusion list.'" The proposed rule includes changes to the 'preclusion list' process, including requirements on length of time for providers with a felony conviction, consolidated and effective dates of appeals process, and beneficiary appeals, held harmless and notifications. See p. 162.

- **Part D Plan Access to Medicare Parts A and B Data Extracts** – Pursuant to the BBA, CMS proposes that Part D plans may access Medicare Parts A and B claims data extracts beginning Jan. 1, 2020. CMS proposes that plans may request such data to "(1) to optimize therapeutic outcomes through improved medication use and (2) to improve care coordination so as to prevent adverse health outcomes." See p. 119.