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# Medicare Advantage & Part D Proposed Rule

## OVERVIEW

On October 26th, the Centers for Medicare and Medicaid Services (CMS) proposed a rule that would update Medicare Advantage (MA) and Medicare Part D policies, beginning in 2020. The rule would: implement telehealth and Dual-Eligible Special Needs Plan (D-SNP) provisions of the Bipartisan Budget Act (BBA) of 2018, make changes to the Star Ratings system, enhance Preclusion List protections, and update Risk Adjustment Data Validation (RADV) audit methodologies.

CMS will accept comments on the rule until December 31st. The rule is available here.

## TELEHEALTH EXPANSION

Traditional Medicare fee-for-service (FFS) generally limits the provision of telehealth services to rural areas and health professional shortage areas. MA plans have been able to offer telehealth benefits without geographic restriction, but only as a supplemental benefit that is paid for through rebates to the federal government or by requiring beneficiaries to pay higher premiums. The proposed rule would further expand MA beneficiary access to telehealth by allowing plans to include telehealth services in their basic benefit package, so that CMS will subsidize the costs beginning in 2020. The expanded benefit would not be subject to geographic restrictions and would allow beneficiaries to receive services in their home.

CMS is seeking comment on the proposal that MA plans that cover a Part B service as a telehealth benefit also be required to offer that service as an in-person visit.

## D-SNP REQUIREMENTS

Prior to the passage of the BBA, all D-SNPs, Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs) were due to expire in 2019. The law permanently authorized SNPs, but mandated that CMS require D-SNPs and C-SNPs to meet new requirements. Under the proposed rule, D-SNPs would be required to meet one of three standards for Medicare and Medicaid integration by 2021:

- Be a Fully Integrated Dual Eligible SNP (FIDE-SNP), a D-SNP that receives capitated payment to cover comprehensive Medicare and Medicaid services, including long-term services and supports (LTSS) *and* behavioral health. In New York, most Medicaid Advantage Plus plans are FIDE-SNPs;
- Be a Highly Integrated Dual Eligible SNP (HIDE SNP), which the proposed rule defines as a D-SNP that is offered by an MA organization that also has a capitated Medicaid managed care contract that includes coverage of LTSS *or* behavioral health; or
- Have a process in place to notify the state Medicaid agency when certain high-risk, full-benefit dual eligible individuals are hospitalized or have a skilled nursing facility admission. The state Medicaid agency may determine which group(s) of dual-eligibles would be considered "high-

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risk," such as beneficiaries who are receiving Home and Community Based Services or are participating in a Medicaid health home program.

The proposed rule would also require that FIDE SNPs and HIDE SNPs with fully aligned enrollment implement a unified grievance and appeals process for enrollees by 2021.

CMS did not propose to implement the new C-SNP requirements through this rulemaking.

## MA AND PART D STAR RATINGS

CMS currently uses a hierarchical clustering methodology to identify the cut points for non-Consumer Assessment of Healthcare Providers and Systems measures to ensure that the measure-level Star Ratings reflect true performance. To improve predictability and stability, the proposed rule will update the hierarchal clustering methodology by incorporating mean resampling and establishing a guardrail for measures that have been in the MA and Part D Star Ratings program for more than three years. The proposed change would apply to data collected during 2020 and would impact 2022 Star Ratings.

CMS is also proposing to make the following changes to four MA and/or Part D measures:

- *Controlling High Blood Pressure (MA)* – Align with new clinical guidelines related to hypertension for performance periods beginning in 2020;
- *Plan All-Cause Readmissions (MA)* – Include observation stays and remove individuals with high frequency hospitalizations for performance periods beginning in 2021;
- *Improvement Measures (MA and Part D)* – Exclude any measure that receives a measure-level Star Rating reduction for data integrity concerns for either the current or prior year, beginning with 2021 Star Ratings data; and
- *Medicare Plan Finder Price Accuracy (Part D)* – More accurately measure the reliability of a contract's advertised prices for performance periods beginning in 2020.

The rule also proposes to make allowances in Star Ratings for plans that have been affected by extreme and uncontrollable events, such as hurricanes, by reverting to the previous year's rating or to the higher of the current or previous year's scores depending on the impact of the disaster or event.

## PRECLUSION LIST

The proposed rule would expand upon the requirement that MA, Part D, Cost, and Programs for All-Inclusive Care for the Elderly (PACE) plans deny claims from prescribers or providers who are identified on a CMS-distributed Preclusion List, beginning in 2019. CMS proposes a number of changes to enhance the Preclusion List for 2020, including:

- Extending the maximum reenrollment bar for prescribers on the Preclusion List from three years to 10 years;
- Ensuring that beneficiaries do not have any financial liability for services or items furnished by a prescriber on the Preclusion List; and

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- Requiring plans to notify the beneficiary that their prescriber is on a Preclusion List within 30 days. Plans would not be able to begin denying claims until 60 days after the beneficiary notice was sent.

## RADV METHODOLOGY

CMS uses RADV audits to recover improper risk adjustment payments to MA plans. CMS finalized a methodology in 2012 to extrapolate audit findings of improper payments in randomly selected groups of enrollees to the entire contract. The proposed rule would impose the 2012-finalized extrapolation methodology for all RADV audits and apply this practice to the audits already performed for payment years 2011-2013 and collect the amounts associated with projected improper payments.

In addition, CMS would not use a FFS Adjuster, which would lower the recovery size by accounting for errors in the traditional Medicare FFS claims data. CMS is considering if it should conduct targeted RADV audits on smaller patient cohorts with high risk of improper payments, such as those with diabetes.

CMS estimates $1 billion in additional collections from MA plans in 2020, and at least $381 million annually thereafter in reduced Medicare payments.