McDermott +CONSULTING | HEALTH LOBBYING ANALYTICS POLICY
Sound Health Policy Objectives Achieved

Rule Summary

CMS Releases MA Advance Notice, Policy and Technical Changes Proposed Rule

Summary

On February 5, 2020, the Centers for Medicare & Medicaid Services (CMS) issued two documents affecting the Medicare Advantage (MA) program:

- The Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule, which codifies existing CMS MA policies and proposes policy changes in several key areas;
- The Advance Notice Part II, the annual guidance that proposes payment rates for plans (Part I was released January 6, 2020).

Comments on the Policy and Technical Changes Proposed Rule are due April 6, 2020. Comments on the Advance Notice Parts I and II are due March 6, 2020. The final rate announcement is expected by April 6, 2020.

Key Takeaways

1. CMS expects an average change in plan revenue of 0.93% (compared to 2020's proposed increase of 1.59% and final increase of 2.53%).

2. CMS proposes to implement a change flowing from the 21st Century Cures Act that will allow end stage renal disease (ESRD) beneficiaries to enroll in MA plans. This change could have significant financial implications for MA plans and should be closely evaluated.

3. Building on the Executive Order on Protecting and Strengthening Medicare for Our Nation's Seniors, CMS proposes to implement flexibilities related to telehealth and network adequacy that could strengthen access to MA in rural areas.

MA Options for ESRD Beneficiaries

Prior to enactment of the 21st Century Cures Act, ESRD beneficiaries generally could not enroll in MA. CMS proposes to implement the Cures Act provision allowing beneficiaries with ESRD to enroll in MA plans for plan year 2021 and beyond.

Under this Cures Act provision, an MA plan is not required to cover kidney acquisition costs for MA beneficiaries, and those costs are also excluded from MA benchmarks and capitation rates. These costs would be covered under the fee-for-service program instead. We expect significant engagement from the stakeholder community over the adequacy of payment rates for this population.

Network Adequacy

MA plans are required to maintain a network of appropriate providers sufficient to meet the needs of the covered population, and CMS regulates network adequacy. Currently, CMS requires organizations to contract with a sufficient number of specified providers/facilities to ensure that 90% of beneficiaries have access to at least one provider/facility of each specialty type within published maximum time and distance standards.

Under the proposed rule, CMS would codify a practice it refers to as "customization," which allows plans to expand the time and distance standards if provider shortage makes the base standards impossible to meet. CMS also proposes to modify its network adequacy policy to further account for access needs in counties, including rural counties, and to take into account the impact of telehealth providers in contracted networks. To encourage MA in rural areas, CMS proposes to reduce the percentage from 90% to 85% in micro counties, rural counties and counties with extreme access conditions where there is evidence of lower supply of physicians compared to urban areas.

CMS proposes to give an MA plan a 10 percentage point credit toward the percentage of beneficiaries residing within published time and distance standards for certain provider specialty types when the plan contracts with telehealth providers. These specialties are dermatology, psychiatry, neurology, otolaryngology and cardiology. CMS also seeks comments relating to measuring and setting standards for access to dialysis services.

CMS further proposes that MA organizations would receive a 10 percentage point credit toward the percentage of beneficiaries residing within the time and distance standards for affected provider and facility types in states with certificate of need laws or other state-imposed restrictions that limit providers or facilities in the county or state.

Out-of-Network Telehealth

In 2019, CMS finalized requirements for MA plans offering additional telehealth benefits. The Bipartisan Budget Act of 2018 authorized MA plans to offer additional telehealth benefits beginning with the 2020 plan year, and to treat these additional benefits as basic rather than supplemental. In its implementing regulations, CMS finalized a requirement that MA plans only furnish these benefits using contracted providers. The regulations provided that benefits furnished by non-contracted providers could only be covered as supplemental benefits. For

example, a PPO plan could cover telehealth services provided out-of-network only as a supplemental benefit.

CMS seeks comments on whether the regulations should be revised to allow all MA plan types to allow additional telehealth benefits through non-contracted providers and to treat those benefits as basic benefits.

Implementation of Opioid Provisions in the SUPPORT Act

In 2018, President Trump signed into law the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. This comprehensive legislation to address the opioid epidemic garnered support from both Republicans and Democrats.

The proposed rule would implement a SUPPORT Act provision requiring Part D plans to establish drug management programs (DMPs) to identify and manage beneficiaries at risk for prescription drug misuse or abuse for plan years beginning on or after January 1, 2022. Plans currently have the option of establishing DMPs but are not required to do so. According to CMS, 99% of enrollees are covered under Part D contracts that offer a DMP.

The proposed rule would also implement the SUPPORT Act's modified medication therapy management program requirements for Part D plans beginning January 1, 2021. These modified requirements aim to better assist enrollees who are at risk for prescription drug abuse.

For plan years 2021 and beyond, Part D sponsors would be required to provide information to certain enrollees about pain treatment, including coverage of non-pharmacological therapies, devices and non-opioid medications.

Second, Preferred Specialty Tier in Part D

CMS allows Part D sponsors to offer plans that are either a defined standard benefit or an alternative benefit design equal in value to the defined standard benefit (actuarially equivalent), and to provide enhanced benefits. Plans with alternative benefit designs often use tiered formularies. The top tier—known as the "specialty tier"—is reserved for the most expensive drugs that are brand name, specialty and not-preferred. Cost-sharing on this tier is typically based on a coinsurance rather than a copayment amount. Part D sponsors are currently permitted to include in their plan design only one specialty tier, which is intended to allow them to manage high-cost drugs separately from tiers with less expensive drugs.

The proposed rule would allow Part D sponsors to establish two specialty tiers, provided that one is a preferred tier offering lower cost sharing than the proposed maximum allowable specialty tier cost sharing. Stakeholders have argued that creating an additional specialty tier could improve Part D sponsors' ability to negotiate with pharmaceutical manufacturers to help lower the prices of high-cost Part D drugs, and could encourage the use of lower-cost biosimilar products and boost competition among existing specialty Part D drugs.

Beneficiary Real Time Benefit Tool

The proposed rule would require Part D sponsors to implement a real time benefit tool that would allow enrollees to view accurate, clinically appropriate, real-time formulary and benefit information, effective January 1, 2022. This proposal aims to support the Administration's goals of improving transparency for consumers and reducing prescription drug costs.

The goal of the proposed tool is to allow prescribers and patients to consider the potential cost differences of medications. The tools would be required to provide real-time values for cost-sharing information and formulary alternatives, where appropriate, and would include the formulary status of clinically appropriate alternatives and utilization management requirements. Plans would be encouraged, but not required, to include the negotiated price. CMS also proposes to allow plans to offer certain rewards and incentives to enrollees who use the tool.

Pharmacy Performance Measure Reporting Requirements

CMS proposes to require Part D sponsors to disclose to CMS the measures they use to evaluate pharmacy performance. CMS seeks to better understand the use of pharmacy performance measures in network pharmacy agreements and to determine financial rewards and penalties incurred at the point of the sale. CMS plans to publish the measures it collects.

CMS states that the required measures information could include:

- Name of performance measure
- Performance calculation methodology
- Success/failure thresholds
- Financial implications of success/failure to achieve threshold(s)
- Pharmacy appeal requirements
- Method of payment or collection.

If this CMS proposal is finalized, the actual reporting requirements, data elements, timelines and method of submission would be proposed through the Office of Management and Budget Paperwork Reduction Act process. In this proposed rule, CMS encourages industry to come together to develop pharmacy performance measures through a consensus process, and to adopt measures to ensure standardization, transparency and fairness.

CMS seeks comments on the principles that should govern pharmacy performance measures and the data elements, timeline and method of submission for reporting measures.

No Risk Adjustment Data Validation Provision

The current proposed rule does not address Risk Adjustment Data Validation audits, pursuant to which CMS would recover funds it deems improperly paid to plans. In a 2018 proposed rule, CMS suggested dramatic and highly-contested changes to its audit methodology, which CMS estimated could result in the recovery of $4.5 billion from plans over ten years.

“Look-Alike” Dual Eligible Special Needs Plans

Special needs plans (SNPs) are designed to provide targeted care to individuals with special needs. SNPs may restrict enrollment to certain categories of enrollees, including individuals who are dually eligible for Medicare and Medicaid. D-SNPs are intended to integrate or coordinate care for this population, and are subject to specific requirements that promote care coordination and protect beneficiaries.

The Medicare Payment Advisory Commission recently reported to Congress the emergence of D-SNP look-alike plans that have similar levels of dual eligible enrollment but are not subject to the same requirements as D-SNPs. In the proposed rule, CMS outlines its concerns with the proliferation of D-SNP look-alike plans and summarizes stakeholder feedback on the issue. CMS proposes that it will not enter into or renew a contract with a D-SNP look-alike in any state where there is a D-SNP or other plan that CMS has authorized to exclusively enroll dually eligible individuals. CMS proposes to establish procedures to transition enrollees from D-SNP look-alike plans to other MA plans.

For more information please contact Mara McDermott.