CMS issues first of two final rules changing the Medicare Advantage and Medicare Prescription Drug Program

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In a final rule issued on May 22, 2020 (and published in the federal register on June 2, 2020), the Centers for Medicare & Medicaid Services (CMS) made several changes impacting Medicare Advantage (MA or Part C) and Medicare Prescription Drug Benefit (Part D) programs for contract year 2021.

According to CMS, this first final rule will "increase access to telehealth for seniors in Medicare Advantage (MA) plans, expand the types of supplemental benefits available for beneficiaries with an MA plan who have chronic diseases, provide support for more MA options for beneficiaries in rural communities, and expand access to MA for patients with End Stage Renal Disease (ESRD)."

The final rule is the first of two final rules CMS plans to issue. CMS' rationale for this two-rule approach (as stated in its fact sheet) is to provide plans with adequate time and information to design the best coverage for Medicare beneficiaries since the "entire healthcare sector is focused on caring for and providing coverage for coronavirus disease 2019 (COVID-19)." In this first final rule, CMS finalized a subset of proposed policies before the MA and Part D plans' bids, which were due on June 1, 2020. CMS intends that the second final rule will address the remaining proposals for plans later in 2020 for the 2022 plan year.

Here are highlights from the final rule:

- *MA plan options for ESRD beneficiaries*. Medicare-eligible individuals with ESRD are permitted to enroll in MA plans beginning January 1, 2021.

- *MA and Medicare fee-for-service (FFS) payment changes*. Kidney acquisition costs are included in FFS and excluded from MA benchmarks used in determining payment to MA plans.
- *MA and Part D Prescription Drug Program quality rating (star rating).*
    - Influence of outliers on cut points are reduced by adding Tukey outlier deletion prior to clustering.
    - Measure weights for patient experience/complaints measures and access measures increase from two to four.
    - The calculation of the 2021 and 2022 Part C and D star ratings is modified to address the expected disruption to data collection and impact on measure scores posed by the COVID-19 pandemic to avoid inadvertently creating incentives to place cost considerations above patient safety.
- *Medical Loss Ratio (MLR).*
    - MA organizations may include in the MLR numerator as "incurred claims" all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of "provider," as defined at 42 C.F.R. § 422.2, in alignment with changes to MA supplemental benefits in recent years.
    - A deductible-based adjustment is added to the MLR calculation for MA medical savings account (MSA) contracts receiving a credibility adjustment. According to CMS, this adjustment removes a potential deterrent to the offering of MSAs by MA organizations that may be concerned about their inability to meet the MLR requirement as a result of random variations in claims experience, the risk of which is greater under health insurance policies with higher deductibles.
- *Network adequacy/telehealth*.
    - Existing CMS network adequacy methodology is codified and new policies are finalized to provide support for more plan options in rural areas and encourage the use of telehealth in all areas. In rural areas, the final rule reduces the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90 percent to 85 percent.
    - To encourage and account for telehealth providers in contracted networks, CMS provides MA plans with a 10 percent credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for dermatology, psychiatry, cardiology, otolaryngology, neurology, ophthalmology, allergy and immunology, nephrology, primary care, gynecology/ OB/GYN, endocrinology and infectious diseases.
    - Outpatient dialysis is removed as a facility specialty type that is subject to network adequacy standards, rather CMS plans to require MA organizations to submit an attestation that it has an adequate network that provides the required access and availability to dialysis services, including outpatient facilities.
    - MA organizations can receive a 10 percent credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have Certificate of Need laws, or other state-imposed anticompetitive restrictions, that limit the number of providers or facilities in a county or state.
- *Special Election Periods (SEPs) for exceptional conditions*.
    - A number of SEPs that have been implemented through sub-regulatory guidance as exceptional circumstances SEPs are codified in the final rule.
    - The scope of the SEP is expanded for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster so that it applies to FEMA-declared emergencies, as well as emergency declarations issued by a federal, state or local government entity; it will be renamed the "SEP for Government Entity-Declared Disaster or Other Emergency."

- Two SEPs are established that did not previously exist in guidance: (1) the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer and (2) the SEP for Individuals Enrolled in a Plan Placed in Receivership.

- "*Look-alike" Dual Eligible Special Needs Plans*.
  - CMS finalized its proposal to limit Dual Eligible Special Needs Plan (D-SNP) "look-alikes."
  - Under the final rule, CMS will not enter into a contract:
    - starting for 2022, for a new MA plan – other than a SNP – that projects in its bid that 80 percent or more of the plan's total enrollment will be entitled to Medicaid, or
    - starting for 2023, for a renewing MA plan – other than a SNP – that has actual enrollment of 80 percent or more of enrollees who are entitled to Medicaid, unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.
  - The final rule allows one additional year for existing D-SNP "look-alikes" to phase out. Under the final rule, D-SNP "look-alikes" would be able to transition their memberships into a D-SNP or other qualifying zero-premium plans offered by the MA organization beginning for the 2021 plan year.

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