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February 7, 2020

CMS Invites Comments on Proposed Rule for Medicare Advantage and Part D

On February 5, 2019, the Centers for Medicare & Medicaid Services (CMS) posted a new notice of proposed rulemaking for Medicare Advantage and Part D (see also the accompanying fact sheet). CMS also released the Advance Notice Part II and fact sheet). Notable provisions of the proposed rule and advance notice include:

- **A Proposal to Limit "D-SNP Look-Alikes."** The Medicare Prescription Drug, Improvement, and Modernization Act created D-SNPs to allow for Medicare Advantage (MA) products that exclusively serve individuals dually eligible for Medicare and Medicaid. D-SNPs must meet a number of additional requirements, relative to non-SNP MA plans, related to health risk assessments, models of care, and Medicaid integration. Most recently, the Bipartisan Budget Act (BBA) of 2018 required CMS to establish additional requirements related to Medicaid integration for D-SNPs.

  Over the last few years, MedPAC[1] has noted an increase in MA plans that exclusively (or almost exclusively) serve dually eligible individuals, yet are not designated as D-SNPs. These MA plans – called D-SNP look-alikes – impede the ability of CMS and states to meaningfully implement existing and new statutory requirements for D-SNPs that Congress created in the BBA by allowing plans that fail to meet the requirement to create look-alikes instead.

  CMS is proposing not to enter into or renew a contract for an MA plan that is a non-SNP that either: (a) projects in its bid that 80 percent or more of the plan's members will be dually eligible; or (b) already has enrollment in which 80 percent or more are dually eligible, unless it is a new plan with enrollment of 200 or fewer individuals. This proposed contract requirement would be limited to states where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as Medicare-Medicaid Plans. CMS is proposing to allow sponsors of plans currently exceeding this 80 percent threshold to transition enrollees from a D-SNP look-alike into a D-SNP or another zero-premium plan offered by the MA organization. (For details on the D-SNP Look-Alike proposals see the following pages in the interim double-spaced "public inspection" version of the proposed rule: pp. 53-78, 524-531, and 727-729. The proposed rule will be officially published in the *Federal Register* on February 18.)

- **Prohibitions on the Marketing of D-SNP Look-Alikes.** The proposed rule also calls for codification of previous sub-regulatory guidance from the Medicare Communications and Marketing Guidelines prohibiting MA organizations from marketing non-D-SNP plans as D-SNPs, implying that such plans are designed for dually eligible individuals, targeting marketing efforts primarily to dually eligible individuals, or claiming a relationship with the state Medicaid agency, unless contracts to coordinate Medicaid services for such plans are in place.

- **Changes to the Programs of All-Inclusive Care for the Elderly (PACE).** CMS proposes to reduce the administrative burden for PACE organizations by allowing service delivery requests to be approved in full by an interdisciplinary team (IDT) member at the time the request is made. CMS is also proposing to enhance PACE

[1] See *June 2018 MedPAC Report to Congress, Chapter 9* at http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0 and *June 2019 MedPAC Report to Congress, Chapter 12* at http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.

participant protections by improving the participant appeals process, adding additional participant rights, increasing requirements related to the provision of services, and ensuring PACE organizations appropriately document care in the medical record while maintaining original communications from caregivers and others. The proposed rule would also to bolster CMS' ability to access records, improve the regulatory framework relating to required services in PACE, and set out appeal processes for PACE organizations following certain enforcement actions. (For details on the PACE proposals, see these pages in the public inspection version of the proposed rule: pp. 422-488, 571-585, 587-657, and 872-894.)

- **"Cross-walking" of D-SNP Enrollees.** Under the proposed rule, there would be two D-SNP-specific circumstances in which CMS would review and decide whether to permit MA plans to transfer or "crosswalk" their enrollees into a different MA plan of the same plan type from year to year when no other election has been made. The crosswalk exceptions are related to: (1) a renewing D-SNP in a multi-state service area that is reducing its service area to accommodate a state contract in part of the service area; and (2) a renewing D-SNP that transitions eligible enrollees into another new or renewing D-SNP, when the two D-SNPs serve different populations.
- **Enhanced SNP Care Management Processes.** The proposed rule calls for enhancements to SNP care management that would require SNPs to conduct face-to-face encounters between the enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff and ensure results of the initial assessment and annual reassessment are addressed in the care plan. The proposal also updates the requirements for evaluation and approval of the SNP model of care (MOC) and defines the minimum benchmark for approval of the MOC.
- **Criteria for Denying MA Applications Based on Past Performance.** The proposed rule would require codification of the criteria CMS would use to make a determination to deny a MA plan application based on past performance. The criteria would exclude intermediate sanctions of D-SNPs when they fail to meet Medicare and Medicaid integration requirements as a past performance factor that could serve as a basis to deny an MA application.
- **Supplemental Benefits Requirements**. CMS proposes to codify existing policy with respect to supplemental benefits, including the Managed Care Manual (Chapter 4) definition of a supplemental benefit, the expanded definition of "primarily health related," and the reinterpreted uniformity requirements, including that reductions in cost sharing are an allowable supplemental benefit.
- **Implementing Certain Cures Act Provisions Related to Individuals with End Stage Renal Disease (ESRD).** The proposed rule implements the 21st Century Cures Act requirements to allow Medicare-eligible individuals with ESRD the option to enroll in a Medicare Advantage plan starting January 1, 2021. This will give patients with ESRD access to more affordable Medicare coverage choices and extra benefits such as transportation or home-delivered meals. The proposed rule also implements related MA and Medicare FFS payment changes made by the Cures Act—FFS coverage of kidney acquisition costs for MA beneficiaries and exclusion of such costs from MA benchmarks.
- **Implementing Several Opioid Provisions of the SUPPORT Act.** The proposed rule implements several provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that require Part D plans to educate beneficiaries on opioid risks, alternate pain treatments, and safe disposal of opioids. The proposed rule also expands drug management programs and medication therapy management programs, through which Part D plans review with providers the opioid utilization trends that may put beneficiaries at-risk and provide beneficiary-centric interventions.
- **Medicare Advantage and Cost Plan Network Adequacy.** CMS proposes to strengthen network adequacy rules for MA plans by codifying existing network adequacy methodology, but also proposing new policies to improve

access in rural areas and encourage the use of telehealth in all areas. In rural areas, CMS is proposing to reduce the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90 percent to 85 percent and is inviting comment regarding additional changes to improve MA access in rural areas. To encourage and account for telehealth providers in contracted networks, CMS is proposing that MA plans receive 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, and Neurology. CMS is soliciting comment regarding whether to expand this credit to other specialty provider types.

Comments on the Advance Notice: CMS will accept comments on all proposals in the Advance Notice through **Friday, March 6, 2020**, before publishing the final Rate Announcement by April 6, 2020. To submit comments or questions electronically, go to https://www.regulations.gov/, enter the docket number "CMS-2020-0003" in the "search" field, and follow the instructions for ''submitting a comment.''

Comments on the Proposed Rule. The proposed rule will be published on February 18 in the *Federal Register*, and CMS will accept comments on the proposed rule up to **5:00 pm on April 6, 2020**. To submit comments electronically, go to http://www.regulations.gov and follow the "Submit a comment" instructions referencing "CMS-4190-P."

[1] See *June 2018 MedPAC Report to Congress, Chapter 9* at http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0 and *June 2019 MedPAC Report to Congress, Chapter 12* at http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0