HEALTH MANAGEMENT ASSOCIATES

Federal Policy COVID-19 Response: Impacts to Medicare Advantage

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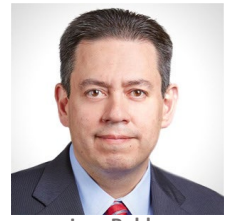

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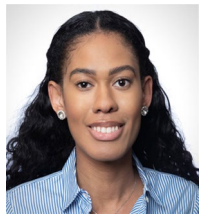

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COVID-19 Public Health Emergency Flexibilities

- On January 31, 2020 the Secretary of Health and Human Services (HHS) declared a public health emergency (PHE) in response to the COVID-19 virus. This was followed by a national emergency declared by President Trump on March 13, 2020.
- These declarations provide the DHHS and the Centers for Medicare & Medicaid Services (CMS) authority to waive certain Medicare and Medicaid regulatory requirements to help health plans and other stakeholders respond to immediate needs of their members and communities.
- The federal authority for COVID-19 flexibilities is provided through several mechanisms:

SSA Section 1135 Waivers

SSA Sec. 1812 (f)

CMS Regulatory Authority

Families First Coronavirus Response Act (FFCRA)

Coronavirus Aid, Relief, and Economic Security (CARES) Act

CMS Stated Goals

Support efforts to help curb the spread of the virus

Ensure MA and Part D enrollees do not experience disruptions in care and prescription drug access

Ensure access to health care items and services, particularly in light of necessary isolation and social distance measures

COVID-19 Public Health Emergency Policy Response

To date, CMS has announced new requirements and flexibilities for Medicare Advantage (MA) and Part D in the following areas, among others:

Cost Sharing	Telehealth	Star Ratings	D-SNP and State Specific
Part D	Audits	Appeals	FFS and Other Changes

In this presentation, HMA will identify the operational implications of these policy changes for Medicare Advantage plans. Health plans and other stakeholders should continue to monitor policy announcements and to work with CMS to identify potential areas of need for regulatory relief.

Cost Sharing Requirements and Flexibilities

- **COVID Testing**: Medicare Advantage plans are required to cover testing and services related to testing with no cost-sharing to the enrollee
- **COVID Treatment**: Plans may waive or reduce cost sharing for COVID-19-related treatments
  - The Food and Drug Administration (FDA) is issuing "Emergency Use Authorization" to rapidly approve COVID-19 tests and drug treatments
- **Vaccine Coverage**: Medicare will cover a future COVID-19 vaccine under Part B with no cost sharing for both the vaccine or its administration; this applies to both traditional Medicare and Medicare Advantage

- Update policies and procedures (P&Ps) related to testing, treatment, and vaccine coverage to avoid confusion and member dissatisfaction.
- Identify strategies for member and provider communication about testing, treatment, coverage, and cost sharing.
- Reduce ambiguity around member liability for COVID-19 related services. Monitor and implement testing, coding, and reimbursement protocols and guidelines from CMS, CDC, State and Federal government, and other health care agencies.
- Make members and providers aware of potential fraud, which increases with national events like COVID-19.

Expansion of Telehealth

- Medicare Advantage plans are able to include “additional telehealth benefits” in their bids, beginning in plan year 2020
  - CMS permits plans to expand coverage of telehealth services beyond those approved in the plan’s benefit package
- CMS clarified that telehealth encounters meet the “face-to-face” requirement for risk adjustment submissions
- For 2021 network adequacy calculations, CMS will provide plans with a 10-percentage point credit towards time and distance standards when they contract with the following telehealth provider specialty types: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, OB/GYN, Endocrinology, and Infectious Diseases

- Consider continued use of telehealth as standard practice after the pandemic.
- Consider developing alternative payment methodologies to reimburse for the new expanded telehealth services.
- Use telehealth encounters for risk adjustment purposes; plans should work with providers to learn how visits are being coded and with internal reporting teams to ensure the data is submitted to CMS appropriately.

2021 Star Ratings Calculations

- CMS removed the requirement for plans to submit HEDIS 2020 data and collect and submit 2020 CAHPS survey data; CMS will use the HEDIS and CAHPS data to calculate the 2020 Star Ratings data
- Health Outcomes Survey (HOS) data collection will be postponed until late summer; CMS will continue to reassess this timeline
- CMS will substitute the score and Star of 2020 for purposes of the 2021 Star Ratings if there is a systemic data quality issue
- 2020 Star Ratings may be used if the pandemic continues
- For purposes of 2022 quality bonus payments (based on 2021 Star Ratings), a "new MA plan" is defined as a plan offered by a parent organization that has not had another MA contract in the previous 4 years

- Take a proactive, member-centric, responsive outreach tailored to the pandemic. COVID-19 related communications need to be developed to assist members in understanding and accessing benefits. Plans can take this opportunity to proactively outreach to their at-risk members.
- Assess if members who had delayed services may require extra assistance. Such anticipatory actions will help in future Stars.
- Assist providers in conducting surveys of those who used telehealth service to measure and code the impact of satisfaction levels (which will tie to future CAHPS and HOS).
- Consider adjusting value-based payments to providers based on 2019 data or other agreed upon data that the Plan has collected.

2022 Star Ratings Calculations

- CMS anticipates Medicare Advantage plans will be able to submit HEDIS data and administer the CAHPS survey for the 2020 performance period (basis for 2022 Star Ratings)
- To address overall performance concerns, CMS has postponed the applicability date of the guardrails policy to January 1, 2021, which will delay implementation of the 5-percentage point cut point cap
- CMS will amend requirements for improvement measures – those used to evaluate year-to-year changes in performance – to expand the hold harmless rule to all contracts (as opposed to only those with 4+ Stars)

- Continue focus on operational excellence in their customer service, authorization, and appeals process.
- Adjust Stars projections modeling tools to incorporate the post-COVID-19 HEDIS, CAHPS, and HOS measure levels. These tools lose their effectiveness because they are reliant on historical data.
- Of note for future periods, new CAHPS weights will remain in place for the Final Rule for Access, Customer Service, and Care Coordination; however, these will not be used until the 2023 Star Ratings. Outlier removal methodology will also be delayed until the 2024 Star Ratings.

D-SNP and State-Specific Flexibilities

- On April 13, 2020, the Medicare-Medicaid Coordination Office released a memo that, among other provisions:
  - Extends the review and approval timelines for D-SNPs to submit revised State Medicaid Agency Contracts (SMACs) or SMAC amendments from August to November 2, 2020
  - Maintains the deadline for initial submission to be July 6, 2020
- In accordance with an updated April 21, 2020 memo, CMS approved a number of state-specific requests to waive certain model of care (MOC) requirements for Special Needs Plans (SNPs)
  - This includes waiving requirements of face-to-face contact with enrollees
- CMS temporarily relaxed enforcement of MA plans that choose to delay involuntary disenrollment of enrollees losing special needs status

- Consider negotiating with your State to include more flexibilities into the SMAC.
- Assure safety of members and staff, including more phone calls and video calls in lieu of in-person care coordination. Integrated SNPs are also working with their states on Medicaid benefits and long-term services and supports (LTSS) flexibilities.
- Consider delaying involuntary disenrollment of members who may lose special needs status and cannot recertify eligibility; however, SNPs must be prepared to disenroll members who do not regain eligibility within required timeframes.

Part D and Other Drug-Related Requirements

- **"Refill-Too-Soon" Edits**
  - Part D plan sponsors must relax their "refill-too-soon" edits if circumstances are reasonably expected to result in a disruption in access to drugs
  - A PDP or MA-PD may not permit an enrollee to obtain a single fill or refill if it is inconsistent with a safety edit (e.g., opioid)
- **Maximum Day Supply**: Part D sponsors must also allow an affected enrollee to obtain the maximum extended day supply available under their plan, if requested, PA or ST requirements have been satisfied and if no safety edits
- **Home or Mail Delivery of Part D Drugs**: Sponsors are permitted to voluntarily relax any plan-imposed policies that may discourage mail or home delivery for retail pharmacies that choose to offer these delivery services
- **COVID-19 Vaccine:** The COVID-19 vaccine will be covered under Medicare Part B

- Ensure communications to PBMs and network pharmacies about plan decisions.
- Prepare for a surge in claims volumes in waive two as was experienced in early March and April.
- Waive signature requirements for mail-ordered supplies due to transmission and infection risk posed by COVID-19.
- Monitor for federal and state actions specific for telepharmacy options available to members and the potential downstream impact.
- Review business continuity plans to address potential business operations disruptions.

Suspension of Audit Activities

- **Contract-Level Risk Adjustment Data Validation (RADV) Audits**
  - CMS has halting RADV activities related to the payment year 2015 audit and will not initiate any additional contract-level audits until after the public health emergency (PHE) has ended
  - MA plans should immediately suspend soliciting RADV-related medical records from providers
- **Medicare Parts C and D and PACE Program Audits**: CMS will continue its oversight, but will temporarily shift oversight activities from conducting routine audit activities to prioritizing the investigation and resolution of:
- Instances of noncompliance where the health and/or safety of beneficiaries are at serious risk
  - Complaints alleging infection control concerns, including COVID-19 or other respiratory illnesses

- The RADV Audit suspension is a temporary hold of activities. While plans need to cease requesting provider records, all other RADV suspect identification activities may continue.
- Continue to demonstrate adherence to new policies and procedures (P&Ps) imposed during the COVID-19 outbreak, including following previous P&Ps prior to the date of the change.
- Focus on member complaints related to COVID-19, as these will remain a priority
- Closely monitor timeliness of utilization management/prior authorization processes for delegated providers
- Focus on proactive interventions to keep complaints at a minimum.

Appeals Extensions and Information Requirements

- CMS will permit MA/Part D plans and Part C/D Independent Review Entity (IREs) extensions to file an appeal
- Part C/D IREs may waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe by up to 14 calendar days if the extension:
  - Is requested by the enrollee
  - Is justified and in enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA plan's decision to deny an item/service
  - Is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest
- MA/Part D plans and Part C/D IREs may:
  - Process appeals with incomplete Appointment of Representation (AOR) forms; any communications will only be sent to the enrollee
  - Process requests for appeals that don't meet all required elements using information that is available

- Expedite determinations for enrollees by processing appeals with incomplete AORs or incomplete elements. If plans are denying appeals in these instances, additional attempts to call and speak with the member to explain the decision may be helpful.
- Codify their approach during COVID-19 in their policies and procedures (P&Ps) with a focus on improving the beneficiary experience. Even with these flexibilities, CMS will continue to hold plans accountable to ensure beneficiaries receive the services they need.

Other MA COVID-19 Flexibilities and Requirements

- **Network Requirements:** MA plans are required to cover services at out-of-network facilities that participate in Medicare, and charge enrollees no more than they would face if they had received care at an in-network facility
- **Prior Authorizations:** MA plans may choose to waive plan prior authorization requirements that otherwise would apply to tests or services related to COVID-19
- **Benefit Enhancements:** Permits 2020 mid-year benefit enhancements and supplemental benefits

- Consider waiving or relaxing prior authorization requirements for COVID-19 tests and services.
- Consider adding mid-year benefit enhancements and/or supplemental benefits to make their plans more competitive to age-ins, such as eliminating cost-sharing and adding meal benefits.

Medicare FFS COVID-19 Flexibilities and Requirements

- Congress and CMS have issued over 200 policy changes that extend to Medicare fee-for-service (FFS) providers, which may have direct or indirect implications for Medicare Advantage plans
- **Coverage and Conditions of Coverage: Scope of practice and site of service flexibilities**
  - Waivers of physician supervision requirements or need for signature; other practitioners able to practice to extent allowed by state law
  - Providers may furnish select services in alternative sites to alleviate surge or support social distancing
- **Payment: Codes and/or rates established for services associated with COVID-19**
  - 20% hospital DRG add-on payment for COVID-19 cases
  - New codes and associated rates for lab/testing services
- **Data Reporting and Quality Performance: Delays in reporting requirements and extraordinary circumstance exceptions granted**
  - Relaxation of requirements for submitting medical records or other documentation
  - Select providers not required to report and/or will not accountable for quality performance data

- Implement Medicare FFS coverage policies.
- Consider following FFS payments to support providers. While payment for covered services is subject to plan/provider negotiations, FFS may provide a baseline for negotiations.
- Consider adopting data reporting/administrative flexibilities for contracted providers.
- Assess whether FFS flexibilities provide new cost containment strategies that could be adopted long-term.

Key Takeaways: The Federal Policy COVID-19 Response

- The requirements and flexibilities affect cost sharing, telehealth, Star ratings, prescription drugs, provider funding, appeals, special needs plans (SNPs), and benefits
- Federal requirements and flexibilities have been put into place to support continued access to needed services for Medicare beneficiaries during the COVID-19 pandemic
- While the policy changes announced to date are intended to be temporary, some may extend past the Public Health Emergency (PHE) or may provide a basis for future payment and care delivery models
- Medicare Advantage plans should anticipate further requirements and flexibilities to be released by CMS in the coming months
- Medicare Advantage plans should monitor requirements and flexibilities provided to Medicare fee-for-service particularly as it affects the Medicare Advantage plan's provider policies, as CMS continues to work to address beneficiary, local providers, and community needs.

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