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Let's Talk Shop – Changes in MA and Part D Compliance Requirements for 2019

Annie Hsu Shieh, Central Health Plan of California
John Tanner, Molina
Kate McDonald, McDermott Will & Emery

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Regulatory Landscape

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- CMS active in guidance and rulemaking
- Administrative burdens (+ / -)
- Forward-looking developments

Roadmap

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1. Preclusion List
2. FDR Training
3. MLR Reporting
4. Benefits Flexibility
5. Encounter Data
6. Appeals and Grievances

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PRECLUSION LIST

Preclusion List Basics

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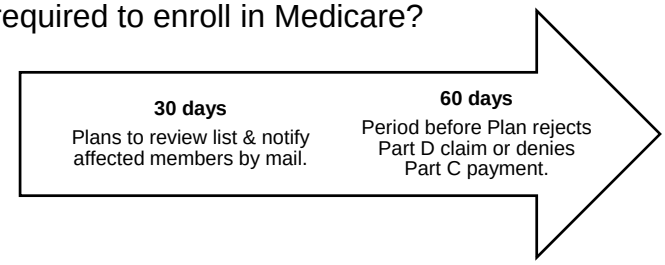
- What is the Preclusion List?
  - When is it in effect?
  - When are Plans expected to be in compliance?
- Are Part D providers participating in Medicare Advantage (MA) required to enroll in Medicare?



Preclusion List – Provider Notice

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- How will a provider know if they are on the Preclusion List?
- Where will the notification letter be sent?
- What is the length of time a provider can expect to be on the Preclusion List?
- Will providers be precluded retroactively?

Preclusion List – Provider Appeal Process

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- What are the appeal rights related to inclusion on the Preclusion List?
  - How will the preclusion appeals process affect appeals of payment denials or enrollment revocations?

Preclusion List – Member Impact

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- How are members notified?
  - Who?
  - Timing
  - Content
  - Translation
- How will the provider's inclusion on the Preclusion List impact a member's ability to:
  - Get their prescriptions filled?
  - Receive items or services through their Medicare Part C benefit?
- What should members do if they have access to care issues due to the Preclusion List?

Preclusion List – Operational Considerations

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- How are providers removed from the Preclusion List?
- Will the Preclusion List be shared publicly?
- How do Plans request access to the Preclusion List?
- When will updates to the Preclusion List be made available?
- What if Plans delegate claims adjudication and credentialing activities to a subcontractor?

Preclusion List – 2020 Proposed Changes

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- Appeals Process for Individuals & Entities on the Preclusion List
- Timing of Addition to the Preclusion List
- Effective Date
- Claim Denials & Beneficiary Notification
- Beneficiary Appeals
- Felony Convictions
- Beneficiary Liability
- Technical Correction Concerning the term “Individual”

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FDR TRAINING

FDR training & oversight - Background

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- Current regulations require compliance programs for Part C & Part D Plans that must include training and education between the compliance officer and the sponsoring organization's:
  - Employees,
  - Senior administrators,
  - Governing body members, as well as
  - First-tier, downstream and related entities (FDRs).

FDR Training & Oversight

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Mandatory Use of CMS Training (OLD)

- Requirement applicable beginning 1/1/16.
- CMS developed web-based standardized compliance program training modules and established that FDRs were required to complete the CMS training to satisfy the compliance training requirement.
- FDRs only have to complete compliance training once annually.
- FDRs could provide certificate of completion to all Part C & Part D sponsoring organizations they served.

Compliance Training No Longer Required of FDRs (NEW)

- Eliminates CMS requirement for FDRs (such as agents and brokers) to complete Parts C & D compliance program and FWA training.
  - Deeming of training requirements is no longer relevant.
- Compliance training will still be required of MA & Part D sponsoring organizations, their employees, chief executives or senior administrators, managers, and governing body members.

FDR Training & Oversight – Why?

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- Affords sponsors much greater flexibility in designing an FDR oversight structure that best suits the needs of each sponsor's organization.
- CMS training content did not alleviate the large administrative burden associated with compliance training and was too generic to be helpful to most FDRs.

FDR Training – Plan Options

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- Plans are free to choose the most effective and efficient method for ensuring all their FDRs are in compliance with all applicable laws, rules, regulations, and Medicare requirements.
  - Example: training attestations, reports, routine monitoring & auditing, and/or corrective actions.
- Plans should continue to evaluate contractual arrangements with FDRs to ensure appropriate levels of accountability for compliance are in place.
  - If plans choose to include compliance program training requirement as part of contract with FDRs that is a private contractual matter between the FDR and sponsoring organization.

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MLR REPORTING

MLR reporting – Background

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- MLR is a percentage of revenue and represents plan expense for "patient care"
- Contract year 2014 and forward, MA organizations and Part D sponsors required to report MLR by contract
- Financial and other penalties for failure to meet MLR of at least 85%
- Potential penalties:
  - Remittance of funds to CMS
  - Prohibition on enrolling new members
  - Ultimately contract termination
- Incentive for MA organizations & Part D sponsors to reduce administrative costs (marketing costs, profits, & other uses of funds earned by plan sponsors)

MLR reporting – Changes

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- Changes MLR calculation by including in the MLR numerator, as quality improvement activities (QIA) all expenditures:
  - for fraud reduction activities, or
  - For Medication Therapy Management (MTM) programs.
- Revises MLR reporting requirements to significantly reduce amount of MLR data MA organizations & Part D sponsors submit to CMS annually.

MLR reporting – Fraud Reduction Activities

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- MLR includes fraud prevention, fraud detection, and fraud recovery
- All expenditures for fraud reduction activities will be included in the MLR numerator as QIA, even if such expenditures exceed the amount recovered through fraud reduction efforts.
  - The thinking is plans will no longer have the same level of incentive to just pursue recovery of paid fraudulent claims, and may now be further incented to invest in fraud prevention.

MLR reporting – MTM

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- Permits all prospective payments for approved and permissible MTM services under the Part D Enhanced MTM model to be treated as QIA for purposes of MLR reporting.
- Encourages sponsors to expand access to these programs.
- Activity must:
  - Improve health quality;
  - Increase likelihood of desired health outcomes in ways capable of being objectively measured and producing verifiable results;
  - Be directed toward individual enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities, and
  - Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

MLR Reporting – Regulatory Changes to Medicare MLR Reporting Requirements

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- Will not affect MLR reporting until MLR data for contract year 2018 is submitted in 2019.
  - Desk reviews of MLR data submitted for contract years 2016 and 2017 will not be affected by the changes to the reporting requirements.
- Medicare MLR reporting requirements will be limited to the following data fields:
  - Organization name
  - Contract number
  - Adjusted MLR
  - Remittance amount

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BENEFITS FLEXIBILITY

Benefits Flexibility in the MA Program

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Bipartisan Budget Act of 2018

- **Chronically Ill Enrollees**
  - CMS may waive uniform benefit requirement
  - Supplemental benefits do not have to be primarily health related
- **Telehealth**
  - MAOs may cover telehealth benefits beyond Original Medicare as basic benefits
- **Effective:** CY 2020

Final Rule / Final Call Letter

- **All enrollees**
  - Uniform benefit requirement reinterpreted to permit targeting
  - Supplemental benefits must still be "primarily health related" but definition expanded
- **Meaningful difference eliminated**
- **VBID Expansion**
- **Effective:** CY 2019

Uniform Benefit Requirement

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Targeted health status/disease state must be based on a diagnosed condition, rather than functional status or medical complexity.

Health criteria must be objective and measurable.

Plan provider must diagnose member or affirm diagnosis.

Supplemental Benefits

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Items and services must:

- Focus directly on a member's *healthcare* needs
- Be medically appropriate

Licensed provider must *recommend* supplemental items and services:

- Physicians orders will not be required (no change from status quo)
- Lower standard of "recommended"
- Considerations for MAOs regarding documentation

Supplemental Benefits

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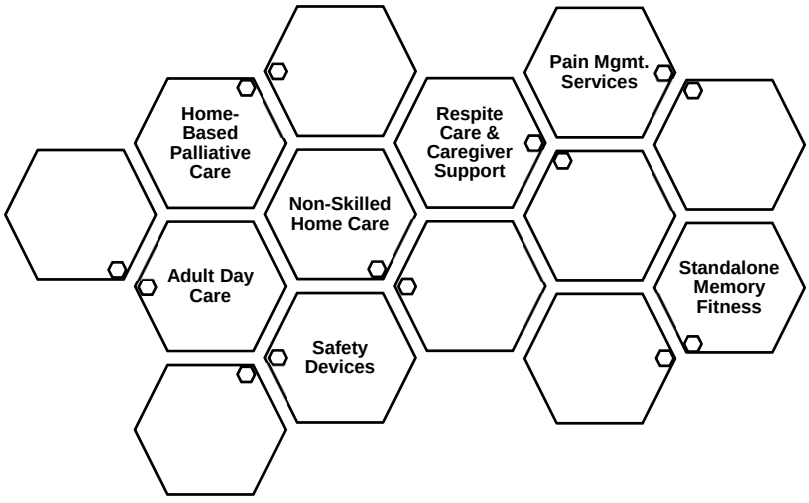

Supplemental Benefits

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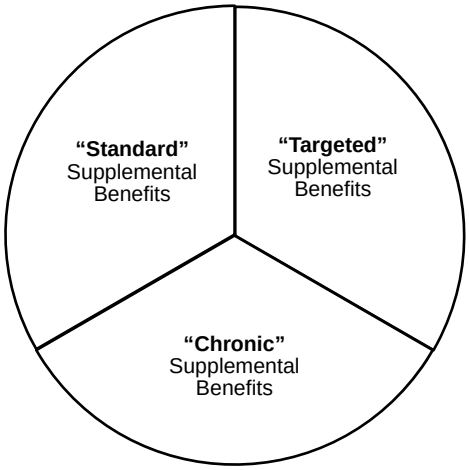

Telehealth Expansion

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Current Telehealth Benefits Under MA

MAOs can offer telehealth as a "basic benefit" only if coverage is limited to the coverage criteria under Original Medicare (*e.g.,* rural originating sites)

MAOs can offer more expansive telehealth benefits as supplemental benefits, but must be paid for entirely by rebate dollars or by members through increased premiums and cost-sharing

Telehealth Expansion

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Expanded Telehealth Benefits Under BBA

- **Effective Date:** CY 2020
- **Applicability:** All members
- **Scope of Change:** MAOs may offer telehealth benefits *beyond* Original Medicare coverage as part of *basic benefits*
- **Proposed Rule 4185-P**
- Published to Federal Register 11/1/18
- Comments due: 12/31/18
- Treat telehealth benefits as basic benefits for purposes of bid submission and payment by CMS.

Telehealth Expansion

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4185-P

- Proposes to define "additional telehealth benefits" as services that meet the following: (1) are furnished by an MA plan for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act; and (2) have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange.
- Defines "electronic exchange" as "electronic information and telecommunications technology"
- Not proposing specific regulation text that defines or provides examples of electronic information and telecommunications technology
- Soliciting comments on how to implement the statutory provision that if an MA plan covers a Part B service as an additional telehealth benefit, then the MA plan must also provide the enrollee access to such service through an in-person visit.

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ENCOUNTER DATA

Encounter Data: History and Issues

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History and Current Use

- Authority to require submission for each item and service
- Uses: risk adjustment model; quality review; program evaluation
- Gradual transition from RAPS data to encounter data
  - 2019: 25% encounter data / 75% RAPS data
  - Up from 15% encounter data in 2018
- New consolidated encounter data submission guide (Nov. 2018)

Industry Concerns and Recent Issues

- Implementation challenges
- Lower risk scores

Encounter Data: Mitigating Steps

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- Supplement encounter data with RAPS inpatient data
- Slower transition from RAPS data to encounter data

Encounter Data: Monitoring

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Operational performance

1. Failure to complete end-to-end testing and certification	2. Failure to submit any accepted records	3. Excessive submission of records at end of risk adjustment submission window (>27%)

Completeness

4. Extremely low volume of overall encounter data records	5. Extremely low volume of inpatient encounter data records	6. Extremely low volume of professional encounter data records	7. Extremely low volume of outpatient encounter data records

Accuracy

Encounter Data: Enforcement

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- Report Cards
- Annual Compliance Actions
  - Outreach to plans
  - Technical assistance
  - Warning letters
  - Corrective action plans
- Comparison to Medicaid
- Obligation to update

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APPEALS AND GRIEVANCES

Overview of Proposed Guidance

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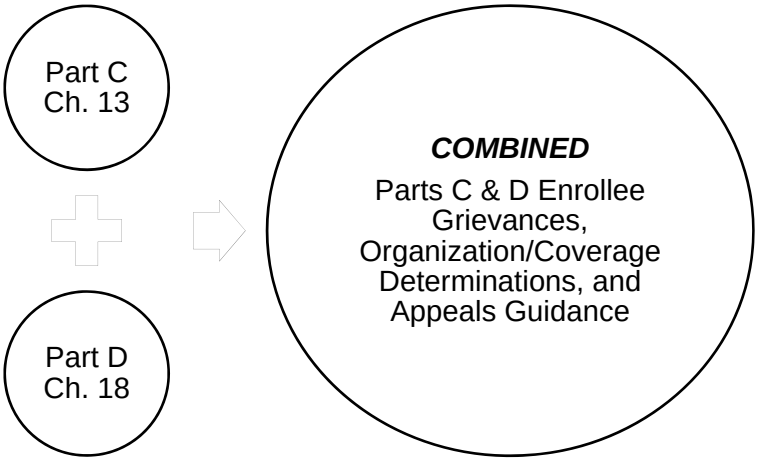

Overview of Proposed Guidance

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Objectives

- Streamline guidance
- Align Part C and Part D policies
- Incorporate regulatory and guidance changes

Observations

- Some entirely new areas of guidance
- Details provided on topics where CMS guidance was previously silent
- Some changes in guidance
- Some nuanced language changes could be significant

Regulatory Changes

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- Part D tiering exceptions
- Part D payment timeframes
- Part D at-risk determinations
- Part C IRE forwarding notification

New Areas of Guidance

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- Specificity on how timeframes are calculated (receipt and delivery; counting days and hours)
- Providing information to members about determination, appeal, and grievance processes
- Role of the Medical Director
- ALJ, Medicare Appeals Council, and judicial review

Calculating Timeframes

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Calculating Days/Hours for Timeframes:	Coverage Request or Prescriber Statement is Received by the Plan When:	Processing Timeframe Begins When Request is Received By:
☐	☐	☐
☐ "Day one" is the day <u>after</u> the plan receives the request.	☐ Plan stamps document received by regular mail;	☐ The plan;
☐ Hours start counting <u>immediately</u> upon receipt.	☐ Delivery service (e.g., FedEx) delivers the document;	☐ Any unit in the plan; or
☐ Unless otherwise specified, days are calendar days and include weekends and holidays.	☐ Faxed document is transmitted as indicated on the fax transmission report	☐ Any delegated entity of the plan.
	☐ Verbal request is made with customer service representative;	
	☐ Message is left on the plan's voicemail system; or	
	☐ Request is received through plan's website.	

Other Changes and Clarifications

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Classifying grievances, inquiries, coverage requests, and appeals	New bases for good cause extensions
Oral versus written notice (to member and from member)	New bases for dismissing reconsideration request
Permissible delegatees	Reopenings versus appeals
Provider outreach	Clerical errors and reopenings
Part D PA and UM requirements extended to Part C	Effectuation of decisions
Permissible representatives for initial requests and appeals	Notices in facilities (hospital, SNF, home health, outpatient rehab)

Oral vs. Written Notice

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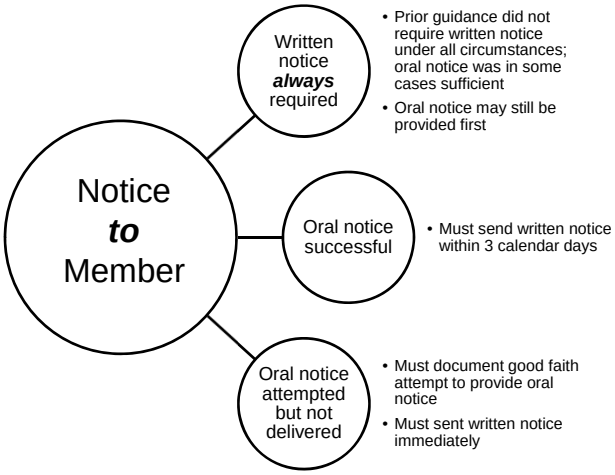

Oral vs. Written Notice

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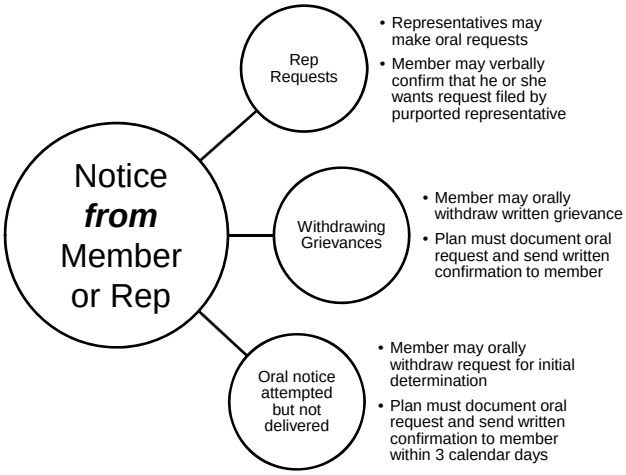

Next Steps for Plans

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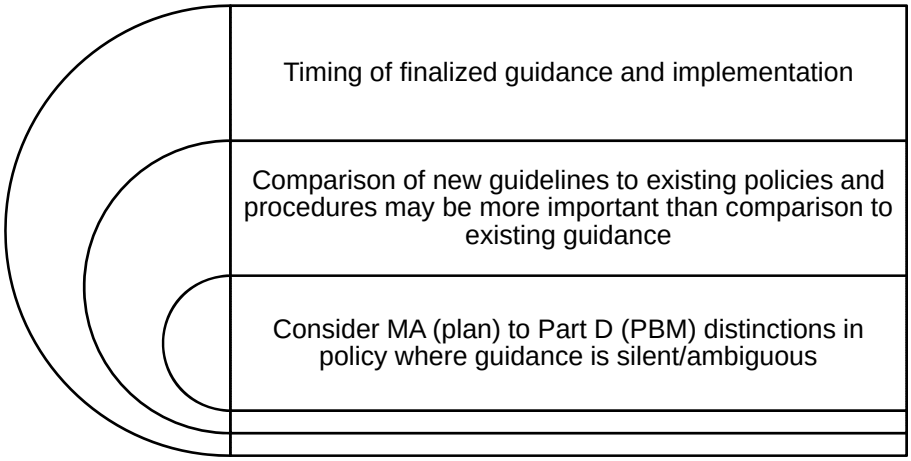

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QUESTIONS?