

# PROVIDER ALERT

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## Medicare Advantage and Part D Plans: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule-making, these temporary changes will apply immediately across the entire U.S. health care system for the duration of the emergency declaration. The goals of these actions are to: 1) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as the Centers for Medicare and Medicaid Services Hospital Without Walls); 2) remove barriers for physicians, nurses and other clinicians to be readily hired from the community or from other states so the health care system can rapidly expand its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community-based settings; and 5) put patients over paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

### Patients Over Paperwork

- **Flexibility to Waive Cost Sharing and to Provide Expanded Telehealth Benefits:** Medicare Advantage plans may waive or reduce cost-sharing for beneficiaries affected by the pandemic, including waiving or reducing cost-sharing for COVID-19 testing. The Centers for Medicare and Medicaid Services (CMS) is also exercising enforcement discretion to allow Medicare Advantage plans to expand telehealth services beyond those included in their approved 2020 benefits.
- **Part D "Refill-Too-Soon" Edits and Maximum Day Supply:** Part D plan sponsors may relax their "refill-too soon" edits if circumstances are reasonably expected to result in a disruption in access to drugs. Part D sponsors may also allow an affected enrollee to obtain the maximum extended day supply available under their plan, if requested and available.
- **Home or Mail Delivery of Part D Drugs:** In situations when a disaster or emergency makes it difficult for enrollees to get to a retail pharmacy, or enrollees are actually prohibited from going to a retail pharmacy (e.g., in a quarantine situation), Part D sponsors are permitted to voluntarily relax any plan-imposed policies that may discourage certain methods of delivery, such as mail or home delivery, for retail pharmacies that choose to offer these delivery services in these instances.
- **Audit Reviews:** CMS is also pausing much of its standard medical review activities, including prior authorization and other reviews that require asking providers for documentation. In addition, CMS is reprioritizing scheduled program audits and contract-level Risk Adjustment Data Validation audits for MA organizations, Part D sponsors, Medicare-Medicaid Plans, and Programs of All-Inclusive Care for the Elderly organizations. Reprioritizing these audit activities will allow providers, CMS and the organizations to focus on patient care.

Updated 4/13/20

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## **Medicare Advantage (Part C) and Part D Star Ratings: 2021 Star Ratings Data Collection**

CMS is committed to allowing health plans, providers and physician offices to focus on caring for Medicare beneficiaries during this public health emergency and not put individuals at risk by requiring travel or collection of data in offices that may be overwhelmed by patients needing care. In light of the public safety issues in continuing to require the collection, validation and submission of data for the 2019 measurement year, the rule removes the requirement for Medicare health plans to submit Healthcare Effectiveness Data and Information Set (HEDIS) 2020 data covering the 2019 measurement year for the Medicare program. Medicare health plans can use any HEDIS data that they have collected for their internal quality improvement efforts.

CMS is removing the requirement for submission of 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for Medicare health and drug plans for similar concerns about the potential associated with activities to collect and submit the survey data. Both Part C and D plans can use any CAHPS survey data collected for their internal quality improvement efforts.

This year's Health Outcomes Survey, administered by the National Committee for Quality Assurance (NCQA) in partnership with CMS as a component of HEDIS data collection, was scheduled to be from April through July 2020. This survey administration has been postponed to late summer, and CMS will continue to monitor the situation to see if any further adjustments are needed.

## **Medicare Advantage (Part C) and Part D Star Ratings: 2021 Star Ratings Calculations**

In addition to modifying the 2020 data submission requirements for HEDIS and CAHPS surveys, CMS is taking the following action with respect to 2021 Star Rating calculations:

CMS will use last year's HEDIS measures scores and ratings from the 2020 Star Ratings (based on care delivered in 2018) for the 2021 Star Ratings. Similarly, CMS will use the CAHPS measures data scores and ratings (from the 2020 measure-level Star Ratings) for the 2021 Star Ratings.

The measurement period and data for all other measures, where there was not a health and safety risk from the COVID-19 outbreak in collecting the data, will not change from what was finalized in the April 2018 final rule, unless:

- In the event that the COVID-19 outbreak prevents CMS from having validated data or results in systemic data integrity issues for any other measures, we will replace the data about 2019 for which there are data quality issues due to the COVID-19 outbreak with the measure-level Star Rating and score from the 2020 Star Ratings.
- In the event that CMS's functions become focused on only continued performance of essential agency functions and the agency and/or its contractors do not have the ability to calculate the 2021 Star Ratings, the 2020 Star Ratings received for contract year 2020 would be used for the ratings for 2021.
- Newer contracts where the 2021 Star Ratings would be the first year that they would receive a Star Rating, will be treated as new for an additional year since CMS would not have enough data to assign a rating.

For the HEDIS and CAHPS measures that are part of the Part C and D improvement measures, CMS will use the measure-level improvement change score from the prior year and for all other measures will use the current measure-level improvement change score as has historically been done.

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## Medicare Advantage (Part C) and Part D Star Ratings: 2022 Star Ratings Calculations

For 2022 Star Ratings, CMS expects Medicare Advantage contracts to submit HEDIS data in June 2021, and Medicare Advantage and Prescription Drug Plan (Part D) contracts to administer the CAHPS survey in 2021 as usual, so there is not a concern about data collection for the 2020 performance period. However, to address concerns about overall performance in 2020, CMS is changing the applicability date of the guardrails policy from January 1, 2020, to January 1, 2021, delaying implementation of the 5-percentage-point cap, so that cut points for the 2022 Star Ratings can change by more than 5 percentage points if national performance declines overall as a result of the outbreak.

CMS will calculate the Part C and D improvement measure scores for the 2022 Star Ratings as codified but recognizes that the COVID-19 outbreak may result in a decline in industry performance, therefore expanding the “hold harmless rule” to include all contracts at the overall and summary rating levels.

## Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program 42 CFR 405.942 and 42 CFR 405.962 and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), 42 CFR 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582, to allow extensions to file an appeal.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals. MA plans may extend the time frame to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee’s interest due to the need for additional medical evidence from a non-contract provider that may change an MA organization’s decision to deny an item or service or; the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee’s interest 42 CFR § 422.568(b)(1)(i), § 422.572(b)(1) and § 422.590(f)(1).
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 405.910 and MA and Part D plans, as well as the Part C and Part D IREs, to process an appeal even with incomplete Appointment of Representation forms 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, to process requests for appeal that don’t meet the required elements using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is allowing MACs and QICs in the FFS program 42 CFR 405.950 and 42 CFR 405.966 and MA and Part D plans, as well as the Part C and Part D IREs, 42 CFR 422.562, 42 CFR 423.562, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

## Additional Guidance

The Interim Final Rule and waivers can be found at:

<https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.

The program and RADV audit guidance can be found at:

<https://cms.gov/files/document/covid-19-programauditsradv-memo.pdf>.