American Hospital Association™
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Special Bulletin

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CMS Issues Proposed Rule for Medicare Advantage, Part D for 2021

The Centers for Medicare & Medicaid Services (CMS) Feb. 5 issued a proposed rule and the second part of the Advanced Notice, which would make policy and technical changes to the Medicare Part C and D programs, including the Medicare Advantage (MA) Program, the Medicare Prescription Drug Benefit Program, the Medicaid Program, the Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Unlike in prior years, the agency is not releasing a separate call letter; however, it will separately issue bidding instructions for plans.

In the rule, CMS proposes to increase the portion of a health plan's risk score that is based on encounter data, enable plans to meet some network adequacy requirements through telehealth, and provide plans with greater flexibility to tailor benefit packages for the chronically ill, among other policy changes. CMS expects that these changes will result in an increase in MA plan revenue of 0.93%.

Factor	Proposed Impact
MA Effective Growth Rate	+2.99%
Rebasing/Re-pricing	TBD
Changes in Star Ratings	+0.23%
MA Coding Pattern Adjustment	0%
Risk Model Revision	+0.25%
Encounter Data Transition	0.0%
Normalization	-2.54%
Expected Average Change in Revenue	**+0.93%**

Key Takeaways

CMS proposes:

- To allow health plans serving rural areas to use telehealth to meet some network adequacy standards.
- To give plans greater flexibility to tailor benefit packages for the chronically ill.
- A number of changes to the Part D program to drive greater utilization of generics and other measures to lower spending, including by requiring plans to offer consumer-facing cost comparison tools.
- To implement several provisions of the SUPPORT Act to reduce opioid use.
- To base 75% of a health plans' risk score on encounter data.

CMS expects these changes will result in a 0.93% increase in revenue for MA.

This Special Bulletin provides additional detail on several of the major provisions that affect hospitals and health systems.

MAJOR PROVISIONS

Risk Adjustment and Encounter Data. The agency proposes to continue its move away from relying on diagnosis information submitted by health plans to diagnoses collected through encounter data for purposes of calculating risk scores that impact plan payment. CMS began this transition in 2015, calculating risk scores based in part on plan-submitted information through the Risk Adjustment Processing System (RAPS) (90%) and encounter data (10%). For plan year 2020, CMS balanced the risk score based on these types of data (50% RAPS/50% encounter data). For 2021, CMS proposes to increase the proportion based on encounter data to 75%.

Network Adequacy and Telehealth. CMS proposes several changes to network adequacy rules for MA plans to address access challenges in rural areas. Specifically, CMS proposes to allow health plans to use telehealth to meet certain access requirements for some specialties, including psychiatry, neurology and cardiology. CMS expects this change also could increase plan choices for beneficiaries in rural areas and facilitate provider adoption of new health care technologies.

Kidney Organ Acquisition Costs. Federal law now permits all individuals with end stage renal disease (ESRD) to enroll in MA plans, effective Jan. 1, 2021. The law also stipulates that MA plans no longer will be responsible for organ acquisition costs for kidney transplants. Those costs will be excluded from MA benchmarks and will be paid for separately under the Medicare fee-for-service program. As this provision is required under federal law, the agency in the rule is clarifying how it will implement this provision rather than proposing policy.

Supplemental Benefits for the Chronically Ill. Federal law already permits MA plans to offer certain supplemental benefits to subsets of beneficiaries who meet certain criteria as chronically ill. These supplemental benefits do not have to be primarily health-related but do have to provide a reasonable expectation of improving or maintaining the health or overall function of the enrollee. CMS proposes changes to this policy to provide plans with more flexibility in identifying who may qualify for this broader range of supplemental benefits that are not offered to all plan participants, and provides further guidance on what types of services may be offered through this policy.

Star Ratings. The agency proposes several changes to the Star Ratings program for MA and Part D plans, including increasing the effect that patient experience and access measures have on a plan's Star Rating. Notably, the agency solicits feedback on a measure concept related to prior authorization, as well as a Part D utilization measure concept to reward plan sponsors for benefit designs that result in high rates of generic utilization. The agency also seeks feedback on measure concepts related to ESRD, physical functioning activities of daily living (patient-reported) and initial opioid prescribing.

Prescription Drug Benefit. The agency puts forth a number of potential changes pertaining to the Medicare Part D program. If finalized, the rule would require Part D plans to offer real-time benefit tools beginning January 1, 2022, providing consumers with out-of-pocket cost data and allowing them to use that data to shop for lower-cost alternative therapies. The proposed rule also would establish a second, "preferred" specialty tier with a lower cost-sharing amount, providing Part D plans with more leverage when negotiating with drug companies. Finally, the proposed rule seeks to implement several provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act by expanding drug management and medication therapy management programs and requiring Part D plans to provide education on opioid risks, alternate pain treatments and safe disposal.

NEXT STEPS

Comments on the proposed rule are due March 6. For more information, contact Molly Smith, AHA vice president for policy, at mollysmith@aha.org.