Published on *The National Law Review* https://natlawreview.com

CMS Publishes Final Rules Implementing Part C and Part D Program Changes

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On April 23, 2024, the Centers for Medicare & Medicaid Services (CMS) published final rules setting forth *Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024--Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program…et al.* These sweeping final rules finalized many changes that were introduced in the Proposed 2025 Rules and other changes that were proposed in the Proposed 2024 Rules. The rules will implement changes related to many areas, including, for example, Star Ratings, marketing and communications standards and requirements, agent/broker compensation, health equity, dual eligible special needs plans (D-SNPs), Part D formularies, utilization management, and the Medicare Advantage and Part D application process.

Although many of the rules are closely aligned with existing sub-regulatory guidance, others, especially those relating to marketing and communications standards and compensation signal a shift in historic CMS guidance. The final rules aim to "strengthen protections and guardrails, promote healthy competition, and ensure Medicare Advantage and Part D plans best meet the needs of enrollees. In addition, these policies promote access to behavioral health care providers, promote equity in coverage, and improve supplemental benefits." While the rules have varying operational effective dates, the earliest impact the bid process for 2025, which is ending in less than 6 weeks from the date of publication of the final rules; the rules universally impact program offerings for Contract Year 2025.

We plan to analyze the final rules in a series of blog posts over the next two weeks, beginning with today's highlight of changes to the risk adjustment data validation (RADV) appeals process, an update on the Overpayment Rule, and a new category of providers to be included in CMS's network adequacy evaluation.

A New, Standardized, RADV Appeals Process

CMS finalized changes that will standardize the RADV appeals process by requiring Medicare Advantage Organizations (MAOs) to exhaust all three levels of appeal for medical record review before the payment error calculation appeals process can begin. CMS stated that it believed this

clarification was necessary “because RADV payment error calculations are directly based upon the outcomes of medical record review determinations.”

There are currently three levels of appeal under the RADV audit processes: (1) reconsideration, (2) Hearing Officer review, and (3) CMS Administrator review. Under the current policies, MAOs can appeal both medical record review determinations and payment error calculations at the same time. The fact that these processes can run concurrently could result in inconsistencies at the various levels of appeal, which would ultimately impact the final calculations of the payment error. The final rule standardizes the RADV appeals process by requiring MAOs to exhaust all three levels of appeal for a medical record review determination before beginning an appeal of a payment error calculation. Ideally, this change will reduce the burden on MAOs who may have historically submitted appeals of error calculation that were later rendered moot by medical record appeals decisions.

Of note, in response to the proposed changes, CMS received a number of comments outside the scope of the proposals and related to the risk adjustment program methodology and the RADV process, generally. CMS thanked commenters but focused solely on the proposal and final rules.

Overpayment Rule Remains Open

Also, related to the risk adjustment area and identification of payment errors, CMS noted that it received a number of inquiries into the status of its December 2022 proposal to update the definition of “identified” in the “2014 Overpayment Rule” regulations (*See* 42 C.F.R. 422.326(c), which was invalidated by the District Court for the District of Columbia’s finding that the regulation was impermissible under the statute. *UnitedHealthcare Ins. Co. v. Azar,* 330 F. Supp. 3d 173, 191 (D.D.C. 2018), rev’d in part on other grounds sub nom. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. 2021), cert. denied, 142 S. Ct. 2851 (U.S. June 21, 2022) (No. 21-1140)).

CMS stated that this change remains under consideration and the agency intends to issue a final rule that will revise the definition of “identified” in the overpayment rules as soon as is reasonably possible. Noting of course, however, that MAOs are still obligated to report and return all overpayments identified under 42 U.S.C. 1320a-7k(d)(2)(A).

New Behavioral Health Providers to be Evaluated During Network Adequacy Review

CMS finalized its proposal to include a new facility type on Medicare Advantage health services delivery (HSD) tables, “Outpatient Behavioral Health.” Under the rule, MAOs are able to include individual providers, group practices, and facilities that provide the applicable behavioral health services.

This change coincides with changes adopted in the Consolidated Appropriations Act, 2023 (P.L. 117-328) that amended the Social Security Act to allow Medicare Part B to pay for services provided by additional behavioral health providers, specifically including Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC). Previously, these types of providers often provided services to private paying individuals, individuals in commercial plans and Medicare Advantage beneficiaries who were enrolled in MA plans that included their services as a supplemental benefit. Because MFTs and MHCs are now recognized by original Medicare as behavioral health providers, MAOs can include such providers in their HSD tables when seeking to satisfy network adequacy for Outpatient Behavioral Health. CMS is also allowing MAOs to include nurse practitioners, physician assistances,

and clinical nurse specialists, so long as the MAO can demonstrate that such provider as or will provide behavioral health services to at least twenty individuals within twelve months. Additionally, because such a large volume of behavioral health services are provided through telehealth, MAOs will be allowed to use the 10 percentage point credit for these provider types if the MAO's plan benefit package offers additional telehealth benefits and its network includes one or more behavioral telehealth providers.

While CMS has made a variety of changes to network adequacy requirements over the years, this change is noteworthy because it demonstrates significant changes in the Medicare program's promotion of behavioral health and continued recognition of telehealth.

Stay tuned for additional posts analyzing other key elements of the final rules.

National Law Review, Volume XIV, Number 114