QUARTERLY COMPLIANCE AND PROGRAM UPDATES

Banner University Health Plans

FDR Newsletter

QUARTER 2 | JUNE 2022

IN THIS ISSUE

QUICK LINKS

- OIG's List of Excluded Individuals and Entities (LEIE)
- System for Award Management (SAM)
- Banner University Health Plan's Compliance Program

The Banner – University Health Plans Compliance Program is committed to compliance and meeting requirements of all applicable laws and regulations of CMS and AHCCCS.

IN THE NEWS

Public Health Emergency (PHE) extension updates

On April 12, 2022, the Secretary of Health and Human Services (HHS) renewed the national public health emergency (PHE) period for COVID-19 through July 15, 2022.

This renewal allows for the continued implementation of existing federal waivers related to the PHE.

Below are URLs/links to AHCCCS and CMS that will give you current and updated information on their waivers, telehealth guidance and more. Stay updated by visiting these sites regularly.

Here are additional links that you might find helpful:

For Medicaid providers:

AHCCCS COVID-19 FAQs, updated Apr. 8, 2022.

Following this link will take you to the FAQ that has many topics related to the Public Health Emergency, including telehealth.

AHCCCS Emergency Authority Requests, revised Apr. 15, 2022.

For Medicare providers:

Telehealth Services

CMS Waiver

COMPLIANCE UPDATES

CY2023 Medicare Advantage and Part D final Rule (CMS-4192-F) Issues April 29, 2022

CMS issued a final rule that advances CMS' strategic vision of expanding access to affordable health care and improving health equity in Medicare Advantage (MA) and Part D through lower out-of-pocket prescription drug costs and improved consumer protections. To view the final rule, please visit: https://www.federalregister.gov/public-inspection/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

Summary of Changes That Have Impacts to FDRs:

Lowering Beneficiary Cost-Sharing at the Pharmacy Counter

In recent years, more Part D plans have been entering into arrangements with pharmacies that may pay less money for dispensed drugs if pharmacies do not meet certain criteria. The negotiated price for a drug is the price reported to CMS at the point of sale, which is used to calculate beneficiary cost-sharing and generally adjudicate the Part D benefit. With the emergence of these payment arrangements, the negotiated price is frequently higher than the final payment to pharmacies. Higher negotiated prices lead to higher beneficiary cost-sharing and faster beneficiary advancement through the Part D benefit. CMS is finalizing a policy that requires Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, so that the beneficiary can also share in the savings. Specifically, CMS is redefining the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2024. CMS is applying the finalized policy across all phases of the Part D benefit. This policy reduces beneficiary out-of-pocket costs and improves price transparency and market competition in the Part D program.

Marketing and Communications Oversight

CMS is finalizing changes to marketing and communications requirements that will protect Medicare beneficiaries by ensuring they receive accurate and accessible information about Medicare coverage. These include strengthening oversight of third-party marketing organizations to detect and prevent the use of confusing or potentially misleading activities to enroll beneficiaries in MA and Part D plans, **reinstating the inclusion of a multi-language insert** in all required documents to inform beneficiaries of the availability of interpreter services, codifying enrollee ID card standards, requirements related to a disclaimer for limited access to preferred cost sharing pharmacies, plan website instructions on how to appoint a representative, and website posting of enrollment instructions and forms.

Beneficiary Access to Care During Disasters and Emergencies

To ensure that beneficiaries have uninterrupted access to needed services, CMS is revising and clarifying timeframes and standards associated with coverage obligations of MA plans during disasters and emergencies. Current regulations have special requirements for MA plans during disasters or emergencies, including requirements for plans to cover services provided by non-contracted providers and to waive gatekeeper referral requirements. The final rule will clarify that an MA plan must comply with the special requirements when there is both a declaration of disaster or emergency (including a public health emergency) and disruption in access to health care in the MA plan's service area.

Preclusion List

The preclusion list is sent out monthly and lists providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Requires denial of payment for items or services furnished by an individual on the Preclusion List. Effective as of the April Preclusion List, any prescriber or provider is to be precluded from all B – UHP lines of business (AHCCCS and Medicare).

REPORT ACTUAL OR POTENTIAL FWA, OR NON-COMPLIANCE

ComplyLine: 1-888-747-7989 *(Reports can be made anonymously 24/7)*	**U.S. Mail:** Banner – University Health Plans Compliance Department 2701 E. Elvira, Tucson, AZ 85756
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