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CY 2023 Medicare Advantage and Part D Policy and Technical Changes Proposed Rule

OVERVIEW

On January 6th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule including policy and technical changes for Medicare Advantage (MA) and Part D plans, and Programs of All-Inclusive Care for the Elderly (PACE) for calendar year (CY) 2023. This is Part I of the 2023 Advance Notice and Draft Call Letter.

CMS expects that the costs associated with its proposals are relatively modest and are not expected to significantly change MA plans' bids, supplemental benefits, or beneficiary premiums. However, a more complete understanding of the effect of regulatory changes on the MA and Part D markets in 2023 will not be possible until Part II of the Advance Notice is released. This typically occurs in late January.

This document summarizes key provisions of Part I of the Advance Notice and Draft Call letter. CMS will accept comments through March 7th, and policies will be finalized in the 2023 Rate Announcement and final Call Letter by April 1st. The proposed rule is available here. A fact sheet is available here.

PHARMACY PRICE CONCESSIONS AT THE POINT OF SALE

The negotiated prices of prescription drugs, as reported by Part D plans to CMS, serve as the "primary basis by which the Part D benefit is negotiated." Currently, the negotiated price plans report is defined to include price concessions from network pharmacies, but exclude performance-based concessions that "cannot reasonably be determined at the point of sale." These lower the price that a plan sponsor ultimately pays for the drug. CMS notes that that performance-based concessions have grown 170 percent each year from 2012 to 2020, and that they have become the second-largest category of post-point of sale compensation, known as Direct and Indirect Remuneration (DIR), behind manufacturer rebates (which are non-pharmacy price concessions, not being modified by CMS at this time). Although such concessions may result in lower premiums, they do not reduce plan enrollees' cost-sharing burden because their cost-sharing is calculated based on the negotiated price reported to CMS.

As such, CMS proposes to re-define the "negotiated price" as the lowest amount a pharmacy could receive as reimbursement for a covered Part D drug under its contract with the Part D plan sponsor or the sponsor's intermediary. For example, if a network pharmacy can receive a performance-based bonus or penalty that would lower the end cost of a drug, the negotiated price must assume that the pharmacy has achieved the lowest possible performance. If the pharmacy ends up receiving a higher payment through performance-based incentives, plans should later reconcile such payments by reporting them as negative DIR.

In addition, CMS proposes to define the term "price concession" in a broad manner to include all forms of discounts, subsidies, and rebates. The term is currently not defined in statute, regulations, or sub-regulatory guidance. CMS believes these changes will lower negotiated prices at the point of sale, thus reducing beneficiary out of-pocket costs, slowing beneficiary advancement through the Part D benefit, and improving price transparency.

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CHANGES TO SPECIAL NEEDS PLANS (SNPS)

Updates to Health Risk Assessments

CMS proposes to require that all SNPs include standardized questions on housing stability, food security, and transportation access as part of their health risk assessment. SNPs are required to conduct such an assessment upon enrollment and annually thereafter, and CMS believes that including these questions will provide SNPs with a more complete picture of the risk factors that may inhibit care access and optimal health outcomes.

Cost-Sharing Accrual for Maximum Out-of-Pocket Limit

MA plans are required to establish a limit on beneficiary cost-sharing for Medicare Part A and Part B services, known as the maximum out-of-pocket (MOOP) limit, after which the plan pays 100% of service costs. Under current guidance, MA plans are permitted to consider only amounts paid by the beneficiary directly, which excludes Medicaid-paid amounts or unpaid amounts from the MOOP limit calculation. As a result, some Dual Eligible Special Needs Plans (D-SNPs) have continued to deduct cost-sharing amounts from provider payments after the beneficiary has accrued expenses exceeding the MOOP.

CMS proposes to require that the MOOP limit is calculated based on the accrual of all cost-sharing, whether paid by the beneficiary, Medicaid, other secondary insurance, or unpaid due to State limits. This would require D-SNPs to pay 100 percent of the costs of covered services, both reducing State Medicaid costs (due to additional cost-sharing that will not be paid) and increasing provider payments (due to the payment of currently deducted costs). CMS estimates that over ten years, states will save $2 billion and providers will receive increased payments of $8 billion due to this change.

D-SNP Policies to Promote Alignment

CMS is proposing a series of policies for D-SNPs which are intended to incorporate lessons learned from fully aligned Medicare-Medicaid Plan (MMP) demonstrations into the broader MA program.

Enrollee Participation in Plan Governance

CMS proposes to require that MA organizations that offer a D-SNP establish one or more enrollee advisory committees in each state in which the plan is offered to solicit direct input on enrollee experiences. The committee must include a reasonably representative sample of individuals enrolled in the D-SNP and must solicit input on topics such as how to improve access to covered services, service coordination, and health equity for underserved populations.

Redefining Fully Integrated and Highly Integrated D-SNPs (FIDE and HIDE SNPs)

CMS proposes to make a number of changes to how it defines FIDE and HIDE SNPs to help differentiate plans, clarify options, and improve integration. These include:

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- Beginning in 2025, CMS proposes that all FIDE SNPs must have exclusively aligned enrollment, and that the FIDE SNP capitated benefit must include coverage for Medicaid primary and acute care benefits; Medicaid home health and durable medical equipment benefits; and Medicaid behavioral health services. Such services must be covered to the full extent that the State Medicaid program covers them.
- All FIDE SNPs would be required to cover Medicare cost-sharing for all full-benefit dually eligible enrollees. Although current federal regulation only requires cost-sharing coverage for Qualified Medicare Beneficiaries (QMBs), this does not reflect a change in existing practice, since all 69 FIDE SNP contracts currently include cost-sharing in the capitation.
- Each FIDE and HIDE SNP's capitated contract with a State Medicaid agency must apply to the entire D-SNP service area for the plan year, beginning in 2025.

Limited carve-outs from the requirement for FIDE and HIDE SNPs to cover long-term services and supports (LTSS) and/or behavioral health benefits would continue to be permitted, upon approval, if they apply to a "minority of beneficiaries" or "constitute a small part of the total scope" of the relevant benefit.

Opportunities for Integration through State Medicaid Agency Contracts

CMS proposes to codify new pathways through which State Medicaid agencies may use D-SNP contracts to require certain D-SNPs with exclusively aligned enrollment to:

1. Establish contracts that only include one or more D-SNPs within a state. Because CMS calculates Star Ratings at the contract level, and a contract may include many different plan types, it is impossible to assess the performance of a specific D-SNP within a state. Limiting contracts to only D-SNPs will allow Star Ratings to reflect the plan's local performance; and
2. Integrate materials and notices to help enrollees more easily understand the full scope of Medicare and Medicaid benefits.

Expanding Application of Simplified Appeals and Grievance Process Requirements

CMS proposes to expand the universe of D-SNPs to which the unified appeals and grievance process applies. Beginning in 2021, new requirements took effect for a subset of D-SNP plans, allowing beneficiaries in these plans to go through one, combined Medicare-Medicaid appeals process at the plan level, rather than separately with the D-SNP and the Medicaid managed care organization. Beginning in 2025, the simplified process would apply to all FIDE SNPs and a subset of coordination-only D-SNPs.

OVERSIGHT

Medical Loss Ratio (MLR) Reporting

CMS proposes to reinstate the detailed MLR reporting requirements that were in effect for contract years 2014 through 2017. These requirements include reporting of underlying data used to calculate and verify the MLR and any remittance amount. In addition, CMS proposes to collect additional details regarding plan expenditures so that it may better assess the accuracy of MLR submissions by plans.

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Star Ratings

CMS proposes to make a technical change to make it possible for the agency to calculate 2023 Star Ratings for three Healthcare Effectiveness Data and Information Set measures that are based on the Health Outcomes Survey. The measures are: Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control.

Past Performance Methodology

CMS proposes a change to its past performance methodology, which is used to determine if CMS should permit an MA organization to enter into, or expand, an existing contract. In addition to net worth and sanctions history, CMS proposes to include the organization's Star Ratings record, bankruptcy issues, and compliance actions.

Marketing and Communications

CMS proposes to more clearly define third-party marketing organizations (TPMOs) that sell multiple MA and Part D plans. These changes are intended to remove any ambiguity surrounding MA plan and Part D sponsor responsibility for TPMO activities, require a new disclaimer when TPMOs market MA plans/Part D products, and require additional plan oversight of TPMO marketing activities. In addition, CMS proposes to require MA/Part D plans to create a multi-language insert informing the reader that interpreter services are available for free. Such insert would be required in all CMS-required materials, such as Evidence of Coverage, Annual Notice of Change, enrollment form, and Summary of Benefits.

Network Adequacy Rules

CMS proposes to amend its network adequacy standards to require plans to demonstrate that they meet these standards as part of the MA application process for new and expanding service areas. As part of this change, plans would be permitted a 10 percentage point credit toward meeting the standards for application evaluation purposes only. The credit would not apply once the contract is operational. Currently, MA plans attest to the adequacy of the provider network in their applications.

SPECIAL REQUIREMENTS DURING DISASTERS AND EMERGENCIES

Current regulations state that MA organizations must comply with special requirements (i.e., ensuring access to any provider at in-network cost-sharing rates) during a disaster or emergency until the earlier of (a) a declared end date, or (b) 30 days after the declaration of the disaster or emergency. This has caused some confusion due to multiple renewals of the current Covid-19 public health emergency.

First, CMS proposes to limit the application of these special requirements to when the declared disaster or emergency disrupts access to health care. Second, CMS proposes to add a 30-day transitional period that begins when the special requirements end; that is, the earlier of a declared end date or 30 days after the declaration of a disaster or emergency. Finally, when multiple disaster or emergency declarations impact a service area, MA plans must follow the special requirements until the conclusion of all declared disasters or emergencies.