Fact sheet

CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P)

Jan 06, 2022

- Medicare Part D
- Prescription drugs

CMS is issuing a proposed rule to lower out of pocket Medicare Part D prescription drug costs and improve consumer protections, reduce disparities, and improve health equity in Medicare Advantage (MA) and Part D.

An increasing number of Medicare beneficiaries receive services through MA and Part D. Over 27 million beneficiaries are enrolled in MA plans (including plans that offer Part D prescription drug coverage), and approximately 24 million beneficiaries are enrolled in standalone Part D plans. Additionally, some MA enrollees are concurrently enrolled in Medicaid, with an increasing number of these dually eligible beneficiaries enrolled in Medicare managed care, Medicaid managed care, or both. About 3.7 million dually eligible beneficiaries currently receive their Medicare services through dual eligible special needs plans (D-SNPs).

This proposed rule would revise the MA and Part D regulations related to marketing and communications, the criteria used to review applications for new or expanded MA and Part D plans, quality ratings for MA and Part D plans, provider network adequacy requirements, medical loss ratio reporting, special requirements during disasters or public emergencies, and the use of pharmacy price concessions to reduce beneficiary out of pocket costs for prescription drugs under Part D. This proposed rule would also revise regulations for D-SNPs, and in some cases other special needs plans, related to enrollee advisory committees, health risk assessments, and ways to improve integration of Medicare and Medicaid. Many proposals are based on lessons learned from the Medicare-Medicaid Financial Alignment Initiative.

CMS expects that the relatively modest costs associated with the provisions in the proposed rule will not significantly change MA plans' bids, supplemental benefits or beneficiary premiums.

To view the proposed rule, please visit: https://www.federalregister.gov/public-inspection

Summary of Proposed Changes

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 proposing a policy that would require Part D plans to apply all price concessions they receive from network pharmacies to the point of sale, so that the beneficiary can also share in the savings. Specifically, CMS is proposing to redefine the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2023. This policy would reduce beneficiary out-of-pocket costs and improve price transparency and market competition in the Part D program.

Marketing and Communications Oversight

CMS is proposing 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 deceptive marketing tactics to enroll beneficiaries in MA and Part D plans, reinstating the inclusion of a multi-language insert in specified materials to inform beneficiaries of the availability of free language and translation 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 proposing to revise and clarify timeframes and standards associated with 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 proposal would require a MA plan to comply with the special requirements when there is a declaration of disaster or emergency (including a public health emergency) and disruption in access to health care.

Past Performance

To hold plans to a higher standard, CMS is proposing additional bases for denying a new contract or service area expansion of an existing contract based on past performance. The current regulations permit CMS to deny applications from organizations under sanction or failing CMS' net worth requirements during the performance period. The proposed rule adds Star Ratings (2.5 or lower), bankruptcy or bankruptcy filings, and exceeding a CMS designated threshold for compliance actions as bases for CMS denying a new application or a service area expansion application.

Network Adequacy

To strengthen its application standards and oversight, CMS is proposing to require that plan applicants demonstrate they have a sufficient network of contracted providers to care for beneficiaries before CMS will approve an application for a new or expanded MA plan. We believe that requiring applicants to demonstrate compliance with network adequacy standards as part of the application process will strengthen our oversight of an organization's ability to provide an adequate network of providers to deliver care to MA enrollees. This change would also provide MA organizations with information regarding their network adequacy ahead of bid submissions, mitigating current issues with late changes to the bid that may affect the bid pricing tool. Due to the proposed changes in the timing of the network adequacy reviews and potential difficulties MA organizations may face with building a full network almost one year in advance of the contract year, we also propose to allow a 10-percentage point credit toward the percentage of beneficiaries residing within published time and distance standards for new or expanding service area applicants. Once the coverage year start (January 1), the 10-percentage point credit would no longer apply and plans would need to meet full compliance.

Greater Transparency in Medical Loss Ratio (MLR) Reporting

To increase value for taxpayers and beneficiaries, we are proposing to reinstate MLR reporting requirements that were in effect for contract years 2014 – 2017. The current regulations require that MA organizations and Part D sponsors report to CMS the percentage of revenue spent on patient care and quality improvement and the amount of any remittance that must be paid to CMS for failure to meet the 85 percent minimum MLR requirement. Our proposal would require MA organizations and Part D sponsors to report the underlying cost and revenue information needed to calculate and verify the MLR percentage and remittance amount, if any. In addition, we propose to require that MA organizations report the amounts they spend on various types of supplemental benefits not available under original Medicare (e.g., dental, vision, hearing, transportation).

2023 Part C Star Ratings Calculations for Certain Measures Given Impacts of the COVID-19 Public Health Emergency (PHE)

We are proposing a technical change to enable CMS to calculate 2023 Part C Star Ratings for the three Healthcare Effectiveness Data and Information Set (HEDIS) measures collected through the Health Outcomes Survey (HOS): Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control. Without this technical change, CMS would be unable to calculate 2023 Star Ratings for these measures for any MA contract since all contracts qualify for the extreme and uncontrollable circumstances adjustment for COVID-19.

Enrollee Input on D-SNP Operations

We believe the health system is stronger when we listen to the people we serve. Federal rules require enrollee advisory processes among Medicaid long term services and supports (LTSS) plans and Programs of All-Inclusive Care for the Elderly (PACE) organizations. CMS applies similar requirements for demonstration Medicare-Medicaid Plans. CMS is proposing that all D-SNPs establish and maintain

one or more enrollee advisory committees and that D-SNPs consult with advisory committees on issues related to health equity.

Social Determinants of Health and Special Needs Plan Health Risk Assessments

Certain social risk factors can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status. Many dually eligible individuals contend with multiple social risk factors such as housing insecurity and homelessness, food insecurity, lack of access to transportation, and low levels of health literacy. All SNPs must complete enrollee health risk assessments (HRAs) at enrollment and annually. Building on experiences from the Innovation Center's Accountable Health Communities model and recent standardization of various post-acute care assessments, we are proposing that all HRAs include specific standardized questions on housing stability, food security, and access to transportation – all of which we know to be important contributors to overall health. This proposal would help better identify – and enable MA SNPs to take steps to address – the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence.

Simplified Appeals and Grievance Processes

The Bipartisan Budget Act of 2018 (Pub.L. 115–123) charged CMS with unifying appeals and grievance processes across Medicare and Medicaid to the maximum extent possible. New requirements took effect in 2021 for a subset of D-SNPs. Beneficiaries in these plans go through one Medicare-Medicaid appeals process at the plan level, rather than filing separate, potentially duplicative, appeals with both the D-SNP and a Medicaid managed care organization (MCO). We propose to expand the universe of D-SNPs for which the unified appeals and grievance processes apply. Our proposal would simplify the appeals and grievance processes and extend the protection of continuation of benefits pending appeal to additional dually eligible beneficiaries.

New Pathways to Simplify D-SNP Enrollee Materials

Many dually eligible beneficiaries have low health literacy yet need to navigate a more complex system of coverage than non-dually eligible beneficiaries. Currently, most D-SNP enrollees receive separate materials (e.g., provider directories) for their Medicare benefits and their Medicaid benefits, which can cause confusion among enrollees. With input from dually eligible individuals, we have successfully integrated materials for demonstration programs and with a small number of D-SNPs to help people better understand their coverage. CMS is proposing to codify a mechanism through which states can require certain D-SNPs to use integrated materials to make it easier to understand the full scope of Medicare and Medicaid benefits available through the D-SNPs.

New Pathways to Have Star Ratings Specific to the Performance of the Local D-SNP

MA Star Ratings are a powerful motivator for plan performance and an important tool to help beneficiaries comparison shop for plans. Star Ratings are calculated at the contract level for MA and Part D plans. In many cases, contracts contain D-SNPs

and other non-SNP MA plans, which can make it impossible to fully assess the performance of a specific D-SNP within a specific state, as Star Ratings are given at the contract level. CMS is proposing a pathway to allow certain states with integrated care programs to require that MA organizations establish a contract that only includes one or more D-SNPs, which would allow for Star Ratings for that contract to reflect the D-SNPs' local performance. This proposal would help to easily identify disparities between D-SNPs and other MA plans and help CMS and states better drive quality improvement for dually eligible beneficiaries.

Maximum Out-of-Pocket Policy for Dually Eligible Beneficiaries

MA plans are required to establish a limit on beneficiary cost-sharing for Medicare Part A and B services after which the plan pays 100 percent of the service costs. Current guidance on calculation of the maximum out-of-pocket (MOOP) amount allows MA plans the option to count only those amounts the individual enrollee is responsible for paying, net of any state responsibility or exemption from cost-sharing toward the MOOP limit, rather than the cost-sharing amounts for services the plan has established in its plan benefit package. In practice, this option does not cap the amount a state could pay for a dually eligible MA enrollee's Medicare cost-sharing, and results in state Medicaid programs paying more in Medicare cost-sharing for dually eligible enrollees than if the plan calculated attainment of the MOOP limit based on cost-sharing amounts for services in its plan benefit package.

CMS is proposing to specify that the MOOP limit in an MA plan (after which the plan pays 100 percent of MA costs) is calculated based on the accrual of all Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance, or remains unpaid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. We project that the change would save state Medicaid agencies $2 billion over ten years while increasing payment to providers serving dually eligible beneficiaries by $8 billion over ten years.

Technical and Definitional Updates for FIDE SNPs and HIDE SNPs

Dually eligible individuals have an array of choices for how to receive their Medicare coverage, including fully integrated dual eligible special needs plans (FIDE SNPs) and highly integrated dual eligible special needs plans (HIDE SNPs). While we have defined these terms through rulemaking, there remains nuance and variation that make it difficult for members of the public – and even the professionals who support them – to readily understand what may be unique about a certain type of plan or what a beneficiary can expect from a plan. CMS is proposing to require, for 2025 and subsequent years, that all FIDE SNPs have exclusively aligned enrollment (i.e., limit enrollment to individuals in the affiliated Medicaid MCO) and cover Medicaid home health, durable medical equipment, and behavioral health services through a capitated contract with the state Medicaid agency. We propose to require that each HIDE SNP's capitated contract with the state apply to the entire service area for the D-SNP for plan year 2025 and subsequent years. Consistent with existing policy, we also propose to codify specific limited benefit carve-outs for FIDE SNPs and HIDE SNPs.

###