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Special Bulletin

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CMS Releases Proposed Rules for 2023 Medicare Advantage and Part D Plans

The agency proposes several policies intended to increase oversight of health plans and solicits information on the impact of prior authorization during a public health emergency

The Centers for Medicare & Medicaid Services (CMS) yesterday released proposed regulations for the 2023 Medicare Advantage (MA) and Part D plan year. Notably, the proposed regulations include a number of changes to increase agency oversight of health plans, including provisions to better monitor provider networks and compliance with the medical loss ratio requirements, as well as stronger oversight of third parties that help beneficiaries choose and enroll in MA and Part D plans. Also of importance to hospitals and health systems are requests for information (RFI) related to: MA prior authorization policies and their effect on patient access to care and health system capacity during a public health emergency; and enrollee access to behavioral health services. CMS proposes a number of other policies related to special needs plans, as well as how pharmacy costs are calculated for purposes of beneficiary cost-sharing at the point of service.

Comments on the rule are due March 7. Additional highlights of the proposed rule and accompanying RFIs follow.

HIGHLIGHTS OF THE RULE

MA Plan Oversight. CMS proposes a number of changes in policy to increase oversight of MA plans. These include:

- **Network Adequacy**. CMS proposes to require MA plans to demonstrate, not simply attest, that they meet the MA network adequacy standards as part of an application to offer a new plan or expand into a new service area. The agency notes that this will strengthen its ability to conduct oversight of MA plans' ability to provide an adequate network of providers to their enrollees. The AHA has advocated previously for stronger oversight of MA provider networks.

- **Consideration of Past Performance as Part of Applications to Enter Into or Expand MA Offerings.** CMS currently looks at certain elements of a plan's past performance when determining whether to permit an organization to enter into or expand an existing contract. The agency proposes to expand the factors that

would be considered as part of that process, including an organization's record of Star Ratings, bankruptcy issues and compliance actions.

- **Marketing and Communications Requirements**. CMS notes that it has received a substantial increase in complaints about the marketing practices of third-party marketing organizations that sell multiple MA and Part D products. As a result, the agency proposes to make several changes to the marketing and communications requirements, including to clarify, and in some instances increase, MA plan responsibilities with respect to oversight of third party marketing organizations. CMS proposes other requirements as well to help ensure beneficiary understanding of their options.

- **Medical Loss Ratio (MLR) Reporting**. CMS proposes to reinstate earlier rules related to plan reporting on the MLR. Specifically, CMS proposes to begin collecting detailed data that enables the agency to better assess the accuracy of MLR submissions.

Special Requirements during a Disaster or Emergency. MA plans are required to comply with certain special requirements during disasters and emergencies to ensure that enrollees can continue to access care, including by covering services provided by non-contracted providers and waiving gatekeeper referral requirements (note: these are not the same as prior authorization requirements). In the proposed rule, CMS reviews its current policies with respect to these special requirements and proposes several modifications. Specifically, the agency proposes to establish an additional condition for triggering the special requirements: In order for these special requirements to be in effect, there must be a disruption in access to health care at the same time as the disaster or emergency. CMS also proposes to clarify the period of time during which MA plans must comply with the special requirements, particularly to address situations where the end date of the disaster or emergency is unclear. The agency proposes to make effective the special requirements until either 30 days after the end of the disaster or emergency or 30 days after the disruption of access to health care ends.

Maximum Out-of-Pocket Limit for Dually Eligible Beneficiaries. CMS proposes to change how cost-sharing is calculated for purposes of determining whether a beneficiary enrolled in an MA plan has met their maximum out-of-pocket cost limit. Once this limit is reached, the plan pays the full cost of services. Currently, state Medicaid coverage of dually-eligible beneficiaries' cost-sharing, other secondary payer payments, and unpaid amounts are not counted. As a result, these patients less frequently hit the maximum out-of-pocket limit, resulting in substantial cost to state Medicaid programs and to providers through uncollected cost-sharing. CMS proposes to change this policy to count these amounts toward an individual's maximum out-of-pocket limit. While CMS estimates this will result in certain plans submitting high-bid amounts, the agency also estimates it will save state Medicaid agencies $2 billion over 10 years and increase payments to providers by $8 billion.

Special Needs Plans (SNPs). CMS proposes a number of policy changes related to SNPs. These include proposals to:

- Require all MA plans offering a dual eligible SNP (D-SNP) to establish one or more enrollee advisory committees to get enrollee input on issues such as ways to improve access to covered services, coordination of services and health equity for underserved populations;
- Require all SNPs to collect as part of the required health risk assessments standardized data on social determinants of health related to housing stability, food security and access to transportation;
- Change certain definitions to help differentiate among various types of plans, clarify options for beneficiaries and improve integration; and
- Provide states with greater options for alignment with D-SNPs, as well as improve coordination between states and CMS of oversight of such plans.

MA Star Ratings. CMS proposes to modify the methodology for calculating three quality measures for 2023 as a result of the COVID-19 public health emergency: Monitoring Physical Activity, Reducing the Risk of Falling, and Improving Bladder Control.

Part D Provisions. CMS proposes to require that all price concessions are taken into account when calculating beneficiaries' cost-sharing at the pharmacy counter. The objective is to lower cost-sharing at the point of service recognizing that this will likely increase premiums.

Requests for Information. CMS includes several requests for information as part of the proposed rule. Two notable ones for hospitals and health systems include:

- **Prior Authorization for Hospital Transfers to Post-acute Care Settings during a Public Health Emergency.** CMS seeks stakeholder input on how MA plan prior authorization policies, as well as waivers of those policies, have impacted patient access to care and health system capacity during the public health emergency. The agency also is interested in other metrics related to prior authorization more generally. CMS provided the following as examples of the type of information sought by the agency:
    - The overall impact of both the relaxation and reinstatement of prior authorization requirements for patient transfer by MA organizations on the provision of appropriate patient care in hospital systems.
    - The overall impact of both the relaxation and reinstatement of prior authorization requirements for patient transfer on MA organizations.
    - Wait times for receiving a response from an MA organization about the authorization of a patient transfer.
    - Information pertaining to industry guidelines that are used to inform prior authorization, including the extent to which such guidelines are

evidence-based, the degree of transparency that exists for such guidelines, and the extent to which such guidelines are standardized.
    - With respect to MA organizations, the denial rates and associated burden, including rates at which denials are upheld and overturned, for prior authorizations for patient transfer from hospitals to post-acute care facilities.
    - Any consequences of delayed patient transfer from hospitals to post-acute care facilities.
    - Recommendations for how CMS can accommodate hospital systems that face capacity issues through policy changes in the MA program.
    - Examples of any contrast in a state's policies for payers (for example, Medicaid managed care) with respect to prior authorizations for patient transfer that do not pertain to MA organizations, and the effects of such policies on hospitals systems' ability to effectively manage resources.

- **Building Behavioral Health Specialties within MA Networks**. CMS notes that MA plans may have challenges building adequate networks of behavioral health providers and solicits stakeholder input on these issues. The agency provided the following prompts to guide stakeholders in their input; however the agency welcomes insights and recommendations regarding:
    - Challenges related to a lack of behavioral health provider supply in certain geographic regions for beneficiaries, health plans and other stakeholders.
    - Challenges related to accessing behavioral health providers for enrollees in MA health plans, including wait times for appointments.
    - The extent to which a behavioral health network affects a beneficiary's decision to enroll in an MA health plan.
    - Challenges for behavioral health providers to establish contracts with MA health plans.
    - Providers' inability or unwillingness to contract with MA plans, including issues related to provider reimbursement.
    - Opportunities to expand services for the treatment of opioid addiction and substance use disorders.
    - The overall impact of potential CMS policy changes as it relates to network adequacy and behavioral health in MA health plans, including in rural areas that may have provider shortages.
    - Suggestions from industry stakeholders on how to address issues with building adequate behavioral health networks within MA health plans.

NEXT STEPS

Comments are due March 7, 2022. If you have questions, please contact AHA at 800-424-4301.