NCPA Member Summary of Proposed MA/Part D Rule For Contract Year 2023

January 7, 2022

On January 6, 2022, CMS released the proposed rule for the Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. CMS drafted regulations to implement changes related to marketing and communications, past performance, Star Ratings, network adequacy, medical loss ratio reporting, special requirements during disasters or public emergencies, and **pharmacy price concessions.** NCPA will continue to analyze the impacts of the language on community pharmacy. The proposed policy changes are intended to take effect on January 1, 2023. The comment period will end on March 7, 2022, and we will be seeking input from members to inform NCPA's comments on the proposal.

Pharmacy Price Concessions:

- CMS is focusing on policy proposals in this section that would be applicable to pharmacy price concessions only, and not applicable to non-pharmacy price concessions, such as manufacturer rebates. **The data shows that pharmacy price concessions, net of all pharmacy incentive payments, grew more than 107,400 percent between 2010 and 2020.**
- CMS is redefining negotiated price for a covered Part D drug to include all pharmacy price concessions and any dispensing fees but exclude additional contingent amounts if these amounts increase prices, such as incentive fees. The negotiated price would be the lowest possible reimbursement a pharmacy will receive in total for a particular drug.
- CMS defines price concessions as "all forms of discounts, direct or indirect subsidies, or rebates that serve to reduce the costs incurred under Part D plans by Part D sponsors." CMS notes "the proposed definition would note that price concessions include but are not limited to discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, coupons, free or reduced-price services, and goods in kind."
- These changes to negotiated price do not apply to Part D drugs in the coverage gap – during the coverage gap, plans would have the flexibility to determine how much of the pharmacy price concessions to pass through at the point-of-sale, and beneficiary, plan, and manufacturer liability in the coverage gap would be calculated using this alternate negotiated price. In essence CMS is setting up a dual track where all pharmacy price concessions have to be passed through to patients at the point of sale except for drugs in the coverage gap.
- Part D sponsors and their PBMs would be required to load revised drug pricing tables that reflect the lowest possible reimbursement into their claims processing systems that interface with contracted pharmacies.
- CMS estimates the new definition of negotiated price is expected to reduce beneficiary costs by $21.3 billion over 10 years, or approximately 2 percent. In addition, the proposal is estimated to cost the government $40 billion in Part D costs over 10 years due to increases in direct subsidy and low-income premium subsidy payments, which represents a 3 percent increase. Manufacturers would save approximately $14.6 billion over 10 years. CMS expects a one-time cost to plan sponsors of $0.1 million to update systems.

Market and Communications:

- CMS is proposing changes to marketing and communications requirements by strengthening oversight of third-party marketing organizations to prevent the use of deceptive marketing practices, including a multi-language insert of materials for free language and translation services, and website updates for appointing a representative and enrollment instructions and forms.

Past Performance:

- To encourage adoption of higher standards, CMS is proposing additional thresholds for denying a new contract or service area expansion. The proposal adds Star Ratings (2.5 or lower), bankruptcy, or exceeding a CMS designated threshold for compliance as a basis for CMS denial.

Network Adequacy:

- CMS is proposing to require that plan applicants demonstrate they have a sufficient network of contracted providers, such as doctors and healthcare facilities, to care for beneficiaries before CMS will approve an application for a new or expanded MA plan as part of the application process.

Medical Loss Ratio (MLR) Reporting:

- CMS is proposing to reinstate MLR reporting requirements that were in effect for contract years 2014 – 2017. The 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, CMS is proposing 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).

Part C Star Ratings:

- Makes a technical change to enable CMS to calculate Star Ratings for 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. Absent this change, CMS would not be able to properly ascertain ratings for 2023.

Social Determinants of Health:

- This proposal is requiring Special Need Plans to include standardized questions about social risk factors as part of the health risk assessments in light of the impact these factors may have on health care and outcomes for the enrollees in these plans and that access to this information will better enable SNPs to design and implement effective models of care.