CAPITOL STREET

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MA & Part D Plan ’24 Rules: Mixed Bag

Prior Auth, Marketing, Star Ratings Policy Improves With Biopharma Wins in Part D

Relevant Companies

CMS released the 2024 Policy and Technical Changes to the MA Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (see here). The regulations are effective on June 5, 2023, and the provisions in this rule apply to coverage beginning on January 1, 2024.

⋙ Our Take & Next Up

The rules have been dialed back in a more plan- and biopharma-friendly manner, making it manageable for plans in 2024. The rule is effective on June 5, 2023 and will apply January 1, 2024. We think that the health equity Star measure is helpful for plans that treat socially and medically complex individuals; and the other measure changes ($6 B cut to plan Star payments) have been dialed back in a reasonable way. CMS continues to crack down on predatory agent & broker marketing to Seniors, and backs down on making health plans record all calls, narrowing it to only sales/marketing & enrollment calls.

(1) We are watching out for the Sen Cassidy (R-LA) MA focused legislation ($12 B over ten in savings) and the possibility of MA being in the crosshairs if Congress goes into deficit reduction mode and cuts Medicare providers across the board.

(2) From the agency, we await CMS guidance on when the agency’s contractors will start RADV audits.

⋙ Key Points

MARKETING - NEGATIVE, BUT IMPROVED OVER THE PROPOSAL

New marketing requirements are onerous but likely apply to bad actors, not all plans. CMS did not finalize proposed rules on how plans/brokers share data with third parties. The final rule:
(1) prohibits ads that do not mention a specific plan name and ads that use words and imagery that could confuse beneficiaries or use language or Medicare logos in a way that is misleading.
(2) CMS prevents predatory behavior and strengthens the role of plans in monitoring agent & broker activity.
(3) ensures beneficiaries receive information about Medicare coverage and are aware of how to access accurate information.

Limiting call recordings to only sales/marketing/enrollment calls as required to be recorded (versus all calls, as in prior regulations). CMS modifies the previous rulemaking to limit calls that must be recorded in their entirety to marketing, sales, and enrollment calls. This was finalized in the May 2022 CY 2023 MA & Part D final rule (here). The agency finalized the recording change mostly as proposed but clarifies that the requirement applies only to the audio portion of web-based calls.

Provisions CMS is finalizing by modifying to commonsense disclaimers by brokers & agents:
(1) permitting agents to make Business Reply Cards available at educational events;
(2) requiring an agent to tell prospective enrollees how many plans are available from the organization for whom the agent sells;
(3) extending the length of time agents can re-contact beneficiaries to discuss plan options to 12 months;
(4) and allowing an agent to meet with a beneficiary without waiting the full 48-hour cooling off period when the timeframe is at the end of an election period, or a beneficiary faces transportation or access challenges or voluntarily walks into an agent's office.

STAR RATING REVAMP — PLANS LOSE, IMPROVEMENT OVER PROPOSAL ($6 B CUT)

$6.4 B savings from Star Ratings changes below. This is a saving so less money flows from the government to MA plans, which is negative. However, this is improved from the proposal which saved $25 B with more dramatic measure changes.

Health equity measure (starts in 2027), which would reward plans for the first time, saves $5 B. In this rule, CMS finalizes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors. This is finalized from the proposed rule. The HEI reward provision has a 10-year savings estimate of
$5.12 B.

CMS reduces the weight of patient experience/complaints and access measures, which is good news for plans. The patient experience/complaints and access measure weight saves $3.28 B over ten. It aligns with measures for other Medicare providers.

PRIOR AUTHORIZATION HEAT IS ON — CMS TARGETS AI & TARGETED DENIALS

CMS finalizes prior authorization (PA) requirements to allow continuous access to care. The rules add continuity of care requirements and reduces disruptions for beneficiaries. AHA (hospitals) supports CMS's rules, saying that they will help reduce delays in care access (see statement here).

- Policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.
- Minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan, and the new MA plan may not require PA for the active course of treatment.
- All MA plans will be required to establish a utilization management committee to review policies annually and ensure consistency with traditional Medicare's NCD & LCDs.

MA MUST COVER MED TECH & BIOPHARMA (AS FFS DOES)

CMS coordinates MA coverage criteria with traditional FFS Medicare, marginally negative for MA plans. This could mean that PA will not take place as more services are provided and at a higher cost for plans. If traditional Medicare must cover a procedure, drug, or test the rule states that MA plans must cover it. The rule finalizes that MA plans must comply with national coverage determinations, local coverage determinations, and general coverage and benefit conditions from traditional Medicare laws. This aligns with recent OIG recommendations (here).

Improves MA plan access to behavioral health given the mental health & substance abuse crises that only spiked during the PHE. This was passed as a part of the omnibus December 2022 bill. CMS will: (1) add clinical psychologists and licensed clinical social workers for network standards, and make them eligible for the 10% telehealth credit; (2) change access to include behavioral health services; (3) codify standards for appointment wait times for primary care and behavioral health services; (4) clarify that emergency behavioral health services must not be subject to PA; (5) require that MA plans notify enrollees when the enrollee's providers are dropped from networks; and (6) require MA organizations to establish care coordination programs.

PART D POSITIVE: DRUG LIMITATIONS REMOVED IN FINAL RULE

Part D proposals that were not finalized include: adding HIV/AIDS to the Part D chronic disease list, lowering max # number of drugs offered (to 5 from 8), and immediate substitution for interchangeable biological products & generics. CMS did not finalize the proposals that would have limited drug choice as proposed by CMS in December.

Limited Income Newly Eligible Transition (LI NET) Program that provides retroactive Part D coverage will be made permanent, as legislated by the *CAA* (here)**.** LI NET currently operates as a demonstration program that provides immediate and retroactive Part D coverage for eligible low-income beneficiaries without prescription drug coverage.

***Inflation Reduction Act* Part D low-income subsidy (LIS) expansion is finalized: 300K now included.** CMS finalized regulations to expand eligibility for the full LIS benefit to individuals with incomes up to 150% of the federal poverty level. Starting on January 1, 2024, the full low-income subsidy will be expanded to include ~300K beneficiaries who currently qualify for the partial subsidy.

VALUE BASED INSURANCE DESIGN PROGRM EXTENDED

In tandem with the MA and Part D rule release, CMS quietly extended to 2030 the value-based insurance design CMMI model. In 2023, the VBID Model has 52 participating MA Organizations with a total of 9.3 M enrollees. VBID focuses on social determinants of health. Participants include ALHC, BCBS, CI, CVS (see here).

The MA value-based insurance design (VBID) model introduces changes intended to better address social needs of patients through CY 2025-2030. The model also has a hospice benefit component, to help patients needing end-of-life care transition to hospice care.

Background

Recent MA Catalysts in Headline Filled Policy Environment:

Legislation was recently introduced by Sen. Cassidy (R-LA), titled "No Unreasonable Payments, Coding, or Diagnoses for the Elderly Act" (see here). This is a Senate MA upcoding bill that would improve RA under MA by using two years of diagnostic data starting in 2024. There would be a provision excluding diagnoses collected from chart reviews and HRAs. It's early days but we could see something move on this front; if it saves dollars and could be packaged with other deficit-reducing provisions (i.e., site-neutral for hospitals, etc.).

CMS released the final MA and Part D rates on March 31 (here) where the agency finalized the 2024 proposed risk adjustment model, but offered a three-year phase-in. The new risk adjustment model – eliminating ~2,000 diagnosis codes – is intended to reflect more current costs associated with various diseases, conditions, and demographic characteristics, used the ICD-10 classification system that has been in use for payment since 2015 and included revisions designed to reduce the sensitivity of the model to coding variation.

RADV rules are manageable for MA plans, VBC providers and we await the start of 2018 audits (which could be ASAP). On Jan. 30, CMS finalized the long-awaited risk adjustment data validation regulations (here). CMS will not apply the FFSA, which means that the planned community may engage in litigation. CMS will not adopt specific sampling or extrapolated audit methodology but will rely on any statistically valid method that is determined to be suited to a particular audit.

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