CMS Response to Public Comments Received for CMS-10142

The Centers for Medicare and Medicaid Services (CMS) received comments from one Public Health student and one Medicare Advantage Organization related to CMS-10142. This is the reconciliation of the comments.

Comment:

The commenter recommends that CMS require MA/PD plans to report: (1) How bid pricing assumptions affect beneficiary cost sharing (2) The percentage of rebate savings passed directly to enrollees, and (3) Transparency on negotiated vs. list prices at the point of sale.

Response: CMS appreciates the comments regarding transparency in bidding assumptions. (1) Plans are required to submit bids that are actuarially equivalent to or better than the defined standard benefit. However, bid pricing reflects prospective assumptions that may differ from actual experience, and variations in realized utilization or costs can affect beneficiary cost sharing over the contract year. (2) Rebates (also known as Direct and Indirect Remuneration or DIR) are factored into both the bidding and reconciliation phases of Medicare Advantage (MA) and Part D plans. Plans estimate expected rebates and other price concessions when submitting their annual bids. These projected rebates reduce the estimated drug costs, which lowers the bid amount and ultimately affects beneficiary premiums and government payments. Plans must project manufacturer rebates, pharmacy price concessions, and other forms of DIR. After the plan year, actual rebates received are compared to the projected amounts in the bid. The Payment Reconciliation System (PRS) performs this reconciliation by comparing prospective payment information to actual costs. If actual rebates differ significantly from projections, this affects the final settlement between CMS and the plan sponsor. (3) Part D payments are not based on manufacturers' list prices, but rather on plans' negotiated prices and actual net costs. As a result, reporting list prices at the point of sale would not provide meaningful information for understanding Part D payment amounts or beneficiary cost sharing.

Comment:

The commenter recommends that CMS require: (1) MA/Part D plans to reimburse pharmacies at or above NADAC, plus a reasonable dispensing fee (2) Public reporting of pharmacy network adequacy, including urban/rural disparities, and (3) Disclosure of PBM payment practices to CMS for oversight.

Response:

This comment is out of scope for CMS-10142 which addresses the Bid Pricing Tools and Bid Instructions.

Comment:

The commenter recommends that CMS: (1) require plans to document clinical and economic justification when a high-cost brand is placed above a lower-cost equivalent (2) Audit formulary decisions for rebate-driven distortions, and (3) Increase reporting around biosimilar uptake and barriers to use.

Response:

This comment is out of scope for CMS-10142 which addresses the Bid Pricing Tools and Bid Instructions.

Comment:

The commenter provided feedback about a proposal made on the November Actuarial User Group Call to update MA Instructions Appendix B Item 23a, 23b and 23c. The plan sponsor supports the proposed update to Item 23a and 23b but has concerns about the details proposed for Item 23c. The sponsor is specifically concerned because they do not currently have the information requested in the proposed form for the projection period, and they believe that developing this information in the proposed form may result in the potential for circularity and cascading recalculation risk, and that developing the information which varies by plan design is burdensome.

Response:

CMS appreciates the comments on the update to MA Instructions Appendix B Item 23 which was proposed during the November Actuarial User Group call. Due to feedback received, we updated the language for MA Appendix B Item 23 in the 30-day PRA. The main changes are summarized below:

- Item 23.1a (Provider Capitation Arrangements) and Item 23.2a (Provider Risk-Sharing Arrangements) must include a description of each arrangement as stated during the November Actuarial User Group call. However, arrangements similar in design may be grouped in the description.
- Item 23.1b (Provider Capitation Arrangements) and 23.2b (Provider Risk-Sharing Arrangements) must include a description and numerical demonstration of the methodology used to allocate payments to service categories as stated during the November Actuarial User Group call. However, the description and numerical demonstration are only needed for each separate methodology, not for each arrangement.
- Item 23.2c (Provider Risk-Sharing Arrangements) must include a description and numerical demonstration of the methodology used to allocate payments across each associated BPT as stated during the November Actuarial User Group call. However, the description and numerical demonstration are only needed for each separate methodology, not for each arrangement.

Comment:

The commenter has concerns about CMS's proposal, beginning in calendar year (CY) 2028, to require risk-sharing payments to be allocated based on the specific types of services a provider directly furnishes. More generally, the commenter is concerned that increasingly prescriptive reporting requirements may limit plans' ability to apply reasonable, actuarially sound assumptions that align with their business models, data structures, and pricing processes. The commenter notes that when multiple methodologies can produce reasonable and auditable results, flexibility is important.

Response:

This comment is in reference to a draft proposal that was made on the November Actuarial User Group call. This draft proposal was not included in the 60-Day Federal Register posting of CMS-10142 and therefore this comment is out of scope. However, CMS appreciates the comments on the CY2028 risk-sharing service category allocation proposal and we intend to address this feedback when drafting the CY2028 Instructions.