Issue Brief

FEDERAL ISSUE BRIEF

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CMS Issues Final Rule for Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

On April 5, the Centers for Medicare & Medicaid Services (CMS) issued a final that revises the Medicare Advantage (MA or Part C), Medicare Prescription Drug Benefit (Part D), Medicare Cost Plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations to implement changes related to Star Ratings, marketing and communications, health equity, provider directories, coverage criteria, prior authorization, network adequacy, and other programmatic areas.

This final rule also codifies regulations implementing section 118 of Division CC of the ***Consolidated Appropriations Act*** (CCA), 2021, and section 11404 of the ***Inflation Reduction Act*** (IRA), and includes provisions to codify existing sub-regulatory guidance in the Part C, Part D, and PACE programs.

A copy of this 724-page document is currently available at: https://public-inspection.federalregister.gov/2023-07115.pdf. The rule is scheduled for publication in the ***Federal Register*** on April 12.

Basic Changes

Cracking Down on Misleading Marketing Schemes

The final rule includes changes to protect people exploring Medicare Advantage and Part D coverage from potentially misleading marketing practices. Ads will be prohibited if they do not mention a specific plan name, or if they use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way.

Removing Barriers to Care Created by Complex Prior Authorization and Utilization Management

CMS is also providing important protections regarding utilization management policies and coverage criteria that ensure that Medicare Advantage enrollees receive the same access to medically necessary care that they would receive in Traditional Medicare. The rule streamlines prior authorization requirements and reduces disruption for enrollees by requiring that a granted prior authorization approval remains valid for as long as medically necessary to avoid disruptions in care, requiring Medicare Advantage plans to annually review utilization management policies, and requiring denials of coverage based on medical necessity be reviewed by health care professionals with relevant expertise before a denial can be issued.

Expanding Access to Behavioral Health Care

CMS says it remains committed to emphasizing the critical role that access to behavioral health plays in whole person care. CMS is strengthening behavioral health network adequacy in Medicare Advantage by

adding clinical psychologists and licensed clinical social workers to the list of evaluated specialties. CMS is also finalizing wait time standards for behavioral health and primary care services and more specific notice requirements from plans to patients when these providers are dropped from their networks. planning.
Promoting More Equitable Care

Additionally, CMS is advancing health equity and driving quality in health coverage by establishing a health equity index in the Star Ratings program that will reward Medicare Advantage and Medicare Part D plans that provide excellent care for underserved populations

Comment
This an extremely complex and lengthy rule. Unfortunately, CMS has chosen (again) not to include any table of contents. Thus, finding specific items is a difficult chore.

This analysis is citing items in the introductory section of the rule.

Effective Dates
These regulations are effective on June 5, 2023.

- The provisions in this rule are applicable to coverage beginning January 1, 2024, except as otherwise noted.
- The revisions to §§ 422.166(a)(2)(i) and 423.186(a)(2)(i) regarding "Tukey" outlier deletion are applicable on June 5, 2023.
- The marketing and communications provisions at §§ 422.2262 through 422.2274 and 423.2262 through 423.2274 are applicable for all contract year 2024 marketing and communications beginning September 30, 2023.
- The revisions to the definition of "gross covered prescription drug costs" in § 423.308 are applicable on June 5, 2023.
- The removal of the Part C Diabetes Care – Kidney Disease Monitoring measure as described in sections V.D.1. of the final rule is applicable on June 5,2023.
- The risk adjustment to the three-Part D adherence measures based on sociodemographic status characteristics as described in section V.D.2. of this final rule is applicable for 2028 Star Rates beginning January 1, 2026.
- The PACE provision on the contract year definition at § 460.6 and the PACE provision on service determination requests at § 460.121 are applicable on June 5, 2023.

Summary of the Major Provisions
1. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 423.182, 423.184, and 423.186) (Page 4)

CMS is finalizing a health equity index (HEI) reward for the 2027 Star Ratings to further incentivize Parts C and D plans to focus on improving care for enrollees with social risk factors (SRFs); as part of this change, CMS also is finalizing the removal of the current reward factor.

CMS is finalizing the reduction in the weight of patient experience/complaints and access measures to further align efforts with other CMS quality programs and the current CMS Quality Strategy, as well as to better balance the contribution of the different types of measures in the Star Ratings program.

CMS is finalizing the removal of the Part C Diabetes Care – Kidney Disease Monitoring measure;

addition of the Part C Kidney Health Evaluation for Patients with Diabetes measure; and substantive updates to the Part D Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), and Medication Adherence for Cholesterol (Statins) measures.

CMS is also finalizing the removal of certain types of Star Ratings measures; removal of the 60 percent rule that is part of the adjustment for extreme and uncontrollable circumstances (also called the disaster adjustment); and technical clarifications and changes related to the disaster adjustment, treatment of ratings for contracts after consolidation, and the correction of an error related to codification of the use of Tukey outlier deletion. Generally, these changes will apply (that is, data will be collected and performance measured) for the 2024 measurement period and the 2026 Star Ratings, except for the removal of the Part C Diabetes Care – Kidney Disease Monitoring measure, which will apply beginning with the 2024 Star Ratings; the HEI reward, which will apply beginning with the 2024 and 2025 measurement periods and the 2027 Star Ratings; the risk adjustment based on sociodemographic status characteristics to the three adherence measures, which will be implemented beginning with the 2026 measurement period and the 2028 Star Ratings; and addressing the codification error related to the use of Tukey outlier deletion which will be applicable upon the effective date of this final rule and apply beginning with the 2024 Star Ratings.

2. Health Equity in Medicare Advantage (MA) (§§ 422.111 and 422.112) (Page 5)

CMS is working to achieve policy goals that advance health equity across its programs and pursue a comprehensive approach to advancing health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. To that end, in addition to the health equity index, CMS is finalizing the following regulatory updates.

First, current regulations require MA organizations to ensure that services are provided in a culturally competent manner. The regulation provides examples of populations that may require consideration specific to their needs. CMS is amending the list of populations to include people: (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minorities; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.

CMS is codifying best practices by requiring organizations to include providers' cultural and linguistic capabilities (including American Sign Language, ASL) in their provider directories.

In addition, as the use of telehealth becomes more prevalent, there is evidence of disparities in telehealth access due in part to low digital health literacy, especially among populations who already experience health disparities. CMS is finalizing policies to address the issue by requiring MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits.

Finally, CMS will require MA organizations to incorporate one or more activities into their overall QI program that reduce disparities in health and health care among their enrollees. MA organizations may implement activities such as improving communication, developing and using linguistically and culturally

appropriate materials (to distribute to enrollees or use in communicating with enrollees), hiring bilingual staff, community outreach, or similar activities.

3. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, 422.138, and 422.202). (Page 7)

In recent years, CMS has received numerous inquiries regarding MA organizations' use of prior authorization and its effect on beneficiary access to care. CMS is finalizing several regulatory changes to address these concerns. First, CMS is finalizing that prior authorization policies for coordinated care plans 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 based on standards specified in this rule.

Second, CMS is finalizing that an approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation, and that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan.

Third, CMS is finalizing that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare laws. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. CMS is finalizing that when coverage criteria are not fully established in Medicare statute, regulation, NCD, or LCD, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature. CMS is also clarifying that coverage criteria are not fully established when additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD, or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria. When additional, unspecified criteria are needed to interpret or supplement general provisions, the MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

Finally, to ensure prior authorization and other utilization managed policies are consistent with the rules CMS is adopting on coverage criteria and coverage policies and relevant current clinical guidelines, CMS is finalizing that all MA plans establish a Utilization Management Committee to review all utilization management, including prior authorization, policies annually and ensure they are consistent with the coverage requirements, including current, traditional Medicare's national and local coverage decisions and guidelines.

4. Medicare Advantage (MA) and Part D Communications and Marketing (Subpart V of Parts 422 and 423) (Page 9)

In accordance with statutory authority to review marketing materials and application forms and to develop marketing standards CMS is requiring MA organizations and Part D sponsors to disclose specific types of information to enrollees. CMS is finalizing the following changes: notifying enrollees annually, in

writing, of the ability to opt out of phone calls regarding MA and Part D plan business; requiring agents to explain the effect of an enrollee's enrollment choice on their current coverage whenever the enrollee makes an enrollment decision; simplifying plan comparisons by requiring medical benefits be in a specific order and listed at the top of a plan's Summary of Benefits; limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that the enrollee first asked for information; limiting the requirement to record calls between third-party marketing organizations (TPMOs) and beneficiaries to marketing (sales) and enrollment calls; prohibiting a marketing event from occurring within 12 hours of an educational event at the same location; clarifying that the prohibition on door-to-door contact without a prior appointment still applies after collection of a business reply card (BRC) or scope of appointment (SOA); prohibiting marketing of benefits in a service area where those benefits are not available, unless unavoidable because of use of local or regional media that covers the service area(s); prohibiting the marketing of information about savings available that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary; requiring TPMOs to list or mention all of the MA organization or Part D sponsors that they represent on marketing materials; requiring MA organizations and Part D sponsors to have an oversight plan that monitors agent/broker activities and reports agent/broker non-compliance to CMS; modifying the TPMO disclaimer to add State Health Insurance Assistance Programs (SHIPs) as an option for beneficiaries to obtain additional help; modifying the TPMO disclaimer to state the number of organizations represented by the TPMO as well as the number of plans; prohibiting the collection of Scope of Appointment cards at educational events; placing discrete limits around the use of the Medicare name, logo, and Medicare card; prohibiting the use of superlatives (for example, words like "best" or "most") in marketing unless the material provides documentation to support the statement, and the documentation is based on data from the current or prior year; clarifying the requirement to record calls between TPMOs and beneficiaries, such that it is clear that the requirement includes virtual connections such as video conferencing and other virtual telepresence methods; and requiring 48 hours between a Scope of Appointment and an agent meeting with a beneficiary, with exceptions for beneficiary-initiated walk-ins and the end of a valid enrollment period.

CMS is finalizing and implementing the changes to Subpart V in this rule for CY 2024. As such, they will become effective on September 30, 2023 for all activity related to CY 2024.

5. Strengthening Translation and Accessible Format Requirements for Medicare Advantage, Part D, and D-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267) (Page 10)

Sections 422.2267(a)(2) and 423.2267(a)(2) require MA organizations, cost plans, and Part D sponsors to translate required materials into any non-English language that is the primary language of at least 5 percent of individuals in a plan benefit package service area. In addition, 45 CFR Part 92 requires plans to provide appropriate auxiliary aids and services, including interpreters and information in alternate formats, to individuals with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question. However, CMS has learned from oversight activities, enrollee complaints, and stakeholder feedback that enrollees often must make a separate request each time they would like a material in a non-English language or accessible format.

In addition, an increasing number of dually eligible individuals are enrolled in managed care plans where the same plan covers both Medicare and Medicaid services. In some cases, Medicaid standards for

Medicaid managed care plans require translation of plan materials into a non-English language not captured by the Medicare Advantage requirements.

CMS is finalizing a requirement that MA organizations, cost plans, and Part D sponsors must provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or accessible format upon receiving a request for the materials or otherwise learning of the enrollee's primary language and/or need for an accessible format. CMS is also finalizing the application of this requirement to individualized plans of care for special needs plans. In addition, CMS is finalizing a requirement that fully integrated dual eligible special needs plans (FIDE SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and applicable integrated plans (AIPs) as defined at § 422.561, translate required materials into any languages required by the Medicare translation standard at § 422.2267(a) plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts.

In this rule, CMS is finalizing and implementing the changes as proposed for materials produced for CY 2024.

6. Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and 422.116) (Page 12)

To strengthen the agency's network adequacy requirements and reaffirm MA organizations' responsibilities to provide behavioral health services, CMS is finalizing to: (1) add Clinical Psychology and Licensed Clinical Social Work as specialty types that will be evaluated as part of the network adequacy reviews under § 422.116, and make these new specialty types eligible for the 10-percentage point telehealth credit as allowed under § 422.116(d)(5); (2) amend the general access to services standards in § 422.112 to include explicitly behavioral health services; (3) codify, from existing guidance on reasonable wait times for primary care visits, standards for wait times that apply to both primary care and behavioral health services; (4) clarify that some behavioral health services may qualify as emergency services and, therefore, must not be subject to prior authorization; and (5) extend current requirements for MA organizations to establish programs to coordinate covered services with community and social services to behavioral health services programs to close equity gaps in treatment between physical health and behavioral health.

7. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (§§ 422.111 and 422.2267) (Page 12)

CMS is finalizing amendments to § 422.111(e) that establish specific enrollee notification requirements for no-cause and for-cause provider contract terminations and add specific and more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. CMS is also amending § 422.2267(e)(12) to specify the content and additional procedural requirements for the notification to enrollees about a provider contract termination. These requirements will generally increase enrollee protections when MA network changes occur and will raise the standards for the stability of enrollees' primary care and behavioral health treatment.

8. Transitional Coverage and Retroactive Medicare Part D Coverage for Certain Low-Income Beneficiaries Through the Limited Income Newly Eligible Transition (LI NET) Program (§§ 423.2500-423.2536) (Page 13)

CMS has operated the LI NET demonstration since 2010. The LI NET demonstration provides transitional, point-of-sale coverage for low-income beneficiaries who demonstrate an immediate need for prescriptions, but who have not yet enrolled in a Part D plan, or whose enrollment is not yet effective. LI NET also provides retroactive and/or temporary prospective coverage for beneficiaries determined to be eligible for the Part D low-income subsidy (LIS) by the Social Security Administration (SSA) or a State.

In this final rule, CMS is making the LI NET program a permanent part of Medicare Part D, as required by the ***Consolidated Appropriations Act, 2021*** (CAA).

9. Expanding Eligibility for Low-Income Subsidies (LIS) Under Part D of the Medicare Program (§§ 423.773 and 423.780) (Page 13)

Section 11404 of the IRA amended section 1860D-14 of the Act to expand eligibility for the full LIS to individuals with incomes up to 150 percent of the Federal poverty level (FPL) beginning on or after January 1, 2024. In addition, the IRA allows for individuals to qualify for the full subsidy based on the higher resource requirements currently applicable to the partial LIS group. This change will provide the full LIS subsidy for those who currently qualify for the partial subsidy.

Summary of Costs and Benefits

CMS provides the following: The material is basically quoted from the rule.

Provision	Impact	Description
a. Medicare Advantage/Part C and PartD Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 423.182, 423.184, and 423.186)	CMS is finalizing several measure changes and methodological clarifications and enhancements to the Part C and Part D Star Ratings as described in section V. In addition to finalizing the addition of an HEI reward as a replacement for the current reward factor and the reduction of the weight of patient experience/ complaints and access measures, we are finalizing removal of the 60 percent rule for extreme and uncontrollable circumstances, a rule for the sub-regulatory removal of Star Ratings measures when a measure steward other than CMS retires the measure, and clarifications around additionalaspects of the existing Star Ratings calculations.	The HEI reward provision, which would replace the current reward factor, is expected to result in net savings of between $670 million in 2028 and $1.05 billion in 2033,resulting in a ten-year savings estimate of $5.12 billion. The patient experience/ complaints andaccess measure weight provision is expected to result in net savings of between $330 million in 2027 and $580 million in 2033, resulting in a ten-year savings estimate of $3.28 billion. The netimpact of all of the Star Ratings provisions finalized in this rule is $6.41 billion in savings over ten years, accounting for 0.10% of the private health baseline.
b. Strengthening Translation Requirements for Medicare Advantage, Cost plans, Part D, andD-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267)	We are finalizing requirements that: (1) MA organizations, cost plans, and Part D sponsors provide materials to enrollees on a *standing basis* in any non-English languages that is the primary language of at least 5 percent of the individuals in that service area and/or accessible formats; and (2) FIDE SNPs, HIDE SNPs and AIPs translate both Medicare and Medicaid materials into any languages required by the Medicare translation standard plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts.	(1) We estimate the requirement for MA organizations, cost plans, and Part D sponsors to establish a process to provide materials to enrollees on a standing basis will cost $10.4 million. We expect that implementing a standing request process will reduce future costs to MA organizations, cost plans, and Part D sponsors by decreasing rework of sending two sets of information, one in the incorrect language or format and the other in the correct format. (2) We estimate it will cost $2.1 million for FIDE SNPs, HIDE SNPs, and AIPs to translate one set of materials into one additional language. Any additional documents needing translation will be a one-time costwith a smaller cost to update the documents in future contract years.

Provision	Impact	Description
c. Health Equity in Medicare Advantage (MA) (§§ 422.111 and422.112)	In this final rule, we establish regulatory requirements that: (1) clarify the broad application of our policy that MA services be provided in a culturally competent manner, (2) require each provider's cultural and linguistic capabilities be included in all MA provider directories, (3) require MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessingany medically necessary covered telehealth benefits, and (4) require MA organizations to incorporate into their overall QI program one or more activities into that reduce disparities in health and health care among their enrollees.	(1) Expanding the list of populations is for purposes of clarity, and is not expected to have any economic impact on theMedicare Trust Fund. (2) Codifying providers' culturaland linguistic capabilities as required provider directory data elements is not expected to haveany economic impact on the Medicare Trust Fund. (3) Requiring MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy is expected to have an unknown economic impact on theMedicare Trust Fund. (4) Aligning MA QI programs with Health equity efforts across CMS policies and programs is notexpected to have any economic impact on the Medicare Trust Fund.
d. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Mandate Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137and 422.138422.4)	In this final rule, we are finalizing: (1) the requirement that MA plans to follow TraditionalMedicare coverage NCDs, LCDs, statutes and regulations when making medical necessity determinations, (2) that MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD; (3) the requirement that an approval granted through PA processes must be valid for as long as medically necessaryto avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation and that plans are required to provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan, switches from Traditional Medicare to an MA plan, or is new to Medicare, and (4) the requirement that MA organizations establish a committee, led by a plan's Medical Director, that reviews utilization management, including PA, policies annually and keeps current of LCDs, NCDs, andother Traditional Medicare coverage policies.	(1) Require MA plans to follow Traditional Medicare coverage guidelines when making medicalnecessity determinations. The impact is difficult to quantify. (2) Requires plans to post internalcoverage criteria and provide public summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations. (3) Requires PA approval to be valid for as long as medically necessary to avoid disruptions incare, in accordance with applicable coverage criteria, the patient's medical history, and thetreating provider's recommendation and is not expected to have economic impact on the Medicare Trust fund. (4) Require MA organizations to establish a committee (similar to aP&T committee), led by the Medical Director, that reviews utilization management, includingPA, policies annually and keeps current of LCDs, NCDs, and other Traditional Medicare coverage policies. This is qualitatively beneficial for enrollees and is not expected to have economic impact on the Medicare Trust fund.

Provision	Impact	Description
e. Medicare Advantage (MA) and PartD Marketing (Subpart V of Parts 422 and 423)	We are finalizing several changes to strengthen beneficiary protections and improve MA and Part D marketing. These include notifying enrollees annually, in writing, of the ability to opt out of plan business contacts from their plan; requiring agents to explain the effect of an enrollee's enrollment choice on their current coverage; clarifying that the contact is unsolicited unless an appointment at the beneficiary's home was previously scheduled; prohibiting marketing of benefits in a service area where those benefits are not available, unless unavoidable due to use of local or regional media; prohibiting the marketing of savings available based on a comparison of typical expenses borne by uninsured individuals; requiring TPMOs to list or mention all of the MA organization or Part D sponsors that they represent in marketing materials; requiring plans and sponsors to have an oversight plan that monitors agent/broker activities and reports non-compliance to CMS; adding SHIPs to the TPMO disclaimer; adding the number of organizations and products a TPMO represents to the TPMO disclaimer; placing limits around the use of the Medicare name, logo, and Medicare card; prohibiting the use of superlatives unless the material provides documentation to support the statement; prohibiting the collection of SOA cards at educational events; prohibiting a marketing event to follow an educational event with 12 hours at the same location; clarifying the requirement to record calls between TPMOs and beneficiaries includes virtual connections such as Zoom and Facetime; limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that theenrollee first asked for information; and requiring 48 hours between a Scope of Appointment and an agent meeting with a beneficiary, with exceptions for beneficiary- initiated walk-ins and the end of a valid enrollment period.	We recognize the impact of these provisions to be primarily one ofchanges to Plans' policy and procedure documents. We estimate the one-time costs of these changes to be $172,593 ($76.20/hr * 2265 hr). We believe the time and cost to plans for the requirement to report non-compliant agents and brokers for substantive violations to CMS will be nominal.
f. Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and422.116)	CMS is finalizing adding Clinical Psychology and Licensed Clinical Social Work as specialty types that will be evaluated using the time, distance and minimum provider standards in our network adequacy reviews; amending our access to services standards to include behavioral health services; codifying minimum access wait time standards (from current example wait times for primary care) to apply to both primary care and behavioral health services; clarifying that behavioral health services may qualify as emergency services and therefore not be subject to prior authorization when furnished as emergency services; and requiring plans to establish behavioral health care coordination programs to ensure enrollees are offered the behavioral health services to which they are entitled to close gaps in behavioral health treatment.	We estimate negligible costs forthese provisions.

Provision	Impact	Description
g. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (§§ 422.111 and 422.2267)	CMS requires notification to MA enrollees when a provider network participation contract terminates. Continuity of care is essential, especially for primary care and behavioral health, and consequently, adequate communication to enrollees is vital when network changes occur so that patients of any terminating primary care or behavioral health providers can decide how to proceed with their course of treatment. CMS is finalizing amendments to § 422.111(e) that establish specific enrollee notification requirements for no-cause and for-cause provider contract terminations and add specific and more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. CMS is also amending § 422.2267(e)(12) to specify the content and additional procedural requirements for the notification to enrollees about a provider contract termination. These requirements will generally increase enrollee protections when MA network changes occur and will raise the standards for the stability of enrollees' primary care and behavioral health treatment.	These provisions are not expected to have any economic impact on the Medicare Trust Fund.
h. Limited Income Newly EligibleTransition (LI NET) Program	We are making the long-standing demonstration program a permanent part of Medicare Part D, as directed by the CAA.	The projected costs, estimated by OACT, are the same as what the government would have incurred if the demonstration continued. Further, the costs of the payments provided for under this program will continue, as under the demonstration, to be covered through the Medicare PrescriptionDrug Account within the Federal Supplementary Medical Insurance(SMI) Trust Fund. The provision is estimated to cost the Medicare Trust Fund $95 million over 10 years. There is an additional 10-year paperwork burden of $ 4.3 million.
i. Expanding Eligibility for Low- Income Subsidies Under Part D of the Medicare Program (§§ 423.773 and 423.780)	We are implementing section 11404 of the IRA to expand eligibility for the full LIS subsidy group to individuals currently eligible for the partial LIS subsidy beginning on or after January1, 2024.	We estimate that this change will increase Medicare spending by $2.3 billion over 10 years.

Final Item

CMS says that in the aggregate, this rule is expected to reduce dollar spending of the Medicare Trust Fund by $4.0 billion over 10 years, with the Star Ratings provisions being the primary driver of savings. Contrastively, the aggregate paperwork burden is small, in aggregate, $17.1 million over 10 years