OPTUM®



Viewpoints on the 2022 CMS Final Rate Announcement and other regulatory guidance for Medicare Advantage and Part D plans

The COVID-19 pandemic continues to have a significant impact on how Americans seek medical care. It continues to impact the delivery of care and operations of health care providers. During the ongoing pandemic, the Centers for Medicare & Medicaid Services (CMS) released several waivers, flexibilities and payment policy changes. This is to support health care providers and health plans as they continue to deliver care. We are committed to being supportive of keeping you informed of new guidance from CMS.

On January 15, 2021, CMS released the 2022 Final Rate Announcement for Medicare Advantage (MA) and Part D plan sponsors ("health plans"). This rate announcement is being made three months earlier than usual to provide health plans more time to prepare their 2022 bids. The earlier release will help health plans to better project and plan for 2022 plan costs, considering the uncertainty of the COVID-19 pandemic. As always, these changes contain both a mix of opportunities and challenges that plans will need to assess and develop strategies to help. Most importantly, commentary about general impact can vary greatly based on specific plan circumstances.

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KEY FINAL CHANGES FOR 2022

1 **Estimated MA and fee-for-service (FFS) effective growth rate of 5.59%**. This results in an estimated 4.08% change in national average plan payments after considering changes in risk score normalization factor, risk model changes, FFS rebasing and changes in Star Ratings. Actual results will vary significantly by county and plan.

SEE PART C PLAN PAYMENT

2 **Estimated cost of $7.63 per member per month (PMPM)** for COVID-19 vaccinations included in the 2022 FFS United States Per Capita Costs (USPCC).

SEE PART C PLAN PAYMENT

3 **Part C risk scores will be calculated using 100% weight** using the 2020 CMS-HCC (Hierarchical Condition Categories) risk adjustment model.

SEE PART C RISK ADJUSTMENT

4 **RAPS data will no longer be used as a source of diagnosis data** for non-PACE HCC and non-PACE RxHCC model risk scores starting in 2022.

SEE PART C RISK ADJUSTMENT

5 **FIDE SNAP frailty scores estimated to increase by 19%.** This is a result of recalibrating the frailty factors used for the 2020 HCC model.

SEE PACE AND FIDE SNP FRAILTY FACTORS

6 **RxHCC model is being recalibrated** based on more recent data periods, incorporating 2017 ICD-10 diagnoses to predict 2018 Part D expenses.

SEE PART D RISK ADJUSTMENT

7 **Normalization factors and risk adjustment models** for CMS-HCC and RxHCC are not being adjusted to reflect potential impact of COVID-19.

SEE PART D RISK ADJUSTMENT

8 CMS is expanding program flexibilities and removing downside risk for plans participating in the **Part D Modernization Model.**

SEE PART D MODERNIZATION MODEL

9 The Biden administration has **delayed until 2023 the Final Rule requiring manufacturer rebates** to be reflected at the point of sale.

SEE OTHER ANNOUNCEMENTS

10 **Starting in 2022, Part D plans** will be able to offer **two specialty tiers,** preferred and non-preferred. Also, Part D sponsors must **disclose details of pharmacy performance** metrics to CMS.

SEE PART D PROGRAM CHANGES

11 **Star Ratings continue to be impacted by COVID-19** as CMS makes changes to threshold determination.

SEE STAR RATINGS PROGRAM



Part C plan payment

Highlights of final changes

- The 4.08% plan payment increase is a national average and does not account for all variables that affect plan payments. It reflects a 5.59% increase due to growth rate and a 1.64% decrease due to normalization factor updates. The national average plan payment increase does reflect a minimal net impact due to Star Ratings and risk model revisions. It does not yet include CMS estimates of plan coding trend. Plans should consider how the following may vary from the national averages:
  - 0.16% impact of FFS rate rebasing, including county-level impacts of adding 2019 FFS data and removing 2014 data from AGA calculation; FFS repricing for the most current geographic price cost indices; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program changes; and Center for Medicare & Medicaid Innovation (CMMI) program impact
  - Impact of revisions to risk model 0.25%
  - Variances from average –0.28% Star Ratings change impact
  - Contract-specific HCC coding trend, not reflected in 4.08% revenue change

4.08% plan payment increase is a national average.

Part C plan payment

- CMS USPCC projected cost estimates for 2020 and 2021 reflect adjustments for COVID-19. This is an estimate of the average across all state and county codes in the country. The 5.59% effective growth rate is an expected blend of the total USPCC growth rate of 6.30% and the FFS growth rate of 5.47%. The FFS growth rate is a component of the total USPCC growth rate. Relative to 2020 estimates:
  - The 2020 total USPCC is 5.6% lower and the 2020 FFS USPCC is 10.7% lower due to the impact of COVID-19. The CMS Office of the Actuary attributes this to care that is "projected to be foregone or deferred to calendar year (CY) 2021 or CY 2022."
  - The 2021 total USPCC is 2% lower and the 2021 FFS USPCC is 4.7% lower primarily due to services projected to be foregone or deferred.
  - The 2022 total USPCC is 2% higher and the 2022 FFS USPCC is 1.2% higher primarily due to deferred care that is expected to be more intensive.
- Beginning Jan. 1, 2022, MA organizations must cover COVID-19 vaccine costs. Within the CY 2022 FFS USPCCs, CMS has estimated the COVID-19 vaccine costs to be $7.63 PMPM using the following assumptions:
  - 52% of FFS beneficiaries will receive the COVID-19 vaccine
  - Average of 2.0 doses per utilizer
  - The average cost per dose would be $88 ($28 administration cost and $60 vaccine cost)
- 2022 applicable ("quartile") percentages have been updated based on 2021 FFS per-capita rates.
- The national average for 2022 end-stage renal disease (ESRD) growth rate is estimated to be 5.00%, an increase from the 2021 4.04% ESRD growth rate.



The **5.59% effective growth rate** is an expected blend of the total USPCC growth rate of 6.30% and the FFS growth rate of 5.47%.



Part C risk adjustment

Highlights of final changes

CMS will continue the phase-in of Encounter Data Submissions (EDS) as a diagnosis source for payment year 2022 with EDS driving 100% of an MA plan's risk score using the 2020 CMS-HCC model. Risk Adjustment Payment System (RAPS) data submissions will no longer be utilized in the non-PACE MA plan's risk score calculations.

- CMS is moving to 100% weight on EDS risk scores using the 2020 CMS-HCC model for 2022. In 2021, EDS risk scores were weighted 75% and 25% on RAPS risk scores using the 2017 CMS-HCC model.
- In 2021, CMS supplemented EDS risk scores with FFS and inpatient (IP) RAPS data. Starting in 2022, EDS risk scores will no longer be supplemented with IP RAPS data.
- FFS filtering logic to identify diagnoses for risk score calculation will be aligned with the encounter data filtering logic, which is based on Healthcare Common Procedure Coding System (HCPCS) codes.
- The MA coding pattern adjustment factor is to remain at 5.9%, consistent with 2021.
- The 2020 CMS-HCC model normalization factor is to increase from 1.097 to 1.118.
- The 2017 CMS-HCC model normalization factor is to increase from 1.106 to 1.128 (applicable for Program of All-inclusive Care for the Elderly [PACE] plans).
- The 2020 ESRD dialysis model normalization factor is to decrease from 1.079 to 1.077.

RAPS data will no longer be used as a source of diagnosis data for non-PACE HCC and all RxHCC model risk scores starting in 2022.



PACE and FIDE SNP Frailty Factors

Highlights of final changes

- For CY 2022, CMS estimates the fully integrated dual eligible special needs plan (FIDE SNP) frailty scores under the recalibrated 2020 HCC Model values will increase 19%. In 2021, frailty scores under the 2020 HCC model declined by 8.6%.
- For CY 2022, CMS has recalibrated the frailty factors applicable to the 2020 HCC model to be based on 2014 to 2015 FFS Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. The 2021 frailty factors for the 2020 HCC model were based on 2008 to 2009 CAHPS data.
- For 2022, the 2020 CMS HCC model frailty factors will be split out for non-Medicaid, Partial Dual and Full Dual beneficiaries consistent with the 2020 CMS-HCC risk adjustment model. For 2021, the 2020 HCC model frailty factors varied by Medicaid versus non-Medicaid only.
- Distribution of members by ADL ranges will still be used to calculate the final plan-level frailty factor used for payment risk scores.
- PACE plans will continue to use frailty factors associated with the 2017 CMS-HCC model for CY 2022.



Part D risk adjustment

Highlights of final changes

In addition to calculating risk scores using 100% encounter and FFS data, CMS is proposing to recalibrate the RxHCC model.

- The final 2022 RxHCC model will be calibrated using 2017 FFS and MA-PD encounter data submissions for diagnoses to predict 2018 Part D expenditures. CMS did not include MA-PD RAPS data as a source of diagnosis data in recalibrating the RxHCC model.
- Diagnosis data sourced from FFS claims will be filtered using a different methodology beginning in CY 2022. The filtering logic to identify diagnoses for risk score calculation will be aligned with the HCPCS-based encounter data filtering logic as opposed to the specialty-based filtering logic applied to FFS claims in CY 2021 and prior. This change decreases risk scores by –0.08%.
- The recalibration incorporates the pre–Affordable Care Act (ACA) catastrophic phase benefit parameter.
  - The ACA temporarily capped the annual increase applied to the member out-of-pocket threshold for the catastrophic coverage. This cap was lifted in 2020. Within the calibration, CMS calculated what the member out-of-pocket threshold for the catastrophic coverage would have been without the ACA cap.
- PACE organizations will continue to use the 2020 RxHCC model. The use of the 2020 RxHCC model for PACE (instead of the new proposed 2022 RxHCC model) maintains alignment on the diagnosis data sources used for payment purposes and for the development of the 2020 RxHCC model coefficients. PACE plans are proposed to still include RAPS data as a source of diagnosis data for CY 2022.

RxHCC model is being recalibrated based on more recent data periods, incorporating 2017 ICD-10 diagnoses to predict 2018 Part D expenses.

Part D risk adjustment

Typically, the normalization factor is calculated by estimating an annual linear growth rate utilizing the most recent five years of data (2015 to 2019 would have been used for CY 2022). The first-year encounter data was included in the risk score calculation was 2015. Because of this, CMS is observing a sharp increase in risk scores from 2015 to 2016 used to calculate the normalization factor. As a result, CMS calculated the RxHCC normalization factor for the 2022 RxHCC model only using four years of data to calculate the annual linear growth rate. Accordingly, the final 2022 Part D normalization factor has been reduced from the initial proposed value in the Advance Notice by about 1.2%.

- Normalization factors and risk adjustment models for CMS-HCC and RxHCC are not being adjusted to reflect the potential impact of COVID-19.
- The 2020 RxHCC model (still used for PACE Part D risk scores) normalization factor has not been explicitly defined in the 2022 Advance Notice or the 2022 Final Rate Announcement. It is not clear whether CMS will use:
  - The 2022 RxHCC model normalization factor of 1.043 for the 2020 RxHCC model for PACE members, or
  - Publish a recalibrated 2020 RxHCC normalization factor using the most recent four years of data, similar to the 2022 RxHCC model, or
  - Carry forward the 2021 Part D normalization factor used for the 2020 RxHCC model.



CMS calculated the RxHCC normalization factor for the 2022 RxHCC model **only using four years of data** to calculate the annual linear growth rate.



Part D program changes

Highlights of final changes

- Part D benefit parameter increases consistent with changes in the annual percentage increase (API) in Part D expenditures are as follows:
  - 7.31% API for 2022 reflects a 5.36% for 2021 trend and 1.85% for prior periods
  - Deductible is increasing from $445 to $480
  - Initial coverage limit is increasing from $4,131 to $4,430
  - True OOP threshold is increasing from $6,550 to $7,050
- Specialty tier threshold has increased from $670 in 2021 to $830 in 2022 for a per-30-day equivalent ingredient cost
- Beginning in CY 2022, Part D plans may offer two specialty tiers, preferred and non-preferred.
  - Preferred specialty drugs are required to have a lower cost-sharing than non-preferred specialty drugs, although the differential between the two is not defined by CMS.
  - The nondiscriminatory cost-sharing limits reflect the maximum amount for non-preferred specialty drugs, if applicable.
  - CMS will require tiering exceptions between preferred and non-preferred specialty tiers.

Beginning in CY 2022, **Part D plans may offer two specialty tiers,** preferred and non-preferred.

Part D program changes

- Beginning Jan.1, 2022, Part D sponsors must disclose to CMS pharmacy performance measures they use to evaluate pharmacy performance in their network agreements.
  - CMS may report pharmacy performance measures publicly to "increase transparency on the process and inform the industry in its new efforts to develop a standard set of pharmacy performance measures."
- Meaningful difference limit remains $22 PMPM between basic and enhanced alternative (EA) Part D (PDP) plans.
- 2022 Coordination of Benefits (COB) user fee remains at $1.05 per member per year (PMPY) and will be collected for the first nine months of the coverage year at $0.116 PMPM consistent with prior years.
- Starting Jan. 1, 2023, Part D sponsors will be required to offer real-time comparison tools to enrollees. The Beneficiary Real Time Benefit Tool (RTBT) will support enrollees to understand the difference in cost for alternative therapies available under their prescription drug benefit plan.



Beginning Jan.1, 2022, Part D sponsors **must disclose to CMS pharmacy performance** measures.



Part D Payment Modernization Model

Highlights of model updates

In January 2020, CMS and CMMI launched the Part D Payment Modernization Model (the Model). Its purpose was to voluntarily test the impact of a modernized Part D program design that included flexibilities to reduce beneficiary OOP costs and overall Part D prescription drug spending. The Model aims to reduce Medicare spend while enhancing or preserving beneficiary quality of care.

Both stand-alone PDP and Medicare Advantage prescription drug (MA-PD) plans are eligible to apply and participate in the model, regardless of the Part D benefit type.[1] Plan sponsors that participate in the Model will take two-sided risk for CMS' federal reinsurance subsidy. They will be given flexibilities not provided to Part D sponsors not participating in the Model.

Increased plan flexibilities and elimination of downside risk for CY 2022

Performance-based payments or losses

Payments and losses are based on performance relative to the spending target benchmark. Model participants will either be eligible for performance-based payments or will be accountable for losses. The target benchmark will be calculated by CMS taking into consideration the reinsurance spending for Model participants after the plan year, for MA-PD and PDP plans separately.

Spending target relative to benchmark	Percent	Plan risk sharing
Losses	Any	10% penalty on the difference[2]
Savings	0% up to 3%	30% of savings
Savings	3%+	50% of savings greater than 3%

1. Medicare Medical Savings Account, private fee-for-service plans, all employer/union group waiver plans (EGWPs), section 1876 cost contract plans, section 1833 health care prepayment plans, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Medicare-Medicaid plans, and religious fraternal benefit plans are not eligible to participate in the Model.
2. For CY 2022, CMS is will be accepting 100% of the downside risk.

Part D Payment Modernization Model

Program flexibilities	
Protected drug classes	Participants will not be required to cover all drugs in five of six protected classes (anticonvulsants, immunosuppressants, antidepressants, antipsychotics and antineoplastics), consistent with how they would treat nonprotected classes.
Therapeutic drug class coverage	Only require one drug per class instead of two (must implement enhanced transition process for enrollees affected by proposed formulary changes).
Medication therapy management (MTM) programs	Allow plans to create their own MTM program, while staying within general requirements outlined in 42 CFR 423.153(d), so CMS can test ways MTM may be developed and implemented to improve beneficiary targeting and engagement (improve adherence, coordination of care and understanding beneficiary medication regimen).
Flexibility to lower beneficiary costs	1. Limit first fill quantity where there is clinical rationale. 2. Cost-sharing smoothing allows enrollees to pay cost-share over time using installment payments. 3. Reduce or eliminate cost-share for generic drugs and biosimilars for low-income members.
Part D rewards and incentives	Provide greater flexibility to provide members rewards and incentives that are related to medication use, with a focus on promoting improved health, medication adherence and efficient use of health care resources.
Plan timeliness for standard initial coverage determinations	Time has increased from 72 hours to 96 hours to support unnecessary denials and delays in beneficiary access to needed medications.
De minimis policy	Potential of a greater de minimis waiver for those plans targeting the low-income subsidy. Actual de minimis amount will be released in the annual release of the Part D national average monthly bid amount and other Part C and Part D bid information and operational guidance.



Star Ratings program

Highlights of final and interim rules

2022 Star Rating update

The updates in this section come from the COVID-19-related Interim Final Rules, the Final Rate Announcement and the Final Rule for 2022 MA and Part D.

- Complaints Tracking Module (CTM) data review by CMS or Independent Review Entity (IRE) deadline is June 30, 2021.
- Extreme and Uncontrollable Circumstances — The 60% designation was removed, thereby including contract data, where 60% or more enrollees in FEMA-designated Individual Assistance area, in clustering analysis and performance summary and variance threshold determination for reward factor.
- New methodology for the Medicare Plan Finder Price Accuracy measure will be included. This measure will not count towards the reward calculation.
- Non-substantive changes to HEDIS® measures
  - Controlling high blood pressure (CBP) permits the use of member self-reported blood pressure readings from any digital device.
  - Telehealth codes can be used to identify members for the denominator, exclude members for advanced illness and frailty, provide numerator hits for functional status assessment and pain assessment, and be factored in the risk adjustment determination for utilization measures.



Controlling high blood pressure (CBP) **permits the use of member self-reported blood pressure readings** from any digital device.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Star Ratings program

2023 Star Rating update

- Statin Use in Persons with Diabetes (SUPD) will undergo planned modifications for Star Rating year 2023:
  - Index prescription start date should occur at least 90 days prior to end of measurement year (MY)
  - New exclusions for rhabdomyolysis or myopathy; pregnancy, lactation, or fertility; liver disease; pre-diabetes; and polycystic ovarian syndrome (PCOS)
  - Weighting reverts back to 1.
- Kidney Health Evaluation for Patients with Diabetes (KED) is expected to be on display page for Star Rating year 2022. It is under consideration to be added to future Star Ratings through rule making.
- CBP returns to Star Rating year 2023.
- Plan all-Cause Readmission (PCR) remains on display for Star Rating years 2022 and 2023.
- Modified two polypharmacy display measures.
- Retired six Part D measures.

Codified measure changes for 2024

- Improving or Maintaining Physical Health and Improving or Maintaining Mental Health (HOS measures) will move to display for Star Rating years 2024 and 2025 for Case Mix Index (CMI) and denominator changes.
- Add Transitions of Care (TRC) and Follow up after ED Visit for People with High Risk Multiple Chronic Conditions (FMC) to Star Rating year 2024.
- Medication Therapy Management (MTM) to include at-risk beneficiaries in the 2022 measurement period (Star Rating year 2024).



Potential new measure concepts for future years

1. Provider Directory Accuracy (Part C)
2. COVID-19 Vaccination (Part C)

Display measures

- Kidney Health Evaluation for Patients with Diabetes (Part C)
- Controlling High Blood Pressure to remain on display for Stars 2022 (Part C)
- Plan all-Cause Readmission to remain on display for one additional year, returning in Stars 2023 (Part C)



Other announcements

Highlights of final changes

CMS flexibilities to fight COVID-19

Since the beginning of the COVID-19 Public Health Emergency (PHE), CMS has issued an array of temporary regulatory waivers and new rules to provide the U.S. health care system maximum flexibility to respond to the COVID-19 pandemic. These temporary changes will apply immediately across the U.S. health care system for the duration of the emergency declaration. Following are COVID-19 MAPD plan flexibilities during the PHE:

1. Flexibility to provide expanded benefits beyond what is approved in bid
2. Waive or relax Medicare prior authorization requirements for Part D drugs
3. Must permit coverage of a 90-day supply of a Part D covered drug if beneficiary asks and relaxes "refill-too-soon" edits
4. Home or mail delivery of Part D drugs — Part D sponsors are permitted to voluntarily relax any plan-imposed policies that may discourage certain delivery methods, such as mail or home delivery
5. Reprioritizing risk adjustment data validation (RADV) audits
6. $0 cost share for diagnostic testing related to COVID-19

The Biden administration has **delayed the start date of the final rule** for Part D Manufacturer Rebates at Point-of-Sale from Jan. 1, 2022 **to Jan. 1, 2023.**

Other announcements

Impact of Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021, increased the Medicare Physician Fee Schedule (PFS) reimbursements by 3.75% for CY 2021. It also extended the removal of sequestration payment reductions to providers through March 2021. MA plans with contracts tied to Medicare reimbursement levels should carefully consider the impact of this in the 2022 bid submission and other trend information released by CMS as it relates to the 2022 bid submission process. Due to the timing of this fee schedule change, these amounts are not reflected in the final 2022 MA ratebook development.

Part D Manufacturer Rebates at Point-of-Sale (POS)

Health plans preparing to submit CY 2022 bids and expecting manufacturer rebates would now be required to pass on rebates at the POS starting Jan. 1, 2022, consistent with the Final Rule published on Nov. 20, 2020. In response to a lawsuit challenging the rule, the Biden administration delayed the start date from Jan. 1, 2022 to Jan. 1, 2023, of the Final Rule amending certain safe harbor protections under the federal Anti-Kickback Statute (AKS) of the Social Security Act.



Four things to consider for bid preparation

Financial impact may vary from plan to plan based on a combination of:

- Benchmark changes
- Risk adjustment changes
- Cost sharing and benefit design requirements
- Star Ratings
- Service-area mix

COVID-19 impact on base period claims costs, trend and risk scores

Plan-specific impact of transition to 100% EDS data, data filtering logic change and exclusion of supplementing EDS with RAPS IP data

Expect and model the potential for more uncertainty to understand financial risk under multiple scenarios

Product strategy to win at member acquisition and Star Ratings in an increasingly competitive market

Optum is here to help

Now more than ever, it is imperative that Medicare Advantage plans continue to execute effectively. They need to leverage quality, risk adjustment and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits, member premiums and margins. Integrating initiatives across each of these functions may improve results, improve the member and provider experience, and reduce program costs.

Optum is unique in its alignment and delivery of the critical combination of actuarial, care management and operational consulting expertise. In an environment where there are often more and more issues to address, we have helped our clients achieve the balanced approach they need to manage the challenges of the Medicare Advantage market.

Optum is unique in its combination of:

ACTUARIAL

CARE MANAGEMENT

OPERATIONS

TECHNOLOGY



Actuarial services and performance reporting: We have the experience and tools to assist in developing strategic bid pricing to help align with a plan sponsor's operational and strategic goals. We also offer both Parts C and D reporting tools to help plan sponsors monitor their performance during the plan year.



Risk score accuracy: We offer clinical and operational insight and delivery support to improve the accuracy and completeness of risk scores, combined with the analytics to illustrate the revenue impacts and critical path for such initiatives.



Star Ratings performance management: We offer projections, assessments, processes, dashboards and other critical components to improve Star Ratings outcomes. In addition, Optum offers consulting for member-reported measures, including CAHPS and HOS Medicare Health Outcomes Survey (HOS).



Foundational analytics and advanced modeling: We have data, experience and analytic models to support your strategic decision-making, risk management and resource prioritization. This includes guidance on how to assess and address emerging opioid challenges and social determinants of health.



Population health management: We offer deep experience in care management and network management to minimize risk, including kidney programs aligned with these final rules.



Enabling risk-based reimbursement: We bring hands-on experience in creating transformational provider risk-sharing arrangements.

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Alex Balmes

Senior Director, Optum Government Programs Actuarial Services

Alex Balmes has 20 years of experience in health care, including 16 years providing actuarial services within Optum Advisory Service. His current focus is on Medicare Advantage, Medicaid and the ACA lines of business. His experience includes MA and Part D bid development, reserving, provider contracting, RA valuation, M&A management, actuarial recruiting and analytical systems development.



Randall Fitzpatrick, FSA, MAAA

Practice Lead, Optum Government Programs Actuarial Services

Randall Fitzpatrick provides consulting services to health insurers, Medicare Advantage organizations, MCOs and health care providers. His expertise includes pricing and filing of Medicare Advantage Part C and Part D bids, reserving, provider contract analytics and strategic market analyses for MA. He also provided actuarial services to CMS for the review and audit of its bid pricing tools.



Helen Kurre

Practice Lead, Star Ratings, Optum Advisory Services

In her role as practice lead, Helen Kurre is responsible for assessing, designing and implementing improvement solutions to support Star Ratings improvements for health plans and providers. She has 30 years of health care experience, including health plan and provider quality improvement leadership, HEDIS, and CAHPS/HOS.

Contact Optum to discuss how we can help you assess and address 2022 regulatory changes.

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This document includes guidelines within our definition of the 2022 CMS Rate Announcement and other regulatory changes.

All information contained herein is provided solely as commentary and should not be misunderstood as constituting legal or compliance advice. Plans should consult their own legal and/or compliance advisors as to recommended next steps.

SOURCES

Final Rate Announcement: https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsannouncements-and-documents/2022

Final Rate Announcement Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/2022-medicare-advantage-and-part-d-rate-announcement-fact-sheet

Part D Modernization Model Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/part-d-payment-modernization-model-calendar-year-cy-2022-fact-sheet

Contract Year 2022 MA and PD Final Rule Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/contract-year-2022-medicare-advantage-and-part-d-final-rule-cms-4190-f2-fact-sheet

CY 2022 Final Part D Bidding Instructions (January 19 Memo): https://www.cms.gov/hpms-memos-wk-4-january-18-22-2021/hpms-memos-wk-4-january-18-22-2021

COVID-19: https://www.cms.gov/files/document/covid-ma-and-part-d.pdf

AKS Final Rule: https://www.federalregister.gov/documents/2020/11/30/2020-25841/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals



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