Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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Proposed Contract Year 2025 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; Health Information Technology Standards and Implementation Specifications

The Centers for Medicare & Medicaid (CMS) have issued a proposed rule is to amend the regulations for the Medicare Advantage (Part C) program, Medicare Prescription Drug Benefit (Part D) program, Medicare cost plan program, and Programs of All-Inclusive Care for the Elderly (PACE).

Please note that the new marketing and communications policies in this rule are proposed to be applicable for all contract year 2025 marketing and communications, beginning September 30, 2024. This proposed rule also includes revisions to existing regulations in the Risk Adjustment Data Validation (RADV) audit appeals process and the appeals process for quality bonus payment determination that would take effect and apply 60 days after publication of a final rule. Revisions to existing regulations for the use and release of risk adjustment data would also take effect and apply 60 days after publication of a final rule. A limited number of the provisions in this rule are proposed to be applicable beginning with coverage on and after January 1, 2026.

The proposal is currently on display at the ***Federal Register*** office with a scheduled publication date of November 15. A copy of the 486-page display version is available at: https://public-inspection.federalregister.gov/2023-24118.pdf. A comment period ending January 5, 2024 is provided.

Comments

The rule identifies each proposed element as a separate heading. They are as follows. Page numbers correspond to the display version of the rule.

- Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies: Past Performance—Section II (Page 15)
- Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Program—Section III (Page 17)
- Benefits for Medicare Advantage and Medicare Prescription Drug Benefit Programs—Section IV (Page 172)
- Enrollment and Appeals—Section V (Page 202)
- Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communications—Section IV (Page 228)
- Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System—Section IV (Page 253)
- Improvements for Special Needs Plans—Section VIII (Page 271)
- Updates to Program of All-Inclusive Care for the Elderly (PACE) Policy—Section IX (Page 347)

CMS has provided the following table (Page 12) that offers very helpful and concise summary of the proposal. Also, the CMS fact sheet on this item is at: https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-policy-and-technical-changes-medicare-advantage-plan-program-medicare .

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

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Provision	Description	Financial Impact
1. Improving Access to Behavioral Health Care Providers	CMS proposes to add a new facility-specialty type called "Outpatient Behavioral Health" to the network adequacy standards under § 422.116(b)(2). For purposes of the network adequacy requirements, the new facility- specialty type would be evaluated using time and distance and minimum number standards proposed here. The new facility type would include services furnished by marriage and family therapists (MFTs) and mental health counselors (MHCs), Opioid Treatment Programs (OTPs) or other behavioral health and addiction medicine specialists and facilities.	The new provision adds requirements for a new facility specialty type, which include providers some of which CMS has data for and some which are new and for which CMS lacks data. Therefore, CMS cannot quantify the effects of this provision though CMS expects it may increase access which may qualitatively increase utilization.
2. Special Supplemental Benefits for the Chronically Ill (SSBCI)	CMS propose to require MA organizations to establish bibliographies for each SSBCI they include in their bid to demonstrate that an SSBCI has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee. This would shift the burden from CMS to the MA organizations to demonstrate compliance with this standard and help ensure that SSBCI items and services are offered based on current, reliable evidence. In addition, CMS is proposing new policies to protect beneficiaries and improve transparency regarding SSBCI so that beneficiaries are aware that SSBCI are only available to enrollees who meet specific eligibility criteria. CMS proposes to modify and strengthen the current requirements for the SSBCI disclaimer that MA organizations offering SSBCI must use whenever SSBCI are mentioned.	The proposed requirements for SSBCI are not expected to have any economic impact on the Medicare Trust Fund.
3. Mid-Year Enrollee Notification of Available Supplemental Benefits	CMS proposes to require MA plans to issue notices to enrollees who, by June 30 of a given year, have not utilized supplemental benefits, to ensure enrollees are aware of the availability of such benefits and ensure appropriate utilization.`	Although the intent is to increase utilization and ultimately create a savings to the Medicare Trust Fund, CMS cannot currently quantify this provision because it is new, and lacks data.
4. Enhance Guardrails for Agent/Broker Compensation	CMS proposes modifications to agent/broker compensation requirements to further ensure payment arrangements and structure are aligned with CMS's statutory obligation to set limits on compensation to ensure that the use of compensation creates incentives for agents and brokers to enroll prospective enrollees in plans that best fit their needs.	There is a paperwork burden of about $31 million annually. Other effects cannot be analyzed at this time because of uncertainty; however, CMS expects any impact would be minimal. See the Regulatory Impact Analysis for further discussion.

Provision	Description	Financial Impact
5. Annual Health Equity Analysis of Utilization Management Policies and Procedures	CMS proposes changes to the composition and responsibilities for the Utilization Management committee, to require: a member of the UM committee have expertise in health equity; the UM committee conduct an annual health equity analysis of prior authorization used by the MA organization using specified metrics; and require MA organizations to make the results of the analysis publicly available on its website.	CMS does not expect any cost impact to the Medicare Trust Fund.
6. Amendments to Part C and Part D Reporting Requirements	CMS proposes to affirm its authority to collect detailed data from MA organizations and Part D plan sponsors under the Part C and D reporting requirements.	CMS does not expect any cost impact to the Medicare Trust Fund.
7. Enhance Enrollees' Right to Appeal an MA Plan's Decision to Terminate Coverage for Non-Hospital Provider Services	CMS proposes to (1) require Quality Improvement Organizations (QIOs) to review untimely fast-track appeals of an MA plan's decision to terminate services in an HHA, CORF, or SNF and (2) eliminate the provision requiring the forfeiture of an enrollee's right to appeal to the QIO a termination of services decision when they leave the facility.	CMS does not expect any cost impact to the Medicare Trust Fund.
8. Additional Changes to an Approved Formulary—Substituting Biosimilar Biological Products	CMS proposes to permit biosimilar biological products other than interchangeable biological products to be substituted for their reference products without requiring that enrollees currently taking the reference product be exempt from the change for the remainder of the contract year.	CMS does not expect any cost impact to the Medicare Trust Fund.
9. Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization	CMS proposes to (a) replace the current dual/ Medicare and Medicaid Dual Low-income subsidy (LIS) quarterly Special Enrollment Period (SEP), (b) create a new integrated care SEP, (c) limit enrollment in certain dual eligible special needs plans (D-SNPs) to those individuals who are also enrolled in an affiliated Medicaid MCO, and (d) limit the number of D-SNPs an MA organization, its parent organization, or an entity that shares a parent organization with the MA organization, can offer in the same service area as an affiliated Medicaid MCO.	Over a 10-year horizon, CMS estimates a $1.3 billion savings to the Trust Fund for Part D plans and an additional $1 billion savings to the Trust Fund for Part C plans.
10. For D-SNP PPOs, Limit Out-of-Network Cost Sharing	CMS proposes to limit D-SNP PPOs' out-of-network cost sharing for certain Part A and Part B benefits, on an individual service level.	We do not expect any cost impact to the Medicare Trust Fund.

Provision	Description	Financial Impact
11. Contracting Standards for Dual Eligible Special Needs Plan Look- A likes	CMS proposes to lower the D-SNP look-alike threshold from 80 percent to 70 percent for plan year 2025 and 60 percent for plan year 2026.	CMS estimates this provision would have an average annual impact of less than $1M for plan years 2025-2027 due to non-SNP MA plans meeting the lower D-SNP look-alike threshold transitioning enrollees into other plans. CMS also estimates this provision would have an average annual impact of less than $1M on MA plan enrollees for plan years 2025-2027 due to enrollees choosing a different plan. CMS expects cumulative annual costs to non-SNP MA plans and MA plan enrollees beyond plan year 2027 to also be less than $1M per year.
12. Standardize the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Appeals Process	"Revising when a medical record review determination and a payment error calculation appeal can be requested and adjudicated is necessary because RADV payment error calculations are based upon the outcomes of medical record review determinations. CMS is also proposing other revisions to its regulatory appeals process to conform with these proposed changes. The proposed changes could reduce burden on some MA organizations that, absent these revisions, would have otherwise potentially submitted payment error calculation appeals that could have been rendered moot by certain types of medical record appeals decisions. The potential reduction in burden to MA organizations cannot be quantified prior to the implementation and execution of the appeals process pursuant to these changes. While the MA RADV appeals regulations have been in place for a period of years, CMS did not issue RADV overpayment findings to MA organizations as it worked to finalize a regulation on its long-term RADV methodology. Therefore, any impact of these proposed policies on MA organization behavior is further unquantifiable. The proposed changes do not impose any new information collection requirements."	The potential reduction in burden to MA organizations cannot be quantified prior to the implementation and execution of the appeals process pursuant to these changes.