CAPITOL STREET

November 6, 2023

Medicare Advantage 2025 Clean-Up Rule

Negative for Plan Brokers, Positive for D-SNPs & Biosimilars as v28 Starts

Relevant Companies

CMS released the proposed 2025 Policy and Technical Changes to the Medicare Advantage (MA), Medicare Prescription Drug Benefit, and Medicare Cost Plan Programs, and PACE regulations after the close of the US markets today here. Proposed policies would be applicable for CY 2025 and start September 30, 2024. Some provisions in the rule are not set to start until January 1, 2026. Comments are due January 5, 2024.

Our Take & Next Up

This is a collection of Medicare Advantage (MA) odds and ends around mental health, data collection, dual eligible & beneficiary protections and cracking down on aggressive marketing behaviors. There is no significant economic cost burden accompanying the proposed rules. MA and Part D plans as well as providers are not expected to incur burden or losses as a result of the proposed rule. CMS rules for MA focus on enhanced reporting requirements with an emphasis on health equity and transparency. The Senate Finance Committee is scheduled to markup this Wednesday, November 8, a number of policies (see here) including the extension of Medicare Advanced Payment Model (APM) Payment Incentives and requiring MA plans to maintain accurate provider directories on a public website beginning in 2026.

More importantly, MA plans are gearing up for v28 while being generally concerned about the 2025 environment as rates are released in 1Q24 and Congress raises eyebrows at MA profits. As a reminder, the new v28 risk adjustment program will be phased in over three years.

Key Points

MENTAL HEALTH

CMS proposes to add a new facility-specialty type "Outpatient Behavioral Health." This is an attempt to improve beneficiary access to behavioral health services and providers by expanding network adequacy requirements for MA orgs. The new type would be evaluated using time and distance standards while providers could include marriage and family therapists, mental health counselors, opioid treatment program providers as well as community mental health centers or other mental health and addiction medicine facilities. MA organizations will have to demonstrate beginning Jan. 1 that they meet network adequacy for four behavioral health specialty types: psychiatry, clinical psychology, clinical social work and inpatient psychiatric facility services.

BIOSIMILARS

CMS proposes to allow biosimilars -- non-interchangeable biologicals -- to be substituted for their reference products. The "maintenance" rules would allow this substitution without requiring that enrollees currently taking the reference product be exempt from the change for the remainder of the contract year. Recall that the government will

be negotiating drug prices in 2024, with policies disincentivizing biosimilar development. This proposal is in response to the Biden Administration Executive Order "Promoting Competition in the American Economy" (here).

SUPPLEMENTAL BENEFITS

CMS proposes new requirements to ensure accurate marketing of benefits to the chronically ill. MA plans are required to demonstrate that an item or service offered as Special Supplemental Benefit for the Chronically Ill (SSBCI) improves or maintains the health of a chronically ill enrollee. The plan must also document its denials of SSBCI eligibility rather than its approvals. CMS is proposing the ability to codify CMS's authority to review and deny approval of an MA org's bid if the MA org has not demonstrated that its proposed SSBCI will improve or maintain health or overall function of the chronically ill enrollee.

Currently, 99% of Medicare Advantage plans offer at least one supplemental benefit. Over time, the benefits offered have become broader in scope and variety, with more rebate dollars directed toward these benefits. Supplemental benefits include transportation, meal delivery and other non-medical benefits.

About 25% of MA plans are offering financial assistance for food and produce (see ATI Advisory here). This is up from just 2% of plans offering these benefits five years ago. CVS offers food benefits in 234 of its MA plans and ELV and HUM are offering the benefits in 200 of their plans.

CMS is also proposing that MA plans offer mid-year notifications for supplemental benefits. CMS is finding that enrollee utilization of benefits is low and is attempting to combat this by requiring MA plans to actively encourage utilization of benefits through notifying enrollees mid-year of the unused supplemental benefits available to them.

MARKETING (BROKER & AGENT) ABUSE

CMS wants to provide a fixed amount for MA compensation and enhance guardrails for agent and broker compensation. CMS proposes to (1) prohibit contract terms between MA organizations and brokers, agents, or other 3rd parties, (2) set a single compensation rate for all plans ($632 vs the existing national compensation cap of $601), (3) revise the scope of items and services included within agent broker compensation, (4) eliminate the regulatory framework that allows for separate payments to agents and brokers for administrative services, and (5) make changes to the Part D broker compensation.

There is increased focus on marketing "middlemen" from both CMS and the Senate Finance Committee. CMS has rejected more than 300 misleading ads as of October 17 from MA plans attempting to market to seniors. The Senate Finance Committee (Chair Wyden, D-OR) held a hearing in mid-October focusing on MA marketing middlemen and how many marketing middlemen/brokers are collecting $1,300+ due to retitling of some of the payments (e.g., technology, referral bonus, health risk assessment).

CMS wants to reduce aggressive MA marketing tactics towards dual eligibles. The agency proposes to limit enrollment in certain D-SNPs to those also enrolled in affiliated Medicaid MCOs and limit the number of D-SNP plan benefit packages an MA organization can have in the same area as an affiliated Medicaid MCO.

DUAL ELIGIBLES

CMS proposes to change the special enrollment process (SEP) for dual eligibles to be once monthly (estimated savings of $1.3 B/10 to the Trust Fund for Part D plans and an additional $1 B in savings to the Trust Fund for MA plans). The proposal would (1) replace the current quarterly special enrollment period (SEP) with a one-time-per-month SEP for dually eligible individuals and others enrolled in the Part D low-income subsidy program and (2) create a new SEP that allows dual eligibles to elect an integrated D-SNP on a monthly basis.

CMS proposes to limit out of network cost-sharing for D-SNP PPOs. This would (1) reduce cost shifting to Medicaid, (2) increase payments to safety net providers, (3) expand dually eligible enrollee's access to providers, and (4) protect dually eligible enrollees from unaffordable costs.

CMS proposes to shine the light on D-SNP look-alikes (by lowering the thresholds). A D-SNP look-alike is an MA plan that is not a SNP, but in which dually eligible enrollees account for 80% or more of total enrollment. CMS proposes to lower this threshold from 80% to 70% for PY 2025 and to 60% for PY 2026. This policy would help to address the continued proliferation of Medicare Advantage Plans that are serving a high % of dually eligible individuals without meeting the requirements to be a D-SNP.

BENEFICIARY APPEALS & RADV

The proposed rules aim to enhance enrollee's rights to appeal an MA plan's decision to terminate coverage for non-hospital provider services (e.g., SNF, home health, comprehensive outpatient rehab facility). Under current regulations, MA enrollees do not have the same access to Quality Improvement Organizations (QIO) that act as the Independent Review Entity (IRE) that traditional Medicare beneficiaries have access to. The proposed rules (1) require the QIO to review untimely fast-track appeals and (2) fully eliminate the provision that requires the forfeiture of an enrollee's right to appeal a termination of services decision when they leave the facility.

The proposed rules attempt to standardize and simplify the RADV appeals process for CMS and MA orgs. Currently, appeals for both medical record review determinations and payment error calculations are appealed separately and move through the process concurrently. CMS proposes that MA organizations must appeal medical record review determinations first before beginning the payment error calculation appeals process.

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