CAPITOL STREET

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More Spring Rain Falls on MA Plans

CMS Finalizes Many Policies As Proposed in Clean-Up Rule ('25/'26)

Relevant Companies

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CMS released the final 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). Policies would be applicable for CY 2025 and some provisions in the rule are not set to start until January 1, 2026.

»» Our Take & Next Up

CMS finalized most MA plan policies as proposed, with supplemental benefit “bibliography” and mid-year benefit notifications being the most onerous to MA plans. The rule also provides policies around dual eligible (D-SNPs), cracking down on aggressive broker/marketing behaviors, mental health, post-acute denials/RADV and biosimilars. There is no significant cost burden accompanying the rules. CMS rules for MA focus on enhanced reporting requirements with an emphasis on health equity and transparency. More importantly, MA plans are gearing up for a 2025 pay cut per the final MA rules released on April 1 (our analysis is here). CMS appears not to believe that plans will reduce benefits in ‘25, but we very much believe that will be the case, with smaller and mid-sized regional plans being particularly vulnerable in the new rate environment.

»» Key Points

SUPPLEMENTAL BENEFITS

CMS is finalizing that MA plans offer mid-year notifications for supplemental benefits, which will only drive-up utilization (costs) for MA plans. 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.

The “Mid-Year Enrollee Notification of Unused Supplemental Benefits” annually, between June 30 and July 31 of the plan year, must be personalized to each enrollee, and include a list of any supplemental benefits not accessed by the individual during the first 6 months of the year. In addition, the notification will include the scope of the benefit, cost-sharing, instructions on how to access the benefit, any network application information for each available benefit, and a customer service number to call if additional help is needed

CMS is finalizing new requirements for Medicare Advantage plans to demonstrate, with support from research by the time they submit bids, that special supplemental benefits for the chronically ill (SSBCI) improve health. SSBCI items and services meet the legal threshold of having a reasonable expectation of

improving the health or overall function of chronically ill enrollees. MA plans must establish and maintain bibliographies of relevant research studies or other data to demonstrate that an SSBCI meets these requirements.

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.

DUALS

CMS will 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). It 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 will limit out of network cost-sharing for D-SNP PPOs (2026). 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 will 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 will 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 MA plans that are serving a high % of dually eligible individuals without meeting the requirements to be a D-SNP.

MARKETING (BROKER & AGENT) ABUSE

CMS will finalize providing a fixed amount for MA compensation and add guardrails for agent & broker compensation. CMS will (1) prohibit contract terms between MA organizations and brokers, agents, or other 3rd parties, (2) set a single compensation rate for all plans, (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 will 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.

PRIOR AUTH – EQUITY

CMS is worried that duals and low-income MA beneficiaries are disproportionately harmed by prior auth. The goal of the health equity analysis is to create additional transparency and identify disproportionate impacts of UM policies and procedures on enrollees who receive the Part D low-income subsidy, who are dually eligible, or who have a disability.

CMS is updating the composition of, and responsibilities for, the prior auth / UM committee to require the following: (1) at least one member of the UM committee has expertise in health equity, (2) the UM committee conducts plan-level annual health equity analysis of prior authorization policies and procedures used by the Medicare Advantage plan, and (3) the results of the analysis be made publicly available on the plan's website.

POST ACUTE APPEALS PROCESS & RADV

SNF, Home Health & Rehab appeals may be fast-tracked if denied by a MA plan. Currently, enrollees in a Medicare Advantage plan do not have the same access to Quality Improvement Organization (QIO) review of a fast-track appeal as individuals in Traditional Medicare.

CMS is revising regulations to do the following: (1) require the QIO, instead of the Medicare Advantage plan, to review untimely fast-track appeals of a Medicare Advantage plan's decision to terminate services in a skilled nursing facility, comprehensive outpatient rehabilitation facility or by a home health agency; and (2) fully eliminate the provision requiring forfeiture of an enrollee's right to appeal a termination of services from these providers when they leave the facility

The rules will 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 notes that MA organizations must appeal medical record review determinations first before beginning the payment error calculation appeals process.

MENTAL HEALTH

CMS is adding network adequacy evaluation standards for a new facility-specialty provider category, called "Outpatient Behavioral Health," that will include a range of providers under one category. Specialists in this new facility-specialty category include MFTs (marriage & family therapists) and MHCs (mental health counselors), Opioid Treatment Program providers, Community Mental Health Centers, addiction medicine physicians, and other providers, like nurse practitioners (NPs), physician assistants (PAs), and Clinical Nurse Specialists (CNSs), who regularly furnish addiction medicine and behavioral health counseling or therapy services covered by Medicare.

Adding NPs, PAs, and CNSs to the benefit. These provider types might lack the necessary skills, training, or expertise to effectively address the behavioral health needs of enrollees, therefore CMS adds specific criteria that MA organizations must use to determine when an NP, PA or CNS can be included in the Outpatient Behavioral Health category to meet the new network adequacy standards for Outpatient Behavioral Health.

BIOSIMILARS

CMS will 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 2026, with policies disincentivizing biosimilar development. This

proposal is in response to the Biden Administration Executive Order "Promoting Competition in the American Economy" (here).

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