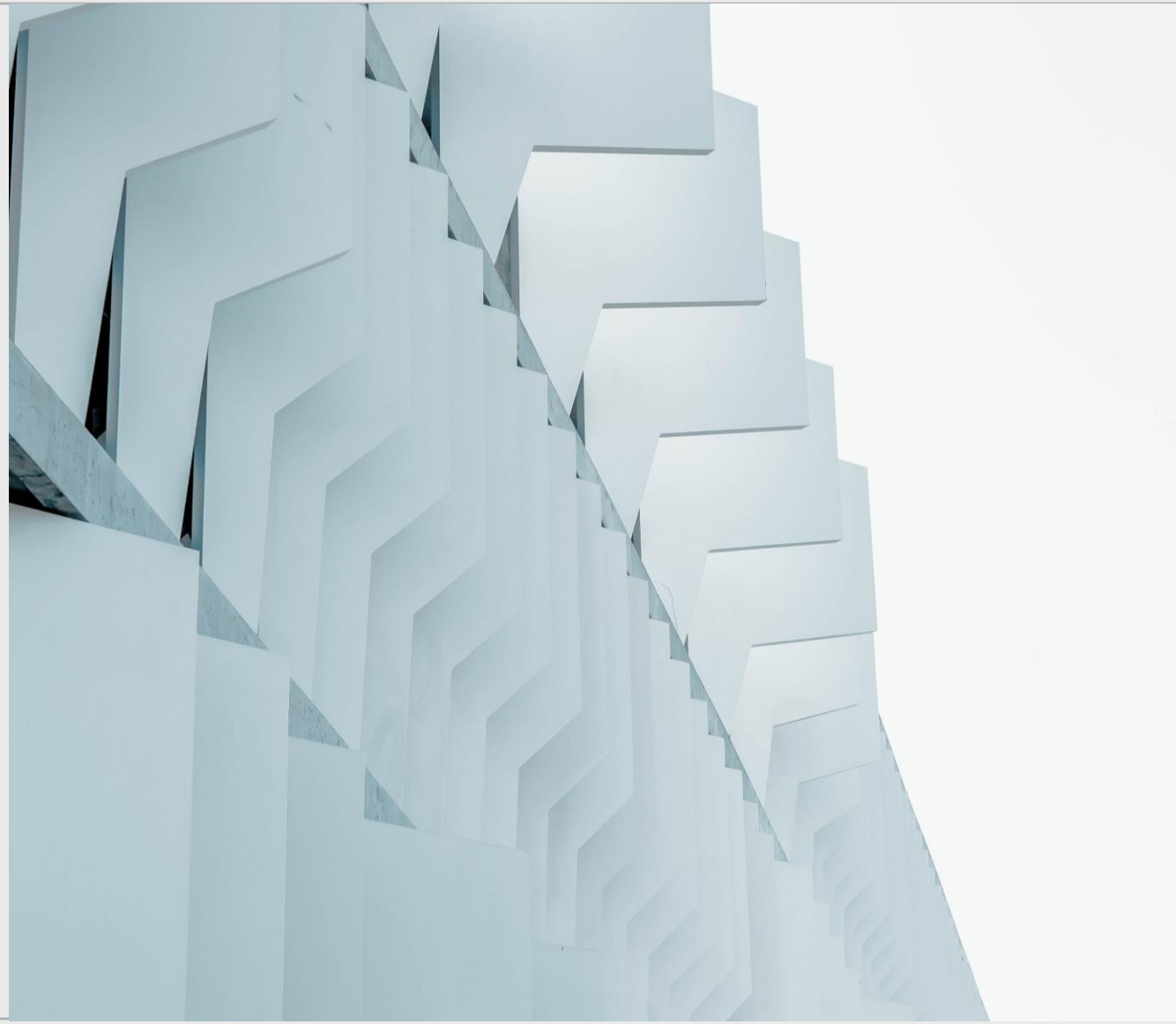
CY2025 Medicare Advantage Proposed Rule

D-SNP, Supplemental Benefits, Part D Formulary, Network Adequacy, and Other Provisions

Revised: November 8, 2023

ATI Advisory



→ Background and Purpose

On November 6, 2023, CMS released its Medicare Advantage and Part D proposed rule: [CMS-4205-P].

Among other things, this Rule addresses dual-eligible special needs plans (D-SNPs) and the role of Medicare Advantage in better serving dual eligible beneficiaries, supplemental benefits, Medicare Advantage enrollment architecture, network adequacy, and equity. Program changes will be implemented beginning in 2025.

This document is intended to provide stakeholders with a summary and insights into key provisions and their market impact on Medicare beneficiaries including dual eligible individuals, providers, Medicare Advantage plans, and states.

Navigate directly to a section of this Rule summary:

SUMMARY OF MARKET IMPLICATIONS FOR KEY PROVISIONS

D-SNP and Dual Eligible Implications

- CMS is continuing to advance Medicare-Medicaid integration and reduce complexity, confusion, and "choice overload"
- Dual eligible individuals in some Medicaid managed care markets would have simplified choice
- D-SNPs and their parent MAOs would face consolidation and new financial considerations in plan design
- States would be better informed on dual eligible individuals' experiences

Supplemental Benefit Implications

- CMS is advancing benefit transparency via expanded requirements around marketing and notifications to beneficiaries of unused supplemental benefits
- Beneficiaries would have access to more information about benefits
- Plans would have increased responsibility for proving that SSBCI are expected to maintain or improve beneficiary health or overall function

Formulary Implications

- CMS is streamlining Part D plans' ability to substitute biosimilars for biologic drugs
- Medicare beneficiaries may see more affordable access to some biologics and/or their biosimilars
- Manufactures of biologics may offer higher rebates to Part D plans for formulary placement over biosimilars, which would keep biosimilar uptake low

Select Additional Provision Implications

- New network adequacy standards for behavioral health could improve access for Medicare beneficiaries; MAOs would have to evolve their provider/facility networks
- Facility-based I-SNPs may have fewer network adequacy barriers due to a new exception request
- CMS would close loopholes in MA/PDP broker payments, which may level the playing field for plans and result in more tailored enrollment support to beneficiaries

KEY DEFINITIONS AND ACRONYMS

CO-D-SNP	Coordination-only D-SNP, a designation for D-SNPs without financial and clinical Medicaid risk for long-term services and supports (LTSS) or behavioral health (BH)
HIDE SNP	Highly-Integrated D-SNP; D-SNP organization also has financial and clinical Medicaid risk for LTSS and/or BH in the state [definition changes detailed in this slide deck]
FIDE SNP	Fully-Integrated D-SNP; D-SNP legal entity also has Medicaid financial and clinical risk LTSS and BH in the state [definition changes detailed in this slide deck]
Exception Request	In this document, a formal request to CMS for an exception to Medicare Advantage network adequacy requirements in a given county and for a given specialty type, if a Medicare Advantage contract is unable to meet the network standards
Exclusively Aligned Enrollment	D-SNPs that only enroll individuals for whom they also have Medicaid financial and clinical risk (e.g., via a companion Medicaid MCO contract)
AIP	Applicable integrated plan, a D-SNP with exclusively aligned enrollment and subject to enhanced integration requirements
Lookalike	Non-SNP Medicare Advantage plan that enrolls a high portion of dual eligible individuals
SEP	Special election period, an enrollment period available to Medicare beneficiaries outside standard enrollment periods such as open enrollment or annual election, associated with personal circumstances or life qualifying events
PPO	Preferred provider organization, a type of health plan that allows enrollees to use out-of-network providers, typically with differential cost sharing based on whether enrollees use in-network or out-of-network providers
Supplemental Benefits	Benefits available through Medicare Advantage that go above and beyond traditional Medicare Part A and B benefits; can include medical, non-medical, and social driver benefits within certain limits
SSBCI	Special Supplemental Benefits for the Chronically Ill; supplemental benefit category introduced by Congress that allows plans to target cost sharing reductions or services and items to individuals with one or more complex chronic conditions, who are at risk of hospitalization and require care coordination

SUMMARY TIMELINE OF SELECT D-SNP AND DUAL ELIGIBLE PROPOSED RULE PROVISIONS

2025
- Lookalike definition threshold reduced to 70%
- Dual eligible special election period policy changes to allow ongoing SEP into FIDE, HIDE, or AIPs, and standalone Part D Plans
- Expanded state access to Medicare Advantage encounters for all dual eligible individuals

2026
- Lookalike definition threshold reduced to 60%
- New out-of-pocket limits applied to PPO D-SNPs

2027
- Lookalike-specific enrollment transition process limited to transitions into D-SNPs only
- D-SNP with Medicaid MCO service area alignment limited to *newly* enrolling dual eligible individuals the D-SNP also served through the affiliated MCO
- Medicare Advantage and Parent Organizations limited to one D-SNP (single plan package) in a service area overlap with its Medicaid MCO

2030
- D-SNP with Medicaid MCO service area alignment limited to only enrolling dual eligible individuals the D-SNP also serves through the affiliated MCO (i.e., must disenroll any unaligned members)

→ CMS is also exploring changes to Medicare Plan Finder, for example adding certain Medicaid benefits covered by an AIP D-SNP. This would not require rulemaking.

SUMMARY TIMELINE OF ADDITIONAL SELECT PROPOSED RULE PROVISIONS

2025

- Biosimilar formulary substitutions beyond interchangeable biological products permitted
- New plan responsibilities (including creation of bibliography) and marketing requirements for SSBCI benefits go into effect
- Outpatient Behavioral Health Specialty Facility Type network adequacy standard added*
- I-SNP network adequacy exception request becomes available
- Agent broker contract and compensation changes go into effect
- Utilization Management committee required to include a member with expertise in health equity
- Utilization Management committee begin conducting annual health equity analysis of prior authorization, and Medicare Advantage plans must publish this analysis
- Update to the Multi-Language Insert [Notice of Availability] to be provided in English and at least the 15 languages most relevant to the State, and in alternate formats for people with disabilities

2026

- Mid-year notice on unused supplemental benefits provision goes into effect, with first notifications mailed between June 30 and July 31

*MA plans are expected to provide sufficient access to providers under the newly created specialty (e.g., MFTs, MHCs) type in January 2024

D-SNP Provisions

PROVISION: LOOKALIKE DEFINITION

CMS would change the percent of dual eligible enrollment at which point a non-SNP is considered a “lookalike,” from 80% currently to 70% in 2025 and 60% in 2026.

Insights and Rule Commentary

- CMS will non-renew or not enter into new contracts with non-SNP plans that project or hit these enrollment thresholds.
- In 2023, 40 Medicare Advantage non-SNPs have dual eligible enrollment between 60 and 70%, and another 30 non-SNPs have dual eligible enrollment between 70 and 80%. This includes a total 145,000 dual eligible individuals.
- California, Minnesota, and Massachusetts have a large share of these newly defined lookalikes.
- Beginning in 2027, CMS will limit lookalike transition processes to transitions into D-SNPs only; lookalikes would still be permitted to use standard crosswalk processes into non-D-SNPs.

PROVISION: SPECIAL ELECTION PERIOD

CMS would change the current quarterly dual eligible SEP with two new monthly SEPs: one allowing dual eligible individuals and those with a low-income subsidy to choose a standalone PDP (switch PDPs or leave their MAPD for traditional Medicare plus a standalone PDP), and another to allow dual eligible individuals to choose an integrated D-SNP.

Insights and Rule Commentary

- Dual eligible individuals would no longer have a quarterly SEP to enroll into a non-integrated Medicare Advantage plan or D-SNP (impacting approximately one million partial benefit dual eligible individuals and LIS eligible beneficiaries).
- CMS is considering modifying the enrollment effective date associated with the integrated SEP, to allow states to align enrollment effectuation dates between Medicare and Medicaid.
- CMS notes the prior quarterly SEP created confusion, subjected dual eligible individuals to concerning marketing and sales tactics, and did not facilitate integrated experiences.
- Approximately 5 percent of plans that can currently using the quarterly dual eligible SEP would be eligible for the new integrated SEP.

PROVISION: EXPANDED STATE ACCESS TO MEDICARE ADVANTAGE ENCOUNTERS

CMS would expand states' permissible use of Medicare Advantage encounter data, specific to dual eligible individuals. States would be able to use encounter data to support their Medicaid program, regardless of whether the Medicare Advantage plan is D-SNP or another type of Medicare Advantage plan.

Insights and Rule Commentary

- CMS notes states can use these data for effective care coordination, conduct quality improvement activities, support program design, conduct evaluations, target community outreach, and improve Medicaid administrative efficiencies.
- States would have access to these data prior to risk adjustment reconciliation to allow for more real-time application of the encounters data.

PROVISION: PPO D-SNP OUT-OF-POCKET LIMITS

PPO out-of-network cost sharing currently can exceed cost sharing that would otherwise occur in Medicare fee-for-service. CMS would limit out-of-network cost sharing for professional services and other specific benefits in PPO D-SNPs, including primary care services, physician specialist services, partial hospitalization, rehabilitation services, chemotherapy, renal dialysis, skilled nursing care, home health services, durable medical equipment, and Part B drugs.

Insights and Rule Commentary

- CMS notes D-SNP PPO enrollment has grown in recent years, with approximately 925,000 enrollees in May 2023, or 17 percent of all D-SNP enrollment.
- Currently, out-of-network cost sharing is typically borne by: states who cover out-of-pocket costs for many dual eligible individuals, dual eligible individuals who do not receive cost sharing support from their state, and safety net providers that are ineligible for state coverage of Medicare cost sharing.

PROVISION: LIMITED D-SNP ENROLLMENT

CMS would limit enrollment into D-SNPs in instances when the D-SNP's Medicare Advantage/Parent Organization or entity within that organization also contracts with a state as a Medicaid MCO enrolling dual eligible individuals in the same service area. Specifically, D-SNP enrollment would be limited to individuals enrolled in the D-SNP's affiliated MCO if there is any overlap in D-SNP and MCO service area.

Insights and Rule Commentary

- CMS notes some markets have a large number of D-SNPs that are not differentiated by benefits or provider networks, creating confusion for dual eligible individuals and leading to unaligned Medicare and Medicaid plan enrollment.
- In 2027, new enrollments into relevant D-SNPs would be limited to dual eligible individuals the D-SNP serves in its Medicaid product; in 2030, all enrollments would be limited to dual eligible individuals the D-SNP serves in its Medicaid product and D-SNPs would be required to disenroll unaligned members.

PROVISION: ORGANIZATIONS LIMITED TO A SINGLE D-SNP

CMS would limit MAOs, their Parent Organizations, or entities that share the Parent Organization to offering a single D-SNP in the same service area as the organization's Medicaid MCO serving full benefit dual eligible individuals, unless a state requires the organization to offer more than one D-SNP (e.g., distinct D-SNPs based on dual eligible individual age).

Insights and Rule Commentary

- An organization can continue to offer multiple D-SNPs if the D-SNPs serve distinct populations.
- CMS would create a new crosswalk exception to allow consolidation and crosswalking across distinct contracts; this exception would not allow crosswalking across different plan types.

SSBCI and Supplemental Benefit Provisions

PROVISION: MA ORGANIZATION RESPONSIBILITIES FOR SSBCI

CMS would require plans offering benefits under SSBCI authority to create a bibliography, made available to CMS upon request, with evidence from the past 10 years that demonstrates an SSBCI benefit has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee.

Plans would also be required to follow their written policies for determining an enrollee's eligibility for an SSBCI when making an eligibility determination and document denials of SSBCI.

Insights and Rule Commentary

- This provision would apply to all benefits offered using SSBCI authority but does not apply to Value-Based Insurance Design (VBID) model authority unless CMMI incorporates this policy into the model.
- CMS could deny MAO bids if the MAO has not demonstrated sufficient evidence justifying an SSBCI benefit; CMS also noted its ability to annually review SSBCI benefits, regardless of whether the benefit was approved in prior years.
- Relevant acceptable evidence would include "large, randomized controlled trials or prospective cohort studies published in peer-reviewed journals, or meta-analyses of the same studies" and must include all literature from the prior 10 years but notes that case studies, Federal policies or reports, and internal analyses can be used in the absence of other evidence.

PROVISION: UPDATING MARKETING PRACTICES FOR SSBCI

CMS would expand existing requirements that plans update marketing practices to clearly list the chronic condition(s) an enrollee must have to be eligible for the SSBCI benefits, indicate that additional eligibility requirements may apply to access the benefits, and adhere to updated font size and the pace of reading in advertisements.

Insights and Rule Commentary

- CMS states that these new disclaimer requirements are intended to ensure that marketing and communications for SSBCI benefits are not misleading or confusing to enrollees who use these materials to make enrollment decisions.
- MAOs would be required to list [up to the top five] chronic condition(s) an enrollee must have for eligibility and note that having those conditions may not be sufficient for accessing SSBCI.
- MAOs would be required to match the formatting and pace used to share plan contact information.

PROVISION: MID-YEAR NOTICE ON UNUSED SUPPLEMENTAL BENEFITS

For all supplemental benefits, CMS would require MAOs to notify members mid-year of the unused supplemental benefits available to them.

Insights and Rule Commentary

- CMS describes this as part of an effort to ensure benefits are not simply marketing tools and individuals are able to equitably access benefits for which they are eligible and which may have influenced their enrollment decision.
- To do this, plans would need to track utilization of benefits at the beneficiary level to identify the unused benefits by individual members and send a notification on unused benefits.
- Plans would have to list the benefits consistent with the EOC, include information on the scope of the benefit, cost-sharing, instructions on how to access the benefit, any applicable network information, and customer service and TTY numbers for additional help.
- For SSBCI, plans must include eligibility criteria, limitations and scope of covered items or services, and provide point-of-contact information for enrollees to ask about or begin the eligibility determination process.

Part D Formulary Provisions

PROVISION: BIOSIMILAR SUBSTITUTION

CMS would permit Part D sponsors to substitute biosimilar products for their reference biologics following a 30-day notice to all enrollees, in addition to a similar rule for substitution of interchangeable biologic products.

Insights and Rule Commentary

- CMS refers to the administration's commitment to competition. The agency positions this policy as improving access to biosimilar and generic products, which are lower-priced than branded alternatives.
- Plans have had the ability to substitute interchangeable biologic products without prior notification to CMS, but that flexibility did not extend to biosimilar products. In addition, biosimilar substitution does not extend to beneficiaries already taking the reference biologic. This proposed rule allows for substitution for all beneficiaries, with some conditions, without prior CMS approval.
- Substituting biosimilars for more expensive branded drugs should result in more affordable out-of-pocket payments for beneficiaries.
- The voluntary nature of substitution means existing rebate dynamics will likely continue. Manufacturers of branded biologics may offer higher rebates to plan sponsors to maintain favorable tier placement relative to biosimilars.
    - Humira, for example, continues to be prescribed over its biosimilars due to the high rebates AbbVie offers, with some sources ranging from 40-60% of the list price.

Network Adequacy Provisions

PROVISION: EXPANDING BEHAVIORAL HEALTH NETWORK ADEQUACY

CMS would create a new behavioral health specialty facility type, "Outpatient Behavioral Health," that combines newly approved behavioral health and substance use disorder providers under one specialty facility type and add the specialty type to network adequacy review.

Insights and Rule Commentary

- The new Outpatient Behavioral Health specialty facility type encompasses Marriage and Family Therapists (MFTs), Mental Health Counselors (MHCs), Opioid Treatment Providers (OTPs), Community Mental Health Centers, and other behavioral health provider types.
- CMS notes this specialty type will be subject to facility criteria rather than provider criteria, partly recognizing the providers included often provide services in facility settings, such as community mental health centers.
- MA plans would be subjected to maximum time and distance network adequacy standards for Outpatient Behavioral Health, but permitted a telehealth credit of 10-percentage points, recognizing the frequency with which these services are provided via telehealth.
- This provision is the latest of CMS' continued efforts to expand behavioral health access for Medicare beneficiaries, with a network adequacy focus aimed at ensuring alignment with newly created benefit categories for services provided by MFTs and MHCs set to take effect January 1, 2024.

PROVISION: IMPROVING I-SNP NETWORK ADEQUACY

CMS would adopt a new exception request from network adequacy requirements for facility-based I-SNP plans operating on a single contract ID.

Insights and Rule Commentary

- CMS notes that many facility-based I-SNPs have struggled to contract with providers outside their facilities, suggesting that established network adequacy time and distance standards may not be a meaningful way to measure provider network adequacy for enrollees of this plan type, recognizing the beneficiary's "home" is the facility.
- Under this proposal, CMS would consider exception requests from facility-based I-SNPs if:
  - An MA organization offering the facility-based I-SNP submits evidence of its inability to successfully negotiate and establish a contract with a provider, including individual providers and facilities, due to the way enrollees in the I-SNP receive care.
  - A facility-based I-SNP provides sufficient and adequate access to basic benefits through additional telehealth benefits when using specialty telehealth providers in place of in-person providers to fulfill network adequacy standards.
- CMS proposes to add a new contract provision to ensure MA organizations that have received the exception do not submit additional plan benefit packages (PBPs) that are not facility-based I-SNPs to their facility-based I-SNP-only contracts.

Other Provisions

PROVISION: AGENT BROKER COMPENSATION

CMS proposes to modify the contract and compensation requirements for agents, brokers, and third-party marketing organizations (TPMOs) to prevent circumvention of existing compensation caps.

Insights and Rule Commentary

- CMS notes that consolidation, complaints of brokers being paid more than the maximum allowed, and amounts being paid outside the umbrella of “compensation,” including administrative or add-on payments that are above fair market value, led the agency to propose these changes.
- CMS proposes a broad provision to prohibit any contract terms that would interfere with an objective assessment and recommendation of a plan that best fits a beneficiary's health care needs.
- The definition of compensation would be expanded to include administrative payments, as well as all payments tied to enrollment, related to an enrollment in an MA plan or product, and for services conducted as part of the relationship associated with the enrollment into an MA plan or product. Accordingly, CMS proposes to increase the current compensation cap by $31.
- The compensation cap would apply to rates paid by all plans, including when the payments are made through a field marketing organization (FMO).

PROVISION: HEALTH EQUITY ANALYSIS OF UTILIZATION MANAGEMENT

CMS would create an additional requirement for MA Utilization Management (UM) Committees to include at least one member with expertise in health equity and conduct an annual analysis and report on the intersection of health equity and the plan's use of PA policies and procedures.

Insights and Rule Commentary

- CMS' proposal cites specific education, credential, and professional experience requisites for use when determining a prospective member's health equity expertise for UM Committees.
- CMS specifics that the annual analysis and report examine the impact of PA at the plan level and compare PA use among enrollees with at least one specified social risk factor (SRF) and those without to identify disparities, with SRFs defined in the rule as (1) receipt of the low-income subsidy, or dual eligible for Medicare and Medicaid, or (2) having a disability.
- CMS requested feedback on whether additional populations, such as racial and ethnic communities, the LGBTQ+ community, individuals with limited English proficiency, or rural communities should be added as SRF for purpose of the required analysis and report.

PROVISION: LANGUAGE TRANSLATION NOTICE UPDATES

CMS proposes to amend its current Multi-Language Insert (MLI) regulation to replace references of MLI with “Notice of Availability” and to require that the Notice of Availability be provided in English and the 15 languages most commonly spoke by individuals with limited English proficiency (LEP) of the relevant state as well as alternate formats for individuals with disabilities.

Insights and Rule Commentary

- In addition to the 15 languages most commonly spoken in a state, plans must also provide a translated Notice of Availability in any language spoken by more than 5% of a specific service area.
- Prior MLI regulations combined with certain state requirements (particularly for programs serving dual eligible individuals) often resulted in lengthy, confusing, and distracting LEP translation notices within enrollee materials.
- CMS anticipates that the updated Notice of Availability provision will streamline LEP efforts by plans, enhance the accessibility of the notice, and increase the overall ability of individuals to understand the benefits available to them and make informed healthcare decisions.

Select ATI Advisory resources on dual eligible individuals and Medicare Advantage:

- Medicare-Medicaid Integration Program Design
- State Resource Center
- Supplemental Benefits Resource Center

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Questions about how we can help? info@atiadvisory.com