

## Publications

# 2025 Medicare Advantage and Part D Proposed Rule: What's New for 2025?

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In early November, the Centers for Medicare and Medicaid Services (“CMS”) published the [contract year 2025 proposed rulemaking](#) (“Proposed Rule”) for Medicare Advantage (“MA”) and Part D sponsors. The Proposed Rule previews potential substantive and technical changes to MA and Part D including coverage for expanded access to behavioral health provider types, changes to the risk adjustment data validation (“RADV”) appeals process, adjustments to special supplemental benefits for the chronically ill (“SSBCI”), and stricter controls around agent and broker compensation. The Proposed Rule continues this Administration’s focus on health equity; in this rule, focusing on health equity and another hot topic—utilization management (“UM”)—and how UM may impact health equity. The Proposed Rule also extends CMS’s push toward integrated care for “dually eligible” individuals—those eligible for both Medicare and Medicaid benefits. The following is a brief summary of some of the Proposed Rule’s notable changes.

## Expanding Network Adequacy Requirements for Behavioral Health

To address the significant supply side challenges for behavioral health, the Consolidated Appropriations Act, 2023 (“CAA 2023”) enabled Medicare Part B to reimburse services furnished by a Marriage and Family Therapist (“MFT”) or Mental Health Counselor (“MHC”). CMS published a [final rule](#) implementing these changes for Medicare Fee for Service on November 16 (“CCA Final Rule”).

Consistent with the CAA 2023 and the CAA Final Rule, the Proposed Rule adds “Outpatient Behavioral Health” as a new type of facility specialty, subject to time-and-distance requirements for network adequacy and allows the term to include MFT, MHC, Opioid Treatment Program providers, and community mental health centers and certain other providers. The Outpatient Behavioral Health specialty type also

would be eligible to receive a 10% credit for the percentage of enrollees who reside within the time-and-distance standards when the MA plan includes one or more telehealth providers of that specialty.

## Changes to an Approved Formulary

Under current policy, Part D plans are required to obtain CMS’s explicit approval for a midyear formulary change when a reference product is replaced with a biosimilar biological product that the FDA has not deemed to be interchangeable. Even if approved, the Part D plan is permitted to apply the substitute only to enrollees who begin therapy after the effective date of the change.

The Proposed Rule, if finalized, would permit Part D plans to substitute an FDA-approved biosimilar biological product, which has not been deemed interchangeable, for a reference product as a maintenance change. A maintenance change permits the substitution to apply to all enrollees, including those who have already begun therapy, after a 30-day notice. CMS proposed that the replacement product must be placed on the same or lower cost-sharing tier as the reference product that it replaces or the replacement product will be subject to negative formulary changes.

**GROOM INSIGHT:** CMS expressed this policy shift would enable Medicare enrollees to more timely access cheaper therapeutically equivalent drugs, further Part D plans’ efforts to lower costs, and overall support competition in the prescription drug marketplace. CMS also noted this proposal would better align Medicare requirements with State pharmacy practices.

## Standardization of MA RADV Appeals Process

The Proposed Rule would revise the RADV audit appeal requirements to “standardize and simplify” the process. The changes follow the [finalization of the RADV audit final rule](#), which may increase the frequency and intensity of RADV appeals given the potential extrapolation of audit findings. The Proposed Rule would require Medicare Advantage Organizations (“MAOs”) to exhaust all levels of appeal—reconsideration, hearing officer, and CMS Administrator—for medical record review determinations *before* the MAO could pursue the payment error calculation appeals process. The Proposed Rule also would require MAOs to identify all disputed Hierarchical Condition Categories (“HCCs”) in an audit report; in effect, an MAO could submit only one medical record review determination per audited contract.

**GROOM INSIGHT:** Payment calculations are based on medical record review determinations, so requiring a complete and accurate medical record review before proceeding to payment error issues should streamline the process for MAOs.

## SSBCI

The Bipartisan Budget Act of 2018 permits MA plans to offer SSBCI to eligible chronically ill enrollees. An item or service offered as an SSBCI must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. CMS has had the burden of generating evidence to determine whether the “reasonable expectation” standard has been met, but the Proposed Rule seeks to shift the burden on the MAO. Specifically, the Proposed Rule would:

- Require an MAO to demonstrate through relevant acceptable information that an item or service offered as SSBCI has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee;
- Clarify that an MA plan must follow its written policies based on objective criteria to determine an enrollee’s eligibility for SSBCI;
- Require that the MA plan document its denials of SSBCI eligibility (rather than approvals);
- Codify that CMS may deny approval of an MAO’s bid if the MAO has not demonstrated that its proposed SSBCI meets the “reasonable expectation” standard; and
- Codify CMS’s authority to review SSBCI offerings annually for compliance.

Further, the Proposed Rule seeks to improve transparency by implementing new policies for the SSBCI disclaimer that MAOs offering SSBCI use when SSBCI is mentioned.

To address concerns that the utilization of supplemental benefits is low, despite an increase in the number of MA plans offering supplemental benefits, the Proposed Rule also would require MA plans to provide a mid-year notice to enrollees, between June 30 and

July 31, of any unused supplemental benefits available to them that they did not use during the first six months of the year. CMS seeks comment on this proposal, particularly on the timing, if any, of the notice for enrollees who enroll in the plan mid-year.

## Annual Health Equity Analysis of Utilization Management (“UM”) Policies and Procedures

Beginning in January 2024, MAOs must have a UM committee—as required by [the contract year 2024 MA/PDP rulemaking](#). The Proposed Rule would require the UM committee to include at least one member with expertise in health equity, such as “experience conducting studies identifying disparities amongst different population groups.” The UM committee also would be required to conduct an annual health equity analysis of the MA plan’s use of prior authorization on enrollees with one or more of the following social risk factors): (1) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid; or (2) having a disability. The Proposed Rule specifies particular metrics for the health equity analysis (aggregated for all items and services), as follows:

- The percentage of standard prior authorization requests that were approved;
- The percentage of standard prior authorization requests that were denied;
- The percentage of standard prior authorization requests that were approved after appeal;
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;
- The percentage of expedited prior authorization requests that were approved;
- The percentage of expedited prior authorization requests that were denied;
- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations; and
- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations.

The MA plan also would be required to post the health equity analysis on its public website. CMS seeks comment on whether additional communities, such as LGBTQ+, limited English proficiency, or other persons should be included in the health equity analysis and how to define what constitutes expertise in health equity.

## Agent and Broker Compensation

CMS cited a chorus of concerns from enrollee advocates, States, and smaller plans that large, national parent organizations have a competitive advantage (based on both contract terms and compensation models that leverage “administrative expenses”) to exceed enrollment and renewal compensation limits. In light of those concerns, CMS proposes three changes to agent/broker compensation and contracts:

- CMS would prohibit contract terms between MAOs and agents, brokers, or other Third-Party Marketing Organizations that “may interfere with the agent’s or broker’s ability to objectively assess and recommend the plan which best fits a beneficiary’s health care needs.”
- CMS would establish a single compensation rate for all plans and revise what is considered “compensation.” Specifically, the Proposed Rule would eliminate variance in compensation paid by plans; all agents and brokers would be paid the same amount whether from the MA plan or field marketing organization (except for referral payments). Further, the concept of “compensation” would extend to cover all agent-beneficiary activities, such as responding to follow-up questions during the year or gathering additional information to assist the beneficiary.
- Third, CMS would eliminate the separate regulatory provision for “administrative payments” because of concerns that such payments “effectively circumvent the Fair Market Value (“FMV”) caps on agent and broker compensation.” Any administrative payment would be a component of the standardized, capped compensation paid to agents and brokers. Beginning in 2025, the FMV compensation would include a \$31 amount to account for the administrative payment changes. That amount would be updated annually.

## Dual Eligibles

The Proposed Rule continues CMS's push toward integrated care for dually-eligible individuals by proposing new monthly special enrollment periods for standalone prescription drug plans and certain integrated care plans ("D-SNPs") available to dual-eligible and low-income subsidy ("LIS") individuals. CMS would also limit cost-sharing in certain D-SNPs and gradually lower the enrollment threshold for MA plans that enroll dual-eligible individuals before the MA plan is considered a D-SNP "look-alike" plan.