2025 Medicare Advantage Reforms: A Comprehensive Shift Towards Equity, Transparency and Patient-Centered Care

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The Centers for Medicare & Medicaid Services (CMS) continues to build upon its strategy to support person-centered, value-based care through the 2025 Medicare Advantage and Part D programs proposed rule. These proposals, a bold stride towards enhancing health equity, transparency, and patient-centric care, promise to enhance the contours of the Medicare Advantage (MA) industry, impacting everything from behavioral health access to agent compensation.

In this article, we'll explore:

- Improving access to behavioral healthcare providers
- Mid-year enrollee notification of available supplemental benefits
- Enhancing guardrails for agent and broker compensation
- New standards for supplemental benefits for the chronically ill
- Annual health equity analysis of utilization management policies and procedures
- Enhancing enrollees' rights to appeal a Medicare Advantage plan's decision to terminate coverage for non-hospital provider services
- Increasing percentage of dual- eligible managed care enrollees who receive integrated Medicare and Medicaid services
- Limiting out-of-network cost-sharing for D-SNP PPOs
- Standardizing Medicare Advantage plan risk adjustment data validation (RADV) appeals process

Improving Access to Behavioral Healthcare Providers

One of the biggest changes within the 2025 Advance Notice is that CMS proposed adding "Outpatient Behavioral Health" as a new provider facility / specialty type for network adequacy requirements; this marks a substantive change for MA plans. Within this new provider classification, CMS added a series of new provider license types that plans will use to meet network adequacy standards for behavioral health. The providers include opioid treatment program (OTP) providers, community mental health centers, marriage and family therapists (MFTs) and mental health counselors (MHCs), which previously hadn't been eligible to provide services under Medicare. CMS intends this initiative to not only generally

increase access, but also to broaden the spectrum of behavioral health services within MA. This initiative aligns with CMS's behavioral health strategy of enhancing access to care in substance-use disorder prevention and treatment, among other critical areas.

In addition to adding these provider types, CMS is also providing, in certain situations, a 10% credit for providers offering telehealth services in this specialty. This not only validates the significance of behavioral health, but also continues to recognize the growing role of telehealth.

In response to the need for additional behavioral health services, MA plans should assess how expanding their provider networks to include the new provider categories may enhance their member care, service levels, member satisfaction and ultimately member retention. Plans may want to take advantage of this new flexibility and institute a rapid contracting effort the first half of 2024. This involves developing credentialing criteria and contracting with OTP providers, community mental health centers, MFTs, and MHCs. Plans need to assess current network adequacy with currently available license types (LMSW, LPC, LPCC, PhD) and identify areas and license types for expansion to meet the new CMS standards. Additionally, with the potential of a 10% credit for telehealth providers in this specialty, MA plans should actively integrate specific behavioral health telehealth services into their plans. This includes partnering with telehealth providers, investing in technology infrastructure, and training staff and providers in telehealth delivery.

Mid-Year Enrollee Notification of Available Supplemental Benefits

The proposed rule would require MA plans to issue an annual, personalized mid-year notification to enrollees informing them of any supplemental benefits not used during the first half of the year. This notification would include a list of unused benefits, the scope of each benefit, cost-sharing details, instructions on how to access the benefits, network application information, and a customer service contact.

CMS intends to address the low utilization rates of supplemental benefits, despite their significant availability and expansion in MA plans. In 2023, a substantial amount of MA funds, amounting to $61 billion, was directed towards these benefits. However, reports suggest that many of these benefits are underutilized by enrollees. This underutilization raises concerns about the efficient use of Medicare funds and the potential missed opportunities for improving beneficiaries' health outcomes and addressing social determinants of health.

By requiring MA organizations to conduct proactive outreach to enrollees about available supplemental benefits, CMS aims to ensure that beneficiaries are fully informed about their benefits. This requirement will lead to better decision-making, increased utilization of beneficial services, and potentially improved health outcomes.

While the advantages for beneficiaries are clear, MA plans must be cognizant of potential impacts. An increase in utilization necessitates an assessment of the costs associated with supplemental benefits.

Plans should anticipate and prepare for 100% utilization, rather than a smaller segment of beneficiaries who may be more informed and proactive in leveraging these offerings.

Additionally, plans will require the implementation of another communication method with beneficiaries, potentially through an Explanation of Benefit or a similar type of document. This will require extra costs and operational efforts, particularly in tracking benefits through the claims experience. It is crucial for plans to proactively engage with their less-traditional supplemental benefit providers to ensure that the reporting requirements for utilization are adequate and effective. This move is clearly a step towards ensuring supplemental benefits are not just used as marketing tools but are effectively communicated and utilized to enhance patient care.

Enhancing Guardrails for Agent and Broker Compensation

The proposed rule responds to concerns that some MA plans may compensate agents and brokers in ways that could lead to inappropriate steering of individuals into plans that do not align with their needs. These concerns arise from the potential for financial incentives to drive agents to favor certain plans, possibly misaligning with beneficiaries' best interests.

Central to the proposed rule and echoing the theme of beneficiary protections, CMS proposes the establishment of a uniform compensation rate of $632 for all MA enrollments, an increase from the current national cap of $601. This standardization aims to address the issue of payment variability, which has been linked to biases in plan recommendations. By fixing a uniform rate, CMS seeks to ensure that agents and brokers prioritize the healthcare needs of beneficiaries over potential financial gains.

In addition to setting a uniform rate, the proposed rule targets the elimination of additional compensation tactics, including administrative payments and bonus arrangements often used by large plans for directing beneficiaries toward certain plans. The rule proposes a broader definition of "compensation" to encompass all activities associated with the sales and enrollment of a beneficiary into an MA or Part D plan. This redefinition is designed to close loopholes that have allowed inflated and inconsistent payments, and to mitigate the risk of biased plan recommendations.

These administrative payments are more than just ways to induce enrollment, they’re also a tactic that plans use to further their needs in the D-SNP health risk assessment (HRA) space as well as scheduling risk adjustment coding visits with in-home providers completing HRAs. In recent years, incentives such as those offered by large nationals, have been instrumental in driving agent and broker engagement in HRA and risk adjustment activities. These incentives ranged from increased monetary compensation for obtaining completed HRAs to additional fees for certain plan enrollments, all aimed at increasing the volume of HRAs.

The rule aims to prohibit certain contract terms between MA organizations and marketing intermediaries, like field marketing organizations. These terms have historically resulted in volume-based bonuses or other incentives tied to enrolling beneficiaries in specific plans, potentially interfering with the agents' or brokers' ability to assist enrollees in finding the best-suited plans.

The impact of these changes on the MA market is expected to be substantial. Agents and brokers, as well as MA plans, will need to adjust their strategies and business models to align with the new compensation structure. The emphasis on standardized and transparent compensation is anticipated to foster a more beneficiary-centric approach in plan recommendations.

The proposed changes are clearly in response to growing concerns about anti-competitive practices and the alignment of agent and broker incentives with beneficiary needs. These changes reflect increasing complaints about marketing practices and beneficiary confusion in the MA market.

New Standards for Special Supplemental Benefits for the Chronically Ill

The proposed rule shifts the burden of proof for special supplemental benefits for the chronically ill (SSBCI), requiring MA organizations to demonstrate through acceptable evidence that their offerings improve or maintain the health of chronically ill enrollees. Previously, CMS had the responsibility to determine whether SSBCI items and services met the legal threshold of having a reasonable expectation of improving the health or overall function of chronically ill enrollees. This includes maintaining bibliographies of relevant research and documenting denials of SSBCI eligibility. MA plans will be required to establish and maintain bibliographies of relevant research studies or data to demonstrate that an SSBCI meets the requirements.

In a move to enhance transparency and fairness, the proposed rule would require MA plans to document denials of SSBCI eligibility rather than approvals. This shift aims to ensure that SSBCI is implemented in an evidence-based, non-discriminatory manner.

Additionally, the proposal introduces changes to prevent misleading marketing related to these benefits. This includes expanding the SSBCI disclaimer to clarify the eligibility requirements for beneficiaries and ensuring that enrollees are not misled about their eligibility for these benefits due to the statutory definition of “chronically ill enrollee.”

These changes are expected to enhance the quality and relevance of SSBCI offerings, making sure they are genuinely beneficial for enrollees. By requiring solid evidence for the efficacy of these benefits and improving transparency in their marketing, CMS aims to ensure that SSBCI offerings truly serve the needs of chronically ill patients and are not just used as a marketing tool.

Annual Health Equity Analysis of Utilization Management Policies and Procedures

If finalized, the proposed rule would require MA plans to undergo an annual health equity analysis of utilization management (UM) policies, particularly concerning prior authorization. This would involve analyzing the impact of these policies on beneficiaries with social risk factors and ensuring that at least one member of the UM committee has expertise in health equity (educational qualifications or experience in identifying and addressing disparities among different population groups). This proposal emphasizes the need for a health equity lens in utilization management practices, with particular focus on prior the authorization processes.

MA organizations will be obligated to conduct an annual analysis of prior authorization policies and procedures, assessing the impact on enrollees with social risk factors such as receipt of the Part D low-income subsidy, dual eligibility for Medicare and Medicaid, or having a disability. This analysis must include specific metrics such as approval and denial rates of prior authorization requests, as well as the average and median time elapsed between the submission of a request and the plan's decision. The results of these health equity analyses must be made publicly available on MA organizations' websites. This requirement aims to enhance transparency and facilitate external evaluation and research based on these analyses.

This proposal reinforces current healthcare trends in the prioritization of equity and inclusivity in healthcare services, ensuring that all beneficiaries, regardless of their social risk factors, have fair access to necessary healthcare services. The introduction of these requirements is seen as a significant step towards ensuring that UM practices, particularly prior authorization, do not disproportionately affect underserved and vulnerable populations. By mandating health equity analyses, CMS is emphasizing the need for MA plans to be accountable for the potential impacts of their policies on health equity.

The requirement for public disclosure of these analyses is seen as a move towards greater transparency in healthcare operations, allowing for external scrutiny and research, which could lead to more informed policy development in the future.

This proposed rule dovetails with CMS' stated mission to transform Medicare with one central objective: to ensure equitable healthcare outcomes for all beneficiaries, particularly low-income seniors and people with disabilities. According to Dr. LaSwhawn McIver, Director CMS Office of Minority Health, "As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a healthcare system that benefits all for generations to come." This is clearly defined in the CMS Framework for Health Equity 2022-2023 and is a road map for the changes that are being seen throughout the Medicare program.

The proposed requirements align with changes CMS introduced with the Star Ratings program for 2027 (with data-gathering starting in 2024) which eliminated the quality bonus payment and implemented the Health Equity Index (HEI). CMS has proposed a requirement for an annual health equity analysis in which plans must critically examine UM policies to identify and address any potential disparities in healthcare access and outcomes. While CMS hasn't yet specified the focus or areas of measure to use to analyze those disparities, plans may want to initially focus those analyses on the same measures CMS used in the Heath Equity Index, namely inequities based on income and disability status.

Since the data measures for the Star Ratings related to the HEI begin to be measured in plan year 2024, plans may choose to combine efforts and start conducting meaningful data analysis on the HEI targeted members to design interventions and simultaneously assess UM and quality assurance policy implications together.

Enhancing Enrollees' Rights to Appeal Decisions to Terminate Coverage

CMS proposes to modify current regulations to allow quality improvement organizations, instead of MA plans, to review untimely fast-track appeals of plan's decision to terminate services in a skilled nursing facility, comprehensive outpatient rehabilitation facility, or by a home health agency. This change is aimed at providing enrollees with equal rights to appeal, similar to those in traditional Medicare. This proposal is a part of CMS's efforts to ensure equitable and fair access to healthcare services for all Medicare enrollees.

Another significant change is the proposed elimination of the provision that currently leads to the forfeiture of an enrollee's right to appeal a termination of services decision when they leave a facility. This means that enrollees will retain their rights to appeal even if they end services prior to the termination date listed on the Notice of Medicare Non-Coverage.

This is seen as an essential step towards ensuring parity in appeal rights between MA and traditional Medicare enrollees. By providing MA enrollees with similar rights to fast-track appeals and removing current barriers, CMS is addressing potential inequities in the appeal process. This is particularly important to ensure that MA enrollees have adequate protection and recourse when facing termination of critical services. The proposed changes align with broader efforts to enhance patient rights and protections within the Medicare program. By standardizing appeal processes and rights across different Medicare programs, CMS is working to ensure that all Medicare beneficiaries, regardless of the type of plan they are enrolled in, have fair and equal access to necessary appeals processes.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Integrated Medicare and Medicaid Services

The CMS 2025 proposed rule is a response to the complex array of enrollment options that dual-eligible members face, focusing on increasing their enrollment in plans that integrate Medicare and Medicaid services. Under the new rule, the previous quarterly special enrollment period (SEP) is replaced with a more flexible monthly SEP. This change is designed to enable dually eligible individuals to align their Medicare and Medicaid plans more easily, which is intended to improve healthcare outcomes and simplify the healthcare experience for this population.

Another significant aspect of the proposed rule is its limitation on enrollment in certain D-SNPs, restricting it to individuals also enrolled in an affiliated Medicaid managed care organization. This aims to streamline service delivery and reduce plan fragmentation, which often can be a source of confusion and inefficiency in delivery and member experience.

This change has been generally seen as positive, recognizing the potential for improved healthcare outcomes for dually eligible individuals. MA plans, particularly those offering D-SNPs, are expected to adapt their strategies to align with these changes. This shifts market dynamics, forcing MA plans to focus more on competing for Medicaid managed care contracts and make operational updates to respond to the new requirements for integrated plans.

These changes could pose challenges for some plans, potentially necessitating significant strategic adaptations. Concurrent with years of enrollment growth in the D-SNP segment, CMS has made a series of significant regulatory changes to increase the level of integration with Medicaid benefits and reduce the prevalence of "D-SNP look-alikes."

In addition to the impact on health plans, these changes are aligned with CMS's goals to address health equity. This includes initiatives such as ensuring that D-SNPs meet integration standards and providing states with new authority to encourage and require integration for dually eligible individuals. The new rule is viewed as a comprehensive effort to improve the healthcare experience for dually eligible individuals, simplifying enrollment processes, enhancing integrated service delivery, and streamlining the healthcare market for these beneficiaries.

Limit Out-of-Network Cost Sharing For D-SNP PPOs

Starting in 2026, this rule proposes a limitation on out-of-network cost-sharing for specific services. This move is a response to several critical needs within the healthcare system.

The rule aims to alleviate the financial burden that often falls on Medicaid when dually eligible individuals seek healthcare services outside their plan's network. Capping the costs that these individuals must bear out-of-network is expected to cap Medicaid's financial load and lead to more balanced healthcare spending.

The proposed rule also underscores a commitment to enhancing support for safety-net providers. These providers are integral to delivering healthcare to underserved populations, including those who are dually eligible for Medicare and Medicaid. By increasing payments to providers, the rule aims to reinforce their capacity to provide essential healthcare services, thus improving the overall health outcomes for these populations.

Another significant aspect of this rule change is its potential to broaden the access of dually eligible enrollees to a diverse range of healthcare providers. This expansion ensures that beneficiaries are not limited in their healthcare choices due to prohibitive costs. Access to a wider network of providers could lead to improved health outcomes, as individuals can seek care that best meets their specific health needs without the constraint of financial barriers.

These policy adjustments align with the goals of President Biden's Competition Council and Executive Order by enhancing beneficiary choice and ensuring access to a robust set of Medicare coverage options for low-income beneficiaries. Protecting dually eligible individuals from high healthcare costs is at the heart of this proposal. The cap on out-of-network cost sharing is a direct measure to shield beneficiaries from high expenses that can arise from necessary healthcare services. This protection is a key step towards ensuring that healthcare is not only accessible but also affordable for one of the most vulnerable segments of the population.

Standardizing Medicare Advantage Plan Risk Adjustment Data Validation Appeals Process

The proposed regulations suggest changes to the MA risk adjustment data validation (RADV) appeals process, aiming to standardize and streamline it. This initiative is part of a broader effort to ensure fairness and efficiency in the audit processes for MA plans.

Currently, plans have the right to challenge RADV audit results, but appeals are limited to either medical record review determinations or payment error calculations. These appeals must be filed within 60 days of receiving the final audit report. The CMS proposal recognizes that this timeframe may not always be practical, especially when challenging both or either aspect of the audit results.

Under the new proposal, if an MA plan is appealing both a medical record review determination and a payment error calculation, it must complete all stages of the medical record review appeals process first. This includes a reconsideration, review by a hearing officer, and an evaluation by the CMS administrator before proceeding to the payment error calculation appeal. This structured process ensures that any recalculation of payment errors due to coding review redeterminations will be accurately reflected in subsequent appeals. Following the completion of these stages, the Medicare advantage organization (MAO) will have an additional 60 days to file an appeal for the payment error calculation after receiving a revised or new final audit report.

Additionally, the proposal suggests that an MA plan forfeits its right to the medical record review appeal if it only files an appeal for the payment error calculation. The proposal also outlines specific guidelines for filing medical record review determination requests, stipulates the finality of decisions by reconsideration officials unless altered or reversed, and details the conditions under which hearing officer decisions become final. Recalculations of payment error rates will be performed once a decision is deemed final.

With the finalization of the RADV rule and CMS set to extrapolate overpayments, this proposal helps MA plans protect their interests. These anticipated changes are designed to simplify the RADV appeal process for both CMS and MAOs, addressing operational challenges across all levels of appeal. While the process may be simplified, plans must understand the appeal process and prepare as CMS places greater emphasis on the repayment process.

As the 2025 Medicare Advantage reforms usher in a new era of equity, transparency, and patient-centered care, ATTAC Consulting Group stands ready to guide your organization through these transformative changes. With our deep expertise in healthcare policy and strategy, we offer tailored solutions to help you navigate the complexities of behavioral health access, agent compensation and integrated services for dually eligible individuals. Contact ATTAC to align your business with these significant reforms, enhance the quality of care for beneficiaries, and seize growth opportunities in a rapidly evolving Medicare Advantage landscape.