Deciphering the 2025 Final Rule: CMS Unveils Sweeping Medicare Advantage Changes

Charles Baker, VP, Compliance Solutions

The Centers for Medicare & Medicaid Services (CMS) ushered in a new era for the Medicare Advantage Part C and Prescription Drug Benefit programs with the unveiling of the Contract Year 2025 Final Rule. This comprehensive regulatory overhaul touches on multiple areas, from data privacy and quality metrics to network adequacy and care coordination, as CMS works toward a more transparent, equitable, and patient-centric healthcare landscape.

ATTAC's compliance experts have reviewed the final rule and present the following high-level analysis of noteworthy changes and potential ramifications for Medicare Advantage Organizations (MAOs).

New Regulations for Third-Party Marketing Organizations

There are substantial regulations for third-party marketing organizations (TPMOs) focused on protecting Medicare Advantage (MA) beneficiaries' personal data.

Key Regulations

- **Explicit Consent Requirement:** TPMOs must now obtain prior express written consent from beneficiaries before sharing personal data. This measure aims to prevent the unauthorized use and dissemination of sensitive information. Plans and field marketing organizations (FMOs) may want to seek clarification about whether or not permission given to an FMO waterfalls downstream to contracted agencies.
- **Protecting Beneficiary Privacy:** By enforcing the consent requirement, CMS is taking a decisive step to safeguard beneficiaries from unsolicited and potentially misleading marketing communications.

Objectives and Implications

- **Empowering Beneficiaries:** The new rule empowers Medicare beneficiaries by ensuring they have a say in who accesses their personal information.
- **Enhancing Transparency and Consent:** The regulations highlight the importance of transparency and consent in the handling of personal data, which is in line with broader societal demands for data protection and privacy.
- **Mitigating Unauthorized Information Sharing:** The consent requirement is designed to curb the unauthorized sharing of personal data, reducing the risk of beneficiaries receiving unwanted solicitations.

This regulatory enhancement has particular impact on MA sales strategies, where the purchase of leads and the operation of tele sales call centers are prevalent. For plans, these changes imply a major shift in how beneficiary data is acquired, shared, and utilized for marketing purposes.

The positive in this new regulation is that it will likely to improve lead quality. By moving away from unconsented contact lists towards opt-in mechanisms, leads will now indicate a beneficiary's genuine

interest. This approach ensures higher value leads, fostering more effective engagements and supporting a trust-based enrollment process.

Health plans may need to revisit strategies around purchasing leads and managing call center operations to achieve compliance with new rules. The requirement for explicit consent could potentially slow the lead generation process, compelling plans to invest more in direct marketing efforts and beneficiary education to encourage voluntary information sharing. Additionally, plans and their downstream marketing partners may need to bolster data management systems to track consent accurately and securely.

Agent/Broker Compensation and Management Adjustments

CMS introduced comprehensive adjustments to the compensation structures for agents and brokers. These adjustments are designed to ensure fairness, transparency and alignment with CMS's statutory obligations, with the goal to prioritize beneficiaries' healthcare needs over potential incentives for higher commissions.

Key Adjustments and Management Changes

- **Compensation Structures:** Adjustments aim to modify existing compensation to prevent undue influence on the enrollment process. This includes implementing limits on the compensation that agents and brokers can receive.
    - CMS is finalizing a policy to make a one-time $100 increase to the fair market value (FMV) compensation rate for initial enrollments. This adjustment reflects a continued focus on ensuring that agents and brokers are adequately compensated for their roles in facilitating enrollments, while adhering to the principles of fairness and transparency.
    - For 2024, the compensation for initial enrollments was set at $611, with renewals at $305. With the proposed $100 increase, the compensation rates for 2025 and 2026 for initial enrollments and renewals, assuming a 2.5% FMV increase in those years, would adjust as follows:
        - 2025 initial enrollment: $726
        - 2025 renewal: $313
        - 2026 initial enrollment: $744
        - 2026 renewal: $372

- **Elimination of Administrative Fees and Bonuses:** CMS hopes to reduce potential conflicts of interest by eliminating administrative fees and performance-based bonuses. This adjustment will help ensure that Medicare Advantage plan selections are driven by the needs and best interests of the beneficiaries, rather than by the potential for agents and brokers to earn additional income. By removing opportunities for agents and brokers to receive variable compensation based on the volume of enrollments or the selection of specific plans, CMS aims to mitigate the risk that financial incentives could unduly influence the enrollment process.

- **Alignment with CMS's Statutory Obligations:** The changes are designed to comply with CMS's obligations under Medicare regulations. The focus is on fostering incentives for enrolling beneficiaries in plans that best meet their healthcare needs, factoring in aspects such as coverage, cost, and provider networks.

- **Oversight and Enforcement:** Enhanced oversight and enforcement mechanisms are likely to be implemented to ensure compliance with the new compensation structures. This could involve more rigorous auditing of MA organizations and Part D sponsors, as well as stricter penalties for violations.

This move is poised to fundamentally alter the landscape of MA plan enrollment, emphasizing a beneficiary-centric approach that supports CMS's objective of delivering high-quality, suitable healthcare coverage.

For health plans, this adjustment necessitates a comprehensive reevaluation of sales strategies and compensation models. To conform with these new requirements, plans will need to implement transparent compensation structures that do not incentivize the promotion of specific plans over others based on potential financial gain for agents and brokers. This should lead to the development of standardized compensation rates for all enrollments, or the introduction of performance metrics that prioritize customer satisfaction and enrollment accuracy over volume.

Plans may need to invest in additional training for agents and brokers so they may guide beneficiaries through the selection process in an unbiased manner, focusing solely on healthcare needs and financial considerations. This may include enhancing oversight mechanisms to monitor agent and broker activities closely, ensuring compliance with the new guidelines and fostering a culture of integrity and transparency in the enrollment process.

Quality and Star Ratings Enhancements

The final rule represents a comprehensive effort to refine and elevate quality measures and management. An important aspect of this initiative is the introduction of the “universal foundation” of quality measures, aimed at harmonizing and standardizing quality metrics.

Key Aspects of the Universal Foundation of Quality Measures

- **Standardization and Alignment:** The initiative seeks to tune quality metrics across CMS programs, focusing on high-impact measures that offer national and global benchmarking capabilities. Examples of these universal foundation measures include:
    - Adult immunization status
    - Depression screening and follow-op for adolescents and adults
    - Social need screening and intervention
- **Broad Applicability**: Measures included in the universal foundation are selected for relevance across diverse populations and healthcare settings, enhancing the identification of care disparities.
- **Encouragement of Digital Quality Measures:** The move towards incorporating digital quality measures represents a forward-looking approach, aiming to modernize and streamline the monitoring and reporting processes.
- **Focus on Health Equity:** By integrating measures that highlight and address disparities in care, CMS emphasizes its strategic initiative of promoting health equity across all beneficiary groups.

Selection Criteria and Implications

- **Scientific Acceptability and Feasibility:** The development of the universal foundation is guided by criteria to ensure that measures are scientifically robust, feasible, and capable of digital computation, without leading to unintended consequences. For example, if quality measures overly focus on the efficiency of care, such as the speed of patient processing and adherence to

specific protocols, providers may prioritize these aspects at the expense of spending adequate time with patients.

- **Impact on Provider Attention and Reporting Burden:** These standardized quality measures are designed to focus provider efforts on crucial care areas while aiming to alleviate the reporting burden.
- **Advancement of Policies for Digital Integration:** The National Committee for Quality Assurance supports these changes, highlighting the importance of embedding digital quality measures into quality ratings and payment programs to enhance care accessibility and equity.

Health plans must undertake a multifaceted approach to align with the integration of the universal foundation of quality measures. This may require plans to enhance their focus and spend on quality improvement initiatives that directly impact the core metrics outlined by the universal foundation. This involves investing in clinical programs and care coordination efforts, as well as optimizing data management and analytics capabilities to ensure accurate collection, analysis, and reporting of relevant data. Addressing health disparities becomes a critical component of this strategy, requiring health plans to develop targeted interventions for underserved and high-risk populations, thereby tailoring services to meet diverse beneficiary needs and improve access to care.

Operational and Administrative Adjustments

Critical operational and administrative adjustments focus on the risk adjustment data validation (RADV) appeals process and the definitions surrounding network-based plans, including private-fee-for-service (PFFS) plans. These adjustments are designed to streamline operations, bolster program integrity, and enhance beneficiaries' access to comprehensive network coverage.

Key Changes

- **Sequential Appeal Process:** MAOs are required to follow a specified sequence in the appeal process, starting with appeals for medical record review determinations and subsequently moving to payment error calculation appeals if necessary. This sequential approach ensures the orderly processing of appeals and helps avoid procedural bottlenecks.
- **Three Levels of Appeal:** There are three distinct levels through which an appeal must progress: reconsideration, hearing officer review, and CMS administrator review. Each level offers an opportunity for MAOs to contest findings with increasing levels of review and scrutiny.
    - **Reconsideration Phase:** At this initial stage, MAOs must clearly specify the HCCs under dispute and provide a rationale for the appeal. A third-party entity, previously uninvolved in the audit, reviews the appeal, offering an independent assessment and, if warranted, recalculates the payment error.
    - **Hearing Officer Review:** Should an MAO contest the reconsideration outcome, it can escalate the appeal to a hearing officer review. This step requires detailed documentation of disputed findings and may include the submission of additional evidence not previously reviewed.
    - **CMS Administrator Review:** As the final appeal level, the CMS administrator's decision whether or not to review serves as the ultimate adjudication of the appeal. The administrator's involvement signifies the appeal's escalation to the highest review level within CMS, stressing its importance and complexity.
- **Operational Adjustments:** The final rule clarifies several procedural aspects, including timelines for appeal submissions, documentation requirements, and specific criteria for advancing through the appeal levels. These adjustments are designed to streamline the appeal process, reducing ambiguity and enhancing operational efficiency for MAOs.

- **Final Agency Action:** Defining specific actions that constitute the final agency action within the RADV audit appeal process is crucial for MAOs. It establishes a clear endpoint to the appeals process, after which the findings and adjustments become binding and enforceable, ensuring procedural closure and clarity for all parties involved.

New Network-Based Plan Definitions

- **Clarification Efforts:** CMS's dedication to clarifying the definitions and requirements for network-based plans extends to PFFS plans, which permit beneficiaries to receive services from any Medicare-approved provider that agrees to the plan's terms.
- **Enhancing Access and Understanding:** By refining the definitions and requirements for network-based plans, CMS seeks to improve beneficiaries' comprehension of plan options and ensure access to adequate network coverage.

Implications

These operational and administrative adjustments necessitate a proactive response by health plans to maintain compliance. Specifically, the standardization of the RADV appeals process requires plans to develop appeals' procedures to conform with the new framework. This may involve updating internal policies, enhancing training for staff involved in the appeals process, securing expert resources to support appeals, and implementing more rigorous internal audits to preemptively address issues that could lead to RADV appeals.

The clarification of network-based plan definitions demands that plans conduct thorough reviews of provider networks to ensure compliance. This may include reassessing provider contracts, enhancing network adequacy monitoring processes, and developing strategies to address any identified gaps in network coverage. Health plans will also need to improve communication for beneficiaries to fully understand the implications of network-based plan choices, thereby enhancing their access to and understanding of healthcare services.

Special Supplemental Benefits for the Chronically Ill

The final rule introduces important enhancements to the special supplemental benefits for the chronically ill (SSBCI). This regulation requires MAOs to substantiate the inclusion of each SSBCI in their bids, with evidence demonstrating potential health benefits for chronically ill enrollees.

Key Requirements

- **Evidence-based SSBCI:** MAOs must compile and maintain bibliographies of research studies or data to demonstrate the efficacy of SSBCIs. This is to ensure these benefits are grounded in current, reliable evidence.
- **Relevant Acceptable Evidence:** This is defined as large, randomized controlled trials, prospective cohort studies, systematic reviews, or similar rigorous studies published in peer-reviewed journals. Evidence must specifically investigate the impact of the item or service on health or overall function.
- **Transparency and Fairness:** MAOs are required to document any denials of SSBCI, ensuring a transparent, evidence-based, and non-discriminatory implementation of benefits.

Efforts to Increase Utilization

- **Mid-year Enrollee Notification:** To combat low utilization of supplemental benefits, CMS requires MAOs to send personalized notifications to enrollees about unused supplemental benefits, including detailed instructions on how to access benefits.

- **Implications:** The policy updates aim to ensure that SSBCIs provide evidence-based health improvements which reach and benefit intended enrollees. By requiring detailed evidence and active communication about benefits, CMS intends to enhance the quality of care and allocate resources responsibly.

Mid-year Enrollee Notification of Available Supplemental Benefits

The rule mandates that plans issue mid-year notifications to enrollees about any unused supplemental benefits, which is meant to improve enrollee awareness of available supplemental benefits and to foster increased utilization of benefits.

Purpose

- **Educating Enrollees:** The primary goal is to inform enrollees about the full range of supplemental benefits available, potentially enhancing their health and wellbeing.
- **Encouraging Utilization:** By informing enrollees of unused benefits, CMS seeks to encourage a greater uptake of these benefits, with enrollees getting the
- maximum value from their plans.

Requirements

- **Personalized Notifications:** Plans must send personalized notifications to each enrollee, detailing the supplemental benefits that have not been utilized in the first half of the year.
- **Content of Notification:** The notification must include comprehensive details about each unused benefit, including its scope, cost-sharing details, instructions on how to access the benefit, any network application information, and a customer service number for additional assistance.
- **Implications:** This policy represents a proactive approach by CMS to bridge the gap between the availability of supplemental benefits and utilization. By mandating mid-year notifications, enrollees will be well-informed about benefits, thereby facilitating better outcomes and more efficient use of healthcare resources.

Annual Health Equity Analysis of Utilization Management Policies and Procedures

Another new requirement is for MAOs to integrate health equity considerations into utilization management (UM) processes.

Requirements

- **Health Equity Expertise:** At least one member of the UM committee must possess expertise in health equity to aid in informed analysis and decision-making.
- **Annual Health Equity Analysis:** The UM committee is required to perform a thorough analysis of how prior authorization policies impact health equity. This includes examining any potential barriers or disparities faced by different population groups within their enrollee base.
- **Public Disclosure:** The findings from the annual health equity analysis must be made publicly available on the MAO's website. This transparency should foster accountability and encourage continuous improvement in addressing health disparities.

Administrative Cost

1. The implementation of these health equity analyses and the integration of health equity expertise into UM committees are associated with an estimated administrative cost of $23.7 million. This would cover ongoing activities such as analyses, operation of the committees,

monitoring and reporting. The expense supports the sustained effort required to continually assess and address health disparities within Medicare Advantage plans, ensuring that the measures remain effective and up-to-date with current health care practices and population needs. This investment will be needed for plans to ensure MAOs effectively incorporate health equity considerations into utilization management policies and procedures.

Implications

This policy furthers CMS's priority to reduce health disparities and promote equitable care access and treatment. By requiring a focused analysis of prior authorization practices through a health equity lens, CMS hopes to identify and mitigate any practices that may inadvertently disadvantage certain groups of enrollees. The requirement for public disclosure of these analyses further enhances transparency, allowing for broader oversight and engagement from stakeholders in the health equity dialogue.

Plans will need to establish and execute robust monitoring and auditing processes to guarantee compliance with prior authorization (PA) policies, effectiveness in achieving intended outcomes, and equitable application. With CMS placing enhanced emphasis on PA practices, it's crucial for plans to invest in comprehensive oversight mechanisms, covering both initial implementation and ongoing operation. Demonstrating the effectiveness of these processes is essential. Additionally, there will be training requirements to ensure staff are well-equipped to adhere to these updated PA policies and oversight practices.

Enhancement of Enrollees' Right to Appeal a Plan's Decision to Terminate Coverage for Non-Hospital Provider Services

There are significant changes aimed at enhancing the rights of beneficiaries regarding appeals for terminated services. Specifically, the regulation mandates that quality improvement organizations (QIOs), rather than MA plans, review untimely fast-track appeals concerning the termination of services in specific settings, such as skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

Purpose

- **Aligning MA Regulations with Traditional Medicare:** This policy is an effort to bring MA regulations in line with those of traditional Medicare, ensuring consistency in the appeals process across programs.
- **Expanding MA Beneficiaries' Rights:** By shifting the responsibility for reviewing certain appeals to QIOs, the rule seeks to provide beneficiaries with an enhanced level of protection and oversight, mirroring the rights afforded to beneficiaries under traditional Medicare.

Requirements

- **QIO Review of Untimely Fast-track Appeals:** When a plan's decision to terminate services is appealed after the timeframe for a standard fast-track appeal, QIOs are now required to conduct the review instead of the plan. This shift will lead to an impartial and thorough review process.
- **Settings Covered:** The requirement for QIO review applies specifically to appeals related to the termination of services provided in skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and by home health agencies.
- **Implications:** This change re-affirms CMS's priority to safeguard the rights and well-being of enrollees by providing an appeals' process that is equitable, transparent, and consistent with the

protections available under traditional Medicare. It reflects a broader effort to ensure that MA beneficiaries have access to necessary services and recourse in situations where service termination may not be in their best interest.

Enhancements to Dually Eligible Managed Care Enrollees' Care Coordination and Protections

New policies are aimed at improving care coordination, accessibility, and affordability for dually eligible individuals—those who qualify for both Medicare and Medicaid services. These changes include modifications to enrollment periods, adjustments in cost-sharing measures for dual-eligible special needs plans (D-SNPs), and new contracting standards for D-SNP look-alikes.

Key Policies

- **Special Enrollment Period (SEP) Adjustments:** The rule replaces the current dual/low-income subsidy quarterly SEP with more frequent opportunities for dually eligible individuals to adjust coverage. This includes the introduction of a new integrated-care SEP designed to streamline access to integrated Medicare and Medicaid services.
- **Limitation on D-SNP PPOs' Out-of-Network Cost Sharing:** For certain Part A and B benefits, D-SNP preferred provider organizations (PPOs) now face limitations on the amount they can charge dually eligible enrollees for out-of-network care. This measure focuses on reducing cost-shifting to Medicaid, with more predictable expenses for enrollees, and support safety net providers.
- **Contracting Standards for D-SNP Look-alikes:** The rule lowers the threshold for what constitutes a D-SNP look-alike, targeting plans that serve a high percentage of dually eligible individuals without adhering to D-SNP requirements. This policy is intended to address the proliferation of plans that may not provide the integrated services or protections typical of D-SNPs.

Objectives and Implications

- **Enhanced Access to Integrated Services:** By facilitating more frequent enrollment adjustments and encouraging integrated-care SEPs, the rule aims to improve access to coordinated health services, reducing administrative barriers for dually eligible individuals.
- **Financial Protections for Enrollees:** The limitations on out-of-network cost-sharing for D-SNP PPOs are designed to protect dually eligible enrollees from unforeseen and potentially unaffordable medical costs, closely aligning with financial protections offered under Medicaid.
- **Greater Program Integrity and Equity:** Adjusting contracting standards for D-SNP look-alikes helps plans serving a significant number of dually eligible beneficiaries meet stringent requirements, promoting higher quality and more equitable care.

These provisions demonstrate CMS's ongoing push to improve the healthcare experience for dually eligible beneficiaries and ensure they have better access to integrated services, financial protections and equitable care.

Medication Therapy Management Program Adjustments

The medication therapy management (MTM) program changes are designed to optimize therapeutic outcomes for Part D beneficiaries, particularly those at higher risk of adverse events due to chronic conditions. By expanding the eligibility criteria to include nine core chronic diseases previously identified in sub-regulatory guidance, and adding HIV/AIDS to this list, CMS's goal is broader access to critical MTM services.

Expansion of Eligibility Criteria

- **Inclusion of Core Chronic Diseases:** The MTM program now formally includes nine core chronic diseases identified by CMS:
    1. Alzheimer's disease
    2. Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
    3. Chronic congestive heart failure
    4. Diabetes
    5. Dyslipidemia
    6. End-stage renal disease
    7. Hypertension
    8. Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
    9. Respiratory disease (including asthma, chronic obstructive pulmonary disease, and other chronic lung disorders)
- **Addition of HIV/AIDS:** Recognizing the complex medication regimens required for managing HIV/AIDS, CMS added this condition to the list of eligible diseases for MTM services. This inclusion highlights the importance of personalized support in managing medications and the potential for MTM services to significantly benefit individuals with HIV/AIDS.

Objectives and Implications

- **Optimizing Therapeutic Outcomes:** The adjustments aim to improve health outcomes by providing personalized medication management support to beneficiaries with specified chronic conditions. This includes making sure that medications are used appropriately, reducing the risk of adverse events, and enhancing the overall effectiveness of treatment plans.
- **Promoting Health Equity:** By expanding access to MTM services for beneficiaries with additional chronic conditions, CMS continues to further its mission to address health equity. These changes recognize the varying needs of Medicare Part D beneficiaries and aim to address disparities in access to essential health services.

By expanding the eligibility criteria for MTM services, CMS is taking a meaningful step towards ensuring that beneficiaries at higher risk due to their health conditions receive the personalized support needed to manage their medications effectively.

Behavioral Health Access Enhancements

There are essential enhancements to network adequacy standards within MA plans, specifically targeting the expansion of outpatient behavioral health services. This strategic move is designed to fill a major gap in access to mental health and substance-use disorder treatments, acknowledging the critical need for a comprehensive approach to behavioral health care.

New Standards for Network Adequacy

- **Introduction of Outpatient Behavioral Health Facility-specialty Type:** CMS added a new facility-specialty type for outpatient behavioral health to its network adequacy standards. This addition is aimed at broadening the spectrum of accessible behavioral health services.
- **Diverse Provider Inclusion:** The enhanced network adequacy standards are set to ensure that enrollees have sufficient access to a wide range of behavioral health providers. This includes marriage and family therapists, mental health counselors, opioid treatment program providers, and specialists in addiction medicine and behavioral health.

Objectives and Implications

- **Meeting the Growing Need for Behavioral Health Services:** The inclusion of a new facility-specialty type for outpatient behavioral health addresses the escalating demand for mental health and substance-use disorder services. This adjustment comes at a pivotal time, as public awareness and understanding of mental health issues and the opioid crisis continue to grow.
- **Adequate Access to Care:** By reinforcing network adequacy requirements with a focus on outpatient behavioral health services, plans need to deliver the necessary support to manage behavioral health conditions. This step is crucial to enhance the overall well-being of beneficiaries and deliver equitable access to vital health services.

The introduction of new standards for network adequacy, particularly for outpatient behavioral health services, showcases CMS's efforts to improve access to behavioral health care for Medicare Advantage enrollees. This initiative makes clear that CMS is most interested in addressing the comprehensive health needs of beneficiaries, promoting health equity, and proactively responding to the growing awareness of mental health challenges and the impact of the opioid epidemic.

The depth of the regulatory changes outlined in the 2025 Final Rule underscore CMS's vision for the future of Medicare Advantage and Part D programs. By tackling issues ranging from data privacy to quality metrics, network adequacy to medication management, CMS is laying the groundwork for a healthcare landscape that prioritizes beneficiary needs, promotes health equity, and fosters a culture of accountability and continuous improvement.

As these reforms take effect, health plans must embrace a proactive mindset, investing in the necessary infrastructure, processes, and expertise to ensure full compliance and, more importantly, to deliver on the promise of high-quality, accessible, and compassionate care for Medicare beneficiaries.

Contact us to learn how ATTAC can help your plan adapt its strategy to align with the 2025 Final Rule.

About ATTAC Consulting Group

ATTAC Consulting Group is nationally recognized as an expert in regulatory interpretation, design, and operation of effective compliance programs for Medicare, Medicaid and commercial health plans, PDPs, ACA plans, ACOs, IPAs, medical groups, dental and vision plans.