RECENT REFORMS TO THE MEDICARE ADVANTAGE PROGRAM, BY POLICY VEHICLE

2024

The annual Medicare Advantage regulatory cycle consists of the Medicare Advantage (MA) and Medicare Part D Rule and the Rate Announcement, which are finalized by the Centers for Medicare & Medicaid Services (CMS) in the spring before the applicable year. The MA and Part D Final Rule and Rate Announcement released in 2024 applied new and revised regulations to the program for contract year 2025 and beyond. The tables below outline key policies included in each and their impact as stakeholders seek to successfully implement these policies in the coming years.

CY 2025 MEDICARE ADVANTAGE AND PART D FINAL RULE

Strengthening Access to Behavioral Health	• Adds a new facility-specialty type "Outpatient Behavioral Health" that includes marriage and family therapists, mental health counselors, opioid treatment programs, or other behavioral health and addiction medical specialists and facilities.
Increasing Oversight of Marketing and Communications Practices	• Prohibits third-party marketing organizations (TPMO) from collecting personal beneficiary data for marketing or enrollment purposes if that data was to be shared with other TPMOs without the beneficiary's written consent. • Finalizes a one-to-one consent structure where TPMOs must obtain written consent for each TMPO that would be receiving beneficiary data. • Updates agent and broker compensation definitions. Note: Implementation of marketing regulations finalized in the CY 2025 final rule, including agent and broker compensation, has been paused in accordance with ongoing legal action.

Implementing New Requirements for the Documentation and Reporting of Supplemental Benefits	• Requires Medicare Advantage Organizations (MAO) to:
	  • Establish a bibliography of evidence that an Special Supplemental Benefit for the Chronically Ill (SSBCI) will improve or maintain the beneficiary's health (applicable for the CY 2025 bid process)
	  • Follow its policies based on objective criteria to determine an enrollee's SSBCI eligibility
	  • Document SSBCI denials and approvals.
	  • Notify beneficiaries midyear of any unused supplemental benefits available to them
	  • List the chronic conditions an enrollee must have to be eligible for an SSBCI
	  • Apply specific font and reading pace parameters for SSBCI disclaimers in advertising
	  • Include SSBCI disclaimers in all marketing and communications materials that mention the SSBCI

Updating Requirements for Utilization Management	• Requires all MAOs that use utilization management (UM) to establish a UM Committee to:
	  • Review and approve all UM policies and procedures at least annually
	  • Ensure consistency with fee-for-service national coverage determinations and local coverage determinations and with relevant Medicare statutes and regulations
	• Updates the composition of and requirements for the UM Committee by requiring:
	  • A member of the UM committee to have expertise in health equity
	  • An annual health equity analysis of prior authorization policies and procedures used by Medicare Advantage plans
	  • MAOs make the analysis results available on their websites

Enhancing Enrollees' Right to Appeal a Medicare Advantage Plan's Decision to Terminate Coverage for Non-Hospital Provider Services	• Ensures that Medicare Advantage regulations align with reviews available in Medicare fee-for-service and to expand Medicare Advantage beneficiaries' ability to fast-track the appeals process connected to terminations in a home health agency, comprehensive outpatient rehabilitation facility, or a skilled nursing facility.
Improving Managed Care for Enrollees in Dual Eligible Special Needs Plans (D-SNP)	• Limits out-of-network cost sharing for D-SNP Preferred Provider Organizations for specific services beginning in 2025 • Lowers the D-SNP look-alike threshold from 80% of dual eligible enrollment to 70% in 2025 and to 60% in 2026 • Beginning in 2027, in states where a parent organization also has a contract with the state to cover Medicaid services for full benefit dual eligibles, limits new enrollment in the parent organization's D-SNP to individuals who are also enrolled in a Medicaid managed care organization with that same parent organization

CY 2025 MEDICARE ADVANTAGE AND PART D RATE ANNOUNCEMENT

Updating Medicare Advantage Payment Factors	• Projects that the FFS growth rate (which is the basis for Medicare Advantage benchmarks) will decrease by 0.16% relative to 2024 • Continues the three-year phase-in of the graduate medical education (GME) adjustment, which was finalized in the CY 2024 Rate Announcement, but will apply 52% of the adjustment in CY 2025, rather than 67% as proposed.
Continuing Phase-In of HCC Model	• Continues phasing-in the 2024 CMS-Hierarchical Condition Category (HCC) risk adjustment model. For CY 2025, CMS will blend 33% of risk scores using the 2020 model and 67% using the updated 2024 model. For 2026 and beyond, 100% of risk scores will be calculated using the updated 2024 model.
Updating Star Ratings Measures	• CMS is considering a "Universal Foundation," or subset of measures that are aligned with CMS's commitment to quality care and value-based strategies. CMS is working to include Universal Foundation measures in the Star Ratings pending future rulemaking.
IRA Part D Redesign Program Instructions	• CMS released a separate document providing guidance on implementation of Part D redesign in 2025. It finalized key policies with additional clarifications regarding changes to true out-of-pocket (TrOOP) cost, the impact of TrOOP changes on Medicare Prescription Payment Plan (MPPP) calculations, beneficiary progression through the deductible, and enhanced alternative plan designs and prescription drug plan (PDP) meaningful difference.