Sent: Tuesday, April 23, 2024 10:45 AM

Subject: CMS Releases CY 2025 Medicare Advantage Final Rule

CPR Members:

Last week, the Centers for Medicare and Medicaid Services ("CMS") finalized the Medicare Advantage Contract Year ("CY") 2025 final rule. You may recall, a whole new set of Medicare Advantage rules were finalized and implemented earlier this year on January 1, 2024. This final rule builds on those now-implemented policies and these finalized regulations will be effective June 3, 2024, **but implemented in next Contract Year beginning Jan. 1, 2025.**

See the Federal Register notice here: Federal Register :: Public Inspection: Medicare Program: Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024--Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, etc.

The CPR Coalition submitted comments in response to the proposed rule in January, and those comments are available HERE.

FINAL RULE SUMMARY

This final rule will revise the Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicare cost plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations to implement changes related to Star Ratings, marketing and communications, agent/broker compensation, health equity, dual eligible special needs plans (D-SNPs), utilization management, network adequacy, and other programmatic areas. This final rule also codifies existing sub-regulatory guidance in the Part C and Part D programs.

Below is a summary of the three most relevant provision of the rule regarding prior authorization, fast track appeals in MA aligning with FFS, and Supplemental Benefits.

Annual Health Equity Analysis of Utilization Management Policies and Procedures:

CMS is finalizing regulatory changes to the composition and responsibilities of the Utilization Management (UM) committee. These policies will require that at least one member of the UM committee have expertise in health equity. These policies will also require that the UM committee conduct an annual health equity analysis of the use of prior authorization at the plan level. The analysis will examine the impact of prior authorization on enrollees with one or more of the following social risk factors ("SRFs"): (i) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid (LIS/DE); or (ii) having a disability. To enable a more comprehensive understanding of the impact of prior authorization practices on enrollees with the specified SRFs at the plan level, the analysis must compare metrics related to the use of prior authorization for enrollees with the specified SRFs to enrollees without the specified SRFs. Finally, the policies will require MA organizations to make the results of the analysis publicly available on their plan's website in a manner that is easily accessible and without barriers.

Enhance Enrollees' Right to Appeal an MA Plan's Decision to Terminate Coverage for Non-Hospital Provider Services:

Beneficiaries enrolled in Traditional Medicare and MA plans have the right to a fast-track appeal by an Independent Review Entity ("IRE") when their covered skilled nursing facility ("SNF"), home health, or comprehensive outpatient rehabilitation facility ("CORF") services are being terminated. Currently, Quality Improvement Organizations ("QIO") act as the IRE and conduct these reviews. Under current regulations, MA enrollees do not have the same access to QIO review of a fast-track appeal as Traditional Medicare beneficiaries in connection with terminations of these types of services. In this final rule, CMS is finalizing proposals to: (1) require the QIO, instead of the MA plan, to review untimely fast-track appeals of an MA plan's decision to terminate services in an HHA, CORF, or SNF; and (2) fully eliminate the current provision that requires the forfeiture of an enrollee's right to appeal a termination of services to the QIO when the enrollee leaves the CORF or SNF or ends HHA services. These finalized policies will bring MA regulations in line with the parallel reviews available to beneficiaries in Traditional Medicare and expand the rights of MA beneficiaries to access the fast-track appeals process in connection with terminations of HHA, CORF, or SNF services.

Mid-Year Enrollee Notification of Available Supplemental Benefits:
In addition, over the past several years, the number of MA plans offering supplemental benefits has increased. The benefits offered are broader in scope and variety and we are seeing an increasing amount of MA rebate dollars directed towards these benefits. At the same time, plans have reported that enrollee utilization of many of these benefits is low. To help ensure MA enrollees are fully aware of all available supplemental benefits and to promote equitable access to care, CMS will now require MA plans to notify enrollees mid-year of the unused supplemental benefits available to them. The notice will list any supplemental benefits not utilized by the enrollee during the first 6 months of the year (January 1 to June 30). Currently, MA plans are not required to send any communication specific to an enrollee's usage of supplemental benefits and CMS believes such a notice could be an important part of a plan's overall care coordination efforts. As finalized, this policy will educate enrollees on their access to supplemental benefits to encourage greater utilization of these benefits and ensure MA plans are better stewards of the rebate dollars directed towards these benefits.

Please feel free to let me know if you have any additional questions or concern.

All the best,