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Deep Dive Webinar: Medicare Part C & D Proposed Rule for 2025

December 4, 2023

Jennifer Podulka, VP of Federal Policy

Valinda Rutledge, EVP of Advocacy & Education

Housekeeping Items

Everyone is welcome to join the conversation.

You can type questions in the Q & A box or raise your hand.

The slide deck will be sent to all registrants.

This webinar will be recorded and sent to all registrants.

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High-level takeaway

The 2025 Medicare Part C & D proposed rule was released November 6, 2023, with comments due January 5, 2024.

CMS's proposals focus on beneficiary protections and avoid significant challenges for clinicians

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Agenda

Topics included in the proposed rule:

- Behavioral health access and network adequacy
- Supplemental benefits
- Agent and broker compensation
- Utilization management and health equity
- Star ratings
- Enrollment and appeals
- Dual-eligible beneficiaries
- Encounter data for Medicare and Medicaid
- RADV appeals process
- Part D formulary changes

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Behavioral health access and network adequacy

Currently, MA networks are required to include: 1) psychiatrists, 2) clinical psychologists, 3) clinical social workers, and 4) inpatient psychiatric facilities.

CMS proposes to add **Outpatient Behavioral Health** as a new specialty type. This group could include:

- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)
- Opioid Treatment Programs (OTPs)
- Community Mental Health Centers
- Physician assistants (PAs)
- Nurse practitioners (NPs)
- Clinical nurse specialists (CNSs)
- Addiction medicine physicians
- Outpatient facilities mental health and substance use treatment facilities

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Supplemental benefits

CMS proposes 3 new key requirements for MA plans that offer supplemental benefits:

- Notifying beneficiaries mid-year of unused supplemental benefits
- Providing CMS with evidence of the efficacy of services selected to include as supplemental benefits for the chronically ill (SSBCI), following policies for determining enrollee eligibility, and documenting denials of eligibility
- Expanding disclaimers regarding SSBCI eligibility to MA marketing materials

Agent and broker compensation

- Congressional focus on use of brokers (especially ghost networks)
- Avoiding broker incentives that would not be in best interests of beneficiaries and potentially anticompetitive by disadvantaging smaller plans
- Changing compensation rates to avoid circumventing current rules
- Prohibiting use of special bonuses on enrollment volume
- Defining payments to include all compensation (eliminate separate administrative payments like fixed costs in travel or training)
- Setting a national FMV compensation rate to include **all** payments and increase MA compensation amount from $611 to $642 in 2025, updating it every year
- Impact will be significant change to broker, TPMO (Third party marketing organizations), FMO (Field marketing organizations), and MAO arrangements

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Utilization management and health equity

- Beginning with 2024/2025 measurement year, contract level data will be collected and scored using SRF (specified social risk factors)
- Concerned about disparity in prior authorization to underserved communities
- UM committee (2024 new requirement) must have one member with health equity expertise by 2025
- Conduct health equity study annually on the use of prior authorizations with specified social risk factors (SRF) like duals or disabilities in comparison to beneficiaries without SRF at the plan level
- Post health equity study on website by July 2025 with approval of health equity UM committee member
- CMS requests comments if other populations (e.g., LGBTQ+, limited English proficiency, rural) should be included in study as well as link submitted to CMS

Star ratings

- Mainly technical changes
- CMS uses MTM (Medication Therapy Management) completion rate for CMR (Comprehensive Medication Review) star rating
  - If previous 2022 proposal to modify is approved will be displayed for 2 years
  - Proposal would include to target 10 chronic disease for MTM
  - **CMS indicated that previous proposed rules can be finalized later**
- A more expanded data review process for MA/Part D sponsors before star rating calculations are done
- Technical changes in calculations of CAI/HEI if plan contracts are consolidated
- CMS continues to move to Universal Foundation measures to align quality measures across all programs (MA, FFS, ACO)

CAI (Categorical Adjustment Index) and Health Equity index (HEI)

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Enrollment and appeals

- Initial coverage election period (ICEP) for MA is modified to begin 3 months before Part A and B enrollment and **end 2 months afterward** to allow more time for decision
- Enrollee right to appeal termination of coverage for non-hospital services like Home Health, SNF, or Rehab:
  - Aligning TM (Traditional Medicare) with MA for appeal rights.
  - Allows MA beneficiaries to access fast track appeal process through QIO (quality improvement organization) when it is untimely (missed deadline to appeal) rather than MA Organization
  - Eliminate automatic forfeiture of appeal when services end before termination date on Non-coverage notice
- If beneficiary is eligible for more than one election period like SEP (special enrollment period), then the MAO or Part D plan must allow beneficiary to choose the election period with the effective date of the election period

Dual-eligible beneficiaries

C-SNP eligibility	• Codify that MAOs must contact the applicant's current physician to confirm the enrollee has the qualifying severe or disabling chronic condition • Require C-SNPs to conduct a post-enrollment confirmation
I-SNP network adequacy	• Establish 2 scenarios for facility-based I-SNPs to request exceptions to network adequacy requirements • 1) Unable to contract with certain specialty types and 2) telehealth in lieu of in-person
D-SNP enrollment	• Replace the quarterly SEP with monthly SEP for PDP enrollment • Create monthly SEP to enroll in integrated D-SNPs • Limit enrollment in certain D-SNPs to individuals enrolled in affiliated Medicaid MCO, beginning in 2027 • Limit D-SNP PBPs offered in the same service area as an affiliated Medicaid MCO, beginning in 2030

C-SNP (chronic condition special needs plan), MAO (MA organization), I-SNP (institutional SNP), D-SNP (dual-eligible SNP), SEP (special election period), MCO (managed care organization)

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Dual-eligible beneficiaries

CMS proposes additional policies to promote integrated care in D-SNPs:

- D-SNP look-alike plans
  - D-SNP look-alike plans are non-D-SNPs with 80% or more enrollment comprised of dual eligible
  - Reduce the definition to 70% for 2025 and 60% for 2026 and later
  - Starting in 2027, plans could only transition dual-eligible beneficiaries into D-SNPs
- D-SNP PPO out-of-network cost sharing
  - Concerns with high out-of-network cost sharing in D-SNPs, which can lead to payment cuts for providers
  - Cap out-of-network cost sharing for certain benefits, such as professional services, including PCPs, specialists, inpatient hospitalization, inpatient psychiatric care, partial hospitalization, and rehabilitation, beginning in 2026

Dual-eligible beneficiaries

CMS seeks stakeholder feedback for future rulemaking:

- Feasibility of requiring integrated D-SNPs to contract with state Medicaid enrollment brokers to manage eligibility and enrollment
- Adding a limited number of Medicaid-covered benefits to the Medicare Plan Finder for applicable integrated plans

Encounter data for Medicare and Medicaid

CMS proposes changes to the use of MA encounter data to improve care coordination for dually-eligible beneficiaries:

- Permit CMS to use and release of MA encounter data – prior to reconciliation – for Medicare, Medicaid, or both
- CMS anticipates that MA encounter date would generally be released to the states

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RADV appeals process

CMS proposes to require MAOs follow a sequential process to appeal RADV decisions.

- First, an MAO may request a **medical record review determination**,
- Then the MAO must wait until the appeal process is completed before requesting a **payment error calculation appeal**
- If the organization appeals the payment error calculation decision, the decision from the medical record review determination appeal will not be considered final until the payment error calculation appeal is complete.

Part D formulary changes

- Biosimilar formulary changes
  - + “biosimilar biological product” in addition to “interchangeable biological product”
  - “Maintenance change” = removal of a reference biologic from a formulary when biosimilar biological product is added, regardless of whether FDA classifies as interchangeable
- Electronic prescribing standards
  - Part D sponsors are required to support the Part D e-prescribing program transaction standards as part of their electronic prescription drug programs
  - Require updated software and standards, per ONC regulations, by January 2027
- Drug management program improvements
  - Replace “active cancer-related pain” with “cancer-related pain”
  - Require plans to send a second notice within 3 days to enrollees originally identified as “at risk” but later identified as exempt, even if that occurs less than 30 days from the initial notice

What's next?

- APG will submit a comment letter by January 5, 2024
- APG members are invited to participate in a focus group to share feedback, December 19 at noon ET
- APG members can also provide feedback by contacting Jennifer Podulka at Jpodulka@apg.org or Valinda Rutledge at Vrutledge@apg.org
- CMS will release the 2025 MA Advance Notice by early February

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