



• COVELL CONSULTANTS, LLC •

MARK
COVELL

ALL I EVER WANTED
TO DO WAS
SELL INSURANCE

THE FINAL RULE 2025

A large, red, distressed stamp with a double-line border. The text inside the stamp is in a bold, sans-serif font, arranged in two lines: "KNOW THE" on the top line and "RULES!" on the bottom line. The stamp has a weathered, ink-like texture.

**KNOW THE
RULES!**

On April 4, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule that revises the Medicare Advantage and Part D programs in significant ways (**The Final Rule**). The Final Rule stems from the CY 2025 Medicare Advantage and Part D proposed rules issued in November 2023 and CY 2024 Medicare Advantage and Part D proposed rules published on December 14, 2022. It continues the trend of regulatory enhancements to the Medicare Advantage and Part D programs and in practice creates additional administrative requirements for Medicare Advantage organizations (MAOs) and Part D plans.

<https://www.reedsmith.com/en/perspectives/2024/04/cms-finalizes-medicare-regulatory-changes-significant-impact-maos>



**Now for
the Rest of
the Story!**

THE STAY

On July 3rd a federal court in Texas stayed provisions of the Centers for Medicare & Medicaid Services' ("CMS") contract year 2025 Final Rule that amended the longstanding Medicare Advantage ("MA") and Part D agent and broker compensation methodology and prohibited certain terms in contracts with third party

BASIS OF THE STAY

THE FINAL RULE

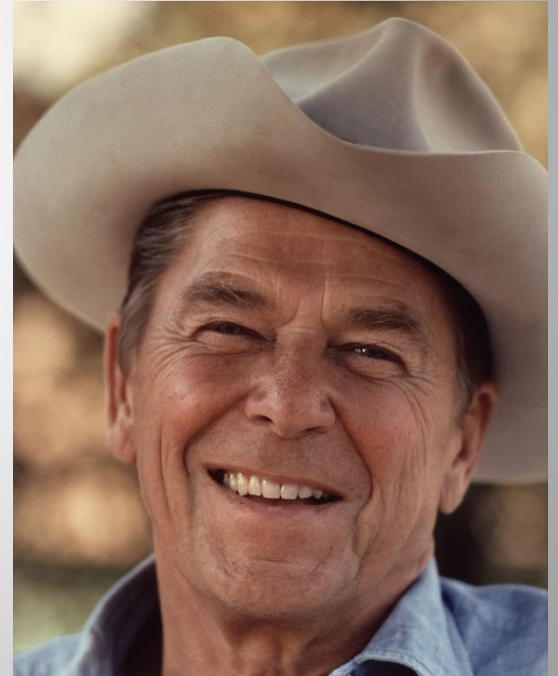
- Exceeds CMS's statutory authority
 - Is incompatible with the language, context, and purpose of the Social Security Act (specifically, § 1395w-21(j)(2)(D))
 - Redefines what constitutes Compensation
- Is arbitrary and capricious
 - Only one commenter “cursorily recommending a \$100 increase”
 - “picked the number (\$100) from thin air,”
- Was promulgated without observance of required procedures
 - The agency's rulemaking only offered “conclusory [and] unsupported suppositions,”
 - Failed to disclose the “critical factual material” CMS relied upon
 - Did not respond to criticisms of its own evidence
 - “refused to acknowledge contrary evidence provided by commenters.”

<https://www.sheppardhealthlaw.com/2024/07/articles/centers-for-medicare-and-medicaid-services-cms/texas-court-stays-cms-cy2025-final-rule-on-agent-and-broker-compensation-and-contract-term-restrictions/#:~:text=On%20Wednesday%2C%20a%20federal%20court,in%20contracts%20with%20third%20party>

I think you all know that I've always felt the nine most terrifying words in the English language are: **I'm from the Government, and I'm here to help.**

Ronald Reagan

August 12, 1986



WHAT IS DRIVING THIS DECISION MAKING PROCESS

These final policies advance the goals of President Biden's historic **Competition Council** and **Executive Order** signed in July 2021, by helping to ensure a robust and competitive Medicare Advantage marketplace.

<https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f>



WHO MAKES THESE DECISIONS?

- HHS Secretary - Xavier Becerra
 - Wants to be Governor of California
- Chiquita Brooks-LaSure - CMS Administrator
- Dr. Meena Seshamani - CMS Deputy Administrator and Director of the Center for Medicare



WHAT WERE THE FINAL RULE CHANGES?

- 1. New Guardrails for Plan Compensation to Agents and Brokers to Stop Anti-Competitive Steering**
2. Limiting the Distribution of Personal Beneficiary Data by Third-Party Marketing Organizations
3. Improving Access to Behavioral Health Care Providers
- 4. Mid-Year Enrollee Notification of Available Supplemental Benefits**
5. New Standards for Supplemental Benefits for the Chronically Ill
6. Annual Health Equity Analysis of Utilization Management Policies and Procedures
7. Enhance Enrollees' Rights to Appeal a Medicare Advantage Plan's Decision to Terminate Coverage for Non-Hospital Provider Services

CHANGES CON'T

8. **Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services From the Same Organization**
9. For D-SNP PPOs, Limit Out-of-Network Cost Sharing
10. Contracting Standards for Dual Eligible Special Needs Plan Look-Alikes
11. Standardize the Medicare Advantage Risk Adjustment Data Validation (RADV) Appeals Process
12. **More Flexibility to More Quickly Substitute Lower Cost Biosimilar Biological Products for Their Reference Products**
13. Medicare Part D Medication Therapy Management (MTM) Program
14. **MA Star Rating Changes**

PLAN COMPENSATION TO AGENTS AND BROKERS

- ~~Revises and broadens the scope and definition of “compensation” to eliminate the framework that allows for separate payments to be made to agents and brokers that are classified separately as “administrative fees.”~~
 - ~~CMS is raising the fair market value (FMV) of initial enrollments by \$100 starting in CY 2025.~~
- Prohibits contract terms between MAOs and agent, brokers or other Third Party Marketing Organizations (TPMOs) that may interfere with an agent or broker’s ability to objectively assess and recommend the plan which best fits a beneficiary’s healthcare needs.
- Establishes a single, standardized compensation rate for all MAOs so that agents and brokers are paid at the same rate, regardless whether payment is through the plan directly or via a field marketing organization (FMO).
- CMS eliminated the ability of MAPs and PDPs to pay administrative fees outside of the commission-based cap. Eliminates HRA fees.

COMPENSATION REDEFINED

Revised the definition of “compensation” at Section 422.2274(a) that includes categories of payments that were previously excluded from the definition including: (a) payment of fees to comply with state appointment laws, training, certification, and testing costs; (b) reimbursement for mileage to, and from, appointments with beneficiaries; and (c) reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

MID-YEAR ENROLLEE NOTIFICATION

- CMS is requiring Medicare Advantage plans to issue a “Mid-Year Enrollee Notification of Unused Supplemental Benefits” annually, between June 30 and July 31 of the plan year, that is personalized to each enrollee, and that includes a list of any supplemental benefits not accessed by the individual during the first six months of the year.
- The notification will include the scope of the benefit, cost-sharing, instructions on how to access the benefit, any network application information for each available benefit, and a customer service number to call if additional help is needed.

DUALLY ELIGIBLE MANAGED CARE

- CMS acknowledges that, on its face, this policy may introduce perverse incentives and may discourage MAOs or their affiliates from participating in Medicaid managed care programs. To combat this enrollment limitation, CMS is providing a monthly special enrollment period (SEP) available only to those DSNPs with an Affiliated Medicaid Plan. Under the Final Rule, FBDE individuals may no longer enroll into any DSNP of their choosing on a monthly or quarterly basis.
- CMS finalized limits on out-of-network cost sharing for D-SNP provider organizations (“PPOs”) for certain Part A and Part B benefits, on an individual service level beginning in 2026.

DUAL ELIGIBLE CON'T

- Revises the current Part D quarterly special enrollment period (SEP) for dually eligible, and other Part D low-income subsidy (LIS) enrolled individuals, to a once-per-month SEP to enroll in a standalone prescription drug plan
- Creates a new integrated care SEP to allow dually eligible individuals to elect an integrated dual eligible special needs plan (D-SNP) when the individual also receives Medicaid services through an affiliated managed care plan.

DUAL ELIGIBLE CON'T

- Limits enrollment in certain D–SNPs to those individuals who are also enrolled in an affiliated Medicaid managed care organization (MCO)
- Limits the number of D–SNP plan benefit packages an MA organization, its parent organization, or entity that shares a parent organization with the MA organization, can offer in the same service area as an affiliated Medicaid MCO.

BIOSIMILAR BIOLOGICAL PRODUCTS

- CMS is also finalizing greater flexibility for Part D plans to substitute, more quickly, lower cost biosimilar biological products (biosimilars) for their reference products so that enrollees may have faster access to equally effective, but potentially more affordable, drug treatment options.
 - Biosimilars may be less expensive than biologics, which can be attributed in part to their streamlined development process. According to the Association for Accessible Medicines, biosimilar competition has lowered costs for both reference products and their biosimilars, providing \$7.9 billion in savings in 2020 and more than \$12.6 billion in savings over the past 10 years.

MA STAR RATING CHANGES

- Medicare Advantage with prescription drug (Part D) coverage (MA-PD) contracts are rated on up to 40 unique quality and performance measures
- MA-only contracts (without Part D coverage) are rated on up to 30 measures
- PDP contracts are rated on up to 12 measures

STAR CATEGORIES FOR MA ONLY

- Breast Cancer Screening
- Colorectal Cancer Screening
- Annual Flu Vaccine
- Monitoring Physical Activity
- Special Needs Plan (SNP) Care Management
- Care for Older Adults – Medication Review
- Care for Older Adults – Pain Assessment
- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Blood Sugar Controlled
- Controlling Blood Pressure
- Reducing the Risk of Falling
- Improving Bladder Control
- Medication Reconciliation Post-Discharge
- Plan All-Cause Readmissions
- Statin Therapy for Patients with Cardiovascular Disease
- Transitions of Care
- Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan
- Care Coordination
- Complaints about the Plan
- Members Choosing to Leave the Plan
- Health Plan Quality Improvement
- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center – Foreign Language Interpreter and TTY Availability

STAR CATEGORIES FOR MAPD

- Call Center – Foreign Language Interpreter and TTY Availability
- Complaints about the Plan
- Members Choosing to Leave the Plan
- Drug Plan Quality Improvement
- Rating of Drug Plan
- Getting Needed Prescription Drugs
- Medicare Plan Finder Price Accuracy
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Medication Therapy Management Program Completion Rate for CMR
- Statin Use in Persons with Diabetes (SUPD)

STAR CATEGORIES FOR PDP

- Call Center – Foreign Language Interpreter and TTY Availability
- Complaints about the Plan
- Members Choosing to Leave the Plan
- Drug Plan Quality Improvement
- Rating of Drug Plan
- Getting Needed Prescription Drugs
- Medicare Plan Finder Price Accuracy
- Medication Adherence for Diabetes Medications
- Medication Adherence for Hypertension (RAS antagonists)
- Medication Adherence for Cholesterol (Statins)
- Medication Therapy Management Program Completion Rate for CMR
- Statin Use in Persons with Diabetes (SUPD)

TUKEY NOT TURKEY!

- CMS is using the commonly accepted Tukey methodology which means that for outliers to be removed they must be far outside the mean. Even so, the new methodology will generally make it more difficult for plans to earn and maintain four- and five-Star overall ratings. Most outliers are on the lower performing end of the spectrum. Removing them will generally shift cut points to a higher range and require plans to perform even better on individual measures than without Tukey.
- “With the wave of changes coming to the Star Ratings program, quick execution of operational enhancements will be needed to be a high-performing plan,” Willis says. “A strong Star governance model, with executive oversight, along with ensuring accuracy of data can aid in improved performance for your plan.”

John Willis, Vice President of Consulting & Professional Services at Healthmine

<https://www.healthmine.com/resources/tukeyoutlier>

IMPACT

- These changes build on earlier CMS efforts to improve the Star Rating system, including adding a health equity index and reducing the weight of patient experience and access measures to better align with the CMS Quality Strategy.
 - The Health Equity Index (HEI) is a CMS-created score to incentivize Part C and Part D health plans to improve care for the most vulnerable patients. The index will consolidate a subset of Star Ratings measures, such as the measures included in CAHPS (Consumer Assessment of Health Providers and Systems), into one score.

EXECUTIVE ORDER ON PROMOTING COMPETITION IN THE AMERICAN ECONOMY

- Such steps align with the goals of President Biden's historic Executive Order on Promoting Competition in the American Economy

BUT WAIT



THERE'S MORE

AGENTS ARE PAWNS IN A MUCH BIGGER GAME



REQUIRED LANGUAGE

email communications, website, print materials, other marketing materials, and within the first minute of sales calls

If marketing **SOME** plans within a service area, use:

- “We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.”

If marketing **ALL** plans within a service area, use:

- “Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices.”

CENTER FOR MEDICARE ADVOCACY

The Center for Medicare Advocacy continues to support reforms that target inappropriate steering and other unfair Medicare marketing strategies. We also suggest that new and existing Medicare beneficiaries make use of the services of their state's SHIP program, which offers free, unbiased counseling and assistance with navigating Medicare coverage options.

- Biased - The adjective that means “exhibited or characterized by an unreasoned judgment” is biased

NEW MEXICO State Health Insurance Assistance Program (SHIP)

- Medicare decisions can be overwhelming. There is so much aggressive advertising that it is hard to know what information to trust. NM SHIP and SMP are your free, unbiased, expert source for Medicare information and assistance.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM

SHIP counselors are staff and volunteers trained and certified by the Aging & Disability Resource Center (ADRC) to provide information on the various options available to Medicare beneficiaries including:

- Medicare Parts A & B
- Medicare Advantage
- Medicare prescription drug coverage (Part D)
- Medigap or Supplement plans
- other programs that help people with limited resources pay for health care costs

“If the only tool you have is a hammer, you tend to see every problem as a nail.”

Abraham Maslow



10th AMENDMENT TO THE US CONSTITUTION

“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”

