CY 2025 Medicare Advantage Rate Announcement and final rule: What do Medicaid leaders need to know?

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The Centers for Medicare and Medicaid Services (CMS) recently released the 2025 Medicare Advantage (MA) and Part D final rule and MA Rate Announcement. CMS continues to use Medicare authority to make changes that have significant policy and financial impacts for state Medicaid agencies, especially for dual eligible beneficiaries. This paper outlines some of the key takeaways for Medicaid leaders.

On April 1, 2024, CMS released the 2025 MA and Part D rate announcement, which contains CMS's updates to MA payment factors for contract year (CY) 2025. On April 5, 2024, CMS issued its 2025 MA and Part D final rule[1] and notified members of its Medicaid distribution list to inform interested parties of the key provisions of the 2025 rule impacting Medicaid. This paper is intended to elaborate on that notification and provide additional context for Medicaid leaders on the following key MA and Part D changes for CY 2025:

- Several changes are intended to further integration between Medicare and Medicaid plans for dual eligible beneficiaries.
- New MA provider network standards and other covered service requirements enhance Medicare coverage of additional services, including those that may be provided through Medicaid.
- Requirements for MA utilization management (UM) and communications to address health equity considerations are added.
- CY 2025 payment rates to MA and Part D plans are expected to increase, as will member cost sharing under traditional Medicare.

Several Changes are intended to further integration between Medicare and Medicaid plans for dual eligible Beneficiaries

1. Increasing aligned Medicare-Medicaid enrollment in dual eligible special needs plans (D-SNPs)
2. Reducing "choice overload" of D-SNP options
3. Further lowering threshold for D-SNP look-alike MA plans
4. Expanding sharing of MA encounter data with state Medicaid agencies
5. Displaying Medicaid benefits on Medicare Plan Finder (MPF)
6. Restricting MA broker commissions for MA enrollment

New MA Provider network standards and other covered service requirements enhance Medicare coverage of additional services, including those that may be provided through Medicaid

1. Expanding MA network adequacy requirements for behavioral health
2. Limiting out-of-network (OON) cost sharing for D-SNP preferred provider organizations (PPOs)
3. Requiring midyear notification of MA supplemental benefits
4. Issuing new standards for MA Special Supplemental Benefits for the Chronically Ill (SSBCI)

Requirements for ma Um and communications to address health Equity considerations are Added

1. Enhancing requirements for annual health equity analysis of MA UM policies and procedures
2. Updating the MA multi-language insert regulation

CY 2025 Payment Rates to MA and Part D plans are expected to increase, as will member cost sharing under Traditional medicare

1. Updating benchmark rates and risk score factors, which CMS expects will increase payment rates to MA plans by approximately 3.7% from 2024 to 2025, up from 3.3% projected from 2023 to 2024
2. Finalizing implementation guidance for the Inflation Reduction Act, which is expected to increase MA and Part D plan costs for CY 2025

1 The full text of the final rule is available at https://public-inspection.federalregister.gov/2024-07105.pdf.

Changes to further integration

In the Bipartisan Budget Act (BBA) of 2018, Congress permanently authorized D-SNPs and strengthened Medicare-Medicaid integration requirements.[2] CMS has further signaled its intent to use D-SNPs as a vehicle for increasing Medicare-Medicaid integration for dual eligible beneficiaries in the CY 2025 MA and Part D final rule and its recent MA and Part D rules. Each of these changes is discussed separately below.

INCREASING ALIGNED ENROLLMENT

Low-income individuals (including dual eligible beneficiaries) currently have a quarterly special enrollment period (SEP) during which they can change Medicare Advantage or Part D plans. Beginning in 2025, CMS will eliminate the quarterly SEP and replace it with a monthly SEP with strict limitations. The monthly enrollment period will be limited to allowing members to 1) choose either an integrated D-SNP model that will align their Medicare and Medicaid enrollment, or 2) move to or between traditional Medicare and Part D plans. For states with integrated options, this new SEP could increase alignment between D-SNPs and Medicaid managed care organizations (MCOs). However, the allowance for monthly changes could increase the burden on states for providing information to align enrollment. For states without integrated options, this will reduce opportunities to switch D-SNPs.

In 2027, CMS will further restrict enrollment in D-SNPs that also contract with a state as an MCO. In 2027, new enrollment of full benefit duals into D-SNPs that also serve as MCOs will be limited to members who are also enrolled in the D-SNP's MCO. In 2030, all membership for these plans will be limited to aligned enrollment, meaning that only members enrolled with the Medicaid managed care plan will be allowed to enroll in the D-SNP.

REDUCING CHOICE OVERLOAD

CMS is also seeking to reduce choice overload for dual eligible beneficiaries in the MA market to address beneficiary confusion. In 2027, each parent organization (including all related organizations) that has an affiliated Medicaid MCO enrolling dual eligible beneficiaries will only be allowed to offer a single D-SNP plan benefit package (PBP) enrolling full benefit duals within a given service area. States will be allowed to grant exceptions, including when a state requires multiple D-SNPs for distinct benefit types (e.g., over and under age 65).

This policy will reduce the number of integrated D-SNPs in many states and may also reduce state oversight and contracting burden. However, the policy does not apply to most coordination-only D-SNPs and would therefore generally not limit the number of coordination-only D-SNPs available to dual eligible beneficiaries.

Lowering threshold for D-SNP look-alikes

In 2023, CMS began not renewing general enrollment MA plans whose membership was comprised of over 80% of dual eligible beneficiaries, known as "D-SNP look-alikes." In the most recent MA and Part D rule, CMS will lower the threshold for defining D-SNP look-alikes from 80% to 70% in 2025 and to 60% in 2026. CMS has noted that California, Massachusetts, and Minnesota have plans that appear as if they could be impacted by the lower threshold. This policy may increase the number of dual eligible beneficiaries in integrated D-SNPs by eliminating general enrollment MA plans that are primarily enrolling dual eligible beneficiaries.

EXPANDING DATA SHARING

The final rule has expanded the permissible data use and data disclosure for MA encounter data with the intent of making MA encounter data available to states to support coordinating care for dual eligible beneficiaries and to improve the states' abilities to understand and improve care provided to dually eligible individuals. This policy change will allow states to use MA data more broadly to analyze and structure their programs.

Additionally, in February 2024 CMS introduced system changes and updated reporting instructions to facilitate easier submission of supplemental benefit encounter data by MA organizations. These changes may lead to enhanced data quality, enabling states to more effectively analyze Medicare-covered benefits and supplemental benefits that may overlap with Medicaid services.

DISPLAYING MEDICAID BENEFITS ON MEDICARE PLAN FINDER

In the final rule, CMS has indicated that it will begin posting a limited number of Medicaid benefits on MPF for plan year 2024. The benefits will be limited to services provided by the D-SNP or an affiliated MCO. CMS will request that states provide Medicaid benefit information via the Health Plan Management System (HPMS) this summer to aid in the display of Medicaid benefits on MPF.

This enhancement to MPF should help dual eligible beneficiaries better understand the scope of services integrated D-SNPs provide across Medicare and Medicaid. This may increase the states' burden as CMS works with them to understand Medicaid benefits for dual eligible beneficiaries.

2 The full text of the Bipartisan Budget Act of 2018 is available at https://www.govinfo.gov/content/pkg/PLAW-115publ123/pdf/PLAW-115publ123.pdf.

RESTRICTING MA BROKER COMMISSIONS

In the final rule, CMS has further limited the amount and type of payments that MA plans may make to agents or brokers for enrolling all members into MA plans. This may help facilitate more even competition between plans (including MA plans and D-SNPs) and allow for further enrollment in integrated D-SNPs.

Medicare service changes impacting Medicaid

In the final rule, CMS has made several changes that may impact states' Medicaid offerings or otherwise impact benefits that D-SNPs provide to dually eligible individuals. Key changes are discussed below.

EXPANDING PROVIDER NETWORK ADEQUACY REQUIREMENTS FOR BEHAVIORAL HEALTH SERVICES

CMS added a new facility-specialty provider category for outpatient behavioral health to promote provider network adequacy for behavioral health services. Provider types under this category can include:

- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)
- Opioid treatment program (OTP) providers
- Community mental health centers
- Other behavioral health and addiction medicine specialists and facilities

Expanding network requirements for behavioral health may result in more behavioral health coverage by MA plans. Given that states are often key payers for behavioral health services, state Medicaid agencies may see that MA plans provide more behavioral health services and decrease Medicaid state and federal financial responsibility for certain behavioral health services for dual eligible beneficiaries.

LIMITING OON COST SHARING FOR D-SNP PPOS

Beginning in 2026, CMS will limit OON cost sharing for D-SNP PPOs to reduce cost shifting to Medicaid. Because state Medicaid agencies pay cost sharing for qualifying dual eligible beneficiaries, limiting the cost sharing for OON providers may reduce cost-sharing payments from Medicaid agencies to providers and may increase payments overall to providers. The impact will depend on each state's lesser of policies and Medicaid fee schedules.

REQUIRING MIDYEAR NOTIFICATION OF UNUSED SUPPLEMENTAL BENEFITS

Beginning in 2026, MA plans will be required to outreach to members to notify them of unused supplemental benefits between June 30 and July 31 each year. Promoting a greater awareness of supplemental benefits, which can overlap with Medicaid benefits, may result in greater use of supplemental benefits and reduced costs to Medicaid, to the extent the benefit is covered by Medicaid.

NEW STANDARDS FOR SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL

Beginning with benefits offered in CY 2025, CMS is strengthening requirements for SSBCIs to ensure the benefit has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. This intent aligns with recent communications in the Medicaid managed care space regarding the intent of "in lieu of" services.[3]

MA plans will be required to have research or data available to demonstrate that an SSBCI meets its requirement to have a reasonable expectation to improve or maintain the health or overall function of a chronically ill enrollee. Additionally, the disclaimer requirements for SSBCIs will be strengthened so that marketing of and communication about these benefits is not misleading or potentially confusing to enrollees when making enrollment decisions. For D-SNPs, SSBCIs often cover food and/or household utilities.

In recent years, MA plans have used SSBCIs to offer a wide range of benefits, including pest control, pet care services, identity theft services, and many others.[4] It is likely that the new standards will cause MA plans to reconsider their SSBCI offerings, which may overlap with waiver or in lieu of service offerings for Medicaid MCOs. This may have a financial impact on Medicaid to the extent the MA plan uses SSBCIs that overlap with in lieu of services or waiver services.

3 CMS (January 4, 2023). Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. Retrieved July 2, 2024, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf.

4 Murphy-Barron, C., Buzby, E.A., & Pittinger, S. (February 2022). Overview of Medicare Advantage Supplemental Healthcare Benefits and Review of Contract Year 2022 Offerings. Milliman Brief. Retrieved July 2, 2024, from https://bettermedicarealliance.org/wp-content/uploads/2022/03/MA-Supplemental-Benefits-Milliman-Brief_20220225.pdf.

Enhancing health equity

ENHANCING REQUIREMENTS FOR ANNUAL HEALTH EQUITY ANALYSIS OF UM POLICIES AND PROCEDURES

In its CY 2023 rule, CMS required MA organizations to establish a utilization management committee to review and approve all UM policies at least annually. In this most recent rule, CMS is amending the rules for 2025 to require at least one member of the UM committee to have expertise in health equity. Additionally, the UM policy review must now occur at the plan level and must examine the impact of prior authorization on enrollees who are low-income or have a disability.

Updating the multi-language insert regulation

CMS is modifying its requirements for translation notification from a multi-language insert to a notice of availability. The notice of availability must be provided in English and at least the 15 languages most commonly spoken by individuals of the relevant state or states in the MA service area. This change will result in increased alignment between translation requirements for Medicaid and MA plans.

Payment rate updates

UPDATING THE CY 2025 MA PAYMENT RATES

In its 2025 MA and Part D rate announcement, CMS announced that it expects payment rates to MA plans to increase by approximately 3.7% from 2024 to 2025, up from 3.3% projected from 2023 to 2024. The effective growth rate in MA benchmark rates is only 2.3%, but CMS expects the MA risk score trend to continue to outpace the risk model revision and fee-for-service (FFS) normalization and drive additional MA revenue increases.

FINALIZING IMPLEMENTATION GUIDANCE FOR THE INFLATION REDUCTION ACT

Changes from the Inflation Reduction Act of 2022 (IRA) are expected to continue to shape the MA and prescription drug (PD) landscape in 2025 as many of the key benefit change provisions take effect in 2025. In 2025, the benefit structure for Part D will change significantly with changes to the member maximum out-of-pocket (MOOP), plan liability, manufacturer drug rebates, and federal reinsurance. Under these changes, the expected impacts in 2025 on key stakeholders are:

- A reduction in cost sharing for some non-low-income (NLI) beneficiaries
- A reduction in federal reinsurance payments
- An increase in plan liability

Low-income (LI) beneficiaries are not expected to be materially impacted by the benefit redesign given the cost-sharing subsidies available for low-income beneficiaries. However, these changes are likely to result in increased revenue and expenditures for MA-PD plans. Additionally, given the uncertainty in revenues and expenditures in the initial years, there may be significant volatility in benefit offerings, including supplemental benefit impacts, which will indirectly impact Medicaid.

In addition to the benefit changes under the IRA, the following Medicare changes from the IRA are already in effect or in progress:

- Rebate requirements for drug companies whose drug prices rise faster than inflation (2023)
- Monthly cost-sharing limits for insulins (2023)
- Elimination of cost sharing for adult vaccines covered under Medicare Part D (2023)
- Expansion of eligibility for full benefits under the Medicare Part D Low-Income Subsidy Program (2024)
- Price negotiations for some drugs covered under Medicare Part B and Part D with the highest total spend (negotiations will begin in 2026, but potential drugs have been identified)

State Medicaid impact summary

FIGURE 1: SUMMARY OF KEY PROVISIONS WITH FINANCIAL IMPLICATIONS

PROVISION OF THE FINAL RULE OR RATE ANNOUNCEMENT	CMS'S STATED GOAL(S)	MEDICAID IMPACT(S)	IMPACTED STATES
Increasing aligned Medicare-Medicaid enrollment	"Promote greater alignment of D-SNPs and Medicaid MCOs"	▪ Changes to Medicaid administrative functions to support changes to Medicare SEPs ▪ Opportunities to increase aligned enrollment and integrated care	▪ States with integrated D-SNPs: Increased frequency of SEP, but more limited options for beneficiaries utilizing SEP ▪ States without integrated D-SNPs: Limits monthly SEP to switching prescription drug plans (PDPs) or leaving MA plans for traditional Medicare
Reducing "choice-overload" of D-SNP options	"Simplify navigation of complex programs for enrollees, their caregivers, and other groups supporting dually eligible individuals"	▪ Opportunities to further aligned enrollment and integrated care ▪ Need to decide whether to allow for exceptions for distinct benefit types beginning in 2027	▪ States with integrated D-SNPs: Reduction in D-SNP offerings from affiliated D-SNPs ▪ States without integrated D-SNPs: None
Lowering threshold for D-SNP look-alikes	"Address the substantial growth in non-SNP MA plans with disproportionately high enrollment of dually eligible individuals"	Opportunities to further aligned enrollment and integrated care	All states with D-SNPs, but particularly California, Massachusetts, and Minnesota
Expanding sharing of MA encounter data with state Medicaid agencies	"Improve States' ability to understand and improve service delivery for dually eligible individuals"	▪ Increased allowable uses for MA encounter data ▪ Opportunities to further aligned enrollment and integrated care	All states
Displaying Medicaid benefits on MPF	"Make it easier for dually eligible MPF users to assess MA plans that cover their full array of Medicare and Medicaid benefit"	▪ Opportunities to further aligned enrollment and integrated care ▪ Additionally, states will need to work with CMS to post Medicaid benefits for integrated plans on MPF.	▪ States with a highly integrated D-SNP (HIDE) or a fully integrated D-SNP (FIDE) ▪ All other states: No impact
Restricting MA broker commissions	"Ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the plan that best fits a beneficiary's health care needs"	Opportunities to further aligned enrollment and integrated care	All states
Expanding network adequacy requirements for behavioral health	"Improve access to behavioral health care"	May expand Medicare Advantage coverage of services often covered by Medicaid	All states
Limiting OON cost sharing for D-SNP PPOs	Address concerns about "the shifting of costs to States, the reduction in net payments to safety net providers, and the potential for excessive cost sharing for those dually eligible individuals, who, while low income, do not benefit from cost sharing protections out-of-network"	May result in reduced cost sharing paid by Medicaid on behalf of dual eligible beneficiaries	States with PPO D-SNPs, but impacts are dependent on state fee schedules and lesser-of policies
Requiring midyear notification of supplemental benefits	"Help ensure MA enrollees are fully aware of all available supplemental benefits and to promote equitable access to care"	May result in reduced costs to Medicaid if supplemental benefits overlap with Medicaid-covered benefits	All states
Issuing new standards for SSBCI	"Ensuring that the MA rebate is provided to enrollees in a way that they can benefit from the value of these rebate dollars"	May impact benefits offered by MA plans; may have a financial impact on Medicaid to the extent the state uses in lieu of services or waiver services that overlap with SSBCIs	All states

PROVISION OF THE FINAL RULE OR RATE ANNOUNCEMENT	CMS'S STATED GOAL(S)	MEDICAID IMPACT(S)	IMPACTED STATES
Enhancing requirements for annual health equity analysis of UM policies and procedures	"Enable a more comprehensive understanding of the impact of prior authorization practices on enrollees with the specified [social risk factors] SRFs"	May address improvements in health equity	All states
Updating the multi-language insert regulation	To "more closely reflect the actual languages spoken in the service are"	Will result in increased alignment between MA and Medicaid translation requirements	All states
Updating MA payment rates	Provide payment rates to MA plans for CY 2025 bidding	Average plan payment rate exceeding the effective growth rate should allow for MA plans to have additional revenue on Part C. However, even if the CMS projections are correct, the impacts of the IRA will likely overshadow any impacts of the MA payment rate for 2025.	All states, but impacts by state will vary significantly as benchmark rates and market vary by county
Finalizing implementation guidance for the Inflation Reduction Act	In 2025, CMS will implement the final parts of the Part D benefit redesign	Significant increase in plan expenses for Part D and market volatility may result in significant short-term changes in the market and supplemental benefits. This, in turn, may impact Medicaid expenditures in terms of D-SNP availability and Medicaid expenses.	All states

Conclusion

The CY 2025 Medicare rules will have policy and financial impacts for Medicaid agencies. Recent Medicare legislation advances change in integrated care for dual eligible beneficiaries, may impact expenditures for services often offered by Medicaid, promotes health equity, and provides a general landscape for continued evolution in the MA market impacting dual eligible beneficiaries and state agencies.

Limitations

The opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

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This information is intended to provide an overview of the CY 2025 Medicare Advantage final rule. The list of considerations outlined in this article is not exhaustive. This information may not be appropriate, and should not be used, for other purposes.

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