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CMS Issues CY 2024 Medicare Advantage, Part D Updates

On Wednesday (April 5), the Centers for Medicare & Medicaid Services (CMS) issued the Contract Year (CY) 2024 Medicare Advantage (MA) and Part D Final Rule. The final rule includes several updates to the MA and Part D programs, including adding new requirements to address potentially misleading advertising, improving prior authorization processes, and increasing access to mental health. The rule also adjusts Star Ratings measures, including finalizing a new health equity index (HEI) reward.

Meena Seshamani, director of the Center for Medicare, said, "This rule takes unprecedented steps to ensure appropriate guardrails are in place to protect beneficiaries from concerns such as barriers to care due to prior authorization and misleading marketing practices, to improved access to behavioral health, and to advance health equity."

"The Biden-Harris Administration has made exceptionally clear that one of its top priorities is protecting and strengthening Medicare," said CMS Administrator Chiquita Brooks-LaSure. "With this final rule, CMS is putting in place new safeguards that make it easier for people with Medicare to access the benefits and services they are entitled to, while also strengthening the Medicare Advantage and Part D programs."

The final rule is one in a series of policies coming from CMS that impact the MA program, including proposals to recover improper payments, improve payment accuracy, and update prior authorization processes. CMS late last week released the MA Rate Announcement for 2024 and is expected to soon issue a final rule to create an electronic prior authorization process.

- MA Contract Year 2024: Press Release, Fact Sheet, Final Rule
- *For more information on the MA 2024 Rate Announcement, click here.*
- *For more information on the proposed Prior Authorization rule, click here.*

Summary of key provisions

Utilization management and prior authorization. The final rule makes several changes to utilization management and prior authorization requirements, intended to address concerns around those processes and advance timely access to medically necessary care for enrollees. CMS clarifies rules related to acceptable coverage criteria for basic benefits by requiring that MA plans must comply with national coverage determinations, local coverage determinations, and general coverage and benefit conditions included in traditional Medicare regulations when making coverage decisions. CMS said MA plans will not be allowed to deny coverage of a Medicare-covered item or service based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies.

In instances in which Medicare rules or coverage determinations are not explicit, CMS said MA plans may use their own internal coverage criteria, however they must be based on current evidence in widely used treatment guidelines or clinical literature. In addition, CMS said plans will have to demonstrate that the clinical benefits of any additional coverage criteria used outweigh any clinical harms, including from delayed or decreased access to items or services. Further, CMS said any coverage denials based on medical necessity must be reviewed by a physician or health care professional with expertise in that field of medicine.

The rule also streamlines prior authorization requirements to add continuity of care requirements and other updates to reduce disruptions for beneficiaries. For example, the rule requires that coordinated care plan prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary; approved prior authorizations must be valid throughout the course of an enrollee's "course of treatment," which CMS defines as "a prescribed order or ordered course of treatment for a specific individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider and clarified that a course of treatment may, but is not required to be part of a treatment plan;" and prior authorizations must be valid for at least 90-days when an enrollee with an active course of treatment transitions to a new MA plan.

In addition, CMS will require all MA plans to establish a Utilization Management Committee to review policies on an annual basis and ensure consistency with traditional Medicare's national and local coverage decisions and guidelines.

Marketing. The final rule also takes steps to address concerns about confusing and potentially misleading marketing related to MA plans, finalizing 21 of the agency's 22 proposed marketing reforms, with 17 of the 21 provisions being finalized as proposed.

Under the rules, ads will be required to mention a specific plan name and will be barred from using potentially confusing words or imagery, as well as misrepresenting Medicare logos. The rules also prohibit the use of superlatives like "best" or "most" in marketing unless those statements can be validated by data from the current or prior year, as well as the use of savings information that is based on a comparison of typical expenses for uninsured individuals, unpaid costs of dually eligible beneficiaries, or "other unrealized costs of a Medicare beneficiary." Plans also will be required to list medical benefits in a specific order at the top of the Summary of Benefits to improve plan comparison.

In addition, MA plans will be required to notify enrollees annually and in writing about their ability to opt out of phone calls. CMS also placed new requirements around MA-related calls from third-party marketing organizations (TPMOs) and modified the TPMO disclaimer to add State Health Insurance Assistance Programs as an option for beneficiaries to get help and to state the number of organizations a TPMO represents.

The rules also prohibit marketing events from occurring within 12 hours of educational events at the same place and from occurring in areas where the service is not available, unless it is unavoidable. In addition, the rule prohibits the collection of Scope of Appointment cards at educational events.

Regarding agents and brokers, the rule finalized proposals to require agents to explain the effect of an enrollee's enrollment choice on their current coverage and require MA and Part D plans to have a plan to monitor agent and broker activities and report instances of non-compliance to CMS. CMS modified proposals to allow agents to have business reply cards at educational events, require agents to inform potential enrollees of the number of plans their organization offers, and give agents more flexibility to re-contact or follow up with beneficiaries regarding plan options.

The only proposal CMS did not finalize would have barred third-party marketing organizations (TPMOs) from distributing beneficiary contact information. CMS said it will address this proposal in future rulemaking. The remaining marketing policies will be applicable for 2024 contract year marketing and communication set to begin September 30.

Behavioral health. The final rule also included several provisions to improve access to behavioral health, including amending general access to services standards to include behavioral health services, codifying wait time standards for primary care and behavioral health appointments, and clarifying that emergency behavioral health services cannot be subject to prior authorization.

The final rule also will require MA organizations to inform enrollees if their behavioral health or primary care provider are dropped from their network and to establish care coordination programs that advance whole-person care. In addition, the rule adds clinical psychologists and licensed clinical social workers to the list of specialty types and make them eligible for the 10-percentage point telehealth credit.

One of the few proposals CMS amended before finalizing was the plan to add clinical psychologists, licensed clinical social workers, and those who prescribe medication for opioid use disorder to the list of specialty types that CMS uses to evaluate MA networks. CMS did not finalize a proposal to require organizations to include in their provider directories notations for medications for opioid use disorder (MOUD)-waivered providers, due in part to the elimination of the "X-waiver" in the Consolidated Appropriations Act of 2023.

Star Ratings updates. CMS in the rule also made changes to MA star ratings measures, adding and removing certain measures.

For example, CMS will add a new health equity index (HEI) which will create a score to represent plans' efforts to support socially vulnerable enrollees, applying beginning with the 2024 and 2025 measurement periods and the 2027 Star Ratings. As a part of this change, CMS is also finalizing the removal of the current reward factor.

For the 2024 Star Ratings, CMS will remove the Part C Diabetes Care – Kidney Disease Monitoring measure. Other removals, additions and updates are generally applicable for the 2024 measurement period and the

2026 star ratings, including reducing the weight of patient experience/complaints and access measures by half, lowering the weight from four to two; adding the Part C Kidney Health Evaluation for Patients with Diabetes measure; and, substantive updates to the Part D Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), and Medication Adherence for Cholesterol (Statins) measures. Risk adjustment based on sociodemographic status characteristics to the three adherence measures, which will be implemented beginning with the 2026 measurement period and the 2028 Star Ratings. CMS also made other updates to the MA Star Ratings program, including removing the 60% rule that is part of the disaster adjustment and addressing the codification error related to the use of Tukey outlier deletion which will apply beginning with the 2024 Star Ratings.

Health equity provisions. The final rule also makes several updates to address care for underserved MA populations. For example, the rule expands the list of populations for whom plans must provide culturally competent services to include people with limited English proficiency or reading skills; people from ethnic, cultural, racial or religious minorities; people with disabilities; people who identify as LGBTQIA+, intersex or nonbinary; rural beneficiaries and beneficiaries in areas of high care deprivation; and low-income beneficiaries.

CMS also finalized a proposal to mandate provider directories include information on the providers' cultural and linguistic capabilities, as well as a proposal for plans to develop and offer digital health education to improve access to covered telehealth services.

If you have questions, please contact Heather Meade or Heather Bell.