Summary of CMS Final Rule: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)

On April 5, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that revises the Medicare Advantage (MA or 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 a series of requirements, including prior authorization, marketing and communications, health equity, provider directories, coverage criteria, network adequacy, and other areas. The final rule will be published in the April 12, 2023 *Federal Register*, and will be effective June 5, 2023. This summary focuses on provisions potentially applicable to the DMEPOS community. The complete final rule can be downloaded here: https://www.federalregister.gov/public-inspection/current.

Provisions Applicable to Medicare Advantage and Medicare Part D

Utilization Management

- CMS states that it is clarifying that the final rule clarifies clinical criteria guidelines to ensure people with MA receive access to the same medically necessary care they would receive in Traditional Medicare. CMS states that this clarification "aligns with recent Office of Inspector General (OIG) recommendations. Specifically, CMS clarifies rules related to acceptable coverage criteria for basic benefits by requiring that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare regulations."

- CMS is also finalizing that when coverage criteria are not fully established, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers. In the final rule, CMS defines when applicable Medicare coverage criteria are not fully established by explicitly stating the circumstances under which MA plans may apply internal coverage criteria when making medical necessity decisions.

Prior Authorization

- CMS states that its final rule streamlines prior authorization requirements, including adding continuity of care requirements and reducing disruptions for beneficiaries. CMS' final 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.

- The final rule requires coordinated care plans to provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan, during which the new MA plan may not require prior authorization for the active course of treatment.

- CMS is requiring all MA plans establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines.

- The final rule requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

Marketing Requirements

- CMS is prohibiting ads that do not mention a specific plan name as well as ads that use words and imagery that may confuse beneficiaries or use language or Medicare logos in a way that is misleading, confusing, or misrepresents the plan.

- In the rule, CMS also reinstates important protections that prevent predatory behavior and finalized changes that strengthen the role of plans in monitoring agent and broker activity. CMS is also finalizing requirements to further protect Medicare beneficiaries by ensuring they receive accurate information about Medicare coverage and are aware of how to access accurate information from other available sources.

Strengthening Quality: Star Ratings Program

- CMS finalizes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors. CMS also reduces the weight of patient experience/complaints and access measures to further align with other CMS quality programs and the current CMS Quality Strategy. In addition, CMS includes an additional rule for the removal of Star Ratings measures and removes the 60 percent rule that is part of the adjustment for extreme and uncontrollable circumstances. The changes will further drive quality improvement and health equity in MA and Part D.

Advancing Health Equity

- CMS is clarifying current rules, expanding the example list of populations that MA organizations must provide services to in a culturally competent manner. These include people: (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minorities; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.

- CMS is finalizing requirements for MA organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to medically necessary covered telehealth benefits.

- CMS is requiring MA organizations to include providers' cultural and linguistic capabilities in provider directories.

- CMS is requiring that MA organizations' quality improvement programs include efforts to reduce disparities.

Improving Access to Behavioral Health

- CMS is finalizing policies strengthening network adequacy requirements and reaffirming MA organizations' responsibilities to provide behavioral health services. CMS will add Clinical Psychologists and Licensed Clinical Social Workers as specialty types for which it sets network standards, and make these types eligible for the 10-percentage point telehealth credit.