TREXIN INSIGHT PAPER

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2024 MEDICARE ADVANTAGE FINAL RULE

Information regarding prior authorization, health equity, quality, and expanded access to behavioral health addressed in the 2024 Medicare Advantage Final Rule.

The Centers for Medicare & Medicaid Services (CMS) published the 2024 Medicare Advantage Final rule on April 5, 2023, which strengthens Medicare and streamlines care delivery in several ways. A matter of special relevance to providers has been the anticipated changes to prior authorization regulations. The regulation announced by CMS on April 5, 2023 has been met with widespread approval from hospitals and payer groups, at least based on first comments. The Biden-Harris Administration is focused on enhancing Medicare and minimizing friction within healthcare to allow individuals to obtain the medically required treatment they need.

Review the simplified rule highlights below; a complete draft of the regulations may be obtained here to learn more about the anticipated Prior Authorization adjustments and other changes made by the rule.

PRIOR AUTHORIZATION

CMS is taking the following actions in the latest rule to address the feedback and concerns it has received about prior authorizations.

- Prior authorization policies must only be used to confirm diagnoses or medical criteria or ensure medical necessity.
- When an enrollee transitions to a new Medicare Advantage (MA) plan, there must be a 90-day transition period during which prior authorization permission remains in effect for as long as medically required.
- MA plans must adhere to national and local coverage determinations and benefit criteria featured in traditional Medicare.
- When no regulations exist, MA plans are allowed to create their own coverage criteria based on the most up-to-date research found in widely accepted treatment recommendations or clinical literature.
- In order to verify that their usage management policies are in compliance with coverage mandates and up-to-date clinical standards, MA plans are required to form a usage Management Committee.

HEALTH EQUITY

Organizations providing MA services need more information on how to implement cultural competence.

- Including providers' cultural and linguistic abilities, such as ASL fluency, is a best practice that should be codified as part of provider directories.
- Requiring MA providers to establish and update systems for identifying members with low digital health literacy and providing them with tailored educational opportunities to improve their skills in this area.
- Requiring MA organizations to include activities in their QI (Quality Improvement) program to address health and healthcare inequities among participants. Communication enhancements and the use of language and culturally relevant materials are just two examples of how MA organizations may utilize their QI program to assist participants from diverse backgrounds in receiving the care they require.

QUALITY RATING SYSTEM

The gist is that the rating systems are being updated to focus on improving the care of beneficiaries. CMS explicitly states in this rule that the remaining proposed Star Rating updates will be addressed in a later final rule. Below is a summary of what is addressed in this current ruling.

- A new health equity index (HEI) reward is being introduced for 2027 Star Ratings to encourage health plans to improve care for people with social risk factors (SRFs).
- The current reward for consistently high performance is being removed.
- The weight of patient experience/complaints and access measures is being reduced to better align with other quality programs and to balance different types of measures in the Star Ratings program.
- The Part C Diabetes Care – Kidney Disease Monitoring measure is being removed and replaced with the Part C Kidney Health Evaluation for Patients with Diabetes measure.
- The Part D Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension (RAS Antagonists), and Medication Adherence for Cholesterol (Statins) measures are being updated.
- Certain Star Ratings measures will be removed in the future, and the 60 percent rule for adjustment due to extreme and uncontrollable circumstances is being removed.
- Technical clarifications and changes are being made related to the disaster adjustment, treatment of ratings for contracts after consolidation, and the use of Tukey outlier deletion.
- These changes will mostly apply to the 2024- and 2026-Star Ratings.
- Other proposed Star Ratings provisions are not finalized in this rule and will be addressed later.

BEHAVIORAL HEALTH ACCESS EXPANDS

CMS has made efforts to improve beneficiaries' access to behavioral health services and resources in response to concerns raised by stakeholders in the agency's most recent rule.

- Strengthening behavioral health networks by requiring MA organizations to meet network adequacy reviews for Clinical Psychology and Licensed Clinical Social Work as specialty categories.
- Requiring behavioral health services will be explicitly included in general access to services standards.
- Criteria for fair wait times for both primary care and mental health treatments will be formalized.
- Certain behavioral health services will be designated as emergency services and not subject to prior authorization.
- MA organizations will be expected to implement programs to integrate behavioral health services with community and social agencies to increase treatment equality.

HOW CAN TREXIN HELP?

If your healthcare organization needs assistance supporting CMS initiatives, please reach out to Trexin Consulting.

References

https://public-inspection.federalregister.gov/2023-07115.pdf

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

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