Medicare Advantage (MA) Program Updates Effective 6/5/2023

Overview

The Centers for Medicare and Medicaid Services (CMS) finalized and published the *Medicare Program; Contract Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*. Changes included in the MA final rule will impact Medicare beneficiaries in nursing homes beginning June 5, 2023.

Updates for Providers

1

Traditional Medicare Coverage Guidelines Apply

MA plans will be required to follow traditional Medicare coverage guidelines when making medical necessity determinations. When coverage criteria are not fully defined by traditional Medicare statute, regulation, national coverage determination (NCD), or local coverage determination (LCD), MAOs may create publicly accessible internal coverage criteria. This coverage criteria must be based on current evidence in widely used treatment guidelines or clinical literature.

2

Internal Coverage Criteria Made Public

MA plans will be required to post internal coverage criteria publicly. Further, MA plans will need to provide a public summary of evidence considered during the development of the internal coverage criteria used to make medical necessity determinations.

3

MAO Responsibility To Ensure Policies Remain Current

MA plans must establish a Utilization Management Committee lead by the Medical Director, to annually review all utilization management policies including prior authorization. This review must ensure MAO policies are consistent with current coverage requirements, including traditional Medicare's national and local coverage decisions and guidelines. It is the MAO Utilization Review Committee's responsibility to ensure their policies remain current with changing requirements and regulations. These changes will help ensure MA beneficiaries have consistent access to medically necessary care, without unreasonable barriers or interruptions. This is qualitatively beneficial for enrollees and is not expected to have economic impact on the Medicare Trust fund.

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Updates for Providers (continued)

4

Use Of Prior Authorization

Prior authorization policies for coordinated care plans 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.

5

Medical Necessity Determination

Approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the beneficiary's medical history, and the **treating provider's recommendation**. When a beneficiary currently undergoing an active course of treatment, enrolls in a new MA plan, the MAO will be required to provide coverage for a minimum 90-day transition period. This is not expected to have economic impact on the Medicare Trust Fund.

Changes for Beneficiary Protections and Improved MA Marketing

1

MAOs will be required to annually notify enrollees in writing, of the ability to opt-out of plan business contacts from their plan.

2

MA agents will be required to explain to the beneficiary, how their enrollment choice will impact their current coverage.

3

MAOs will need to clarify that the contact is unsolicited unless an appointment at the beneficiary's home was previously scheduled.

4

MAOs will be prohibited from marketing benefits in a service area where those benefits are not available.

5

Use of the Medicare name, logo, and Medicare card image in MAO marketing materials will be limited.

6

MAOs will be prohibited from using superlatives in marketing materials unless the material provides documentation to support the statement.