New CMS Rules Regarding Medicare Advantage Prior Authorizations and Marketing

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While the SHIP program is obligated to be neutral and objective in its presentation of different coverage options under Medicare, including between Medicare Advantage (MA) and traditional Medicare, SHIPs regularly encounter problems faced by clients who try to navigate MA prior authorization (PA) requirements. (See last September's *Messenger* story Prior Authorization and Medicare Advantage Plans.) Similarly, SHIPs regularly encounter marketing misconduct by MA and Part D plan sponsors and those selling such plans.

In response to some of these problems, the Centers for Medicare & Medicaid Services (CMS) published a final rule for 2024 regarding MA and Part D, available in the Federal Register at 88 Fed Reg 22120 (April 12, 2023). From a consumer standpoint, this rule makes meaningful improvements to the MA prior authorization process as well as consumer protections surrounding MA and Part D plan marketing, among other issues.

The Center for Medicare Advocacy issued a Special Report: Summary of Final 2024 Medicare Advantage and Part D Rule: Important Consumer Protections Regarding MA Prior Authorization, Marketing and Other Issues (May 2023), which goes into detail about these new provisions; also see a CMS fact sheet about the rule (April 2023).

In short, the rule states that PA should only be used by MA plans to confirm diagnoses or other criteria and to ensure an item/service is medically necessary.

New Medicare Advantage Prior Authorization Provisions

In the final rule, CMS makes it clear that the agency's intent is to narrow the discretion of MA plans' use of PA. In short, the rule states that PA should only be used by MA plans to confirm diagnoses or other criteria and to ensure an item/service is medically necessary.

The rule makes a distinction between scenarios in which coverage criteria are clearly established under Medicare rules and when they are not. When such **criteria are clearly established**, MA plans cannot use any other internal or external rules to decide whether items or services are covered. When such **criteria are not clearly established**, as defined in the rule, plans do have the discretion to

use outside "widely used treatment guidelines or clinical literature," which must be made publicly available.

- **Practice Tip:** If you are assisting an MA enrollee and believe that the outside criteria that are being used are too restrictive, challenge it: New language in the regulations (at §422.101(b)(6)(i)(A)) states: "The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services."

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The rule also has provisions aimed at ensuring continuity of care. For example, the rule says that an approval granted through the PA processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation. Plans can overrule a treating provider's recommendation, including a prescribed order or ordered course of treatment. Plans must also provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to/enrolls in a new MA plan.

New Marketing Provisions

The final rule makes a number of important changes to MA and Part D communications and marketing requirements. These provisions are applicable as soon as plans start advertising for the 2024 plan year on October 1. The rules have provisions that apply to advertising limits, plan obligations, and agent/broker conduct. For a summary of all of the marketing provisions, see the Center for Medicare Advocacy Special Report that is referenced above. Here are some of the highlights:

Limits on advertising include: "placing discrete limits" around the use of the Medicare name, logo, and Medicare card"; prohibiting marketing of benefits in a service area where those benefits are not available (unless unavoidable because of use of local or regional media that covers the service area(s); and modifying the Third Party Marketing Organization (TPMO) disclaimer to add SHIPs as an option for beneficiaries to obtain additional help and to disclose the number of all entities the TPMO represents.

New obligations on plans include: notifying enrollees annually, in writing, of the ability to opt out of phone calls regarding MA and Part D plan business; having a searchable provider directory – "searchable by every element, such as name, location, and specialty, required in CMS' model provider directory" and must also "include providers' cultural and linguistic capabilities;" and simplifying plan comparisons by requiring medical benefits to be in a specific order and listed at the top of a plan's Summary of Benefits (SB).

Regarding **education versus marketing events, educational events** "are meant to provide generic, factual, non-biased information about different coverage options" compared to **marketing events**, where information designed to persuade beneficiaries to enroll in a particular type of plan (for example, MA–PD or Medigap) or in a plan offered by a specific organization is provided.

- CMS prohibits a marketing event from occurring within 12 hours of an educational event at the same location. (Note: This reinstates a policy in effect prior to 2018 requiring separation in time and distance between such events.)
- CMS prohibits the collection of scope of appointment (SOA) cards at educational events. CMS still allows agents to collect business reply cards (BRCs) at educational events while prohibiting agents from setting up future marketing appointments at such events.

Additional **agent/broker limitations** include: requiring 48 hours between an SOA and an agent meeting with a beneficiary, with exceptions for beneficiary-initiated walk-ins and the end of a valid enrollment period (e.g., the last four days of the Annual Enrollment Period (AEP), the MA Open Enrollment Period (MA-OEP), the Initial Coverage Election Period (ICEP), and a Special Enrollment Period (SEP); clarifying that the prohibition on door-to-door contact without a prior appointment still applies after collection of a BRC or SOA; and limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that the enrollee first asked for information.

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CMS requires agents to "explain the effect of an enrollee's enrollment choice on their current coverage whenever the enrollee makes an enrollment decision." This is to be done through a new requirement to the Pre-Enrollment Checklist (PECL), which is provided along with hard-copy enrollment forms (and agents must review them during telephonic enrollments). "Effect on current coverage" is added to the list of information plans must provide to prospective enrollees.

Separate from the PECL, CMS has added a list of required elements agents and brokers must discuss with beneficiaries prior to enrollment in an MA or Part D plan. The final rule adds new language to the regulations (at 42 CFR §422.2274(c)(12) (for Part D, see §423.2274(c)(12))) stating that MA organizations must:

> "Ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary's current providers are in the plan's network), regarding pharmacies (that is, whether or not the beneficiary's

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current pharmacy is in the plan's network), prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs."

- **Practice Tip:** This provision will hopefully lead to more robust discussions between agents/brokers and beneficiaries and more informed decision-making. If you are counseling someone who thinks they were misled or not fully informed before enrolling in a plan, this provision provides a good checklist of topics to review with the beneficiary to see if they were adequately discussed with an agent/broker.

Conclusion

These new CMS rules provide important consumer protections against the misuse of PA and marketing misconduct. As with any other consumer protections, the efficacy of these new rules will depend on MA plan compliance and effective CMS oversight.

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