# Navigating the 2024 Medicare Advantage Final Rule: **A Roadmap to Compliance**

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The 2024 Medicare Advantage (MA) and Part D final rule reflects a comprehensive effort by CMS to create a more streamlined, equitable, and effective healthcare delivery system that improves care quality and accessibility. Heralded as providing significant value to members, this rule is intended to simplify prior authorization processes, ensure consistent and undisrupted access to medically necessary care and protect members from arbitrary denials.

**But to comply with this rule, health plans have a lot of work to do.**

The implications to utilization management operations are substantial and require health plans to invest in new levels of staff training, technology upgrades and process optimization to comply with the rule's requirements. Plans are finding four issues particularly challenging to implement—and with mandatory audits on the horizon may risk penalties for non-compliance.

1. **Alignment with traditional Medicare standards** – Aligning utilization management policies with traditional Medicare's national and local coverage decisions, while always a requirement, limits a plan's ability to utilize additional criteria to establish medical necessity. Plans must follow a hierarchy of coverage decision guidelines—starting with national then local guidelines—before ever consulting internal or third-party guidelines such as MCG or Interqual, limiting their ability to impact treatment plans and requiring additional expertise to ensure alignment.

2. **Medical necessity reviews by clinical professionals with expertise in the field** – Ensuring that denials are reviewed by healthcare professionals with relevant experience—not just the typical primary care physician serving as reviewer—can add an extra step in the decision-making process and potentially require additional resources to ensure compliance.

3. **Establishing a utilization management committee for policy review** – While most health plans already have utilization management committees, the structure must now include a majority of practicing MDs, specialists, and an independent, conflict-free physician. This adds an additional layer of administrative complexity and may require additional resources.

4. **Medical criteria publishing requirements** – Whether organizations use third-party guidelines or internally developed policies, criteria and included services must be published, along with a rationale and evidence that shows that the guidelines are valid and widely used. Not only does this requirement create a compliance burden, but the proprietary nature of content from organizations like Interqual and MCG may complicate publishing.

## So what does this mean for health plans?

While the depth of impact to health plans remains uncertain, it is clear that the policy and process changes to meet rule requirements are having an immediate effect on operations.

**It takes more effort to be compliant.** Health plans are already struggling to deploy the right clinical resources to operate effectively. The changes necessary to follow the new regulations around medical criteria and medical expertise require knowledge and resources that plans may not have readily available.

**Health plans have less control over utilization management operations.** While prioritizing physician recommendations over medical necessity guidelines is intended to remove barriers, it may also create some risk for patients as the physician-recommended course of treatment may not consider alternative, safer and less costly settings and services that could result in the same or better outcomes.

**As a result, higher utilization costs are almost inevitable.** For example, even when a patient can safely be discharged to home health after hospitalization it's easy for a physician to recommend a skilled nursing facility, despite the fact that many patients would recover better at home without the risks inherent to an institutional setting. Similarly, some patients may benefit from trying physical therapy and/or medication rather than going straight to an invasive (and high-cost) option such as surgery. In both cases, the physician's recommendation must be authorized if the national or local decision criteria do not include options, regardless of the plan's evidence-based care guidelines, even if the recommendation skips interim treatment options.

## Don't have the right resources to bring it all together? Toney Healthcare can help.

We offer deep expertise in utilization management operations and how Medicare Advantage and other policies and regulations impact health plans. Our clinical experts can evaluate your operations and help you align your processes, people, and systems with regulatory requirements. And, we can quickly augment your staff with seasoned professionals to fill leadership, physician, clinical specialty and frontline UM operational gaps for as long—or as short—as you need.

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## Key Steps to Bringing Your Plan into Compliance

*While the final rule is effective now, many plans are not yet in compliance. Here are some concrete steps that will get you on the right path.*

1. **Become educated**—or hire expertise—to understand the national and local coverage decisions that are prioritized over the evidence-based criteria you already use. You'll need to publish your policies, criteria, and services, so make sure you understand how they all fit together.

2. **Evaluate processes and resources** to see what needs to change. Your system's rules and other automation will likely need modification to address the new regulations for coverage decisions, and you may not have the specialty or physician resources to cover the new authorization review and UM committee guidelines.

3. **Conduct internal audits** so you have time to correct deficient processes before receiving a CMS audit notice. The majority of MA plans will be audited for the new requirements in 2024, and CMS takes these audits seriously. You should too.

4. **Consider engaging with experienced resources** who have strong knowledge of Medicare coverage criteria to help you identify gaps and corrective actions and to provide onsite or remote support to ensure your CMS audit goes as smoothly as possible.

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