Holding Medicare Advantage Plans Accountable to New Policies

On April 5, 2023, CMS finalized a new set of regulations applicable to coverage beginning on Jan. 1, 2024, to increase oversight of Medicare Advantage plans and better align coverage with traditional Medicare. This document provides strategies for hospitals in holding Medicare Advantage payers accountable to the new requirements. These changes do not address all the concerns with Medicare Advantage plans; however, they are an important first step and new tool for improving patient care.

Key Provisions for Hospitals

The Contract Year (CY) 2024 Medicare Advantage Final Rule includes many significant changes that have been long-standing priorities for hospitals. The changes seek to increase oversight of Medicare Advantage plans and better align coverage with traditional Medicare. New policies important to hospitals include:

- Require Medicare Advantage plans to comply with national coverage determinations, local coverage determinations, and general coverage and benefit conditions included in traditional Medicare laws, prohibiting plans from using InterQual or Milliman Care Guidelines to change coverage of basic benefits;
- Prohibit Medicare Advantage plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions do not exist in traditional Medicare;
- Establish restrictions on when and how a plan may create internal coverage criteria in specifying instances where coverage criteria are not fully established under traditional Medicare;
- Direct Medicare Advantage plans to adhere to the Two-Midnight Rule for coverage of inpatient admissions, which requires coverage for inpatient care when the admitting physician expects the patient to require hospital care that extends over two midnights;
- Clarify that the CMS inpatient-only list applies to Medicare Advantage plans;
- Prohibit Medicare Advantage plans from establishing restrictions on the site of service for basic benefits if such restrictions do not exist in traditional Medicare;
- Clarify the circumstances under which Medicare Advantage plans may use prior authorization;
- Require health plan clinicians reviewing prior authorization requests to have expertise (i.e., specialized training, certification, or clinical experience) in the relevant medical discipline for the service being requested;
- Require prior authorizations to be valid for an entire course of approved treatment and to be valid through a 90-day transition period if an enrollee undergoing treatment switches to a new Medicare Advantage plan;
- Prohibit Medicare Advantage plans from denying payment for a service based on medical necessity if the service was prior authorized; and
- Establish additional processes to oversee Medicare Advantage plan utilization management programs including an annual review of policies to ensure consistency with federal rules.

Strategies to Hold Payers Accountable

Given a well-documented history of inappropriate delays and denials of care by Medicare Advantage plans, it is important that hospitals have tools to hold Medicare Advantage plans accountable to these new changes. Best practices for monitoring Medicare Advantage plan compliance with these new regulations include:

- **Exercising Provider Appeal Rights:** Providers can formally dispute and appeal adverse determinations when appropriate. For contracted providers, this process is governed by the provider contract with the Medicare Advantage plan. For non-contracted providers, CMS has a five-stage appeal process (more information here).

- **Support Patients in Exercising Beneficiary Appeal Rights:** Encourage patients to report concerns or problems with Medicare Advantage coverage to 1-800-MEDICARE; direct patients to the Medicare Beneficiary Ombudsman or complete a formal Assignment of Appeal Rights to conduct member-assisted appeals on behalf of patients.
- **Report Violations of Federal Rules:** If you suspect or have evidence of violations of federal policy related to the Medicare Advantage program, submit complaints or information to the CMS Regional 8 Office at RODENORA@cms.hhs.gov.
- **Align Contractual Language with Provisions of the Final Rule:** Engage in proactive conversations with your contracted Medicare Advantage plans about the provisions in this final rule and, where possible, negotiate contractual language that aligns with Medicare coverage rules.
- **Leverage the Medicare Advantage Organization Utilization Management Committees (UMCs):** Per the final rule, Medicare Advantage plans must create UMCs led by the plan's medical director to check compliance with key provisions of this rule related to prior authorization and the use of medical necessity criteria.
- **Collect Data and Examples to Demonstrate Challenges for Patients and Providers:** Providers should identify and report examples of, and data on, non-compliance or inappropriate delays and denials of patient care to federal regulators. Some suggested metrics to track include prior authorization turnaround time, percent of prior authorization claims denied and appealed, number of claims denied and appealed, average length of stay for observation cases, number of observation stays exceeding Two Midnights, and number of Medicare Advantage inpatient admissions downcoded to observation status.

ADDITIONAL RESOURCES:

- AHA CY2024 Medicare Advantage Final Rule Implementation Handbook
- FAQs Related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule

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