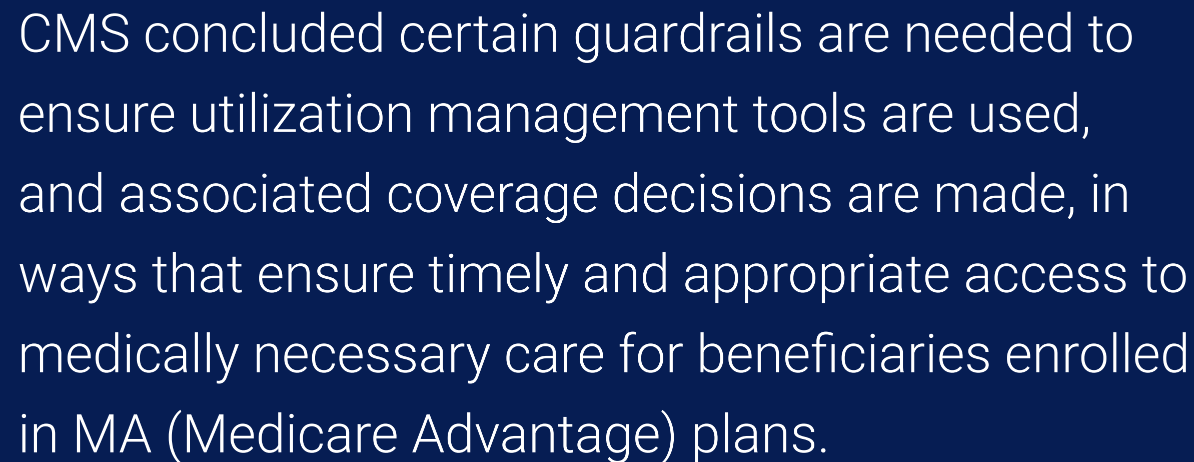
Closer Look

2024 Medicare Advantage Program Changes

CMS Final Rule Analysis


CMS concluded certain guardrails are needed to ensure utilization management tools are used, and associated coverage decisions are made, in ways that ensure timely and appropriate access to medically necessary care for beneficiaries enrolled in MA (Medicare Advantage) plans.

CMS, Final Rule, 88 FR 22186

Table of Contents

Ensemble Health Partners' team of subject matter experts prepared the following analysis to provide clarity on the 2024 Medicare Advantage program changes and how they may impact you.

For questions, please contact:

Brad Gingerich
VP, Revenue Cycle Operations, Payor Strategy
Brad.Gingerich@EnsembleHP.com

Stacie Sutter
Sr. Director, Payor Performance, Denials Avoidance
Stacie.Sutter@EnsembleHP.com

01 2024 Medicare Advantage + Part D Final Rule Background

02 New Rules for Medicare Advantage Coverage Criteria

03 New Rules for Prior Authorizations

04 New Requirement: Utilization Management Committee

05 3 Tips for Success: How to Prepare + Hold MA Plans Accountable to New Requirements

2024 Medicare Advantage + Part D **Final Rule Background**

APR. 25, 2023

CMS issued final rule implementing new requirements for Medicare Advantage Organizations (MAOs) with respect to utilization management and review of organization determinations.

JAN. 1, 2024

Although the final rule is technically effective June 5, the new utilization management requirements are applicable to coverage beginning Jan. 1, 2024.

Key Changes Include:

- MA plans must comply with traditional Medicare coverage criteria requirements and standards.
- MA plans can only use the prior authorization process to validate medical necessity and clinical appropriateness of service.
- MA plans must establish a Utilization Management (UM) committee to review and approve all UM policies and procedures to ensure alignment with traditional Medicare.

New Rules for MA Plan Coverage Criteria

MA Plans Must Comply With:

- Local Coverage Determinations (LCD)
- National Coverage Determinations (NCD)
- General coverage + benefits included in traditional Medicare laws
- **MA plans may no longer limit or deny coverage when the item or service would be covered under traditional Medicare as a basic benefit.**

Example of What This Includes:

- MA plans will follow the Inpatient Only list released yearly by CMS indicating which procedures must be performed in a hospital + are automatically approved for coverage.
- The Two-Midnight Rule (coverage + payment for an inpatient admission when the admitting physician expects the patient to require hospital care that crosses two midnights) will now apply to MA plans.

The Final Rule doesn't dictate how MAOs must decide which of these claims are subject to medical review. While CMS tells their contractors to presume hospital stays spanning two or more midnights are reasonable and necessary for Part A payment, CMS makes clear this same audit instruction doesn't and will not apply to MAOs. MAOs will therefore still be able to audit these claims for compliance.

Why It Matters

The Final Rule clarifies rules related to acceptable coverage criteria for basic benefits, and limits when MAOs may establish their own internal coverage criteria. For providers and beneficiaries, it adds transparency to coverage determinations and ensures MA beneficiaries receive access to the same medically necessary care as they would receive in Traditional Medicare.

What's the Impact?

This should drastically reduce the volume of prior authorization requirements and denials and remove ambiguity of what's covered.

FAQ:
MA Internal Coverage Criteria

When can MAOs apply their own internal coverage criteria?

When coverage criteria are not fully established in Medicare statute, regulation, NCD or LCD, MAOs may create publicly accessible internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature.

When is coverage criteria not "fully established"?

> When additional, unspecified criteria are needed to interpret or supplement general provisions to consistently determine medical necessity. The MAO must demonstrate the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including delayed or decreased access to items or services.

> When NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications listed in the NCD or LCD.

> When there's an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

MAOs must make medical necessity determinations based on:

> Coverage + benefit criteria as specified in Medicare regulations

> Whether the provision of items or services is reasonable + necessary

> The enrollee's medical history, physician recommendations + clinical notes

> Involvement of the MAO's medical director, where appropriate

FAQ:
MA Internal Coverage Criteria, cont'd

Can MAOs deny coverage of an item or service based upon internal coverage criteria?

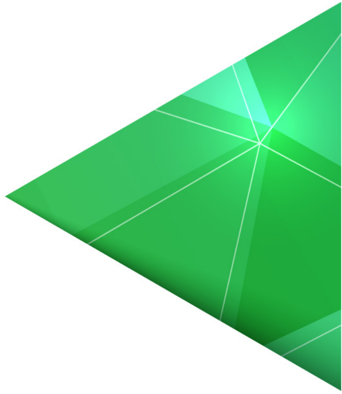
Yes, so long as the MAO compliantly developed and applied internal coverage criteria. If an MAO denies care based on internal criteria, that criteria must be clearly stated in the denial notice with the specific reason for the denial.

Can MAOs continue to use utilization management products like InterQual + MCG?

Yes, so long as the requirements for use of internal coverage criteria are previously met. Use of these tools, in isolation, without compliance with requirements in this Final Rule, is prohibited.

Why It Matters

An MAO can't deny coverage of an item or service with fully established coverage criteria based on internal, proprietary or external clinical criteria not found in traditional Medicare coverage policies.



New Rules for Prior Authorizations

Ensuring access to covered benefits is one of CMS' policy goals for the MA program. Regulating use of prior authorization to ensure inappropriate barriers to services are not being established supports that policy goal.

Prior authorization processes may only be used for one or more of the following purposes:

> To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service.

> For basic benefits, to ensure an item or service is medically necessary.

> For supplemental benefits, to ensure the furnishing of a service or benefit is clinically appropriate.

Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history and the treating provider's recommendation.

Why It Matters

Traditional Medicare requires prior authorization on 3% of claims compared to the average 28% of commercial payors (source: Ensemble data).

93% of surveyed physicians report care delays while waiting for authorization. 82% have seen treatment abandoned as a result (source: AMA survey with additional stats).

What's the Impact?

MA plans can't later deny coverage of an item or service based on medical necessity if it previously issued a prior authorization for that item or service.

MA plans also can't reopen such a decision for any reason except for good cause or if there's reliable evidence of fraud or similar fault.

New Requirement:
Utilization Management Committee

- MAOs that use utilization management (UM) policies and procedures, including prior authorization, must establish a UM committee for the annual review of all UM and prior authorization policies and procedures used by the MAO.
- UM committee may only approve policies and procedures that comply with Medicare coverage criteria requirements and standards. These committees must document in writing the reasons for their decisions regarding the development of UM policies and procedures and make the documentation available to CMS upon request.
- UM committee must be led by a plan's medical director and include a certain composition of members, including at least one practicing physician who's independent and free of conflict relative to the MAO, and members who represent various clinical specialties.
- MAOs may not use any UM policies and procedures for basic or supplemental benefits on or after Jan. 1, 2024, unless those policies and procedures have been reviewed and approved by the UM committee.
- CMS will perform oversight through its current monitoring activities.

3 Tips for Success:
How to Prepare + Hold MA Plans Accountable to New Requirements

01 UM + case management is your first line of defense under these new guidelines. Ensure your UM team is educated and equipped to identify instances of noncompliance and hold MA plans accountable to these new requirements.

02 Get appeal templates ready. Be able to identify the issue and respond timely and appropriately to hold MA plans accountable.

03 Be prepared to identify noncompliance with denials. Have a plan to escalate with the MA plan and their leadership / provider relations. There'll be no method for providers to file complaints with CMS — it'll monitor MA plans through existing oversight activities, and through request and review of UM committee documentation.

We take a holistic approach to financial health.

Ensemble is a leading provider of tech-enabled revenue cycle managed services, partnering with more than 250 hospitals and health systems across the U.S.

We're driven by people, fueled by technology and focused on progress.

© 2023 Ensemble Health Partners | EnsembleHP.com

These materials are for general informational purposes only. These materials do not, and are not intended to, constitute legal or compliance advice, and you should not act or refrain from acting based on any information provided in these materials. Neither Ensemble Health Partners, nor any of its employees, are your lawyers. Please consult with your own legal counsel or compliance professional regarding specific legal or compliance questions you have.