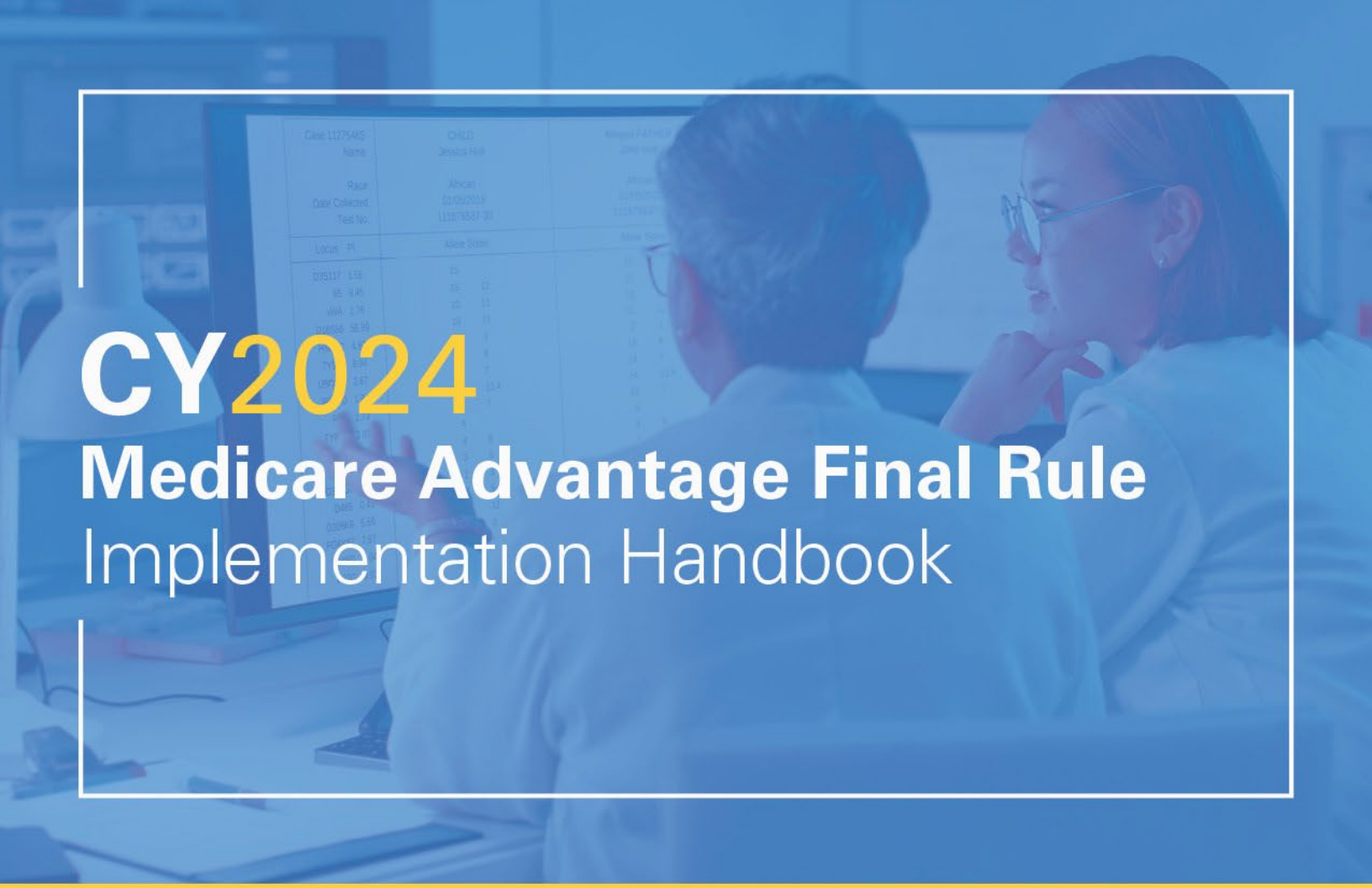

CY2024
Medicare Advantage Final Rule
Implementation Handbook

November 2023

American Hospital Association™
Advancing Health in America

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American Hospital Association™
Advancing Health in America

Introduction

On April 5, the Centers for Medicare & Medicaid Services (CMS) finalized its Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program for contract year (CY) 2024. The final rule increases oversight of Medicare Advantage (MA) plans and seeks to better align MA coverage with Traditional Medicare. The provisions in the final rule are applicable to coverage beginning on Jan. 1, 2024, unless otherwise noted in the rule.

The following sections provide:

- A summary of the various provisions of the final rule;
- AHA analysis of key provisions for hospitals and health systems;
- Frequently asked questions;
- Best practices for monitoring MA plan compliance;
- Suggested metrics to track;
- Details on AHA's enforcement priorities; and
- AHA resources and staff contacts.

The AHA strongly supports these regulatory changes intended to protect coverage of Medicare enrollee benefits, promote more timely access to care, ensure better alignment and coverage parity between Traditional Medicare and MA, and reduce the administrative burden of health plan requirements on health care providers and their patients. However, we understand that the hospital field is concerned about Medicare Advantage Organization (MAO) adherence with new policies given the well-documented history of inappropriate delays and denials of patient care by MA plans.

In addition to finalizing new policies that hospitals have urged the agency to adopt, CMS also notes in the final rule that it is codifying longstanding existing policy in a number of areas where there is concern about compliance with current policy necessitating further clarification in regulation. Given these historical challenges, we recognize that compliance with the new rules may require significant shifts from current MA plan practices, as well as ongoing monitoring from CMS and providers.

With this in mind, we have developed this implementation guide as a resource to help prepare hospitals and health systems for the upcoming regulation changes and to equip them with tools to better advocate for MA plan compliance with regulatory requirements. We provide a summary of the final rule's provisions to help member hospitals understand the policy changes and their implications, address common questions and nuances in the rule, and provide guidance on best practices for holding MA plans accountable — such as mechanisms for reporting violations of federal rules. We also are continuing our advocacy with the Administration, urging CMS to conduct rigorous oversight to enforce the policies and safeguards included in the rule and to ensure that appropriate action is taken in response to any violations.

While the AHA is concerned about compliance with new rules, it is important to note that we do not believe all MAOs are bad actors; in fact, many have active partnerships with providers in service of their shared patients and members and consistently act in good faith to follow the rules. To this end, we believe that enforcement actions should be targeted, to the extent possible, to MAOs who have a history of suspected or actual violations or whose performance metrics related to appeals, grievances and denials could be indicative of a broader problem warranting investigation. Every effort should be made in carrying out enforcement activities to ensure that undue burden is not placed upon MAOs who consistently act in good faith and adhere to CMS rules.

The AHA stands ready to support hospitals and health systems in the implementation phase of this final rule and the next chapter of our shared advocacy to enhance patient access and improve the way MA works for patients and their providers.

Disclaimer: Please note that the information contained in this guide is based on the AHA's best understanding of the law and regulations at this time. This information should not be considered legal advice. We encourage hospitals and health systems to consult with their legal counsel to ensure compliance with all federal laws and regulations.

Key Provisions for Hospitals and Health Systems

The final rule will:

- Require MA plans to comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare laws;
- Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria in a way that differs from requirements under Traditional Medicare;
- Establish restrictions on when and how a plan may create internal coverage criteria in specific instances where coverage criteria are not fully established under Traditional Medicare;
- Direct MA plans to adhere to the two-midnight rule for coverage of inpatient admissions (see Frequently Asked Questions, question one for details);
- Clarify that the CMS inpatient-only list applies to MA plans;
- Limit MA plans' ability to apply site-of-service restrictions not found in Traditional Medicare;
- Clarify the circumstances under which MA plans may use prior authorizations;
- Require health plan clinicians reviewing prior authorization requests to have expertise 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 MA plan;
- Prohibit MA plans from denying payment for a service based on medical necessity if the service was prior authorized;
- Establish additional processes to oversee MA plan utilization management programs including an annual review of policies to ensure consistency with federal rules;

- Strengthen behavioral health network adequacy requirements;
- Tighten MA marketing rules to protect beneficiaries from misleading advertisements and pressure tactics;
- Expand requirements for MA plans to provide culturally and linguistically appropriate services;
- Establish a new Health Equity Index to be incorporated into MA plan Star Ratings beginning in 2027; and
- Implement statutory provisions of the Inflation Reduction Act and the Consolidated Appropriations Act of 2021 related to prescription drug affordability and coverage for eligible low-income individuals.

Notably, the final rule did not codify the proposed change to the legal standard for identifying an overpayment, which was of concern to hospitals and health systems.

For additional details and detailed summary on each of the provisions referenced above, please refer to the **CMS Fact Sheet** and **AHA's Regulatory Advisory on the MA CY24 Final Rule**.

Frequently Asked Questions

1. Does the CY 2024 MA final rule require MA plans to follow the two-midnight rule for inpatient admissions?

The final rule explicitly clarifies that MA plans must adhere to the two-midnight rule under Traditional Medicare, which requires that an MA plan provide coverage for inpatient care when the admitting physician expects the patient to require hospital care that extends over two midnights. The rule states that "under § 422.101(b)(2), an MA plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the 'two midnight benchmark'); when admitting physician does not expect the patient to require care that crosses two-midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the 'case-by-case exception'); and when inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2))."

Accordingly, MA plans will be prohibited from applying requirements or standards for inpatient admissions that are based on alternate or additional criteria that are not consistent with the two-midnight benchmark. For example, an MA plan cannot apply a short stay policy that applies internal or proprietary criteria which is unrelated to the two midnight benchmark or uses more restrictive criteria, such as applying a standard of 48 hours instead of two midnights.

However, the rule does not prevent MA plans from reviewing the appropriateness of the admitting physician's order for inpatient admission — or in other words, from evaluating the reasonableness of the physician's expectation that the patient's condition would require inpatient level care exceeding two midnights based on factors documented in the medical record. CMS states, "the two-midnight presumption (the presumption that all inpatient claims that cross two midnights following the inpatient admission order are 'presumed' appropriate for payment and are not the focus of medical review absent other evidence) does not apply to MA plans" *(emphasis added)*. As a result, MA plans will be permitted to review admissions retrospectively to evaluate whether the documentation in the clinical record supported the expectation that the patient's case would extend over the course of at least two midnights.

MA plans may still use prior authorization or concurrent case management review of inpatient admissions based on whether the complex medical factors documented in the medical record justify the admitting clinician's order for inpatient care, under either the two-midnight rule or case-by-case exception. But again, the criteria the plan uses in evaluating the appropriateness of care through prior authorization or concurrent case management must be consistent with Traditional Medicare criteria and the two-midnight benchmark.

2. Can MA plans still use their own medical necessity criteria, such as InterQual or MCG guidelines, in making coverage determinations? If so, in what circumstances can they use their own criteria?

The final rule requires MA plans to adhere to Traditional Medicare coverage policies when making a medical necessity determination, including an explicit statement that plans cannot utilize alternative criteria to deny coverage of an item or service that would be approved under CMS rules. The rule specifically requires that MA plans must comply with NCDs, LCDs, and general coverage and benefit conditions included in Traditional Medicare regulations when applying coverage criteria for basic benefits. This change effectively precludes the use of InterQual or MCG guidelines (or other proprietary criteria) to change coverage of basic benefits and requires MAOs to rely on Traditional Medicare coverage policies and criteria for these services. At 412.622(a)(3)), CMS states, "MA plans may not use InterQual or MCG Criteria, or similar products, to change coverage or payment criteria already established under Traditional Medicare laws."

If a service does not have fully established coverage criteria under Traditional Medicare rules, plans may adopt their own coverage criteria, but they must do so in a way that meets certain standards set forth by CMS. CMS states that "when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD, an MA plan may create internal coverage criteria." However, CMS requires that the MA plan make such criteria available, in a publicly accessible way, including a summary of evidence that was considered during the development of the internal coverage criteria, a list of the sources of such evidence and an explanation of the rationale that supports the adoption of the coverage criteria used to make a medical necessity determination. Additionally, before an internal coverage policy can be used, "MA organizations must ensure that they are making medical necessity determinations based on the circumstances of the specific individual, as outlined at § 422.101(c), as opposed to using an algorithm or software that doesn't account for an individual's circumstances."

3. The new rules require that MA plan physicians or other qualified health care professional reviewing prior authorization requests have relevant expertise in the discipline of the service being requested. Does that mean they have to be practicing in the same specialty?

No, the final rule requires that if an MA plan anticipates issuing a partial or full denial of requested services based on review of the initial prior authorization request, the plan's determination must be reviewed by a physician or other qualified professional with expertise in the medical field or health care that is appropriate for the service at issue prior to the plan issuing a denial. However, the reviewer is not required to be practicing in the same specialty or subspecialty as the treating health care provider. CMS notes in the rule that "if the plan reviewer is not of the same specialty or

subspecialty as the treating physician, it's our expectation that the physician or other appropriate health care professional have specialized training, certification, or clinical experience in the applicable field of medicine in order to satisfy the requirement of expertise in the field of medicine that is appropriate for the requested item or service."

4. **Does a prior authorization request have to be reviewed by a physician or can it be another type of clinician with appropriate expertise in the medical field that is appropriate for the service being requested?**

   An initial determination can be made by a physician or other qualified health care professional, as set forth in the CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. However, any reconsideration or other appeal of a medical necessity determination must be conducted by a physician, as defined in Social Security Act Section 1861(r).

5. **Under the new rules, can an MA plan retroactively deny a service for being medically unnecessary if the service requested was approved under prior authorization?**

   No, an MA plan cannot retroactively deny a service for being medically unnecessary if that service had previously received prior authorization. Specifically, CMS states, "if the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter) or if there is reliable evidence of fraud." Note that this provision codifies existing and longstanding policy in the Medicare Managed Care Manual, Chapter 4, Section 10.16.

6. **There are a number of prior authorization provisions finalized in the rule. Does this have any implications for the proposed prior authorization rule CMS issued in December 2022? What is the status of that separate regulation on prior authorization?**

   The MA final rule and the December 2022 Interoperability and Prior Authorization Processes proposed rule are separate and distinct. The MA rule finalized several provisions related to prior authorization, which are included in the summary above. The Interoperability and Prior Authorization Processes proposed rule is designed to streamline prior authorization processes and advance electronic health information exchange through policies and technology. It would apply to MAOs, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service programs, Medicaid managed care plans and CHIP managed care entities, and Qualified Health Plan issuers on the federally facilitated exchanges. For more details on the provisions included in this proposed rule, please review AHA's Special Bulletin and the CMS Fact Sheet. AHA's comments on the proposed rule can be found here. A final rule currently is under development and will be posted to the federal register once released.

7. Do the new rules limit MA plans' ability to apply site of service restrictions?

Yes, the final rule prohibits MA plans from establishing restrictions on the site of service for basic benefits if such restrictions do not exist in Traditional Medicare. Specifically, the rule states, "under our proposal at § 422.101(c)(1)(i), when care can be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for an MA enrollee, the MA organization may only deny coverage of the services or setting on the basis of the ordered services failing to meet the [Traditional Medicare] criteria." This limits MA plans' ability to restrict when and how covered benefits are furnished when Traditional Medicare will cover different provider types or settings. For example, if a surgery would be covered under Traditional Medicare in either an outpatient hospital or in an ambulatory surgery center (ASC), the MA plan must provide coverage in the same settings and may not limit coverage based on the plan's preferred setting (e.g., only provide coverage in an ASC) if there is no basis for that restriction in Traditional Medicare. MA plans may still use benefit design structures, such as differential patient cost sharing based on the site of service to incentivize utilization in lower-cost settings, but they may not restrict coverage based on this preference. MA plans that opt to use benefit design structures to apply tiering or differential cost sharing to certain sites of care must still adhere to CMS rules which prohibit patient cost sharing amounts in excess of 50% of the MA plans' financial liability for the covered service.

8. Can an MA plan deny coverage of certain post-acute care settings in order to redirect the patient to a lower intensity setting of care?

Under the site of service restrictions described in the question above, an MA plan may not require a patient to receive care at an alternate provider type or setting if the basis for that restriction does not exist in Traditional Medicare. An MA plan can only deny coverage based on the site of care if the patient does not meet the established Traditional Medicare coverage criteria required for that setting. This precludes an MA plan from denying coverage based on its preference for a lower-cost or lower-intensity care setting. CMS further explains, "if an MA patient is being discharged from an acute care hospital and the attending physician orders post-acute care at a SNF [skilled nursing facility] because the patient requires skilled nursing care on a daily basis in an institutional setting, the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for SNF care."

9. Do the new rules limit step therapy?

The final rule does not prohibit step therapy for Part B-covered drugs, but it restricts step therapy arrangements for non-drug items and services where an MA plan may require an enrollee to receive a different or lower cost service prior to the item or service their clinician ordered. Specifically, CMS states, "certain utilization management processes, such as clinical treatment guidelines that require another item or service be furnished prior to receiving the requested item or service, would violate the proposed requirements at § 422.101(b) and (c), and thus, their use by an MA organization would be prohibited unless specified within the applicable NCD or LCD or Medicare statute or regulation."

For example, under this policy, an MA plan could not require a patient to receive a CT scan as a condition of approval for an MRI if the request for an MRI is medically necessary and meets applicable Medicare coverage criteria.

10. When do the new rules go into effect?

The provisions in the final rule are applicable to coverage beginning on Jan. 1, 2024, unless otherwise noted in the rule. There are several provisions included in the rule with variable effective dates, such as those governing changes to MA marketing and communications requirements, which are effective beginning Sept. 30, 2023, for contract year 2024. Additionally, there are a number of provisions in the final rule which codify existing, longstanding policy for MA plans and are therefore already in effect.

11. Do you anticipate CMS issuing a subsequent or second final MA rule this year?

CMS indicated in the preamble of the CY 2024 final rule that it intends to publish a second final rule to address remaining proposals from the December 2022 proposed rule that were not addressed in final rulemaking. This includes proposals related to formulary flexibility for biosimilars and changes to the legal standard for identifying an overpayment. AHA expressed significant concern over the agency's proposal to change the standard for identifying an overpayment and is pleased this provision was not finalized. We will continue to express our concerns and objections to the proposal should it return in subsequent rulemaking. The agency notes that a second final rule would have a later effective date, applicable to coverage beginning no earlier than Jan. 1, 2025.

In addition, CMS published Nov. 6, 2023, the CY 2025 MA proposed rule. After the public comment period, which ends Jan. 5, 2024, the CY 2025 rule will be finalized in spring 2024 and take effect Jan. 1, 2025. CMS notes in the CY 2025 proposed rule that there are still outstanding proposals from the CY 2024 proposed rule that were not finalized and still may be addressed in subsequent rulemaking.

Best Practices for Monitoring MA Plan Compliance

Exercise Provider Appeal Rights

Hospitals providing care for MA beneficiaries should understand their appeal rights and should be prepared to formally dispute and appeal adverse determinations where appropriate. This includes understanding the differences in provider appeal rights for contracted and non-contracted providers, as well as pathways for expedited appeals in time sensitive cases.

Contracted Providers: The appeals process for contracted providers (when the appeal is on behalf of the provider) is governed by the provider contract with the MA plan.

Non-contracted Providers: CMS provides non-contracted providers with a five-stage appeal process consisting of the following levels:

- Level 1: Reconsideration from your plan
- Level 2: Review by an Independent Review Entity
- Level 3: Decision by the Office of Medicare Hearings and Appeals
- Level 4: Review by the Medicare Appeals Council
- Level 5: Judicial review by a federal district court

More information and guidance on Medicare appeal policies and processes can be found on the CMS website.

- Medicare Managed Care Appeals and Grievances: Notices and Forms
- Provider Payment Dispute Resolution for Non-Contracted Providers
- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
- Office of Medicare Hearings & Appeals (OMHA)
- Medicare Parts A & B Appeals Process (Traditional Medicare)

Support Patients in Exercising Beneficiary Appeal Rights

Hospitals and health systems regularly support patients in navigating the health care system and their insurance coverage. This can include helping patients to exercise their Medicare appeal rights when services are denied. Members are entitled to the five-stage appeals process detailed above regardless of whether they sought care at an in-network or out-of-network facility.

Strategies to support patients in exercising their appeal rights may include:

- Providing patients with information about how to file a complaint or grievance;
- Encouraging patients where appropriate to report concerns or problems with MA coverage to 1-800-MEDICARE;
- Directing patients to the Medicare Beneficiary Ombudsman (MBO); or
- Conducting member-assisted appeals on behalf of patients where appropriate, including working with patients to complete a formal assignment of appeal rights (AOR) to allow the provider to appeal on a patient's behalf.

How can hospitals help patients who have been denied care?

Specific steps to share with patients if you believe a medically necessary, Medicare-covered service has been inappropriately denied by their MAO.

- **Call your plan.** If your inquiry is related to your Medicare Part D or Medicare Advantage (Part C) plan, contact your plan first using the phone number on your plan member ID card. Your plan is the best resource to resolve plan related issues.
- **Call 1-800-MEDICARE.** Call 1-800-633-4227; TTY users should call 1-877-486-2048. If your concern is related to Original Medicare, or if your plan was unable to resolve your inquiry, contact 1-800-MEDICARE for help.
- **Contact the SHIP.** The State Health Insurance Assistance Programs (SHIPs) are state programs that provide free local health insurance counseling to people with Medicare regarding their benefits, coverage, appeals and complaints. Find your local SHIP here.
- **Contact the MBO.** If you have been unable to resolve your concern with your plan or 1-800-MEDICARE, ask a 1-800-MEDICARE representative to submit your complaint or inquiry to the MBO. The MBO will help to ensure that your inquiry is resolved appropriately.

Additional information about patient appeal rights for MA beneficiaries are available on the CMS website and can be found here.

Report Violations of Federal Rules

The non-interference clause in federal statute limits CMS' ability to intervene in matters that relate to contractual disputes or payment issues between MA plans and providers. However, violations of federal policy are not just a contractual issue, and therefore, private dispute resolution is not the appropriate oversight mechanism to address broader issues of non-compliance with federal laws and regulations. The AHA continues to advocate for more streamlined ways for providers and patients to report violations of federal rules, including a provider complaint process. While we continue to pursue this as an advocacy priority, it is critical for health care providers to report violations of federal rules to oversight authorities, especially when patient care and access are being inappropriately denied or impeded. Certain MA plans are engaging in business practices designed to circumvent federal rules, so flagging cases of non-compliance with CMS regulations is needed to ensure patient access and underscore the need for greater oversight of the MA program and rigorous enforcement of the new rules.

The following reporting mechanisms are available when providers suspect or have evidence of violations of federal policy related to the MA program. You may submit complaints or information to:

CMS Regional and Central Office Staff

Regional Offices and Contact Information

CMS Region	Regional Office Location	Contact	States served by the Region
1	Boston	ROBOSORA@cms.hhs.gov	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
2	New York	RONYCORA@cms.hhs.gov	New Jersey, New York, Puerto Rico, Virgin Islands
3	Philadelphia	ROPHIORA@cms.hhs.gov	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
4	Atlanta	ROATLORA@cms.hhs.gov	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
5	Chicago	ROCHIORA@cms.hhs.gov	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
6	Dallas	RODALORA@cms.hhs.gov	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
7	Kansas City	ROKCMORA@cms.hhs.gov	Iowa, Kansas, Missouri, Nebraska
8	Denver	RODENORA@cms.hhs.gov	Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
9	San Francisco	ROSFOORA@cms.hhs.gov	Arizona, California, Hawaii, Nevada, Pacific Territories
10	Seattle	ROSEA_ORA2@cms.hhs.gov	Alaska, Idaho, Oregon, Washington

In addition to emailing the office mailbox for your region (see above), you may also consider identifying the appropriate staff on the CMS organization chart to send information or complaints.

- Beginning on page 75: Find your regional office and identify the director and/or deputy director in charge of "Drug and Health Plan Operations."
- Beginning on Page 30: Find the CMS central office staff in charge of "Medicare Drug and Health Plan Contract Administration" or "Medicare Parts C and D Oversight and Enforcement."
- The standard format for CMS staff emails is firstname.lastname@cms.hhs.gov.

Note that the CMS organization chart is updated regularly. You may need to refer to this resource periodically to identify or confirm the appropriate individuals to contact in cases of agency staff turnover. However, the email addresses listed in the table above are the general email inboxes for the regional offices and generally do not change.

CMS Division of Appeals Policy for Part C and D

- Guidance resources for CMS Division of Policy, Analysis and Planning (DPAP) Medicare Part C Policy (including question submission portal for Part C Policy Questions)
- The CMS Part C or Part D Appeals Inbox
  - Part C Appeals: Part_C_Appeals@cms.hhs.gov
  - Part D Appeals: PartD_Appeals@cms.hhs.gov

Medicare Advantage Benefits Mailbox (including question submission portal for Part C Benefits Questions)

Other Agencies and Contacts

The Health and Human Services Office of Inspector General (HHS-OIG)

The Department of Justice Civil Fraud Division

Local U.S. Attorney's Office

ProPublica Investigative Reporting on Health Insurer Denials

AHA Staff

- Submit data or examples on the AHA health plan accountability website
- Email your AHA Regional Executive

Align Contractual Language with Provisions of the Final Rule

Hospitals may consider negotiating contractual language that aligns with Medicare coverage rules, or in other words, codify provisions of the final rule in their contracts with MAOs. We recognize many hospitals and health systems do not have the leverage to negotiate favorable terms beyond the standard contract language with large, national insurers, but efforts to align contractual standards with regulations can help to bolster oversight and accountability for plan compliance with new rules.

For example, the rule requires prior authorization requests to be reviewed by a clinician with relevant expertise in the requested service area. A best practice may include memorializing this requirement in contractual language and stipulating how the rule will be enforced or monitored in the contract. It may be difficult to validate compliance with this rule because MA denials often are not signed by a physician or reviewer, so it is not consistently clear who reviewed or signed off on the denial. One approach could be to include contract language requiring that all adverse determinations provide identifying information about the reviewer and their qualifications so that compliance with the rule and contract provisions can be independently verified.

Regardless of whether organizations are able to explicitly incorporate changes in federal rules into contractual provisions, we encourage hospitals and health systems to engage in proactive conversations with their contracted MA plans about the issues addressed in the final rule and your expectations for compliance. This may include discussing your understanding of the new rules taking effect Jan. 1, 2024, inquiring about changes MA plans may be considering or planning in response, and articulating expectations about current practices which you believe do not comply with the new rules that you anticipate will need to change.

Leverage the MAO Utilization Management Committees (UMCs)

The final rule requires MA plans to create UMCs, which are responsible for ensuring MA plans adhere with key requirements in the rule related to prior authorization and the use of medical necessity criteria. Specifically, the regulations require the UMC to be led by the plan's medical director and to conduct an annual review of plan prior authorization and other utilization management polices to ensure compliance with Medicare rules and consistency with current clinical guidelines, as well as Traditional Medicare's local and national coverage decisions. The regulations governing the UMC and requirements for its composition and functions can be found at 42 CFR §422.137.

Hospitals and health systems may want to consider:

- Requesting to review UMC documents (note, the regulations do not require the documents to be public; however, the MA plan must "document in writing the reason for its decisions regarding the development of UM policies and make this documentation available to CMS upon request");
- Submitting inquiries or requests to the UMC about concerning policies or practices that may violate CMS rules; or
- Nominating a physician or clinical leader to serve as a network provider representative on the MA plan's UMC.

Collect Data and Examples to Demonstrate Challenges for Patients and Providers

The MA final rule contains substantive policy changes that seek to better align MA with Traditional Medicare and improve patient access to care. However, the changes in the final rule govern operational processes that are carried out at the individual claim level, making it challenging for the government to oversee in aggregate a program with more than 30 million people enrolled nationwide without sufficient oversight mechanisms. As the AHA continues to fight for more rigorous enforcement and oversight mechanisms, it is critically important that health care providers and patient advocates identify and report examples of non-compliance or inappropriate delays and denials of patient care to federal regulators. Providing data and examples to demonstrate challenges with MA practices and the resulting impact on patients and providers is essential to inform CMS' oversight and policy development process.

The AHA has identified a series of metrics that hospitals may consider tracking as part of this effort (discussed in greater detail in the following section), but regardless of whether your organization participates in a broader data collection initiative, we encourage hospitals and health systems to document, track and measure compliance with the new rules within your institution or system to the extent possible and to share examples of concerning practices with AHA and/or federal regulators as appropriate. The AHA team stands at the ready to support members in taking these steps and developing a plan to hold insurers accountable.

Suggested Metrics to Track

CMS has invited hospitals and health systems to share your experience in the field as their eyes and ears on the ground and as trusted partners who frequently support patients in navigating their insurance coverage. As discussed above, collecting data and examples to illustrate the challenges providers and patients face — such as circumstances where Medicare coverage policies are not being followed or patients are being denied access to medically necessary services — is critical to informing the direction of federal oversight policy in the MA program.

Below is a list of possible metrics (both quantitative and qualitative) that hospitals and health systems may consider collecting as part of their efforts to monitor MAO compliance with the new rules. This is not an exhaustive list, and we recognize hospitals may not be able to track all of these metrics, but we encourage members to evaluate opportunities to collect concrete data and examples in these areas to share with AHA and/or directly with federal regulators as described above (see Best Practices section). The suggested metrics are designed to inform whether MA plans are adhering to policies in the MA final rule either directly or via proxy data and to generate a data set of tangible results that could be shared with CMS to further the case for greater oversight and targeted enforcement action against non-complaint plans where appropriate.

Suggested Metrics for Hospitals and Health Systems

Suggested Quantitative Data

1. **Prior Authorization Turnaround Time:** Average number of days in between request and response to prior authorization requests
    a. Consider splitting out by service line where possible to look at inpatient admission, drug infusions, radiology services and post-acute care admissions
2. **Prior Authorization Data:**
    a. Number or percent denied
    b. Number or percent appealed

c. Number of appealed prior authorization requests pending after 14 days without payor response.

d. Number or percent overturned

e. Consider splitting out by service line where possible to look at inpatient admissions, drug infusions, radiology services and post-acute care admissions

f. Requests for prior authorization for an active course of treatment that was previously approved (e.g., under the new rules a series of 10 infusions that are approved as a course of treatment should not require new authorizations for each infusion in the approved treatment plan)

g. Number and dollar amount of lost revenue associated with medical necessity denials for services with prior authorization approval on file

3. **Claims Data:**

   a. Number or percent denied

      i. Number of claim denials based on medical necessity after the service was approved via prior authorization

   b. Number or percent appealed

      i. Number of appealed claims pending after 60 days without payor response

   c. Number or percent overturned

   d. Consider splitting out by service line where possible to look at inpatient admissions, drug infusions, radiology services and post-acute care admissions

4. **Average Length of Stay for Observation Cases:** Compare MA versus Traditional Medicare; consider pre- and post- 1/1/24 to monitor effects of new MA rules and adherence to the two-midnight rule

5. **Number of Observation Stays Exceeding Two Midnights** (or 48 hours as proxy): Compare MA versus Traditional Medicare; consider pre- and post- 1/1/24 to monitor effects of new MA rules and adherence to the two-midnight rule

6. **Number of MA Inpatient Admissions Downcoded to Observation Status:** Consider collecting/estimating the dollar value of the revenue reduction associated with inpatient stays that were downcoded to observation status

<u>Suggested Qualitative Data (Examples)</u>

1. Examples of MA plans applying commercial clinical criteria decision support tools (e.g., InterQual or MCG) to evaluate or deny coverage of a basic benefit (instead of applying Traditional Medicare criteria consistent with LCDs and NCDs as required by the final rule).

2. Examples of MAOs applying unpublished or proprietary clinical criteria to make coverage decisions for basic benefit services that are not widely available or consistent with Traditional Medicare criteria.

3. Examples of MAO clinicians reviewing prior authorization requests who do not have training or expertise in the medical field that is appropriate for the service being requested. Note: The reviewer is not required to be practicing in the same specialty or subspecialty as the treating health care

provider but must have "expertise in the field of medicine or health care that is appropriate for the requested service."

4. Examples of claims that are denied based on medical necessity after the service was approved via prior authorization.

5. Examples of impermissible site of service policies where an MAO restricts coverage based on setting of care where no such restriction on setting exists in Traditional Medicare (e.g., If an MAO will only cover an outpatient surgery at an ambulatory surgery setting and not in a hospital-based setting, but Traditional Medicare would cover the surgery in either setting).

6. Examples of inadequate MAO networks for behavioral health or post-acute care (e.g., referring hospital is unable to identify an in-network provider for these services or the in-network facilities in the service area are full or not accepting new patients). Note: The final rule includes provisions to strengthen behavioral health network adequacy standards but does not address post-acute care, which is an area AHA continues to advocate for stronger network adequacy standards.

7. Examples of an MAO requiring prior authorization for emergency inpatient or outpatient hospital services.

8. Examples of MA plan coverage or payment policies that limit coverage of services in a way that is below or more restrictive than Traditional Medicare levels (e.g., units of service, observation hours, readmission policies).

AHA Enforcement Priorities

The AHA has a series of recommendations for improving oversight of the MA program. We believe rigorous monitoring, including plan-level data collection and reporting, regular auditing, improved pathways for stakeholders to report suspected violations, and penalties for non-compliance are critical to ensure the changes included in the MA final rule become standard operating procedures for MAOs and have the intended effects on beneficiary protection and access to care.

AHA's enforcement asks are summarized below in detail and were included in a recent AHA letter to the Administration urging CMS to conduct rigorous oversight of the new rules.

As established above, it is important to note AHA believes that enforcement actions should be targeted, to the extent possible, to MAOs who have a history of suspected or actual violations or whose performance metrics related to appeals, grievances and denials could be indicative of a broader problem warranting investigation. Every effort should be made in carrying out enforcement activities to ensure that undue burden is not placed upon MAOs who consistently act in good faith and adhere to CMS rules.

With this in mind, the AHA recommends that CMS take the following actions to increase oversight of the MA program and bolster enforcement and compliance efforts pursuant to the CY 2024 MA final rule.

Data Collection and Reporting

There are limited data reporting mechanisms available to provide CMS with information about plan-level coverage denials, appeals and grievances, or delays in care resulting from plan administrative processes. These are important indicators of beneficiary access and are necessary for meaningful oversight of MAOs. For example, plans with excessively high service and payment denial rates compared to other plans, or plans with unreasonably high beneficiary grievance rates, may be indicative of inappropriate behavior that warrants further inquiry or audit. Similarly, plans with high rates of unpaid claims, even absent denials, may be indicative of inappropriate plan behavior to avoid payment to providers while simultaneously avoiding high denial rates when reporting data to CMS. The HHS-OIG made a recommendation in 2014 for

CMS to identify whether outlier data values reflect inaccurate reporting or atypical performance, and to use reporting requirements data as part of its reviews of MA organizations' performance. We believe this could be a useful approach to conducting data-driven enforcement activity.

In addition, we recommend that existing MAO data, which is submitted to CMS annually and must be audited by an outside organization, be used to a greater extent to guide oversight and enforcement activities. It appears to us that CMS uses MAO determination data in a relatively limited manner; the determination data are not used in Star Ratings and there is no documentation to suggest that this specific data drives oversight decisions like identifying which MAOs to audit. CMS could consider:

- Using existing data to identify MAOs for program audits to determine if the plan is correctly applying plan terms or medical necessity criteria;
- Increasing the frequency of plan-reported data to quarterly;
- Publishing a public list of MAOs that are subject to a Corrective Action Required (CAR) plan; or
- Incorporating organizational determination data into Star Ratings.

Routine Auditing

CMS conducts routine audits for some aspects of the MA program, such as risk adjustment data validation. We believe that additional auditing is necessary to ensure compliance with CMS rules, especially those around medical necessity criteria, which are needed to achieve the intended alignment between Traditional Medicare and MA. Such audits should be focused on MAOs that are outliers in reported plan performance data or have a history of suspected or actual CMS rule violations on their record. With these factors in mind, we recommend that CMS regularly audit a sample of MAO denials, using a similar methodology as the 2022 HHS-OIG report, to review MAO determinations for the appropriate application of Medicare coverage rules and criteria. Without this level of detailed auditing, there will be ample opportunity for certain MAOs to continue circumventing federal rules without detection, rendering the proposed beneficiary protections ineffective.

Pathways to Report Suspected Violations

Patients and health care providers have a high degree of interaction with MAOs as users and providers of health care services and are therefore well-positioned to identify suspected violations of CMS rules that warrant further investigation. In fact, hospitals and health systems often act on behalf of their patients when working with insurers to obtain approval and coverage for medically necessary care, making them especially capable of identifying faulty or outdated program rules or bad actors. Unfortunately, there currently is no streamlined or direct way for providers to report such concerns to CMS. And as described above, when issues are raised, they are frequently labeled as "contractual disputes" and therefore not subject to agency intervention. However, what may appear to be a contractual dispute may be evidence of

a violation of federal policy, including systemic issues with the potential for negatively affecting patient care. Without a way for providers to report issues, CMS has no ability to establish a fact pattern needed to engage in enforcement activity. Accordingly, we encourage CMS to establish a process for health care providers to submit complaints to CMS for suspected violation of federal rules as part of its enforcement strategy.

Enforcement Penalties

Penalties are a necessary part of enforcement to ensure there is accountability for complying with CMS rules. Given CMS' acknowledgement in the final rule that many of the included provisions are restatements of existing CMS policy, enforcement is critical to ensure meaningful change. We recommend that based on the results of audits and plan-reported data, CMS be prepared to initiate issuing warning letters and CARs to non-compliant MAOs. If the non-compliance persists, we recommend that CMS impose intermediate sanctions (e.g., suspension of marketing and enrollment activities), civil monetary penalties or terminate the contract.

Next Steps on MA Advocacy and Insurer Accountability

As the new rules take effect on Jan. 1, 2024, the AHA will continue advocating for the enforcement priorities described above and will work with members to collect information to reflect possible challenges with enforcement and/or identify new gaps and priorities based on real-time member experience implementing the final rule. We look forward to learning more about the experience of hospitals and health systems as the rules go live and welcome your insights and perspective in the coming weeks and months.

In addition, the AHA continues to evaluate and pursue additional advocacy opportunities related to advancing our health plan accountability strategy and increasing oversight of the MA program. These include:

- Monitoring MAO compliance with the two-midnight rule
- Advocating for stronger network adequacy standards for post-acute care providers
- Advocating for greater controls and oversight on third-party MA plan vendors
- Pushing back on problematic MAO practices such as excessive or inappropriate clinical validation audits
- Securing additional prior authorization reforms
- Improving data collection and reporting on health plan accountability metrics
- Advocating for downcoding to be classified as an adverse determination with full appeal rights
- Ensuring the overpayment provisions included in the MA proposed rule is not finalized

AHA Resources and Contacts

Recent AHA Comment Letters on MA

- AHA Letter to CMS with MA Final Rule Enforcement Asks (October 2023)
- AHA Letter to CMS on MA CY24 Proposed Rule (February 2023)
- AHA Response to CMS RFI on MA (August 2022)

Selected AHA Health Plan Accountability Resources

- New Surveys Find Majority of Patients, Doctors & Nurses Say Health Insurer Policies Reduce Access to Care
- Infographic: New Consumer Poll Finds Patients Are Concerned about Commercial Insurer Barriers to Care
- Addressing Commercial Health Plan Challenges to Ensure Fair Coverage for Patients and Providers
- Infographic: Commercial Health Insurance Practices that Delay Care, Increase Costs
- US News Op Ed: Health Insurance Barriers Delay, Disrupt and Deny Patient Care

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