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CMS implements new regulations to restrict Medicare Advantage organizations

by Kristen Dobson

As the number of Medicare enrollees choosing Medicare Advantage (MA) over traditional Medicare has steadily increased over the past decade and a half, healthcare providers have been sounding the alarm with Centers for Medicare & Medicaid Services (CMS) about MA organizations (MAOs) inappropriately delaying and denying coverage of medically necessary care. (As of last year, the share of eligible Medicare beneficiaries enrolled in MA has more than doubled since 2007.)[1] Last year, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a report that echoed those concerns, finding that MAOs sometimes delay or deny care even when that care meets traditional Medicare coverage rules.[2]

OIG further found that MAOs often denied prior authorization requests that met Medicare coverage rules by using clinical criteria not contained in Medicare rules and requiring unnecessary documentation to support the medical necessity of the services. In many of these cases, OIG found that the clinical information in the case file was already sufficient to demonstrate the medical necessity of the services requested.[3] Based on its findings, OIG made several recommendations to CMS, including recommending that CMS "issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews."[4]

Earlier this year, CMS issued new regulations aimed at addressing some of these issues.[5] Based on the OIG report and the feedback it received from stakeholders, CMS concluded that "certain guardrails are needed to ensure that 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 plans."[6]

Most notably, the new rules clarify that:

- MAOs must comply with general coverage and benefit conditions set forth in traditional Medicare laws when making coverage decisions and medical necessity determinations;
- The two-midnight rule, and the admissions criteria set forth in 42 C.F.R. § 412.3, apply to MAOs; and
- Prior authorizations should be used only to confirm the presence of diagnoses or other medical criteria and ensure that the furnishing of a service or benefit is medically necessary. Additionally, prior authorizations must be valid for an entire course of approved treatment.

While the new rules are a good start for addressing many of the systemic issues providers have encountered with MAOs for years, it remains an open question regarding how they will be enforced. With respect to the new prior

authorization requirements, CMS declined one commenter's suggestion to develop a process for providers to report when MAOs fail to follow the rules, noting that CMS currently monitors MAOs' compliance with existing policies and will continue to do so to ensure compliance with the new regulations.[7]

Therefore, providers should familiarize themselves with these new rules to ensure they can effectively hold MAOs accountable. These new regulations—coupled with statements made by CMS in preamble commentary to the surprise billing rules issued in 2021—offer useful points for providers to argue when challenging unsupportable and unreasonable denials from MAOs.