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Medicare Advantage in 2024—New rules, new loopholes

by Ronald Hirsch, MD, FACP, CHCQM, CHRI

In the utilization management world, the adoption of CMS-4201-F—the new rule regulating many Medicare Advantage (MA) plan activities—was a game changer.[1] Like many new rules, the adoption of the rule by the Centers for Medicare & Medicaid Services (CMS), brought with it confusion over when the provisions became applicable. The final rule was published on April 8, 2023, and had an effective date of June 5, 2023, but it also specified that for most provisions, the applicability date was January 1, 2024. Under these new regulations, the MA plans have had to abide by several requirements that they previously stated did not apply to them.

These new requirements include recognizing the many nuances of the two-midnight rule, including the two midnight expectation, the Medicare Inpatient Only list, the exception for unplanned mechanical ventilation, the case-by-case exception, and the one-day inpatient admissions due to death, transfer against medical advice, hospice, and unexpected rapid recovery. In addition, in CMS-4201-F, CMS reiterated that the MA plans must honor Medicare criteria for access to inpatient rehabilitation admissions, skilled nursing facility care, and home health care.

But for 2024, there remain many ways that MA differs from traditional Medicare, and understanding these is crucial. While these differences are based on regulation, it is essential to note that individual plans may choose to follow these guidelines.

MA plans do not need to recognize the two midnight presumption

Although part of the 2014 Inpatient Prospective Payment Rule that established the two-midnight rule, the two midnight presumption was introduced to guide Medicare review contractors to presume that if the patient spent two or more midnights as an inpatient, it could be presumed that the inpatient admission was appropriate. But this presumption is not part of the 42 C.F.R. § 412.3 regulations defining the two-midnight rule provisions, and as CMS specified in CMS-4201-F, does not apply to MA plans. That means inpatient admissions of any length can be audited to ensure that hospital care spanning two or more midnights was medically necessary without delays in care or provision of care that could have been safely provided in another setting.

MA plans do not have to honor the ASC–CPL

These surgeries, delineated by Healthcare Common Procedure Coding System (HCPCS) code, are those that CMS has determined—based on 42 C.F.R. § 416.166—that "would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC [ambulatory surgery center], and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure." 42 C.F.R. § 416.2 also addresses surgeries permitted at ASCs, noting

that ASCs operate "exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission."

Still, MA plans face no regulatory obstacles to approving surgeries not on the inpatient-only list being performed at ASCs, even if those surgeries are not on the ASC–CPL as neither CMS-4201-F nor any other regulation requires MA plans to adhere to the ASC-covered procedures list (CPL). For example, lumbar spine fusion, HCPCS code 22630—which is not on either the inpatient-only list or the ASC–CPL—therefore would not be allowed at an ASC for a traditional Medicare patient; however, it can be performed at an ASC on an MA patient if the surgeon deems it appropriate for the ASC setting due to surgical and medical considerations and the MA plan approves it.