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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.

MA plans do not need to approve LTACH admissions

Unlike inpatient rehabilitation facilities and skilled nursing facilities, long-term acute care hospitals (LTACHs) are notably absent from the list of providers where MA plans must follow the same guidelines for patients to be covered as a basic Medicare benefit. While CMS does not explain this, it should be remembered that LTACHs are mostly acute care hospitals with patients who have a significantly longer length of stay than most acute care hospital patients. LTACHs generally provide the same services that "regular" acute care hospitals perform with medical units, surgical suites, intensive care units, and so on, but are paid differently.

In some instances, patients are transferred to LTACHs for care that could be provided at the acute care hospital—such as long-term IV medication administration. That transfer may be desired to create capacity for the acute care facility or financial reasons; however, in some cases, LTACHs do provide specialized care that is not available at the acute care facility, such as complex wound care, long-term ventilator weaning, and comprehensive medical management along with comprehensive rehabilitation. In these latter cases, the transfer to the LTACH should be viewed as no different than a transfer to a tertiary or quaternary care facility, and the discussion with the MA plan should focus on those specialized services and not on payment.

MA plans do not have to pay readmissions as does traditional Medicare

Contrary to common belief, when a traditional Medicare patient is readmitted as inpatient to the hospital after an index inpatient admission within 30 days, the hospital is paid for the second admission in full unless the second admission is on the same calendar day for the same reason. Perhaps by exploiting this misunderstanding, many MA plans can avoid paying for readmissions. Most MA plans have their own policy on how they pay for readmissions to contracted providers, with these policies based on their own time frame and many based on whether the readmission was determined by their reviewers to be related to the index admission or preventable by hospital action. If the provider is not contracted with the MA plan, they must be paid the full amount the hospital would be paid from Medicare for that readmission without applying their own policies.

The payment or nonpayment for readmissions by MA plans is considered a contractual payment issue and should be addressed by the hospital contracting team. Recently, readmission policies have appeared that do not pay for readmissions that occur at any affiliated hospital, "penalizing" the entire health system, or policies that only pay for the higher weighted admission, be it the index admission or the readmission—a policy that completely defies logic.

It should be noted that when an MA patient is admitted or readmitted, the hospital not only sends a claim to the MA plan for payment but also submits a "shadow claim" to CMS, with specific condition codes, indicating the patient was admitted as inpatient. This shadow claim results in payment from CMS to the hospital for many of the "add-on payments" provided to hospitals, such as medical education, disproportionate share payments, and payment for uncompensated care. So, while the MA plan may not pay the hospital for the readmission, the

hospital will still receive shadow payments from CMS.

CC 44 process is not needed for many MA patient status changes

The condition code 44 (CC 44) process was created by CMS in 2004 to allow hospitals to compliantly change the status of patients improperly admitted as inpatients and receive Part B payment for the services provided. As MA plans became more popular, the question of whether that process is required for MA patient improperly admitted as inpatient arose. The National Uniform Billing Committee's definition of CC 44 provides the answer. CC 44 process is required when the hospital's internal utilization review (UR) process determines whether a patient was inappropriately admitted as inpatient. In other words, if a doctor with admitting privileges ordered inpatient admission, and the patient was formally admitted, and the hospital's UR team decides the patient should have been placed as outpatient, then the case should be reviewed by your UR committee physician for agreement, discussed with the attending and a new order obtained, and the appropriate parties, including the patient, should be notified in writing, following the CC 44 process.

But if the UR team determines that inpatient is correct and the MA plan stubbornly refuses to approve it—and the hospital reluctantly agrees to change to outpatient/observation—then simply get a new order from the attending physician. The hospital may choose to tell the patient what happened if they already received their Important Message from Medicare since they think they are inpatient, and the patient may need a Medicare Outpatient Observation Notice depending on the timing, but they do not need written notification that their status changed from inpatient to outpatient nor does the UR committee physician need to review the case, except to monitor the denials by MA plans and decide if they are violating the provisions of the two-midnight rule.

MA inpatient admissions do not require self-denial and rebilling

For Medicare, if a patient is admitted as inpatient and discharged, and after discharge it is determined that inpatient admission was improper, the hospital must follow the steps specified in 42 C.F.R. § 482.30(d)—including review by a UR committee physician and written notification to the patient—then submit a no-pay inpatient Part A claim followed by submission under Part B to get payment. In most cases, there is no order for observation services, so the payment will not be the "usual" Medicare payment for an "observation stay" but will be a payment based on line-item coverage of the individual services provided to the patient, which in most cases will not include any payment for nursing care and room and board. However, if an MA patient is admitted as inpatient and after discharge, the MA plan refuses to pay for the inpatient admission, the MA plan staff often indicate that the hospital can submit an "observation claim" and get paid.

In this scenario, the hospital does not have to go through the same process as previously outlined but may simply prepare the claim as an outpatient claim, "converting" the inpatient time (from the admission order until the end of necessary care) into observation hours using HCPCS G0378 and submitting that claim to the MA plan for payment. Since the payer is making the determination, it is their responsibility to notify the patient if warranted. In addition, while not allowed for Medicare, the payer instructs the hospital to add observation hours even without an order, so it is permitted.

Now, if you submitted an inpatient claim that was denied by the MA plan and you either decided not to appeal or exhausted your appeals, then as with traditional Medicare, you can simply submit an outpatient claim. If the MA plan allows you to add observation hours, then be sure that is done. However, it is vital to remind your billing staff that a shadow claim was submitted at the time of the original inpatient claim submission, and they should determine if that claim needs to be canceled with payment refunded to CMS.

Conclusion

The changes imposed by CMS on MA plans for 2024 that work to level the playing field are welcomed by all. But there remain significant differences between traditional Medicare and MA that must still be noted to remain compliant.

Takeaways

- Medicare Advantage (MA) plans must now follow all the two-midnight rule provisions but are not bound by the two midnight presumption.
- MA plans must permit patients who meet Medicare criteria to access care at inpatient rehabilitation facilities and skilled nursing facilities and receive home health services but are not obligated to approve long-term acute care hospital admissions.
- While the Medicare ambulatory surgery center (ASC)-covered procedures list limits which outpatient surgeries can be performed at ASCs, that limitation does not apply to MA-covered patients.
- The condition code 44 process should be used if the hospital's internal utilization review process determines a patient was inappropriately admitted as inpatient but is not required if the MA plan refuses to approve inpatient.
- Hospitals should carefully review their readmission payment provisions with MA plans to ensure they are equitable and not based on nonexistent Medicare policies.

1 Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 14, 2023), https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.