Reporting MA/SNP plan noncompliance with 2024 Medicare Advantage Rules

Step 1: Please click REPORT to share any instances of Medicare Advantage (Part C) plans not complying with the 2024 MA rules. By clicking the "report" link above, you can submit the following information to Nicole Fallon at LeadingAge about the non-compliance you've observed. This information will be aggregated and shared with CMS on a regular basis to identify trends. If you want to review what is changing for 2024 that the plans must comply with, here is a summary of the 2024 MA rules.

1. **Which Medicare Advantage plan/organization is not complying?**

2. **What state did this happen in?**

3. **What requirement is the plan not complying with?** (Please cite one of the non-compliance issues listed below, and provide a brief description of why you believe the plan is not complying with MA or Medicare requirements)
   - **Medically Necessary Medicare Covered Services Denied or Inappropriately Limited Not Following Medicare guidelines for service.** Plans are required to follow Medicare coverage for Part A and B services. Plans can be more generous but are not supposed to be more restrictive (e.g. IV medications are ordered for 30 days but plan terminates skilled care on day 16). Under the new rules, CMS says plans must also use national and local coverage determinations to govern their decision making.
   - **Medicare covered services denied based upon plan's internal coverage criteria.** Plans are permitted to develop and apply their own internal coverage criteria in cases where Medicare coverage rules are not "fully established", absent or require additional information is needed to determine medical necessity. However, those criteria must be based upon "current evidence in widely-used treatment guidelines or clinical literature" and the plan's criteria must be publicly accessible. Please report cases where the service is denied based upon plan's internal coverage criteria and when their determination is inconsistent with "widely-used treatment guidelines or clinical literature."
   - **Prior authorizations inadequate or all approvals for the same number of days/visits.** Approved a prior authorization but for fewer days than the assessments suggest, or health care staff requested or is appropriate for to ensure a safe discharge – Course of treatment. Or MA plan authorizes all services for the same duration of time even though the patient/resident has a different diagnosis, different co-morbidities, or chronic conditions.
   - **Improper use of artificial intelligence/algorithm tool (e.g., NaviHealth, myNEXUS – now called Carelon Post-acute Solutions)**. Did a third party--NaviHealth or My Nexxus, for example—issue a report or other document that indicated the expected length of service for the individual (e.g, nhPredict, etc.)? If yes, do service terminations directly align with the date specified in the report regardless of changes in condition or inconsistent with assessed needs? OR did the third party deny or terminate coverage inconsistent with Medicare policies? If service denied, what was the reason(s) cited? Did your health care staff believe

the termination was appropriate or believe additional services were medically necessary? If possible, please share the report (without the patient name/birthdate, etc.) and note the discharge date.

- **Payment denial for prior authorized services.** Services were prior authorized but the plan denied payment for the claim due to no longer believing there was medical necessity.
- **Plan overruled physician order.** If a physician ordered SNF care or home health services and the plan overruled and sent them home or to another PAC setting, this is out of compliance with the 2024 requirements.
- **LTC nursing home residents refused SNF care when medically necessary.** Beneficiaries who reside in nursing homes for long-term supports and services are denied PAC SNF care following a hospitalization. Please share the reason(s) the plan gave for denying care. We've heard that this is becoming a common practice among some plans.
- **Deceptive marketing.** This includes misleading materials or using the Medicare logo or agents/brokers contacting beneficiaries without permission.
- **Other.** If none of the items above describe the non-compliance issues you've encountered, please note other and briefly describe your concerns with the plan behavior and why you believe it is non-compliant with Medicare Advantage rules.

4. **When did this happen?**

5. **Who can we contact for more information and what is their email/phone number?**

6. **Are you comfortable with us identifying your organization as reporting this information or would you prefer those details remain private?** If private, we will only include details without reporting organization information and share as an example of trends being observed across providers, states and plans related to non-compliance.

Step 2: Report Issue to local CMS contact.

If you have a state-level or regional CMS contact, ask them where you can report Medicare Advantage plan non-compliance issues you've observed. This should result in the information being entered into the Compliance Tracking Module.