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MA Final Rule: CMS Requires Two-Midnight Rule, Puts Limits on Internal Coverage Criteria

By Nina Youngstrom

In what passes for neon lights in the regulatory world, CMS said Medicare Advantage (MA) plans must follow the two-midnight rule, its case-by-case exception and the inpatient-only (IPO) list, according to the final 2024 rule on policy and technical changes to MA plans announced April 5.[1] Having MA and traditional Medicare on the same page brings more coherence to utilization review and case management, but hospitals should expect MA plans to closely review the medical necessity of admissions, an expert said.

While the proposed rule stated that MA plans have to live by the same coverage criteria as traditional Medicare, it didn't explicitly cite the two-midnight rule, IPO list and case-by-case exception. This time around, CMS didn't mince words. "It's exciting," said Ronald Hirsch, M.D., vice president of R1 RCM. "They confirmed the two-midnight rule applies to Medicare Advantage and the inpatient-only rule applies to Medicare Advantage."

As CMS explained in the final rule, "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))."

But CMS draws the line at the two-midnight presumption of the two-midnight rule, which has a slightly different meaning. Under the presumption, hospital stays that cross two midnights after a patient has been admitted as an inpatient generally are considered payable under Part A and insulated from Medicare reviews (e.g., Medicare administrative contractors [MACs], recovery audit contractors and quality improvement organizations). In the MA final rule, CMS said MA plans are free to audit hospitals for compliance with the two-midnight presumption. Hirsch said in contrast to the presumption, which is applied after the hospital stay is over, the benchmark is applied at the time of the admission decision, and if the physician admits a patient as an inpatient based on an expectation of two midnights and it's clinically supported, the MA plan must accept that admission even if the resulting hospital stay is fewer than two midnights.

There has been some debate about the effective date, especially because the rule refers to a June 5, 2023, effective date and a Jan. 1, 2024, applicability date, and because CMS is codifying existing requirements rather than introducing new regulatory language. But attorney Judy Waltz, with Foley & Lardner LLP in San Francisco, said the two-midnight, IPO and case-by-case exception clarifications wouldn't take effect until the latter date because MA plans are in the middle of a contract year. Another attorney disagreed, saying they're effective immediately because CMS is simply codifying them.

A CMS spokesperson said MA plans "are currently required to cover Part A and B benefits on the same conditions

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that apply to the Fee-For-Service (FFS) program, so requirements on when an inpatient stay is covered under Part A apply to MA plan coverage as well, and CMS's interpretation of the current MA statutory requirements and regulations is consistent with the explanation in the final rule related to § 412.3, but the amendments to the current MA regulation on coverage criteria made by the final rule, including the new explicit reference to § 412.3, are applicable beginning with coverage beginning January 1, 2024."

Hospitals Still Have Their Work Cut Out for Them

The scope of the rule is broad. It states that "MA organizations may not limit coverage through the adoption of policies and procedures—whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity—when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item." But the clarifications about the two-midnight rule, IPO list and case-by-case exception, which allows hospitals to bill for inpatient admissions even when physicians don't expect a two-midnight stay in rare and unusual circumstances, were particularly welcomed in some quarters.

"This is absolutely huge," said Juliet B. Ugarte Hopkins, M.D., president of the American College of Physician Advisors. It doesn't mean things will be easy. "Hospitals should not look at this as 'Yay, we won,'" Ugarte Hopkins said. "They need to continue to look critically at these cases in real time or they will be hit in a couple months or years with multiple retrospective denials." Hospitals would be wise to avoid the mindset that it's enough for the physician to anticipate a two-midnight stay in the history and physical without paying attention to the reason why, she said. It's always been important for physicians to rationalize the medical necessity of the hospital stay and the services being provided, and "hospitals should continue those same efforts because Medicare Advantage plans will have a very close eye on these cases," Ugarte Hopkins said.

Case management and utilization review should be simpler with MA plans on the same page as traditional Medicare because "you're taking one category out of the mix when it comes to inpatient/outpatient determinations," she noted. But hospitals still must navigate the admission criteria at multiple commercial plans.

CMS also clarified that access to post-acute care—skilled nursing facilities (SNFs), home health care and inpatient rehabilitation facilities (IRFs)—is the same for MA and traditional Medicare, Hirsch said. MA plans "can't direct the patients to a different setting if the patient meets CMS guidelines for admission to a SNF or IRF."

No Difference Between Payment and Coverage Rules

CMS also hammers home that MA plans are required to apply the same standards to beneficiary coverage decisions that are applied to traditional Medicare patients, Waltz said. As the rule explains, "Our goal to ensure that MA enrollees receive the same items and services as beneficiaries in the FFS program is accomplished when the same coverage policies and approaches are used."

Similar to MACs in traditional Medicare, CMS expects MA plans to base medical necessity decisions on national coverage determinations (NCDs), local coverage determinations (LCDs) and other coverage criteria. "The final rule makes clear that managed care organizations cannot avoid any of the parameters set forth in an NCD or applicable LCD to limit coverage for MA beneficiaries," Waltz said.

MA plans are already required to provide the same basic benefits available to a Medicare beneficiary under Parts A and B. The services must be medically necessary to qualify for coverage under the Medicare statute, with interpretations for specific requirements to demonstrate medical necessity, as spelled out for certain items and

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services in NCDs and LCDs. But Waltz said CMS went a step further in the preamble by asserting NCDs and LCDs govern the means of delivery (i.e., the site of service) in addition to the item or service to be covered. As the rule stated, "we intended this proposal to clarify, as recommended by the OIG [Office of Inspector General], that limited clinical coverage criteria can be applied to basic benefits and reinforces our longstanding policy that MA organizations may only apply coverage criteria that are no more restrictive than Traditional Medicare coverage criteria found in NCDs, LCDs, and Medicare laws."

CMS also rejects any distinction between a "payment rule" or "coverage rule" in determining what the NCD/LCD requires, concluding that "both serve to establish coverage criteria in MA."

MA plans also are already required to comply with NCDs, LCDs written by the MACs with jurisdiction over the claims, and other guidance applicable to traditional Medicare. But as the rule now makes abundantly clear, MA plans are only allowed to create internal coverage criteria when qualifying requirements aren't fully established in Medicare statutes, regulations, NCDs or LCDs. The coverage criteria must be based on "evidence in widely used treatment guidelines or clinical literature" and publicly accessible.

Only One Prior Auth Per Course of Treatment

CMS finalized new prior authorization requirements for MA coordinated care plans, which Ugarte Hopkins said was a "warm fuzzy" for providers who complain about having to request additional prior authorizations for treatment that's already underway. When the rule takes effect, MA coordinated care plans will be required to honor prior authorizations for the duration of the treatment or service. Plans must "provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan," CMS said. If the plan approved five sessions with a physical therapist, it can't require additional prior authorization.

"This will ensure that services delivered during the approved and previously authorized course of treatment remain consistent with Medicare coverage guidelines, are reasonable and necessary for the individual enrollee, and do not overly burden the provider with unnecessary and repeated prior authorization requests," the rule states.

It was also "very gratifying," Ugarte Hopkins said, that CMS added people "who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex" to its list of populations "that may require consideration specific to their needs." MA regulations require plans "to ensure services are provided in a culturally competent manner."

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1 Centers for Medicare & Medicaid Services, "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," proposed rule, accessed April 7, 2023, https://bit.ly/43r3hgX.

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