2024 CMS Changes to Medicare Advantage Programs to Promote Elder Healthcare Equality

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What is a Final Rule?

A final rule, in the context of administrative rulemaking, is a federal administrative regulation that advanced through the proposed rule and public comment stages of the rulemaking process and is published in the Federal Register with a scheduled effective date.

The Medicare Program was established though and is built upon the Rules and Regulation established through Final Rules.

Medicare Final Rules are annual with final report on October 1st and January 1st

All Medicare Programs are governed by the "Final Rule" and other Compliance Expectations

- Medicare Rules & Regulations established by Congress annually and Administrations – They are laws!
- Laws requiring Compliance for all Providers to participate in Medicare

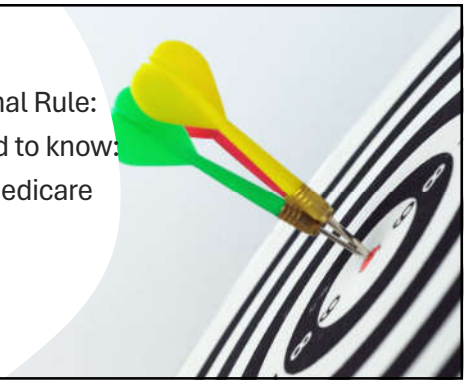
Other Medicare Rules and Regulations....

- Conditions of Participation: Admission Status determination (2 Midnight Rule), Discharge planning regulations (IM, MOON), HINN's, etc.
- The Final Rule is published in the Federal Register section 42 CFR 482 –containing the health and safety requirements that hospitals and their supports must meet to participate in the Medicare programs.....Medicaid requirements also located there.

2024 Final Rule

- This year's Final rule takes steps to modernizes the health care system and reduces patient and provider burden
- Among many, the rule sets requirement of Medicare Advantage (MA) organizations.

2024 CMS Final Rule: What we need to know: Medicare & Medicare Advantage!



More on the 2024 Final Rule

- A new collection of rules rolled out on January 1st, 2024, and responded to many of the concerns Medicare Advantage patients, families, healthcare teams, including case managers and hospitals had sent to CMS, AHA and AMA.

These new rules for MAs……

- The components of the Final Rule provide Medicare Advantage beneficiaries added benefits, and addresses each of their concerns, including those expressed by case managers and physicians, well as issues identified by the government.

Why Now for the 2024 MAP Final Rule…?

- Reported on Feb 20, 2024…….Roughly 33.4 million people or approximately 51% were enrolled in a Medicare Advantage plan at the start of 2024 or approximately according to new federal data……this is increased from 47% since 2021.

Yes, more Medicare Advantage Patients! First Time Ever!

Original or Traditional Medicare	Medicare Advantage Programs
49%	51%

The Administration is Leading to Protect Beneficiaries

The Biden-Harris Administration is taking actions to protect beneficiaries. The Administration has finalized bold actions and recently proposed policies to strengthen Medicare Advantage and hold health insurance companies offering Medicare Advantage plans to higher standards by the changes in the Final Rule and monitoring compliance.

Concerns with Medicare Advantage Programs

What are the Medicare Advantage Issues

- Treat the Medicare Advantage Patient differently then Original/Traditional Medicare. Depriving the Medicare beneficiary of their rights. Clients were dissatisfied.
- Denying Medicare Benefits: accurate clinical assignments of inpatient stays vs observation, and denying Post-Acute Stays (SNF, LTACH, IR)
- Questionable MA Advertising.....Misleading potential clients.....shifting the Competitive Market, Monetary Incentivizing of Healthcare Agents/Brokers.
- Transparency of the Medicare Advantage Programs, clients saying services promised at time of purchasing the plan were not made available.
- Drug prices

Why is this update important to Case Managers?

- Protect and Optimizing your patient's Medicare Benefits & Rights....also you if you are receiving Medicare being informed, as well sharing advice with family members and friends
- Case Managers are on the **front-line**---who else can enforce this new CMS Rule and Regulations---Hold the MAP accountable?
- Being aware the US is participating in a period of Healthcare Reform.....

More.....Why is this update important to Case Managers?

- Case Managers are Advocates!
- We are on the Front Lines at the bedside, in community and telehealth, who else is best to hold the Medicare Advantage Program Accountable?

Original Medicare vs. Medicare Advantage…

Let's stop a minute and review the Basic:

Medicare vs. Medicare Advantage

Medicare & Medicare Advantage History

- On July 30, 1965, President Lyndon Johnson traveled to the Truman Library in Independence, Missouri, to sign Medicare into law. His gesture drew attention to the 20 years it had taken Congress to enact government health insurance for senior citizens after Harry Truman had proposed it. Comprised of Medicare Part A & B.
- Part C (or Medicare Advantage) was instituted during the Clinton administration in 1997 to allow beneficiaries to choose a health maintenance program (HMO) instead of traditional fee for service. It was implemented under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),

Medicare 101: The Basics Reviewed!

Eligibility: 65 or disabled, ESRD, Lou Gehrig's (ALS), railroad retirement workers

Worked 40 work quarters = 10 years……..US Citizen who Paid into FICA…….

Medicare is a "right"……

_____

Medicare A- finances health care services related to hospital stays, skilled nursing facilities, and hospices

Medicare B- outpatient services/DME/hospice- 20% co-pay

Medicare C = Medicare Advantage Program

Medicare D = Prescription Drug Coverage

Part B

covers doctors' services, diagnostic screenings, lab tests, preventive services, outpatient care, plus some medical equipment and transportation.

Important Part C.....

- Part C is a one of the Medicare Options.....Part C is a component of Medicare.....It is not separate, it is an alternative to Part A, B and even D
- A patient enrolled in Part C is enrolled in Medicare!!!
- Medicare Advantage is a Medicare-approved plan from a private company offering an alternative for coverage, with healthcare provided through a network of care givers requiring authorizations.

To enroll in Medicare....General Description

- Receive a notice from Social Security Office with steps for initial enrollment, for some enrollment is automatic.....also, can go on-line or call 800-Medicare...
- If choose a Medicare Advantage Plan, client obtains Original Medicare Part A & B, then uses a healthcare agent or broker. They offer all plans, provide advice and costs...client chooses one.
- What Final Rule explanation revealed.....the larger Medicare Advantage plans were paying Agents/Broker an extra commission to divert patients toward a few plans.

Medicare is a Right (when eligible!)

A Right based on the Individual Financial Contributions of citizens to the Medicare Healthcare Program through FICA and taxes

CMS states Medicare beneficiaries have 3 rights and protections:

- Ensure you obtain the health care services the law says you can get and the same services as all Original and Traditional Medicare beneficiaries
- Provide for your safety when you get health care, while treated with courtesy, dignity and respect **at all times, "Protected from discrimination"**.
- Shield you against unethical practices.

Medicare is a right, not an entitlement!

Medicare funding is supported by our paycheck deductions to FICA and taxes, all these make-up the Medicare Trust…

The Value of your Paycheck Deductions to Medicare..

- If you paid 40 quarters (10 years) towards Medicare, then when eligible your monthly cost is $0, but when hospitalization pay a premium.
- But if only paid Medicare taxes for 30-39 quarters, your 2024 Part A premium will be $278 per month. If you paid Medicare taxes for fewer than 30 quarters, your premium will be $505 per month.

What is the Medicare Trust and How Financed?

- **The Medicare trust fund finances health services for beneficiaries of Medicare**
- The Medicare trust fund comprises two separate funds. The hospital insurance trust fund is financed mainly through payroll taxes on earnings and income taxes on Social Security benefits.
- The Supplemental Medical Insurance trust fund is financed by general revenues (Part B payments) and the premiums enrollees pay.

The Medicare Trust……

The Medicare Trust Fund…….a method of paying it forward…….

Providing Medicare Healthcare for the generations before us and future generation are paying for us!

TABLE 1

Hospital Insurance Trust Fund Receipts, Expenditures, and Assets

Billions of dollars, 2022

	Amount
Assets at end of 2021	**$136**
Total income	**$387**
Payroll taxes	$344
Taxation of benefits	$33
Premiums	$5
Interest and other	$5
Total expenditures	**$345**
Benefits	$340
Administrative expenses	$5
Net change in assets	**$42**
Assets at end of 2022	**$178**

Source: Centers for Medicare and Medicaid Services (CMS), April 2023. *2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund*. Table V.H5.

How much do Medicare Advantage plans receive from the government?

- Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage. Plus MA receives the patient's monthly premium
- The government pays Medicare Advantage plans a set rate per person, per year (around $12,000 in 2019, not including Part D–related expenses) under what's known as a risk-based contract. That means that each plan agrees to assume the full risk of providing all care for that inclusive amount. Jan 31, 2024

How much do Medicare Advantage plans receive from the government?

- Our Government….Switching seniors to Medicare Advantage plans has cost more than Original Medicare
- In late 2018, CMS officials said the agency would collect an estimated $650 million in overpayments from 90 Medicare Advantage audits conducted for 2011 through 2013, the most recent ones available. Some analysts calculated overpayments to plans of at least twice that much for the three-year period. Jan 30, 2023

Key Disadvantage of Medicare Advantage Plans

Key Disadvantages of Medicare Advantage plans

- Restrictive networks. ...
- Prior authorization requirements. …Increasing Denial Rate!
- Plans change each year. ...
- Aggressive marketing and sales tactics. ...
- Know your Medicare Insurance options. ...
- Consider current and future needs.

Medicare Advantage Denials Jump 56%, Commercial Denials 20%

Claim denials are on the rise as hospitals also see diminishing cash reserves, according to a new AHA report.*

Cuts into hospital revenue at a financially challenging time.

Article by: Jackeline LaPointe

- CMS has finalized the CY 2025 Medicare Advantage and Part D rule that promotes competition, increases access to care, and protects individuals from inappropriate marketing and prior authorization.
- CMS is taking action to expand enrollee protections to address predatory marketing of Medicare Advantage and Part D plans, and incentivizing agents and brokers to help Medicare enrollees searching for a plan that best suits their needs, rather than steering people based on financial incentives from plans.

Center for Medicare & Medicaid Services

Center for Medicare & Medicaid Services

- In addition, today's rule promotes competition by providing greater flexibility for people with #Medicare to have faster access to lower cost biosimilar biological products and drives access to behavioral health providers and services for Medicare Advantage plans to help ensure they can receive essential treatments for mental health and substance use disorders. Learn more: https://go.cms.gov/43KjtdC

The Medicare Advantage Final Rule Changes….

Address Medicare expectations which Medicare Advantage plans were not held accountable for in the past, but now are!

Establish new Medicare Final Rule expectation for Medicare Advantage Plans

Present in Every Final Rule including 2024, Now being enforced:

Medicare Advantage Programs (MAP) are to be compliant by offering the MAP patients the same "medically necessary care" as those with Original or Traditional Medicare!

Final Rule = Patient Equality/Equity/Access

Medicare Healthcare Equity and Equality

- In the Medicare & You Handbook it states on page 62: Medicare Advantage Plans must follow Medicare Rules.

Not new expectation to provide equal benefits……prior MA's not held accountable.

- Not a new expectation for MA's, prior to January 2024 not enforced, but now is being enforced by CMS…….
- The MA's need time to adjust, but a challenge……..since their non-compliance resulted in financial gains
- Denying patients care rights, resulted in positive financial bottom-lines for payors.

The Final Rule in the Federal Register states:

- **§ 422.101 Requirements relating to basic benefits.**
- Except as specified in § 422.318 (for entitlement that begins or ends during a hospital stay) and § 422.320 (with respect to hospice care), each MA organization must meet the following requirements:
- (a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

§ 422.101 Requirements relating to basic benefits (continued)

- (2) General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR412.3, services and procedures that the Secretary designates as requiring inpatient care under 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) Care, Home Health Services under 42 CFR part 409, and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3).

Case Managers can Hold MA Plans Accountable to Final Rules, thereby, Promoting Healthcare Equity.....

- Original Medicare does not require authorization for physician services or post-acute transfers to facilities (SNF, LTACH, IRF).
- Holding the MAP accountable decreases and possibly eliminates Denials.
- Case Managers provide CMS Statements from Federal Registry and other documents to Payor.

FAQ'S: Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F) On April 5, 2023, CMS issued the "Medicare Program; Contract Year 2024 Policy and Procedure

7. Question: Can an MA organization deny admission of a patient to a post-acute care facility from an: acute care hospital if it's ordered by their physician and the patient meets the coverage criteria for admission into that facility?

- Answer: No, if a patient is being discharged from an acute care hospital to a post-acute care facility that would be covered under Traditional Medicare and the patient's attending physician orders post-acute care in the specific type of facility (i.e., Skilled Nursing Facility (SNF), Long Term Care Hospital (LTCH)) and the patient meets all applicable Medicare coverage criteria for admission into that facility type, the MA organization cannot deny admission to that post-acute setting and/or redirect the care to a different setting.

2024 Final Rule Changes for Medicare Advantage Plans

- Establishing new guardrails to address predatory Medicare Advantage marketing, including removing misleading TV ads;
- Proposing new standards for plan compensation to agents and brokers to prevent steerage of patients to plans based on compensation, rather than on the patients' best interests;
- Stopping prior authorization practices that prevent seniors and people with disabilities from accessing the care they are entitled to;
- Giving Medicare enrollees more accurate, timely, and personalized information about their plan's supplemental benefits; and
- Making it easier for seniors and people with disabilities to access vital behavioral health care nationwide.

Eliminate Misleading Advertisement Final Rule…

- Establishing new guardrails to address predatory Medicare Advantage marketing, including removing misleading TV ads and producing "honest representation of the plan."
- Evidence of this Final Rule's expectations in TV Commercials, no longer say, "And you don't have Medicare C. Call us to learn how to get Medicare C."
- Mailing Advertisements currently seem more accurate.

Replace Incentives to Healthcare Brokers/Agents by Insurance Companies

- Problem: Larger Insurance Companies paying incentives to Healthcare to steer patients towards their company. Causing patients to be mis-directed to insurance companies and creating an imbalance of competition in the insurance market.
- Expectation to establish a new standard of compensation for Healthcare Brokers/Agents..

Pre-authorization 2024 Final Rule:
Stopping prior authorization practices preventing seniors from accessing the care they are entitled to…..

- In the final rule, CMS requires plans to implement and maintain technology that enables provider electronic health records (EHRs) or practice management systems to: Ascertain whether prior authorization is required for most items and services (the rule currently excludes drugs).Feb 15, 2024

Giving Medicare enrollees more accurate, timely, and personalized information about their plan's supplemental benefits

- MA Beneficiaries dissatisfied about receiving their benefits promised.
- Expectation of this Final Rule is that in six months from January 1st, payors are to have a program in place which informs patients of their benefits.
- Blue Cross/Blue Shield implemented the "New Flex Card with Addition Savings Totaling $2100. Their benefits are identified and are accessed through using the BC Card.

More on BC Flex Card/Debit Plan: An example of a company's response to Final Rule.

- Within its suite of plans starting with premiums as low as $0 per month, Blue Cross has a new Flex Card debit card loaded with up to $2,160 in savings for over-the-counter expenses; fitness and weight-loss programs; dental, vision and hearing copays; and rewards for healthy activities like annual wellness visits. It also expanded the types of fitness classes to include pool-only facilities, as well as fitness equipment and virtual classes.

Medicare Advantage Patients informed of their benefits.....also benefits Case Managers.

- Dual benefit of this Final Rule supports patient and case management.... When implemented in a few months, patients can inform us of their expanded insurance benefits, such as meals, transportation, and caregiver.

Making it easier for seniors and people with disabilities to access vital behavioral health care nationwide

- The new rules increased the availability of behavioral health services, including support for substance abuse. The enhancement of each of these programs is necessary for case managers to understand and apply to their practices.
- Proposed MA regulation would make an outpatient care benefit available to clients. The behavioral health providers would come from a 2024 traditional Medicare Final Rule, effective on January 1, 2024. Under the change Medicare will broaden the mental health workers who are eligible to provide Medicare services. The mental health providers eligible include licensed marriage and family therapists, and mental health and addiction counselors. Expected are 400,000 additional clinicians will be eligible for Medicare reimbursement and available to treat patients under the change.

Final Rule Part D changes...

- CMS is taking action to expand enrollee protections to address predatory marketing of Part D plans, and incentivizing agents and brokers to help Medicare enrollees searching for a plan that best suits their needs, rather than steering people based on financial incentives from plans.
- In 2024, after paying the initial deductible, a person on Medicare will pay 25 percent of drug costs. They will have a cap of about $3,300 and will no longer pay five percent of drug costs in the catastrophic phase.

Helpful Resource: Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)

Apr 04, 2024
- Medicare Part D
- Policy

https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f

Opening a can of worms…….How much of Original Medicare to expect MA to follow?

The Final Rules reviewed maybe only the beginning. How much does the Medicare Advantage Plans need to mirror Original Medicare's Condition of Participation? Like the 2 Midnight Rule or the 3 Overnight's before a SNF admission?

Yes on following the 2 Midnight Rule and MA's not to use InterQual or MCG.

See next slide for CMS language!

2-Midnight Rule for Medicare Advantage Plans

Does the 2-midnight rule and the IPOL apply to Medicare Advantage plans? April 5, 2023 CMS Releases CMS-4201-F • Therefore, 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)). H

Federal Registry 2023 in prep for 2024 Final Rule

Federal Registry 2023 in prep for 2024 Final Rule

the MA organization cannot deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in Traditional Medicare coverage policies (i.e., InterQual/MCP). Under this proposal, certain utilization management processes, such as clinical treatment guidelines that require another item or service be furnished prior to receiving the requested item or service, would violate the proposed requirements at § 422.101(b) and (c), and thus, their use by an MA organization would be prohibited unless specified within the applicable NCD or LCD or Medicare statute or regulation. We note that we did not propose to revise § 422.136, which authorizes MA plans to use step therapy policies for Part B drugs under certain circumstances; in the next paragraph, we discuss the basis for authorizing MA plan-specific step therapy for Part B drugs in § 422.136 in more detail. Otherwise, clinical criteria that restrict access to a Medicare covered item or service unless another item or service is furnished first, when not specifically required in NCD or LCD, would be considered additional internal coverage criteria that are prohibited. When MA plans are allowed to create internal coverage criteria as specified at proposed § 422.101(b)(6), the current evidence in widely used treatment

A Case To Remember:

66 y/o complex medical case with multiple co-morbidities in ICU.

Patient from out of state approved once family appealed to their Medicare Advantage Plan for this hospital stay, because the life-saving procedure required not offered in the home state.

At day 45 LOS, the physician wrote order for transfer to an LTACH which was identified as essential for the patient's continued recovery and ultimately the return to her home state. The MA denied the transfer, saying the patient could receive the rehab in the hospital.

Case to remember continued…..

- The case was appealed by the case manager with the support of her director.
- 2 levels of appeal were completed and both lost.
- The spouse was adamant that the patient receive the rehab. He reported the MA to the Insurance Commission in both States and contacted his senator for support.
- The case manager and her director reported the incident to their state hospital association where MA practices were tracked
- The ultimate decision was to change the patient's insurance to Original Medicare.

Case to remember continued…..

- Steps were taken to change the MA to Original Medicare. The Spouse stated he was disappointed in his Healthcare Agent's choice for the patient. The case manager was shocked by the Agent's choice, as a complex patient benefits from Original Medicare.
- The Spouse who was the patient's legal representative made the call to 800-Medicare, since a MA patient already has Original Medicare. the request was accepted.
- In one week on the 1st day of the next month, the patient transferred to the LTACH……..it was immediate, no authorization was needed.
- Note the disparity in this case Original Medicare vs MA Plan.

Compare Original Medicare & Medicare Advantage Patient Education Resource

CMS.gov is the resource for this info when guiding patients/families, friends, family……..

- Consider in the next 4 slides these things when deciding between Original Medicare and a Medicare Advantage Plan for your health coverage pertaining to Doctor and Hospital Choice
- Factors to consider when comparing are Doctors/Hospitals, Cost, Coverage, and Foreign Travel

Doctor & hospital choice

Original Medicare	Medicare Advantage
You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you can **only use doctors and other providers who are in the plan's network and service area** (for non-emergency care).
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.

Cost

Original Medicare	Medicare Advantage
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your deductible . This amount is called your coinsurance .	**Out-of-pocket costs vary** – plans may have lower or higher out-of-pocket costs for certain services. You may also have an additional premium.
You pay a **premium (monthly payment) for** Part B . If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D) .	You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Some plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out-of-pocket, unless you have supplemental coverage – like Medicare Supplement Insurance (Medigap) .	Plans have a **yearly limit** on what you pay out of pocket for services Medicare Part A and Part B cover. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B covers for the rest of the year.
You **can choose to buy** Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.	You **can't buy** Medigap.

Coverage

Original Medicare	Medicare Advantage
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.	Plans must cover all medically necessary services that Original Medicare covers. Plans may also offer some **extra benefits that Original Medicare doesn't cover** - like certain vision, hearing, and dental services.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans.** In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.
In most cases, you don't need approval for Original Medicare to cover your services or supplies	In many cases, you may need to get approval from your plan before it covers certain services or supplies.

Foreign Travel

Original Medicare

- Original Medicare generally **doesn't cover medical care outside the U.S.**
- You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.

Medicare Advantage

- Plans generally **don't cover medical care outside the U.S.**
- Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.

Biden-Harris Administration Takes Historic Action to Increase Access to Quality Care, and Support to Families and Care Workers announced 1/23/2024---3 new Final Rules

Nursing home minimum staffing standards promote resident care and safety

Medicaid and CHIP to have historic access standards, advance fair compensation for direct care workers

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), issued three final rules to fulfill President Biden's commitment to support family caregivers, boost compensation and job quality for care workers, expand and improve care options, and improve the safety and quality of care in federally-funded nursing homes. The actions, announced during Care Workers Recognition Month and the Month of Action on Care, represent a transformational investment to support America's families and workers.

The three rules announced build on the President's historic Action Plan for Nursing Home Reform and support of President Biden's April 2023 Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers (Care EO).

Ways to Report your Insurance Concerns:

- Do you need help with your complaint within 10 days? Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048
- 1-800-MEDICARE is available 24 hours a day, 7 days a week, except some federal holidays
- Use Medicare Compliant Form: Google to access or Medicare.gov
- Consider State Insurance to Division of Insurance or Office of Consumer Affairs and Business Regulation. Supportive Organizations AHA…

Conclusion:

- The 2024 MAP Final Rules clearly enhance the provision of care for the MAP beneficiaries, while promoting hospital throughput by eliminating delays in prior authorizations and denials.
- The removal of barriers and the promotion of timely care may lead to reduced readmissions due to gaining access to their healthcare rights.
- Other focuses of the 2024 Final Rule, positive impact on drug costs, increases access to behavioral healthcare services, changes to prior authorizations, legitimate MAP advertising, alteration in admission clinical status determinations.

Resources

- Data Sources
- Centers for Medicare and Medicaid Services. 2023. "2023 Expanded and Supplementary Tables." Baltimore, MD.
- Further Reading
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