Alliance Submits Comments on Proposed MA Plan Changes

Alliance Daily | Feb. 3, 2025

The Alliance **submitted comments** on the proposed Contract Year 2026 Policy and Technical Changes to the Medicare Advantage (MA)Programs.

The proposed rule addresses refinements for several existing provisions aimed at protecting MA plan enrollees. While the rule does not address home health specifically, certain proposals have implications for Medicare beneficiaries that may be of interest to providers delivering care in the home.

Clarifying the Definition of an Organization Determination

CMS proposes to include concurrent reviews and that enrollees in receipt of inpatient or outpatient services are covered under §422.138(c) as follows.

§ 422.138(c) Effect of prior authorization, preservice, or concurrent approval. If the MA organization approved the furnishing of a covered item or service through a prior authorization preservice determination of coverage or payment, or a concurrent determination made during the enrollee's receipt of inpatient or outpatient services, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 and §422.616 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. The definitions of the terms "reliable evidence'' and "similar fault'' in § 405.902 of this chapter apply to this provision

The Alliance recommended that that CMS clarify the circumstances with which the MA plan is prohibited from reopening a determination for medical necessity and that CMS provide transparency to the provider community and enrollees in the enforcement activities around non-compliance with the requirements.

Promoting Community-Based Services and Enhancing Transparency of In-Home Service Contractors

CMS proposes to codify the definition of community-based organizations (CBOs) that provide in-home or at-home supplemental benefits to enrollees. The definition would limit CBOs to

not-for- profit organizations. Although CMS does not require organizations that provide supplemental benefits be not for profit, they are proposing that CBOs are notated in the provider directory which suggest that these organizations are preferred providers.

The Alliance requested that CMS not finalize the proposed definition or in any way limit CBO service providers to nonprofits.

The Alliance also submitted the following additional concerns and comments related to MA plans and prior authorization, and payment policies.

Prior Authorization

The Alliance recommended that CMS should require the MA plans to provide prior authorization determinations for home health services within 72 hours of a request for authorization, align the time frame with the home health Conditions of Participation, and establish policies to protect ct providers from the impact of delayed authorization decisions caused by the payer. CMS should consider aligning the time frame for MA plan prior authorization with the CMS CoPs for home health services.

Additionally, the Alliance recommended CMS should require MA plans to waive prior authorization requirements for enrollees in need of home health care immediately following an acute or post-acute care facility stay.

Payment Policies

The Alliance recommended that CMS should require plans to reimburse HHAs on an episodic basis, consistent with Traditional Medicare.

The Alliance comment letter can be **here**.