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Policymakers Must Address Premature Terminations of Coverage by Medicare Advantage Plans

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Background

Private Medicare Advantage (MA) plans are allowed under the law to employ utilization management techniques in order to control spending and ensure that plan enrollees receive medically necessary care. Prior authorization, or pre-approval, for coverage of items and services is widespread within the MA program. As noted by KFF, virtually all MA enrollees are required to obtain prior authorization for some services, "most commonly, higher cost services, such as inpatient hospital stays, skilled nursing facility stays and chemotherapy."[1]

In response to growing attention to problems posed by MA plans' use of prior authorization, the Centers for Medicare & Medicaid Services (CMS) issued a rule in 2023 (for CY2024) aimed at limiting MA plans' ability to inappropriately deny care.[2] The final rule included a number of significant improvements to the rules surrounding MA plans' use of prior authorization to restrict access to service. These included requirements that prior authorization may only be used for limited purposes, including confirming the presence or diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service.[3]

While this rule has somewhat narrowed MA plans' ability to overutilize prior authorization, there remain significant gaps to fill with respect to consumer protections.[4] One issue that continues to negatively impact MA enrollees is when care is initially authorized by the plan but terminated before it is clinically appropriate to do so. In the Center for Medicare Advocacy's experience, this occurs most frequently with skilled nursing facility (SNF) stays. Such terminations, when appealed by MA enrollees, are often overturned. However, when such terminations are successfully challenged by a Medicare beneficiary, MA plans often quickly issue new notices of termination, which, if they continue to be appealed, can lead to multiple denials of coverage during the same episode of care.

The Problem: Premature Terminations of Coverage and Multiple Denials

Before terminating covered services authorized by an MA organization, certain contracting providers, including skilled nursing facilities (SNFs) and home health providers, are required to provide a Notice of Non-Coverage (NOMNC) to an MA enrollee. If the individual wishes to contest the termination, the NOMNC includes instructions on how to file an expedited appeal with the local Medicare-contracted independent reviewer, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO).

While the Center for Medicare Advocacy encounters inappropriate and premature discharges from SNFs in traditional Medicare, we far more often see such denials of care for MA enrollees.

When there is no question that an MA enrollee needs coverage in a SNF (as opposed to being denied such care), we often find that coverage is terminated by the MA plan before it is clinically appropriate to do so. Those individuals who successfully appeal such denials often fairly quickly get subsequent denials even though there has often been no change in the individual's condition.

As an organization we have provided assistance to numerous MA enrollees who encounter a new MA termination notice within a day or several days of receiving a favorable decision from the QIO reversing an MA plans' termination of services. For example, a *CMA Alert* we posted in April 2022 outlined the experiences of one of our clients, an 80-year-old woman enrolled in United Healthcare who had to file more than 10 appeals on the plan's repeated decisions to terminate her coverage of a SNF stay as she tried to regain mobility after a hip operation.[5]

RECENT CASE EXAMPLE: Mrs. S, age 82, a resident of Connecticut enrolled in an MA plan, was hospitalized after falling out of her wheelchair and breaking her leg. Although she has multiple sclerosis (MS) and was limited in function, she entered a SNF for daily skilled therapies so she could return to her apartment with her husband. Her doctors believed this would take at least 8 weeks, if not more. ***Just 7 days into her stay at the SNF, she received her first termination notice****, even though she had not reached her discharge goal and she still needed 24-hour care and a Hoyer lift for transfers. She appealed this denial as well as* ***five more*** *over the course of the next six weeks. In the meantime, she developed Stage 3 pressure wounds and spent an estimated 20 hours a week on her appeals, which included gathering medical information, talking with her treating professionals, and calling the insurance company and QIO. This took a tremendous toll on her physical and mental health while she was trying to recover and heal. Ultimately, the system wore her down. After the last denial, she left the SNF. Her wounds worsened, and she required amputation of her leg.*

Unfortunately, too few people appeal denials of care. According to KFF, only 11.5% of MA prior authorization denials were appealed in 2024 (of those who appealed, most denials (80.7%) were partially or fully overturned).[6] MA-contracted providers find this problematic as well. A recent article in *McKnights Long-Term Care News* noted that the board chair of the American Health Care Association (AHCA), while complaining about MA plans, noted that he had to help residents of his own chain of nursing facilities "appeal to continue their stays up to 12 times — winning every time."[7]

Acentra Health is a Medicare-contracted BFCC-QIO for 29 states across the country. Among its roles is to process appeals for hospital and skilled nursing facility discharges or terminations in both traditional Medicare and Medicare Advantage. In January 2026, Acentra released the results of a focused review it performed concerning MA SNF terminations during a webinar titled "Medicare Advantage Plan Appeals in Skilled Nursing Facilities – A Data-Driven Review of Coverage Decisions and Clinical Implications".[8] Focusing on MA plans' issuance of the

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NOMNC informing MA enrollees that the plan will no longer cover their SNF stay, Acentra found that between May 2024 and April 2025, **93% of SNF appeals they handled originated from MA enrollees** (vs. 7% from those in traditional Medicare), despite MA enrollment constituting 51.6% of Medicare beneficiaries in the states they cover. Acentra claimed that NOMNCs issued by MA plans "are disagreed with and reissued more frequently" than termination notices given in traditional Medicare. Key findings about MA terminations included "**92% of beneficiaries required continued skilled nursing or therapy services at NOMNC issuance**" and "**72% of beneficiaries were at high risk for decline, injury, or readmission if discharged**" [emphasis added].

Acentra also noted that "[m]any beneficiaries received multiple repeat NOMNCs, up to 12 in some cases." As highlighted in a *McKnights Long-Term Care News* article that covered the webinar, Acentra also stated:

> In addition, 27% of notices of non-coverage in the MA pool were repeated during the same nursing home stay. That equates to an average of 2.7 repeats per beneficiary. One patient received 12 notices after winning previous appeals.
>
> Often, those denials were "just repeated on regular intervals, like weekly intervals," [Chief Medical Officer] Whitley said. **Across all repeat appeals, Acentra's reviewers disagreed with the plans' intention to stop coverage in 77% of cases** [emphasis added].[9]

CMS Efforts to Address Improper Denials of Coverage by MA Plans

As noted above, CMS issued a rule in 2023 (for CY2024) aimed at limiting MA plans' ability to inappropriately deny care.[10] In the preamble to the proposed CY2024 rule, CMS recognized the problems posed by multiple denials during the same episode of care, and acknowledged feedback provided by various stakeholders:

> that MA coordinated care plans' prior authorization processes sometimes require enrollees to interrupt ongoing treatment. We also have received complaints that MA plans require repetitive prior approvals for needed services for enrollees that have a previously-approved plan of care or are receiving ongoing treatments for a chronic condition. When MA plans require repetitive prior approvals, enrollees may face delays in receiving medically necessary care or experience gaps in care delivery that threaten an enrollee's health (p. 79504).

Similarly, later in the same proposed rule, CMS noted that it had received complaints "about potential quality of care issues regarding early termination of services in post-acute care settings by MA organizations." Such complaints:

> allege that MA organizations are increasingly terminating beneficiaries' coverage of post-acute care before the beneficiaries are healthy enough to return home. It is further alleged that, in some situations, even after a beneficiary has successfully appealed to the Quality Improvement Organization (QIO) and received a favorable decision to reauthorize coverage of services delivered by providers of services described in §§ 422.624 and 422.626, the MA organization sends another notice of termination of services a day or two after the coverage was reinstated (p. 79507).

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The final CY2024 rule included a number of provisions aimed at limiting MA plans' use of prior authorization to restrict access to service, including requirements that it may only be used for limited purposes, including confirming the presence or diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service.[11] In addition, CMS revised continuity of care guidelines at 42 C.F.R. §422.112(b)(8)(i) to state that MA plans must ensure continuity of care, including:

> With respect to basic benefits, policies for using prior authorization that at a minimum include that for enrollees undergoing an active course of treatment — (A) Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation.

Through these and other combined restrictions to MA plan conduct, CMS appeared to believe that such changes would greatly reduce inappropriate denials of prior authorization and foster greater continuity of care for MA enrollees during a course of treatment without improper interruption. As evidenced by Acentra's findings discussed above, along with our own experience, they have not.

Policy Recommendations

In order to adequately protect Medicare Advantage plan enrollees, reduce the burdens on providers treating them, and enhance oversight of MA plans, policymakers must take additional steps to improve consumer protections. We offer the following suggestions:

- *Impose a Minimum Grace Period for Overturned Denials/Terminations of Care*

In the proposed CY2024 rule, CMS solicited comments on potential changes to existing rules or potential new rules concerning "termination of services from home health agencies, SNFs, and comprehensive outpatient rehabilitation facilities and how enrollees must be notified of upcoming terminations of services" and how to "better manage incentives between MA organizations and post-acute care providers to deliver the best possible care for Medicare beneficiaries" (p. 79507). CMS offered topics for comments, including

> • "When coverage is reinstated based on a QIO decision, whether the enrollee should have more than the 2 day period from the date of a new termination of services notice before coverage can be terminated again by the MA organization, taking into account any medical necessity determinations made by the QIO."

In response to CMS' proposal, which they did not finalize and have not addressed since, CMA offered the following comment:

> Similar to CMS' proposals to require continuity of care during a course of treatment, including during transition periods, CMS should impose a minimum time period during which MA plans cannot issue a termination notice after their prior termination decision has been reversed by the QIO. The MA plan should have to meet a higher burden of proof demonstrating a significant change in condition or need – particularly if the provider disagrees with the termination. CMS should consider a grace period of 14 days, at minimum, before a plan can issue another termination notice. This time period would allow a reasonable amount of time to reassess a beneficiary's condition.

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Although Medicare regulations cited above require MA plans' "approval of a prior authorization request for a course of treatment [to] be valid for as long as medically necessary to avoid disruptions in care" far too many MA plans continue to terminate coverage that is still medically necessary. As noted by Acentra, as discussed above, the QIO found that "92% of beneficiaries required continued skilled nursing or therapy services" in SNFs at the time the MA plan issued a notice of termination of coverage. A minimum time period during which MA plans cannot issue a termination notice after their prior termination decision has been reversed by the QIO would be an important step towards reducing improper, repeated terminations.

- *Require MA Plans to Detail Any Change in Condition Before Issuing Termination Notice*

Arguably, this is already required by the continuity of care regulations, and CMS does require this through sub-regulatory guidance. As outlined in a *CMA Alert* (Jan. 2025),[12] CMS updated their appeals guidance concerning when an individual is given a NOMNC and chooses to appeal, at which point the MA plan is obligated to provide a Detailed Notice of Non-Coverage (DENC). Effective January 2025, a new element was added to instructions to MA plans for completing the DENC:[13]

> **Special instructions for repeat appeals within the same episode of care:**
> If the enrollee has previously received a favorable QIO appeal decision during the current episode of care, detail the specific change(s) in the enrollee's condition since the previous appeal that provide the basis for this decision to terminate services.

Given the ongoing, repeated and inappropriate denials catalogued by Acentra, it does not appear that MA plans are approaching compliance with this provision with enough attention. This requirement should be codified in regulation (if not statute) and strictly enforced by CMS, with escalating penalties or sanctions for non-compliance.

- *Deference to Treating Clinician(s)*

Existing Medicare rules require MA plans to rely somewhat on the opinion of an MA enrollee's treating clinician when making coverage decisions. For example, as noted above, the revised regulation at 42 C.F.R. §422.112(b)(8)(i) states that "With respect to basic benefits, policies for using prior authorization that at a minimum include that for enrollees undergoing an active course of treatment— (A) Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation."

In practice, these requirements do not appear to amount to much. As we noted in our comments to the proposed CY2024 rule:

> Our experience serving Medicare beneficiaries, reinforced by numerous interactions with providers such as SNFs, home health agencies and physicians, shows that MA plans all too often substitute their own clinical judgment for that of the treating physician or other clinician, often without even evaluating the beneficiary in person.
>
> Providers often describe the plan-provider relationship to us as being "one-sided" with little or no participation of providers' views. The treating provider's judgment from the patient's bedside is second to the plan's. Neither the providers' nor the patients' and their

families' needs and wishes are accounted for. One physician specializing in home care with whom we recently spoke commented: "I want the plan to ask my approval before terminating services [but that doesn't happen]; the plan needs to get my input. There needs to be some balance of shared decision- making."

In order to better ensure that coverage decisions properly incorporate clinical considerations, MA plans should be required to offer some deference to, or shared decision-making with, treating providers. For example, some providers have called for certain physicians' protocols to be a rebuttable presumption that ordered services are medically necessary. The MA plan would then bear the burden of proving that the physician's protocol is not medically necessary.[14]

Conclusion

Public and provider outcry over prior authorization abuses by health insurance plans across different types of coverage has rightly focused more attention from policymakers to such issues. While the final CY2024 Part C and D rule took some important, but incomplete steps, little else has been done to address ongoing concerns.[15] In June 2025 the Trump Administration announced a series of voluntary (and unenforceable) commitments that certain representatives of the insurance industry pledged to take to address some of the problems with prior authorization across different types of health coverage. As noted by some commenters, many of these reforms were already required, at least in Medicare Advantage.[16] Policymakers must restrict abusive prior authorization practices and the attending problem of inappropriate and premature termination of care that is initially authorized by plans.

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[1] KFF, "Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024" by Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman (Jan. 2026), available at: https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a.

[2] 88 Fed Reg 22120 (CMS-4201-F), April 12, 2023, available at: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf.

[3]For a summary of these provisions, see, e.g., Center for Medicare Advocacy, Special Report: "Summary of Final 2024 Medicare Advantage and Part D Rule: Important Consumer Protections Regarding MA Prior Authorization, Marketing and Other Issues" (May 2023), available at: https://medicareadvocacy.org/wp-content/uploads/2023/05/2023-C-D-Rule-Report.pdf.

[4] See, e.g., Center for Medicare Advocacy, Comments to Proposed CY2024 Part C & D Rule (Feb. 13, 2023), available at: https://medicareadvocacy.org/wp-content/uploads/2023/02/C-and-D-Comments-CY-2024.pdf.

[5] CMA Alert, "When Artificial Intelligence in Medicare Advantage Impedes Access to Care: A Case Study" (April 21, 2022), available at: https://medicareadvocacy.org/ai-plus-ma-equals-bad-care-decisions/.

[6] KFF, "Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024" by Jeannie Fuglesten Biniek, Nolan Sroczynski, Meredith Freed, and Tricia Neuman (Jan. 2026), available at: https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a.

[7] *McKnights Long-Term Care News*, "A compassionate look at the 'big, big picture' with AHCA Board Chair Chris Wright" by Kimberly Marselas (Feb. 23, 2026)

[8] Acentra, Care Review Connections, Winter 2026,"Appeals Update" https://acentraqio.com/newsletter/winter-2026-post-acute-providers/#appeals; also see https://acentraqio.com/webinars - see January 21, 2026 presentation slides, webinar recording and Q&A.

[9]*McKnights Long-Term Care News*, "Medicare Advantage nursing home denial practices shredded by appeals contractor research" by Kimberly Marselas (Jan. 21, 2026), available at:

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https://www.mcknights.com/news/medicare-advantage-nursing-home-denial-practices-shredded-by-appeals-contractor-research/.

[10] 88 Fed Reg 22120 (CMS-4201-F), April 12, 2023, available at: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf.

[11]For a summary of these provisions, see, e.g., Center for Medicare Advocacy, Special Report: "Summary of Final 2024 Medicare Advantage and Part D Rule: Important Consumer Protections Regarding MA Prior Authorization, Marketing and Other Issues" (May 2023), available at: https://medicareadvocacy.org/wp-content/uploads/2023/05/2023-C-D-Rule-Report.pdf.

[12] CMA Alert, "New CMS Rule Helps MA Plan Enrollees Against Repeated SNF Denials in the Same Episode of Care" (Jan. 9, 2025), available at: https://medicareadvocacy.org/new-rule-for-repeated-snf-denials/.

[13] See §100.2.1 at p. 113, CMS, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (updated Nov. 18, 2024), available at: https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf.

[14] See policy framework developed by the American Physical Therapy Association (APTA), the American Occupational Therapy Association (AOTA) and APTA Private Practice, supported by a coalition of national organizations, including the Center for Medicare Advocacy, titled "Care Delayed Is Care Denied: A Therapy Consensus to Reform Prior Authorization" (March 2026), available at: https://www.apta.org/siteassets/pdfs/advocacy/apta-priorauth-coalition-principles.pdf.

[15] Instead of reining in troublesome prior authorization practices, the Centers for Medicare & Medicaid Innovation (CMMI), a division of CMS, has rolled out the Wasteful and Inappropriate Service Reduction (WISeR) Model in six states starting in January 2026. The model, designed in theory to cut down on "fraud" and "unnecessary" services, introduces AI-powered prior authorization requirements for about a dozen procedures into traditional Medicare, importing some of the worst elements of Medicare Advantage utilization management.

[16] See, e.g., HEALTH CARE un-covered, "The Fox Guards the Hen House – Translating AHIP's Commitments to Streamlining Prior Authorization" by Seth Glickman (June 24, 2025), available at: https://healthcareuncovered.substack.com/p/the-fox-guards-the-hen-house-translating.

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