# September 2024 Third Party Changes of Significance

## MISSISSIPPI MEDICAID

**Mississippi Awards Medicaid Contracts. Rylee Wilson, Becker's Payer Issues. Thursday, August 29th, 2024**

"Mississippi awarded Medicaid contracts to Centene, Molina Healthcare and new nonprofit TrueCare, Mississippi Today reported Aug. 28.

UnitedHealthcare, which currently manages the state's Medicaid program, did not receive a contract. Centene and Molina Healthcare received renewed contracts.

Mississippi also selected TrueCare, a nonprofit health plan formed by the Mississippi Hospital Association and hospitals in the state, to administer its Medicaid program.

The contracts were first awarded in 2022. The process was delayed for two years by challenges from UnitedHealthcare and Elevance Health, Mississippi Today reported. Court challenges are still pending, according to the news outlet, but officials said they did not expect any additional delays in implementing the contracts.

The state expects enrollment in the new contracts to begin in May 2025."

https://www.beckerspayer.com/contracting/mississippi-awards-medicaid-contracts.html

## CMS, NOVITAS, RAILROAD MEDICARE

**Reminder: 2023 Targeted Review Available. CMS QPP. September 12, 2024**

"Review your MIPS performance feedback, including your MIPS final score and payment adjustment factor(s), on the Quality Payment Program website.

Individual clinicians, groups, subgroups, virtual groups, APM Entities (including Shared Savings Program ACOs), designated support staff and authorized third party intermediaries may request that CMS review the calculation of their MIPS payment adjustment factor(s) through a process called targeted review.

**When to Request a Targeted Review**

If you believe there's an error in the calculation of your MIPS payment adjustment factor(s), you can request a targeted review now until October 11, 2024, at 8 p.m. ET.

**For example:**

Data were submitted under the wrong TIN or National Provider Identifier (NPI).

You have Qualifying APM Participant (QP) status and shouldn't receive a MIPS payment adjustment.

Performance categories weren't automatically reweighted even though you qualify for reweighting due to extreme and uncontrollable circumstances.

**Note:** This isn't a comprehensive list of circumstances. If you have questions about whether your circumstances warrant a targeted review, please contact the QPP Service Center by phone at 1-866-288-8292 (TRS: 711) or by email at QPP@cms.hhs.gov.

**How to Request a Targeted Review**

You can access your MIPS final score and performance feedback and request a targeted review:

Sign in using your HARP credentials (ACO-MS credentials for Shared Savings Program ACOs); these are the same credentials that allowed you to submit your 2023 MIPS data.

Click "Targeted Review" on the left-hand navigation.

CMS generally requires documentation to support a targeted review request, which varies by circumstance. A CMS representative will contact you about providing any specific documentation required. If the targeted review request is approved and results in a scoring change, we'll update your final score and/or associated payment adjustment (if applicable), as soon as technically feasible. Please note that targeted review decisions are final and not eligible for further review.

**Targeted Review Resources:**

2023 Targeted Review User Guide (PDF, 15MB) – Reviews the process for requesting a targeted review and examples for when you would or wouldn't request a targeted review.
2025 MIPS Payment Year Payment Adjustment User Guide (PDF, 710KB) – Reviews information about the calculation and application of MIPS payment adjustments, and answers frequently asked questions. "

**Reminder: 2024 QPP Exception Applications are Available. CMS APP. September 12, 2024**

"The 2024 Quality Payment Program (QPP) Exception applications are available through December 31, 2024, at 8 p.m. ET. There are 2 types of exception applications that allow users to indicate the reason they're unable to report data for one or more Merit-based Incentive Payment System (MIPS) performance categories.

**MIPS Promoting Interoperability Performance Category Hardship Exception Application**

Individual clinicians, groups, and virtual groups (or a third-party representative) can submit a MIPS Promoting Interoperability Performance Category Hardship Exception application for the following reasons:

- You have decertified Electronic Health Record (EHR) technology (must be decertified under the Office of the National Coordinator for Health Information Technology's (ONC) Health IT Certification Program).
- You have insufficient internet connectivity.
- You face extreme and uncontrollable circumstances such as a disaster, practice closure, severe financial distress, or vendor issues.
- You lack control over the availability of certified EHR technology (CEHRT).

This application is specific to the MIPS Promoting Interoperability performance category. If your application is approved, you won't be required to report data for this performance category.

**MIPS Extreme and Uncontrollable Circumstances Exception Application**

Individual clinicians, groups, and virtual groups (or a third-party representative) can submit a MIPS Extreme and Uncontrollable Circumstances (EUC) Exception application for one or more MIPS performance categories (quality, cost, improvement activities, and Promoting Interoperability) due to extreme and uncontrollable circumstances, defined as rare events entirely outside of your control and the control of the facility in which you practice.
These circumstances would:

- Cause you to be unable to collect information necessary to submit for a MIPS performance category.
- Cause you to be unable to submit information that would be used to score a MIPS performance category for an extended period of time (for example, if you were unable to collect data for the quality performance category for 3 months).
- Impact your normal processes, affecting your performance on cost measures and other administrative claims measures. …

**How to Apply**

To submit either Exception application:
Sign in to the QPP website with your Health Care Quality Information System (HCQIS) Access Roles and Profile (HARP) account.
Choose "Exceptions Application" from the left-hand navigation.
Click "Add New QPP Exception" on the right side of the screen.
Choose your exception type.

**Additional Resources**

Quality Payment Program Access User Guide (ZIP, 3MB) – Refer to "Step 1: Register for a HARP Account"
Exception Applications (webpage on the QPP website)
2024 MIPS Promoting Interoperability Hardship Exception Application Guide (PDF, 1MB)
2024 MIPS Extreme and Uncontrollable Circumstances Exception Application Guide (PDF, 1MB) "

**CMS Says It Is Targeting Oversight Of Third-Party Vendors Following Change Healthcare Cyberattack. AOA First Look. September 16, 2024**

Modern Healthcare (9/13, Early, Subscription Publication) reported CMS Principal Deputy Administrator Jonathan Blum said the agency plans to add oversight of third-party health vendors following the February Change Healthcare cyberattack. Blum "said at Modern Healthcare's Leadership Symposium Thursday that the agency is working to determine what levers it can pull to ensure severe disruptions in care like those linked to the cyberattack on the UnitedHealth Group subsidiary aren't repeated."

Article: https://www.modernhealthcare.com/policy/cybersecurity-oversight-cms-policies-jonathan-blum

**National Correct Coding Initiative: October Update. CMS. September 12, 2024**

Get the National Correct Coding Initiative (NCCI) fourth quarter edit files, effective October 1, 2024, on these Medicare NCCI webpages:

Procedure-to-Procedure Edits
Medically Unlikely Edits
Add-on Code Edits

**House Committee Advances Measure That Would Extend Medicare Telehealth Waivers. AOA First Look. September 19, 2024**

Bloomberg Law (9/18, Belloni, Subscription Publication) reports, "A bill that would extend several telehealth regulatory flexibilities implemented during the Covid-19 pandemic advanced through a key House committee with bipartisan support." On Wednesday, the House Energy and Commerce Committee "voted 41-0 in favor of the Telehealth Modernization Act of 2024 (H.R. 7623)." The measure, "introduced by Rep. Buddy Carter (R-GA) and cosponsored by 19 lawmakers, would extend several telehealth flexibilities in the Medicare program over the next couple years."

STAT (9/18, Aguilar, Cohrs, Subscription Publication) reports that in 2022, lawmakers "extended pandemic-era flexibilities about where and what kinds of care Medicare enrollees could receive over telehealth." The legislation "would temporarily make more telehealth services available to Medicare enrollees in their homes nationwide. Before the pandemic, telehealth coverage was available only to people living in rural areas with many restrictions." The measure "also extends for five years a program that allows approved hospitals to deliver inpatient care in people's homes."

Bloomberg Law: https://news.bloomberglaw.com/employee-benefits/bill-extending-telehealth-waivers-advanced-by-house-panel
STAT: https://www.statnews.com/2024/09/18/house-congress-medicare-telehealth-flexibility-extension/

**Help Reduce Health Disparities for Hispanic or Latino Patients. CMS Medlearn Connects. September 19, 2024**

"Hispanic Americans are at greater risk of various health conditions due to a lack of preventive care and language barriers. During National Hispanic Heritage Month, increase your awareness of health disparities and learn about culturally and linguistically competent health care.

More Information:

- Introduction to Language Access Plans web-based training
- Latino Partners webpage
- Understanding the Health Needs of Diverse Groups of Hispanic Medicare Beneficiaries (PDF) data highlight"

## OTHER

**New Eyeglass Rule Requirements Take Effect Sept. 24: Resources To Prepare. AOA First Look. September 17, 2024**

"Doctors of optometry must abide by new eyeglass prescription release and document retention requirements starting Tuesday, Sept. 24, 2024, with the AOA offering a compliance toolkit to prepare practices.

Per the Federal Trade Commission's (FTC's) June 27 update to Ophthalmic Practice Rules, or the "Eyeglass Rule," eye doctors must now obtain confirmation that the patient received their eyeglasses prescription and, in cases where the prescription is provided electronically, doctors must obtain consent to send the prescription electronically, in addition to retaining such documentation for at least three years. These rule updates mirror the FTC's Contact Lens Rule update, finalized in 2020.

To help doctors of optometry meet these new requirements, the AOA offers a PDF compliance toolkit that includes:

Frequently Asked Questions
Template consent form for electronic prescription delivery
Links to FTC compliance resources

Have questions about compliance? Send an email to askaoa@aoa.org."

**AOA To Update Profession On Health, Vision Plan Advocacy Efforts. AOA First Look. September 10, 2024**

The AOA issues a call for the entire optometric profession to join an important townhall discussion on reimbursement and coverage fairness via a webinar on **Tuesday, Oct. 29.**

**What:** AOA Reimbursement and Coverage Fairness Townhall

**When:** 9 p.m. ET, Tuesday, Oct. 29

Register here to attend this Zoom townhall. After registering, you will receive a confirmation email with information about joining this townhall event.

This second profession-wide townhall on the AOA's health and vision plan advocacy efforts will provide attendees:

- Updates on reimbursement and coverage fairness activities in Congress.
- The latest information on state vision plan legislation.
- Impact of AOA advocacy on health and vision plans.

The AOA, affiliates and doctors of optometry across the country are standing up for reimbursement and coverage fairness, supporting optometric practice success and doctors' ability to deliver quality patient care. Learn more about this advocacy.

**Administration Updates Oversight Standards of Medicaid Fraud Control Units. AOA First Look. September 18, 2024**

"Bloomberg Law (9/17, Belloni, Subscription Publication) reports the Biden Administration on Tuesday updated "performance standards for its Medicaid Fraud Control Units," an oversight arm of HHS that investigates and prosecutes "fraud across state and territorial Medicaid programs." Under the new standards, "Medicaid Fraud Control Units in each state will be graded on 12 performance categories that will assist the HHS OIG in its recertification audits.""

https://news.bloomberglaw.com/pharma-and-life-sciences/biden-hhs-updates-oversight-of-medicaid-fraud-control-units

**Coordination of Benefits: 3 Takeaways for Optometric Billing Practices. AOA. September 25, 2024**

"Coordination of benefits in eye care is critical to ensure patients maximize the benefits they are owed and can reduce the need for multiple appointments when both medical and vision are billed together. Keep reading for tips from the AOA Third Party Center. "

https://www.aoa.org/news/practice-management/billing-and-coding/coordination-of-benefits-3-takeaways-for-optometric-billing-practices?sso=y

**AOA Advocacy Alert: Help Stop the Impending Medicare Cut. AOA. September**

"Failure to stop a 2.8% cut outlined by the Centers for Medicare & Medicaid Services' (CMS') CY 2025 Medicare Physician Fee Schedule (PFS) Proposed Rule could threaten beneficiary access to doctors of optometry come Jan. 1, 2025. Immediate action is needed to stop this reduction. A bipartisan group of lawmakers is circulating a sign-

on letter to House leadership urging an immediate stop to this cut. Contact your representatives to ask them to join this letter. Or, send a letter to your U.S. Representatives and Senators. The AOA is available to help answer questions or discuss appropriate follow-up after your outreach."

https://www.aoa.org/advocacy/federal/action-center?sso=y
https://www.aoa.org/advocacy/aoa-on-capitol-hill?sso=y

**Save the date: AOA Reimbursement and Coverage Fairness Townhall. AOA. September 2024**

"Hear updates from Congress, get the latest on state vision plan legislation and enforcement, learn about the impact of AOA's direct dialogue with health and vision plans, and make your voice heard on the reimbursement and coverage fairness issues that impact your practice the most. Register to attend this webinar on Oct. 29 at 8 p.m. CT. [9pm EDT]

https://eyelearn.aoa.org/learn/courses/569/102924-aoa-reimbursement-and-coverage-fairness-townhall/sessions/257/aoa-reimbursement-and-coverage-fairness-townhall

**A Screening Strategy to Mitigate Vision Impairment by Engaging Adults Who Underuse Eye Care Services. E. Sherman, et al. JAMA Ophthalmology. August 22, 2024**

"**Question** Were adults at high risk of eye disease using eye care services before participating in the Screening and Intervention for Glaucoma and Eye Health Through Telemedicine Program?

**Findings** In a cross-sectional study including 1171 participants in an eye care program, 55% had not had an eye examination in 2 or more years. Of those screening positive for glaucoma, cataract, diabetic retinopathy, or age-related macular degeneration, 41% to 54% had not had an eye examination in 2 or more years.

**Meaning** These results suggest that free eye disease screenings in primary care clinics within underserved communities engaged people at risk of eye disease and underuse of eye care; this approach may enhance eye disease detection and treatment, potentially reducing vision loss in the US."

https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2822694#google_vignette

**UHC Medical Policy Updates (excerpts) (See Below)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/commercial/medical-policy-update-bulletin-september-2024.pdf

**UHC Oxford Medical Policy Updates: (See Below)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/oxford/oxford-policy-update-bulletin-september-2024.pdf

**UHC UMR Medical Policy Updates: (See Below)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/umr/umr-medical-policy-update-bulletin-september-2024.pdf

**UHC Individual Exchange Medical Policy Updates: (See Below)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/exchange/exchange-medical-policy-update-bulletin-september-2024.pdf

**UHC Community Plans Mississippi Medical Policy Updates (None Relevant)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/comm-plan/ms/community-plan-ms-medical-policy-update-bulletin-september-2024.pdf

**UHC Medicare Advantage Plans Medical Policy Updates (See Below)**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/mamp/medicare-advantage-medical-policy-update-bulletin-september-2024.pdf

**UHC Relevant Policy Change**

**Brow Ptosis and Eyelid Repair Policy Number: MP.002.24. Effective Date: October 1, 2024**

**Summary of Changes**

**Related Policies**

• Added reference link to the Medical Policy titled Gender Dysphoria Treatment

**Coverage Rationale**

• Replaced language indicating "Internal Browpexy is not considered reconstructive and is not medically necessary as it does not correct a functional impairment" with "Internal Browpexy for any condition is considered cosmetic and not medically necessary"

• Revised coverage criteria for:

**Lid Retraction Surgery**

o Removed criterion requiring "clear, high-quality, clinical photographs document the pathology"

**Canthoplasty/Canthopexy**

o Removed criterion requiring "clear, high-quality, clinical photographs document the pathology"

o Removed: – Dermatochalasis – Ectropion – GPC that is not related to FES – Ptosis of the lid(s)

**Floppy Eyelid Syndrome (FES)**

o Replaced criterion requiring "other causes of the eye findings have been ruled out" with "infections of the eye have been ruled out"

o Revised list of examples of infections of the eye:

♣ Replaced "contact lens (CL) complication" with "contact lens (CL) complication [e.g., giant papillary conjunctivitis (GPC)]"

♣ Removed: – Dermatochalasis – Ectropion – GPC that is not related to FES – Ptosis of the lid(s)

**Medical Records Documentation Used for Reviews** (previously titled Documentation Requirements)

• Replaced list of Required Clinical Information with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews

**Definitions**

• Added definition of:

o Canthopexy
o Canthoplasty
o Lagophthalmos

• Removed definition of:

o Congenital Anomaly
o Cosmetic
o Cosmetic Procedures (California only)
o Functional or Physical or Physiological Impairment
o Reconstructive Procedures o Visual Field Testing

• Updated definition of:

o Floppy Eyelid Syndrome (FES)
o Internal Browpexy
o Marginal Reflex Distance -1 (MRD-1)

**Supporting Information**

• Updated Clinical Evidence and References sections to reflect the most current information

• Archived previous policy version MP.002.23

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/brow-ptosis-eyelid-repair-10012024.pdf

**UHC Oxford Brow Ptosis and Eyelid Repair Policy Number: SURGERY 018.39 Effective Date: October 1, 2024**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/oxford/brow-ptosis-eyelid-repair-ohp-10012024.pdf

**UHC UMR Brow Ptosis and Eyelid Repair Policy Number: MP.002.24 Effective Date: October 1, 2024**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/brow-ptosis-eyelid-repair-10012024.pdf

**UHC Individual Exchange Brow Ptosis and Eyelid Repair Policy Number: MP.002.24 Effective Date: October 1, 2024**
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/brow-ptosis-eyelid-repair-10012024.pdf

**UHC Medicare Advantage Plan Brow Ptosis and Eyelid Repair Policy Number: MMP007. Effective Date: September 1, 2024**
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-mp/brow-ptosis-eyelid-repair.pdf

**United Health Care Reimbursement Policy Updates:**

**Anatomical Modifier Requirement Policy, Professional – Reminder. Effective November 1, 2024**

• Effective with dates of service on or after November 1, 2024, UnitedHealthcare will enhance the Anatomical Modifier Requirement Policy, Professional.

• This policy update requires the use of appropriate laterality or anatomical modifiers for surgical procedures that are assigned a bilateral status indicator of 1 on the CMS National Physician Fee Schedule for the claim to be considered for reimbursement.

-The relevant modifiers include: 50, LC, LD, LM, RC, RI, E1-E4, FA, F1-F9, LT, RT, TA, T1-T9

• Modifiers are essential in medical coding to provide clarity. Anatomical and lateral modifiers specify the part of the body on which service was performed, which is important when the procedure could potentially be performed on multiple sites. The use of modifiers assists with ensuring appropriate reimbursement for services rendered.

**Reimbursement Policy Code Updates – Multiple Policies**

In response to provider feedback and in an effort to provide more transparency, UnitedHealthcare is providing additional information regarding code updates that impact reimbursement policies. These updates are not changing the intent or the coding requirements of the policy, but reflect changes made to industry standard code sets.

• The following UnitedHealthcare policies have recently been updated to include code changes:
  • Contrast & Radiopharmaceutical Materials, Professional
  • Maximum Frequency per Day, Professional
  • Procedure and Place of Service, Professional
  • Procedure to Modifier, Professional
  • Supply Policy, Professional

• Information regarding these code updates can be found in the history section which is located at the end of the posted policy.

• Code sections/lists/tables within a policy may not be comprehensive but may be provided as examples. Please review the full policy to understand applicability.

• Code updates could include, for example, CPT, HCPCS, ICD-10, Modifiers, Revenue Codes, or other industry standard code sets.

• UnitedHealthcare routinely updates its reimbursement policies in response to code updates made by, for example, Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), and the World Health Organization (WHO). This information is provided as a courtesy and may not include all code updates.

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/rpub/UHC-COMM-RPUB-September-2024.pdf

**UHC Community Plan Reimbursement Policy Updates:**
https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/rpub/community-plan-reimbursement-update-bulletin-september-2024.pdf

**UHC Individual Exchange Reimbursement Updates**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/exchange-reimbursement/erpub/UHC-Exchange-RPUB-SEPTEMBER-2024.pdf

**UHC Medicare Advantage Reimbursement Updates**

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/rpub/UHC-MEDADV-RPUB-SEP-2024.pdf

## UHC Gold Card Program. September 2024

**How to check your Gold Card status**

UnitedHealthcare recently announced the national Gold Card program, which will reduce prior authorizations in favor of advance notification for some high-performing providers. Provider groups can now view their Gold Card program status in the UnitedHealthcare Provider Portal.

**Find out if your tax ID number qualifies today**

Visit our national Gold Card program page for detailed instructions on how to identify Gold Card status and access to an interactive guide that can help you navigate our resources.

**How the program works**

Effective Oct. 1, 2024, the program simplifies the prior authorization process for qualifying providers and eligible services. Qualifying providers will need to submit advance notification, which confirms eligibility and network status, but no clinical information will be requested.

**Learn more**

For more information on the program, including eligibility criteria and a comprehensive list of Gold Card-eligible CPT® codes, visit our national Gold Card program page. You can also view the Gold Card program criteria and provider performance data to help in the future qualification of additional provider groups.

**Questions?** We're here to help

Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal. For additional contact information, visit our Contact us page.

https://www.uhcprovider.com/en/resource-library/news/2024/qualify-national-gold-card-program.html?cid=em-providernews-2024nnb2-Sep24

## New GA Modifier Requirement For Unitedhealthcare Commercial Plans. September 1, 2024

Beginning Feb. 1, 2025, we're adding the following GA modifier requirement for UnitedHealthcare commercial plans claims to our Charging members for non-covered services protocol. This requirement should help improve health care transparency by helping to ensure patients were made aware of their potential cost-sharing liability.

**The new requirement**

In addition to the consent requirements in the Protocol, if you know or have reason to suspect that a commercial member's benefits do not cover the service (as described further in the Protocol), a GA modifier must be submitted on the claim if you want to bill our member for the non-covered service. You will use the GA modifier to document when the enhanced content requirements of the consent were met. The aim of requiring use of the GA modifier is to improve health care transparency by helping ensure members were made aware of their potential liability in advance of any procedure or bill they may receive for services. If you didn't meet all of the consent requirements in the Protocol, it is not appropriate to submit the GA modifier on the claim and you cannot bill our member.

**What you need to do**

If you obtain written consent from a commercial member for a service you know or suspect is not covered by their benefits, and the consent met all the requirements in the Protocol, you must include the GA modifier on your claim for the non-covered service. Including the GA modifier on your claim for the non-covered service helps ensure it is adjudicated as member liability where appropriate.

Note, the new requirement will also be included in our 2025 Administrative Guide for Commercial Plans.

https://www.uhcprovider.com/en/resource-library/news/2024/ga-modifier-requirement-commercial-plans.html?cid=em-providernews-2024nnb2-Sep24

**United Healthcare Provider Portal Enhancements**

**RHW: Some provider action maybe required.**

> We can't make your task list any shorter, but our portal resources page and the following UnitedHealthcare Provider Portal enhancements are designed with your workload in mind.
> Check out the most recent changes.

https://www.uhcprovider.com/en/resource-library/provider-portal-resources/provider-portal-enhancements.html?cid=em-providernews-2024nnb2-Sep24

**Income, Poverty and Health Insurance Coverage in the United States: 2023. US Census Bureau. September 10, 2024**

> "The U.S. Census Bureau today announced that real median household income increased by 4.0% between 2022 and 2023. This is the first statistically significant annual increase in real median household income since 2019. The official poverty rate fell 0.4 percentage points, to 11.1%, in 2023. The Supplemental Poverty Measure (SPM) rate in 2023 was 12.9%, an increase of 0.5 percentage points from 2022. Meanwhile, 92.0% of the U.S. population had health insurance coverage for all or part of 2023, not statistically different from 2022. An estimated 26.4 million or 8.0% of people did not have health insurance at any point during 2023, according to the 2024 Current Population Survey Annual Social and Economic Supplement (CPS ASEC), also not statistically different from the previous year."

https://www.census.gov/newsroom/press-releases/2024/income-poverty-health-insurance-coverage.html

**Medicare Advantage Bonus Payments Decline For First Time Since 2015. Rylee Wilson. Becker's Payer Issues. September 11, 2024**

> "Bonus payments to Medicare Advantage plans will decline by around 8% in 2024 compared to 2023, according to a report from KFF.
> The analysis, published Sept. 11, found bonus payments to MA plans will decline by around $1 billion to $11.8 billion in 2024. …"

https://www.beckerspayer.com/payer/medicare-advantage-bonus-payments-decline-for-first-time-since-2015.html?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

**AI Linked to Surge In Medicare Advantage, Commercial Claims Denials: AHA. Jakob Emerson. Becker's Payer Report. September 12, 2024**

> "Administrative costs now account for more than 40% of hospitals' total expenses for delivering patient care, with a significant portion driven by the rising number of care denials stemming from the growing use of artificial intelligence tools by insurers.
> Between 2022 and 2023, claims denials surged by an average of 20.2% for commercial plans and 55.7% for Medicare Advantage plans, according to a Sept. 10 brief from the American Hospital Association shared with *Becker's*. …"

https://www.beckershospitalreview.com/finance/ai-linked-to-surge-in-medicare-advantage-commercial-claims-denials-aha.html?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

**Insurers Went All-In On Medicare Advantage. Now, Some Are Scaling Back. Tara Bannow. Stat News. September 13, 2024**

"For years, health insurers battled to gain market share in the lucrative privatized Medicare program. Now, the opposite is true. Some of the companies say they designed their 2025 plans with an eye toward ditching members. …"

https://www.statnews.com/2024/09/13/2025-medicare-advantage-plans-analysis-humana-aetna-unitedhealth/

**The State of Medicare Advantage In 2024. Jakob Emerson. Becker Payer Issues. September 17, 2024**

"Medicare Advantage continues to grow fast, diversifying its membership of 33.8 million people, or about 55% of the total Medicare population, according to the Better Medicare Alliance's 2024 "State of Medicare Advantage Report."

The annual report released Sept. 17 is a compilation of the latest MA research and data that provides insight into the program's demographics, enrollment trends, benefits and health outcomes. . .."

https://www.beckerspayer.com/payer/the-state-of-medicare-advantage-in-2024.html?origin=PayerE&utm_source=PayerE&utm_medium=email&utm_content=newsletter&oly_enc_id=5767J8016534I8J

**Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System: Comparing Performance in 10 Nations. David Blumenthal et al. The Commonwealth Fund. September 2024.**

**"Goal**: Compare health system performance in 10 countries, including the United States, to glean insights for U.S. improvement.

**Methods**: Analysis of 70 health system performance measures in five areas: access to care, care process, administrative efficiency, equity, and health outcomes.

**Key Findings**: The top three countries are Australia, the Netherlands, and the United Kingdom, although differences in overall performance between most countries are relatively small. The only clear outlier is the U.S., where health system performance is dramatically lower.

**Conclusion**: The U.S. continues to be in a class by itself in the underperformance of its health care sector. While the other nine countries differ in the details of their systems and in their performance on domains, unlike the U.S., they all have found a way to meet their residents' most basic health care needs, including universal coverage."

https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024