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Transforming Rural Healthcare

How are Medicare Advantage Plans Cutting Payment, and What You Can do About it?

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01 Coverage of Basic Medicare Benefits
02 MA Plan Rules for Clinical Criteria
03 Pre-Service Issues
04 Post-Claim Issues
05 Successful Appeal Strategies

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Resources You Need On Hand

- **Managed Care Manual IOM 100-16**
  https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033
- **2024 Final Rule (4201)** https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit
- **CMS Memo to MAOs**
  https://www.cms.gov/files/document/hpms-memo-faq-coverage-criteria-and-utilization-management-cms-4201-f-02-6-2024-pdf.pdf

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How MA Plans Deny Payment

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Medicare Advantage plans may increasingly be applying criteria for coverage and payment that are more restrictive than Traditional Medicare




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Basic Medicare Benefits

CMS has a longstanding policy that MA plans must make medical necessity determinations that are no more restrictive than Traditional Medicare

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Existing Rules for MA Plan Coverage of Basic Medicare Benefits

- **Social Security Act:** MA plans shall provide to members the benefits under traditional Medicare *42 U.S.C. 1395w–22*
- **Federal Regulation:** Each MA plan must cover all services covered by Part A and Part B *42 CFR 422.101*
- **Managed Care Manual:** An MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services *IOM 100-16, Ch 4, Section 10.2*

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Basic Medicare Part A and Part B Benefits: The Longstanding Regulatory Requirements

- **Medicare Advantage Plans:**
  - Must provide basic Medicare benefits by furnishing directly, through arrangement, or by paying for those benefits
  - Cannot design benefits to inhibit access to services
  - Must comply with:
    - Applicable LCDs, NCDs
    - General coverage guidelines included in original Medicare manuals
  - Must specify that basic benefits are provided through, or payments made to, the provider in provider contracts

2022 OIG Study

- **MA Plan Clinical Criteria:** Medicare Advantage Organizations (MAOs) used clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an x-ray before approving more advanced imaging)
- **High Denial Overturn Rate:** MAOs overturned about 75 percent of their own prior authorization denials and payment denials
- **CMS Citations:** CMS cited more than half of audited MAO contracts in 2015 for inappropriately denying prior authorization and payment requests

OIG Audit of MA Plan Denials

- CMS officials reported that MAOs may use internal clinical criteria that do not contradict Medicare coverage rules; however, existing guidance was not sufficiently detailed for OIG to determine whether CMS would consider each of these denials in our sample to be inappropriate
- 18% of payment denials were for claims that met Medicare coverage rules and MAO billing rules, which delayed or prevented payments for services that providers had already delivered

2022 OIG Study

As of March 2022, CMS has not yet implemented these recommendations

Therefore, we recommend that CMS:

Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews

To help ensure that Medicare Advantage enrollees receive all medically necessary and covered services, to help promote MAO compliance with Medicare coverage rules, and to help improve program transparency, CMS should issue new guidance on both the appropriate use and the inappropriate use of MAO clinical criteria that are not contained in Medicare coverage rules. The guidance should clarify what the Medicare Managed Care Manual means when it says that MAO clinical criteria must not be "more restrictive" than Medicare coverage rules, and it should include specific examples of criteria that would be considered allowable and unallowable. CMS

CMS's 2024 Final Rule for MA Plans

> "In light of the feedback received and OIG recommendation", CMS issued updated guidance on the appropriate use of MA organization clinical criteria in medical necessity reviews"

Clarifications

- **422.101(b) and (c):** Federal regulatory requirements for MA plans to cover basic Medicare benefits
- **Purpose:** Amendments **to clarify** MA plan obligations and responsibilities
- **Traditional Medicare Policy:**
  - *Limits or conditions on payment and coverage in the Traditional Medicare program—such as:*
    - *who may deliver a service;*
    - *in what setting;*
    - *criteria adopted in relevant NCDs and LCDs; and*
    - *other substantive conditions*
  - *apply to define the scope of basic benefits*

> When Traditional Medicare has fully established coverage criteria, an MA plan 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

Fully Established Coverage Criteria

- MA plans must comply with coverage and benefit conditions in Traditional Medicare, including:
  - Inpatient only list (p. 22192)
  - Inpatient criteria (p. 22194)
  - SNF (p. 22194)
  - Home health (p. 22194)
  - Inpatient rehab (p. 22194)

How MA Plans Deny Payment

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MA plans can only apply coverage criteria if Traditional Medicare has not fully established coverage rules, and in those instances, must meet very stringent requirements

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There are other benefits for which Traditional Medicare has not fully established coverage criteria through regulation, NCD, or LCDs

> "[W]hen coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD, an MA plan may create internal coverage criteria"

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Criteria for Coverage Criteria

(i) ***Coverage criteria not fully established.*** Coverage criteria are not fully established when:

(A) additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services;

(B) NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or

(C) There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

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Creating MA Plan Internal Coverage Criteria

- Publicly Accessible
- Based on Current Evidence
- Widely Used Treatment Guidelines; or
- Widely Used Clinical Literature

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Coverage Criteria Versus Payment Polices

- Contracts between hospitals, professionals, and health plans often address policies and procedures
- Plan may develop rules in the form of policies (or similar terms)
- MA regulations address non-interference with private contracts

Coverage Criteria Versus Payment Polices

- A decision related to coverage and payment can only be re-opened for good cause
- Includes any decision related to prior authorization
  - Inpatient admission
  - Post-acute admissions

CMS weighed in on post-acute claim reviews of services that were prior authorized

> If an MA plan MA approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, 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

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How MA Plans Deny Payment

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CMS has clarified when prior authorizations can be used, what they can look for, and who must decide their outcome

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Prior Authorizations

- **Only Two Permitted Uses**
  - confirm presence of a diagnosis or other medical criteria; or
  - ensure an item or service is medically necessary based on standards specified in the rule
- **No Use for Emergencies**
  - MA Plans cannot use prior authorizations for treatment of emergency medical conditions
- **Inpatient Only Procedures**
  - Cannot be denied for the inpatient setting
- **Revocation**
  - If approved by prior authorization, MA plan cannot deny coverage later for medical necessity

Two Midnight Rule and MA Plans

- **Basic Two-Midnight:** An inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights
- **Unexpected Short Stay:** Unexpected death, other circumstances can still qualify; defer to initial expectation
- **Inpatient Only:** MA plans may permit *more* procedures as IOP, but not fewer, than Traditional Medicare's IOP list

Two Midnight Rule

- Two-Midnight Benchmark Applies
- Two-Midnight *Presumption* is a medical review instruction from CMS to MACs, RACs, QIOs; does not apply to MA
- Feb. 6, 2024 Memo from CMS to MA Plans:

> An MA organization may evaluate whether the admitting physician's expectation that the patient would require hospital care that crosses two-midnights was reasonable based on complex medical factors documented in the medical record. Consistent with § 412.3, that evaluation should defer to the judgment of the physician **as long as that judgment was reasonable** based upon the complex medical factors documented in the medical record.

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How MA Plans Deny Payment

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DRG downgrades, clinical validation, post-claim status changes all significantly reduce reimbursement

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DRG, Clinical Validation Audits

- **DRG Validation:** Confirms DRG assignments are based on the correct diagnostic and procedural information, and application of Official Guidelines for Coding and Reporting
- **Clinical Validation:** A separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented.

DRG, Clinical Validation Audits

- Traditional Medicare does not permit contractors to perform clinical validation; does your contract?
- Public accessibility

> [W]e consider coverage policies that dictate specific definitions of medical diagnoses to be additional coverage criteria that are only authorized in accordance with § 422.101(b)(6) as finalized in this rule. – 88 Fed Reg 22202 April 12, 20232202 April 12, 2023

Post-Claim Status Changes

9. **Question: Are plans able to do post-claim audits and deny payment and still be compliant with the effect of a prior authorization or pre-service approval rule at 422.138(c)?**

- **Limitation:** If MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, 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
- **Good Cause:** Evidence of fraud or fault; ***new*** and material evidence that was not known or available to the plan at the time of its initial decision

> This means that if the MA organization pre-authorized the inpatient admission, it would be a violation of § 422.138(c) to later deny payment based on a determination that the level of care was not medically necessary.

Medical Necessity Versus Payment Policy

- The Response Plan Gives:
  - This is not a medical necessity decision; this decision is based on our payment policy
  - CMS cannot interfere in private contracts

> [W]e have heard that MA organizations characterize these reviews as "payment" reviews and that these reviews are "not organization determinations" or "level of care or medical necessity reviews." We disagree with those characterizations

Response Strategy

Knowing the rules, expending early and frequent efforts to enforce them, and knowing avenues to amplify them **can** effectuate real results and changes

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New CMS Complaint Process

		Fill in required information below. Indicate option selection with "X."
1.1	Date of Submission to CMS	
1.2	Entity Submitting Complaint	X Provider ___ Organization Representing Provider ___ Appointment of Representative (attach form) ___ Other (Summarize)
	Name of Organization Representing Provider	
1.3	Submitter's Name	Richella Martinz
	E-mail Address	martinz@richellemartinz.com
	Telephone Number	123-456-7890
1.4	Beneficiary Name	
1.5	Beneficiary Health Insurance Claim Number (HICN) / Medicare Beneficiary Number (MBN)	
1.6	Provider Name, telephone number, E-Mail address	ABC Hospital, 000-765-4321, abchospital@abchospital.com
1.7	Medicare Advantage Organization	___ Aetna ___ Cigna ___ UHC ___ BCBSKS ___ Humana ___ Other:
1.8	Claim Number	
1.9	Date(s) of Service	
1.10	Provider Contract Status	X Provider Contracted with MAO during Date(s) of Service ___ Provider NOT Contracted with MAO during DOS
1.11	Complaint Type	X Contracted Provider Appeal ___ Non-Contracted Provider Appeal X Contracted Provider Claims Payment Dispute ___ Non-Contracted Provider Claims Payment Dispute ___ Other
	Brief Summary of Complaint	See page 2
1.12	Did MAO communicate your appeal rights.	X Yes ___ No
1.13	Have you exhausted all appeals rights per the non-contracted provider appeals or per contract w/MAO	___ Yes X No
1.14	Provider or their representative has Communicated with MAO in Attempt to Resolve Issue	X Yes ___ No *(NOTE: CMS will only review this case if the provider has already attempted to resolve it by working directly with the MAO.)*
	If Yes, Name(s) of Individual(s) at MAO	

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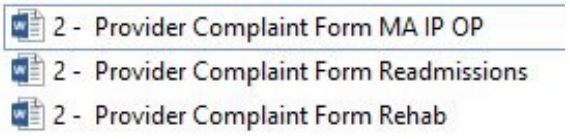
New CMS Complaint Process

- Tips
  - Submit concurrent with your P2P or other appeal
  - Notify your contracting or provider rep of your concern with common issues such as IP status, post-acute care denials
  - Include the plan number from the ID card
  - Must be password protected
  - Develop templates where page 2 outlines your argument



New CMS Complaint Process

- Why Use This Process

Table 7: 2021 - 2024 Average Star Rating by Part C Measure

Measure	2021 Average Star	2022 Average Star	2023 Average Star	2024 Average Star
Complaints about the Plan	4.8	4.7	4.3	3.9

What to Expect

- CMS will provide a CTM number
- Plans should be contacting you within 2-3 days
- You may be asked to send issues directly to the plan's complaints department; advise you will continue to use CTM until the issues resolve
- Some plans won't contact you at all and will send a written letter, similar to an appeal decision letter

What to Expect

- Notify CMS if you don't have any response within 30 days
- Notify CMS if the plan didn't contact you promptly
- Notify CMS if the plan's decision continues to misconstrue the rules
- You may quietly see payments or reversals
- You may have plans agree to stop a particular type of post-claim audit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Thank You

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2025 IHA SMALL & RURAL HOSPITALS ANNUAL MEETING

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