A Physician Advisor's Perspective on CMS -2401-F

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Special Bulletin

April 7, 2023

CMS Finalizes CY 2024 Medicare Advantage Rule

The final rule increases oversight of Medicare Advantage plans and seeks to better align traditional Medicare and Medicare Advantage coverage

The Centers for Medicare & Medicaid Services (CMS) April 5 finalized its Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program for Contract Year (CY) 2024. The final rule increases oversight of Medicare Advantage (MA) plans and seeks to better align MA coverage with traditional Medicare.

KEY HIGHLIGHTS

The final rule will:

- Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions don't exist in traditional Medicare;
- Direct MA plans to adhere to the "Two-Midnight-Rule" for coverage of inpatient admissions;
- Limit MA plan ability to apply site of service restrictions not found in traditional Medicare;
- Require health plan clinicians reviewing prior authorization requests to have expertise in the relevant medical discipline for the service being requested;
- Require prior authorizations to be valid for an entire course of approved treatment and to be valid through a 90-day transition period if an enrollee undergoing treatment switches to a new MA plan;
- Establish additional processes to oversee MA plan utilization management programs including an annual review of policies to ensure consistency with federal rules;
- Strengthen behavioral health network adequacy requirements;
- Tighten MA marketing rules to protect beneficiaries from misleading advertisements and pressure tactics;
- Expand requirements for MA plans to provide culturally and linguistically appropriate services;
- Establish a new Health Equity Index to be incorporated into MA plan Star Ratings beginning in 2027;
- Implement statutory provisions of the Inflation Reduction Act and the Consolidated Appropriations Act of 2021 related to prescription drug affordability and coverage for eligible low-income individuals.

Notably, the final rule did not codify the proposed change to the legal standard for identifying an overpayment, which was of concern to hospitals and health systems.

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Atrium Health

Carolinas
Rehabilitation

Learning Objectives

Understand how CMS regulates Medicare Advantage Plans coverage of Medicare basic benefits.

Recognize disparities between Medicare Advantage Plans and Medicare coverage that led to CMS-4201-F3.

Present solutions to Medicare Advantage Plan denials of Inpatient and Post-Acute Care services that meet CMS coverage criteria.

Medicare Advantage Regulations

Beneficiary Regulatory Protections

Social Security Act (Law) Section 1852

Code of Federal Regulation 42 CFR 422.100

Medicare Managed Care Manual, Chapter 4

Decision and Appeal Rules

Medicare Managed Care Manual Chapter 13

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance

Medicare Advantage Covers All FFS Medicare Benefits

Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

10.2 – Basic Rule

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

An *MAO* offering an MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered "Part B only" enrollee. The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying *for the benefits* on behalf of enrollees.

Medicare Advantage Can Limit Network

Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

10.2 – Basic Rule

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

- Access: MA enrollees must have access to all medically necessary Part A and Part B services. However, MA plans are not required to provide MA enrollees the same access to providers that is provided under original Medicare (see accessibility rules for MA plans *under section* 110 of this chapter).

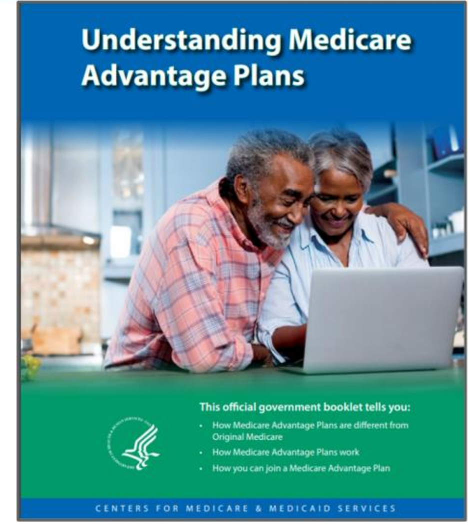
Medicare Advantage Can Create Own Billing and Payment

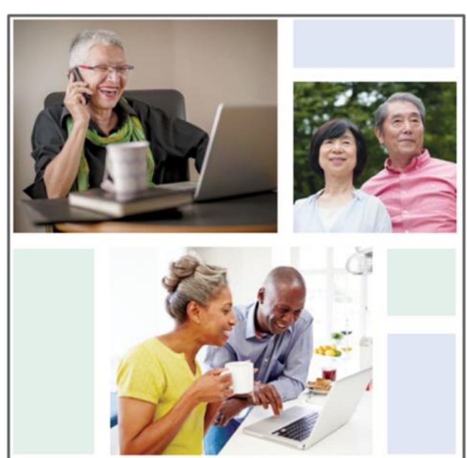
Medicare Managed Care Manual
Chapter 4 - Benefits and Beneficiary Protections

10.2 – Basic Rule
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

- Billing and *Payment*: MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail. MA plans may not require enrollees to pay providers – whether contracted or not – for original Medicare services and then be reimbursed by the plan. See *section* 110.1.3 of this chapter for rules governing payment to non-contracted providers for original Medicare non-emergent services.

What does Medicare Advantage Cover?



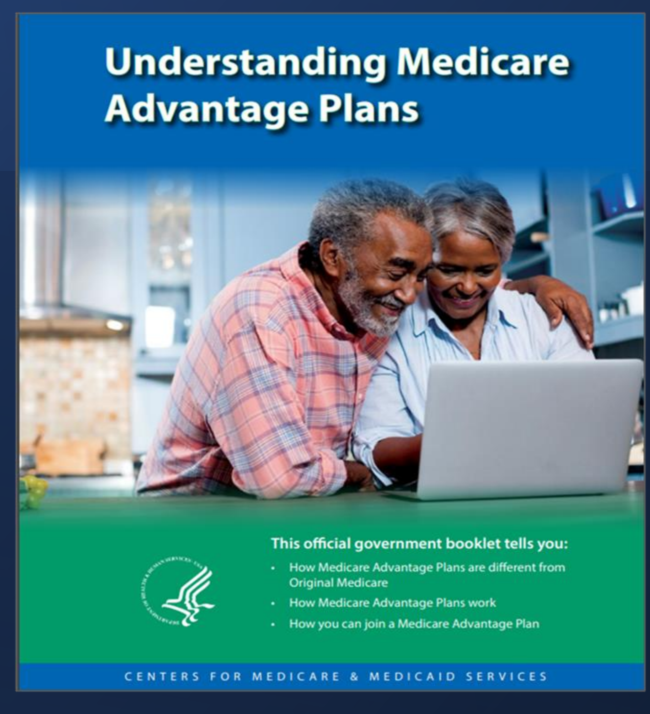


Organization determinations

You can get a decision from your plan in advance to see if it covers a service, drug, or supply. You can also find out how much you'll have to pay. **This is called an "organization determination."** Sometimes you have to do this as prior authorization for your plan to cover the service, drug, or supply.

You, your representative, or your doctor can request an organization determination. A representative is someone you can appoint to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. Based on your health needs, you, your representative, or your doctor can ask for a fast decision on your organization determination request. If your plan denies coverage, the plan must tell you in writing, and you have the right to appeal.

Scope of the Problem 2023



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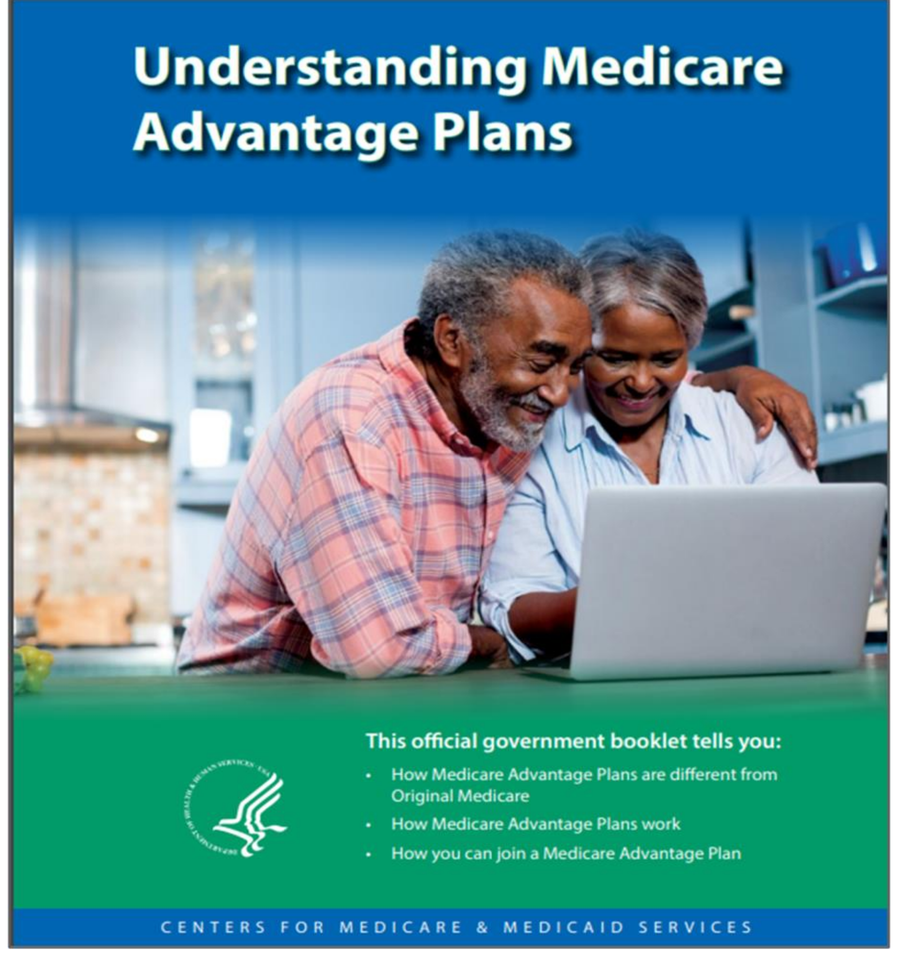


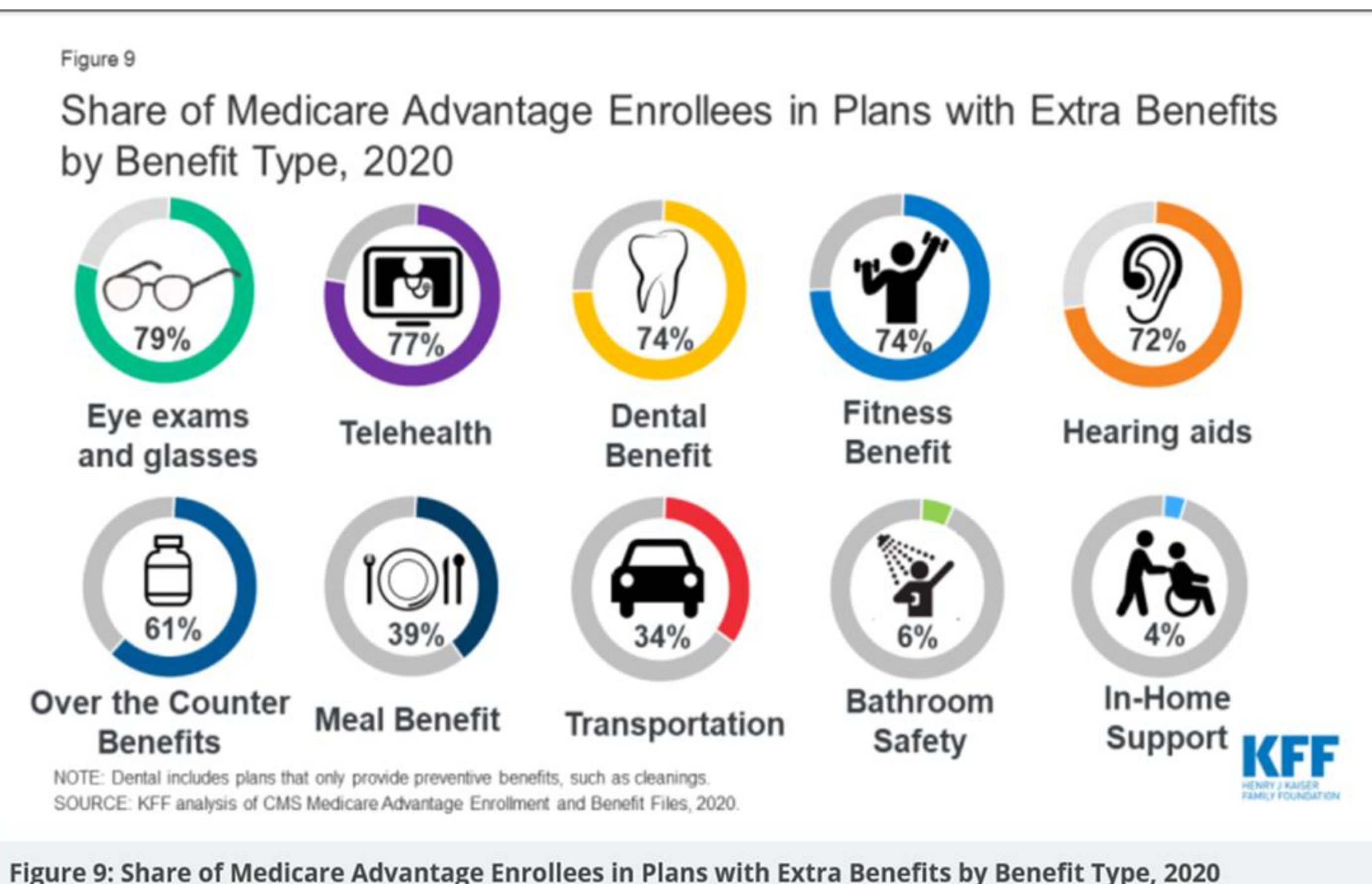
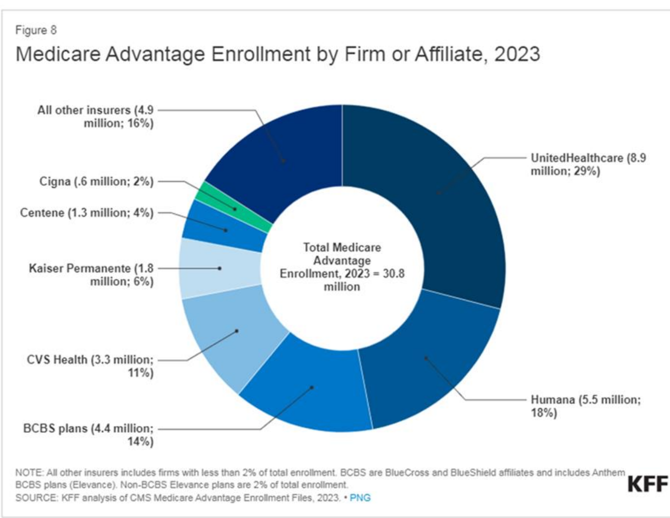


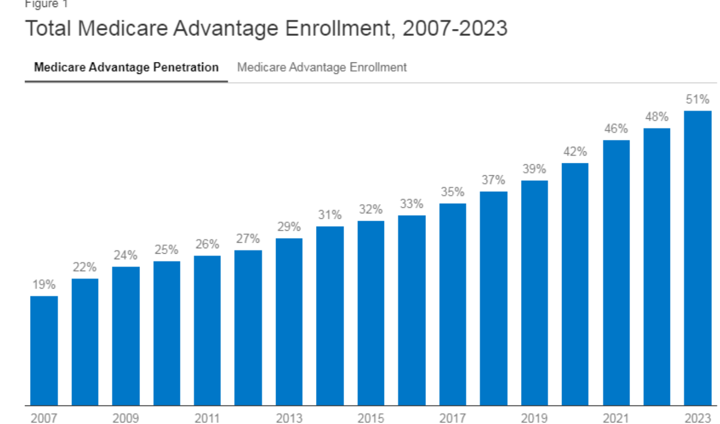
Figure 9: Share of Medicare Advantage Enrollees in Plans with Extra Benefits by Benefit Type, 2020

https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf

Scope of the Problem 2023 – Has Anything Improved?



UnitedHealthcare and Humana have consistently accounted for a relatively large share of Medicare Advantage enrollment.



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April 16, 2019 08:08 AM

UnitedHealth revenue grows with Medicare members, OptumHealth patients

So…what's the problem?

2018 OIG Report

Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials

09-25-2018 | Report (OEI-09-16-00410) | Complete Report

2018 OIG Report

- Examined Medicare Advantage denials from 2014-2016 for 581 plans
- Issued 101,136,253 full or partial denials
- Only @ **1%** of these denials were sent for first level appeal
  - 75% Overturned their own Denial at 1st Level Reconsideration
- Audit of Denials - Findings
  - 45% of Denials had insufficient denial letters to patients & providers
  - 56% of Denials had either Incomplete Clinical Information or Incorrect Decisions
    - Insufficient outreach before issuing denials
    - Incorrect clinical decisions
- MA Plans might be denying medical care for profit

2018 OIG Report

WHY WE DID THIS STUDY

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for MAOs to inappropriately deny access to services and payment in an attempt to increase their profits. An MAO that inappropriately denies authorization of services for beneficiaries, or payments to health care providers, may contribute to physical or financial harm and also misuses Medicare Program dollars that CMS paid for beneficiary healthcare. Because Medicare Advantage covers so many beneficiaries (more than 20 million in 2018), even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers.

2018 OIG Report

WHAT WE FOUND

When beneficiaries and providers appealed preauthorization and payment denials, Medicare Advantage Organizations (MAOs) overturned 75 percent of their own denials during 2014-16, overturning approximately 216,000 denials each year. During the same period, independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers. The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment. During 2014-16, beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.

2018 OIG Report

Centers for Medicare & Medicaid Services (CMS) audits highlight widespread and persistent MAO performance problems related to denials of care and payment. For example, in 2015, CMS cited 56 percent of audited contracts for making inappropriate denials. CMS also cited 45 percent of contracts for sending denial letters with incomplete or incorrect information, which may inhibit beneficiaries' and providers' ability to file a successful appeal. In response to these audit findings, CMS took enforcement actions against MAOs, including issuing penalties and imposing sanctions. Because CMS continues to see the same types of violations in its audits of different MAOs every year, however, more action is needed to address these critical issues.

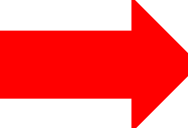
2022 OIG Report

U.S. Department of Health and Human Services

Office of Inspector General

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

Christi A. Grimm
Inspector General
April 2022, OEI-09-18-00260



Key Takeaway

MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- using MAO clinical criteria that are not contained in Medicare coverage rules;
- requesting unnecessary documentation; and
- making manual review errors and system errors.

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (hhs.gov)

2022 OIG Report

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MAOs reversed some initial prior authorization denials and payment denials for requests that met Medicare coverage rules and MAO billing rules	18
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Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews	20
Update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria, and/or examine particular service types	21
Direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors	21
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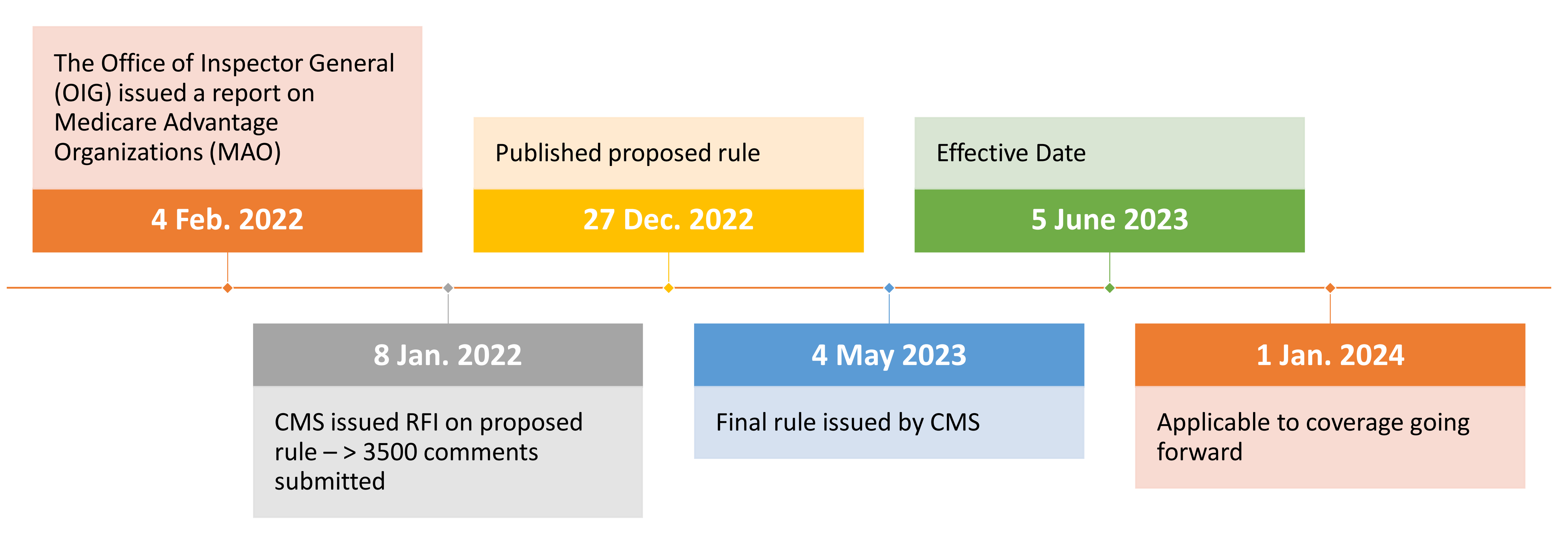
Timeline of the CMS 4201-F rule



CMS Clarifies MA Coverage

Advocacy is working and rules clarified but were they the problem?

Authorization and Noncontracted Pathways with IRE = Helpful

Strategy for Contracted Providers

How will you operationalize…

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Codifies Use of Coverage Criteria for Basic Benefits

- MA plans must make medical necessity determinations based on internal policies that include coverage criteria that are no more restrictive than Traditional Medicare’s national and local coverage policies (Section 10.16 Chapter 4 MMCM)
- General coverage and benefit conditions in Traditional Medicare that apply to basic benefits in the MA plan §422.101(b)(2)
    - Inpatient admissions
    - Inpatient Rehabilitation
    - Skilled Nursing Facility(SNF) care
    - Home Health Services

Codifies 2 MN Rule for Inpatient

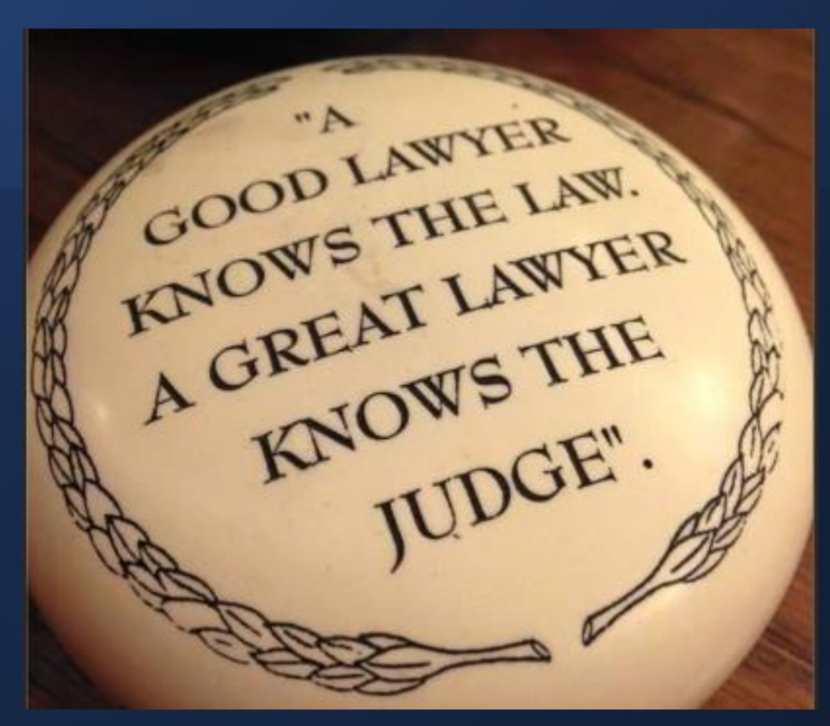
The final rule reaffirms that MA organizations (MAO) cannot limit or deny coverage for services that would be covered under Traditional Medicare Per CFR 422.101(b)(2)

- The CMS inpatient-only list applies to MAOs

- MAOs must follow the “two midnight benchmark” as well as the “caseby-case exception”

- 2-midnight rule, presumption versus benchmark

So…what's the solution?



Dispute Resolution

Increased MA Plan Enrollment

Increased Denials and Administrative Burden/Delays

Increased Profitability of MA Products

CMS Oversight / Noninterference

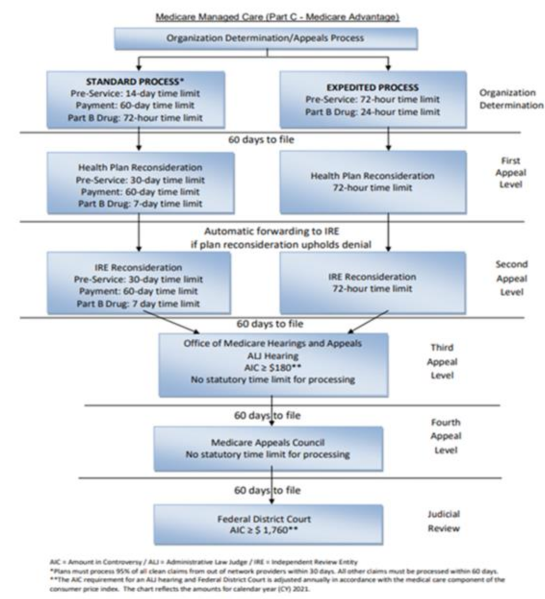
Expertise in MA Plan Dispute Resolution...

Effective Dispute Resolution

CMS Grievance and Appeal Pathways

Contract

Note: Contract providers (including subcontracted entities) do not have appeal rights under the provisions discussed in this guidance. Contract provider disputes involving plan payment denials are governed by the appeals/dispute resolution provisions in the contract between the provider and the plan.



Lessons Learned – Expedited Authorization and Appeals for PAC

- Expedited authorizations reduce delays
- Plans complain about expediting “non-emergency cases”
- Plans often confuse their practice with CMS policy
- Be aware that Plans “Clarify” expedited intent
- Expedited appeals overturn majority of denials
- Initial denials & appeal upholds increasing
- IMHO – IRE is failing

How to Use the Regs to Push Back on MA Plans: PAC Delays / Denials – Where to Start?

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Effective January 1, 2020

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How to Use the Regs to Push Back on MA Plans Delays and Denials: PAC Journey

The Rules for Post Acute Auth!

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https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

How to Use the Regs to Push Back on MA Plans: PAC Delays

40.6 – Who May Request an Initial Determination

Enrollees or their representatives may make a request for all types of *decisions about* coverage under both Part C and Part D. Other parties that may request an initial determination include:

Type of Request	Who May Request
Part C, Standard Pre-Service Request	• Contract or non-contract provider/physician that furnishes, or intends to furnish, services to the enrollee. • Staff of said provider's/physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead *or otherwise indicates staff is working under the direction of the provider*).
Part C, Expedited Request	• A physician or staff of said physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).
Part C, Payment Request	• Contract or non-contract providers.

- Who is requesting the auth?
- Is it expedited or standard?
- How is the plan processing?

Source: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

Expedited vs. Standard Authorization Matters

Part C

Type	Processing Timeframe	With Extension*
Pre-Service	14 calendar days	
		N/A
		N/A
Expedited: *Pre-Service*	72 hours	
		N/A

Includes Weekends / Holidays

Includes Weekends / Holidays

*14-day extension if the enrollee requests the extension or if the MA plan justifies a need for additional information

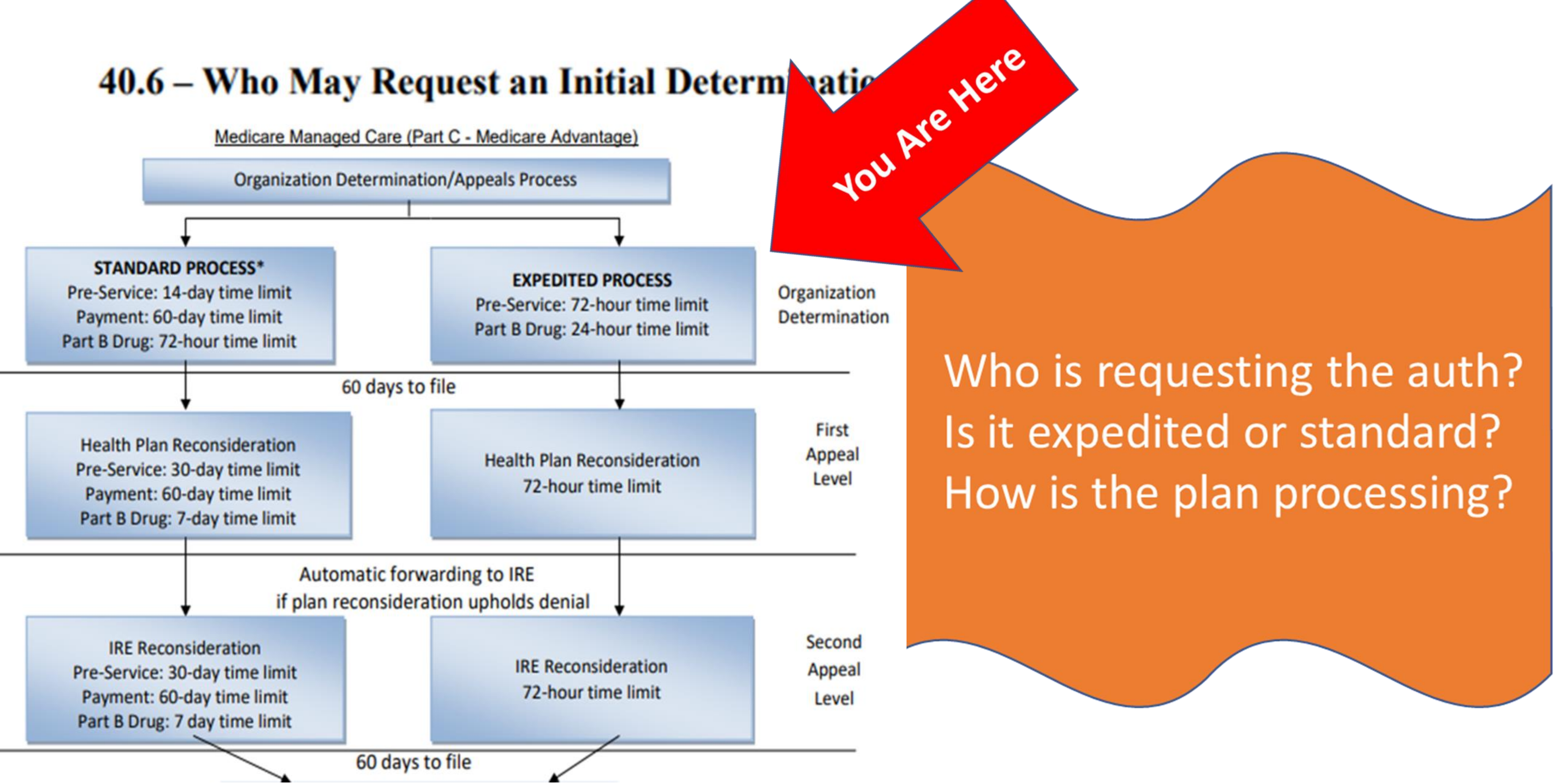
40.11 – Effect of Failure to Meet the Timeframe for an Initial Determination

Part C Only

The MA plan must explain in its annual Evidence of Coverage (EOC) that enrollees have the right to a level 1 appeal if the MA plan fails to provide timely notice of a decision. If a plan fails to provide the enrollee with a timely notice of its decision, this failure constitutes an adverse decision.

Source: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

How to Use the Regs to Push Back on MA Plans: PAC Delays



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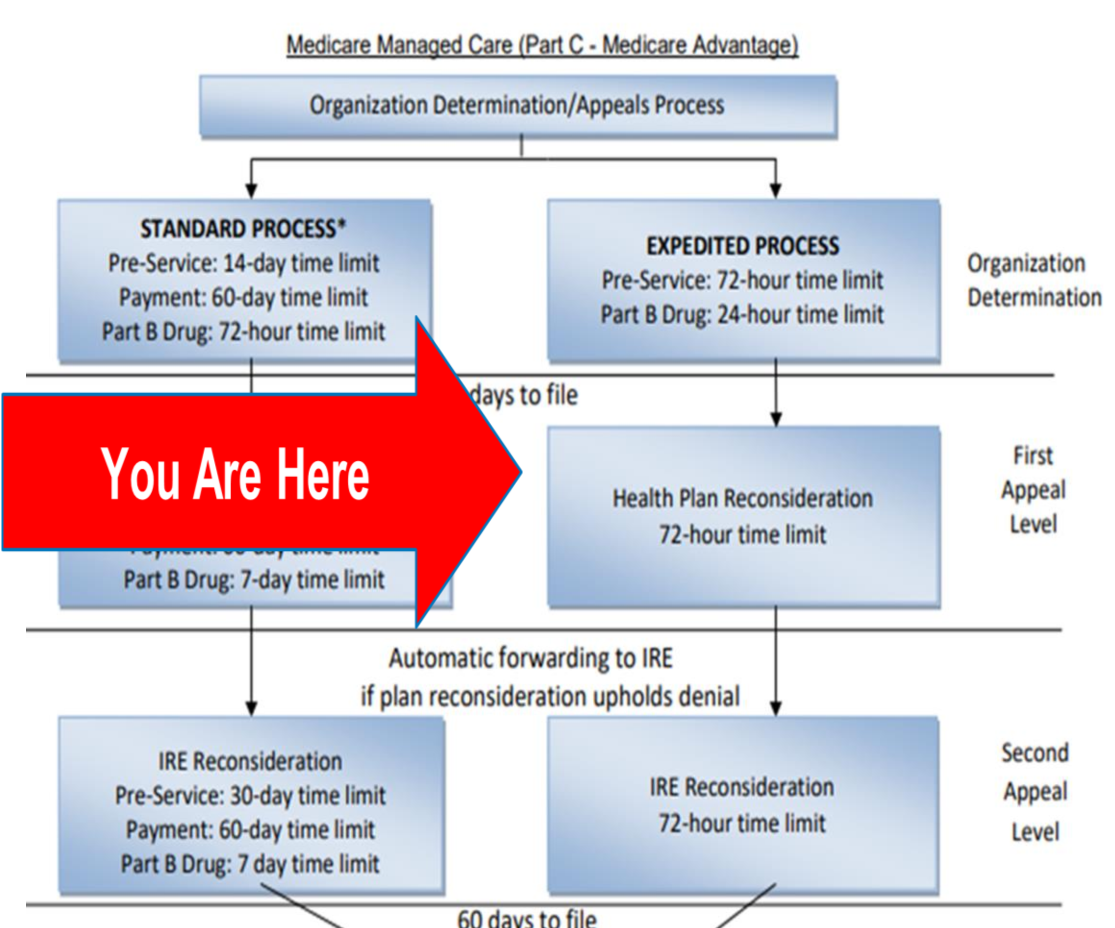
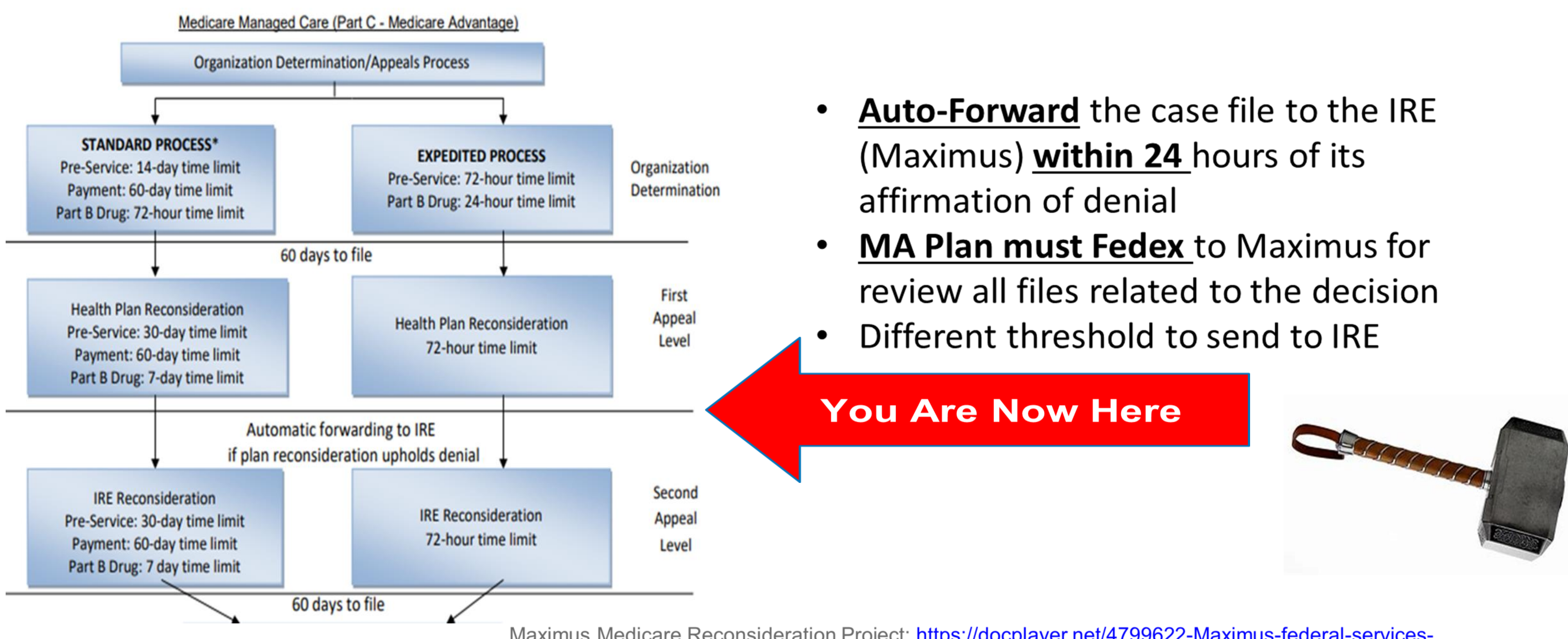
MA Plan Processes Expedited Reconsideration



- **2nd** Plan Medical Director
- **Must** Request Clinicals if needed to support denial
- As expeditiously as the enrollee's health condition requires, but **no later** than 72 hours after the request, the **MA plan must**:
  - Make the decision and notify patient / representative of auth if fully favorable
  - If partial or complete denial **MA plan must:**

Maximus Medicare Reconsideration Project: https://docplayer.net/4799622-Maximus-federal-services-medicare-health-plan-reconsideration-process-manual-medicare-managed-care-reconsideration-project.html

MA Plan Processes Expedited Reconsideration



Maximus Medicare Reconsideration Project: https://docplayer.net/4799622-Maximus-federal-services-medicare-health-plan-reconsideration-process-manual-medicare-managed-care-reconsideration-project.html

PAC Auth Denied– Rules for Plan Reconsideration

Type of Request	Who May Request An Appeal
Standard Pre-Service Reconsideration	• An enrollee; • An enrollee's representative; • The enrollee's treating physician acting on behalf of the enrollee* or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).; or • Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.
Standard Payment Reconsideration	• An enrollee; • An enrollee's representative; • Non-contract provider (see §50.1.1 for non-contract provider payment appeals); or • The legal representative of a deceased enrollee's estate.
Expedited Reconsideration	• An enrollee; • An enrollee's representative; • Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead) acting on behalf of the enrollee.

Importance of Denial Letters

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Humana

Step 1: You, your representative, or your doctor must ask us for an appeal. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Address: Humana Grievances and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961
Phone: 1-800-457-4708 TTY: 711

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-800-867-6601 TTY: 711 Fax: 1-800-949-2961

What happens next?

If you ask for an appeal and we continue to deny your request for a service, we'll send
and automatically send your case to an independent reviewer. **If the independent**
request, the written decision will explain if you have additional appeal rights.

Get help & more information

- If you have questions, please call us at Humana Toll Free: 1-80
You can call us seven days a week, from 8 a.m. - 8 p.m. How
phone system may answer your call during weekends a

Form CMS 10003-NDMCP (Expires: 01/31/2020)

Sample Fax Reconsideration

FAX

TO Denying MA

Name: Denying MA Expedited Appeals & Grievances Department
Fax Number: 1-800-555-5555
Date: 6/7/2019
 # Pages:

FROM (Requesting Physician and Patient Information)

Physician: Brian Moore, MD NPI 1111111111
Address: 1000 Blythe Blvd. Charlotte NC, 55555
Fax # 704-555-5555 **Cell #** 704-555-5555
Patient: John Doe
Address: PO Box 5555 Charlotte NC 55555
Member #: 55555555555 (Plan Number)

Subject

Formal Expedited Appeal Request John Doe's Acute Inpatient Rehab Denial

Message

Type of Appeal Requested: **Expedited (Fast) Appeal** – Dr. Moore feels John Doe's health and recover adversaly affected if required to wait the standard timeframe and his recommended Acute Inpatient further delayed.

Reason for Appeal: Dr. Moore and the patient strongly disagree with the Medical Director who denie original request and feel the patient meets Medicare Criteria for Acute Inpatient Rehab and will bene Acute Inpatient Rehab that cannot be accomplished at a lower level of care. We formally request an e reconsideration of this denial by a second Medical Director. Please review prior clinical information se original authorization request and also information received via this fax. Additionally, your company h electronic access to the EMR and should be able to retrieve all clinical information related to this requ

Documents Included: AOR

Request: On behalf of the patient, please provide me a copy of all medical records, other documents guidelines used to render your decisions as offered in your denial notice. Thank you.

Scope of Project – No Delay Authorizations

Countermeasure to MA Payor Denials and Delays

Use CMS Regulations and Appeal Expertise Combined with Regulatory Changes

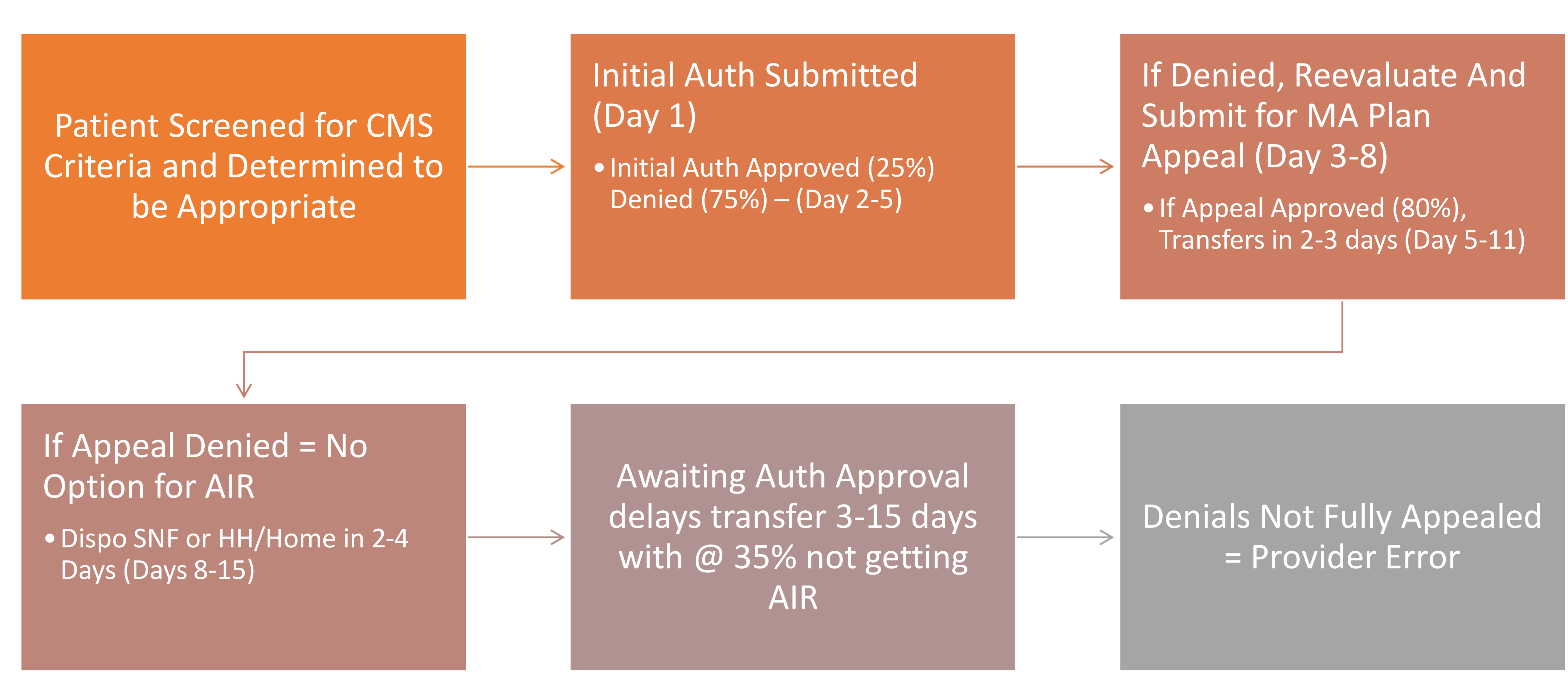
Initiate PAC Authorization in Acute, Complete Auth and Appeals in or after PAC

Measure Results Demonstrating Actual Denials and Delays

Regular Auth – Denials Not Pursued, Delays Difficult to Measure, Appeals Not Pursued = Agreement with Denial, Attempts to Address via MHR and Payor Contacts Failed

No Delay Auth – Measures Actual Delays and Denials, Commitment to Pursue All Levels of Appeal b/c Self Auth

Old Process – Complete Auth In Acute



New Process – Complete Auth and All Appeals In IRF

Patient Screened for CMS Criteria and Determined to be Appropriate

Initial Auth Submitted (Day 0) and Transferred (Day 1)

Measure Time from Transfer to Final Auth Approval

Medicare Advantage – No Delay Authorization ALJ Outcome

- Case Details

Patient denied initial authorization + Level 1 + Level 2 appeal

- 65 y/o female, independent in all mobility and daily living activities
- Elective CABG x2 w/very complicated post op course. Prolonged ICU with NSTEMI, respiratory failure, trach, CVA, kidney injury, DVT, pneumonia, trach bleeding, airway edema, pressure ulcer…
- 84 day acute hospital stay

- ALJ Level 3 Appeal Approved

This decision is **FULLY FAVORABLE** to the Enrollee/Appellant with respect to this request for prior approval of inpatient rehabilitation facility (IRF) services, which was initially filed with [redacted], the Enrollee/Appellant's Medicare Advantage Plan ("MA Plan"), on March 28, 2023.

CONCLUSIONS OF LAW

The preauthorization coverage requested by Enrollee is reasonable and necessary in accordan with section 1862(a)(1)(A) of the Act and the EOC. The Plan is required to cover the servic provided to Enrollee from March 28, 2023, through April 15, 2023.

ORDER

The undersigned directs the Plan to process the claim in accordance with this decision.

Appeal Best Practices

Know the Rules (Regs vs Contract)

Prioritize Authorization Process and Denials on IP and PAC

Auth and Claim Denials – Should Mirror Medicare

Contracted vs Noncontracted

CMS Noninterference

Ask the Plan in Writing about CMS 4201-F

Know the Judge (Formalize Appeal Strategy)

Escalate to IRE or Next Level Appeal if Available

Value if Outside of Payor

Contractual Dispute Process

- Operational
- Aligned Organizational Knowledge / Incentives / Plan

Key Takeaways

Advocacy

- Tell the Story (Here Comes Managed Care Medicaid)
- Patient / Physician Centered
- Read Regs / OIG / AHA / HFMA etc
- Executive Support - Operationalize Data Capture
- Attack Overutilization

Rules / Judge

- Understand Rules vs Interpretation when dealing with Payors
- Value of IRE
- Contractual Dispute Process
  - Operational
  - Aligned Organizational Knowledge / Incentives / Plan
- Integrity

So…what's the real problem?

Links to CMS 4201-F and AHA Bulletin

- https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f

- https://www.aha.org/system/files/media/file/2023/04/cover-cms-finalizes-cy-2024-medicare-advantage-rule-bulletin-4-7-2023.pdf

Other Resources & Links

- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (cms.gov) – CMS Revised 2022
- 42 CFR Part 422 Medicare Advantage Program Subpart M Grievances, Organization Determinations & Appeals: https://www.law.cornell.edu/cfr/text/42/part-422
- MedicareAppeals.com
- Maximus Medicare Reconsideration Project: https://docplayer.net/4799622-Maximus-federal-services-medicare-health-plan-reconsideration-process-manual-medicare-managed-care-reconsideration-project.html
- All Denial Letters from MA plans
- Your Contracts

Questions?