2024 SPRING CONFERENCE

Masters of Healthcare

Money Matters, Patients Count

Medicare Advantage Plan Rules and Restrictions

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RICHELLE MARTING, JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I

Areas of Impact in the MA Plan Rule

01 Coverage of Basic Medicare Benefits

02 MA Plan Rules for Clinical Criteria

03 Prior Authorizations

04 Two-Midnight Rule

05 Denials and Appeals

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

BASIC MEDICARE BENEFITS

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

2024 Final Rule

CMS is codifying standards to ensure that basic benefits coverage for MA enrollees is no more restrictive than Traditional Medicare

88 Fed. Reg. 22120, 22187 (April 12, 2023

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

Basic Medicare Part A and Part B Benefits:

Medicare Managed Care Manual

Medicare Advantage Plans

- Must allow for individualized medical necessity determinations
- Must have a licensed physician review any intended full or partial medical necessity denial
- Cannot use internal criteria to make coverage decisions that are more restrictive than original Medicare
- Must make determinations based on, among other criteria, physician recommendations and clinical notes
- Cannot deny coverage on the basis of medical necessity if it approved the furnishing of a service through an advance determination of coverage

2022 OIG Study

MA Plan Clinical Criteria

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

As of March 2022, CMS had not yet implemented these recommendations.

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

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

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

2022 OIG Study

In response to the draft report, CMS stated that it is committed to oversight and enforcement of the requirements of the Medicare Advantage program and concurred with all three recommendations. CMS reiterated that MAOs must follow Medicare coverage rules. CMS further stated that MAOs may implement additional coverage requirements to better define the need for a service as long as the additional requirements do not violate the requirements in the relevant NCD or LCD. However, as we note in our report, this statement is not clearly outlined in existing guidelines.

CMS concurred with the first recommendation to issue new guidance on the appropriate use of MAO clinical criteria for medical necessity reviews, stating that it plans to issue such guidance.

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”

New Explicit References to Traditional Medicare Criteria

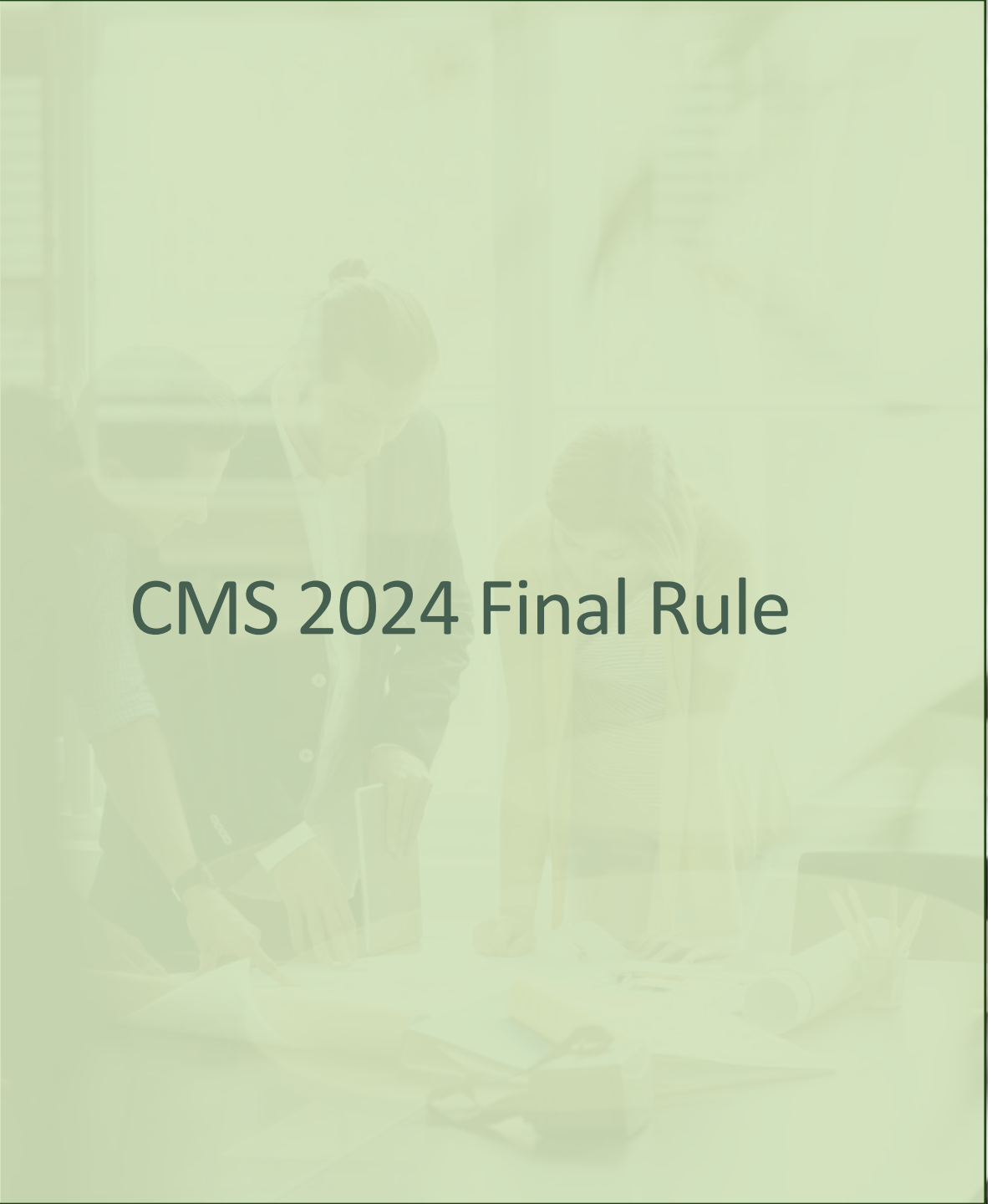
Criteria for Part A inpatient admissions

Skilled Nursing Facility (SNF) care

Home Health Services

Inpatient Rehabilitation Facilities (IRF)

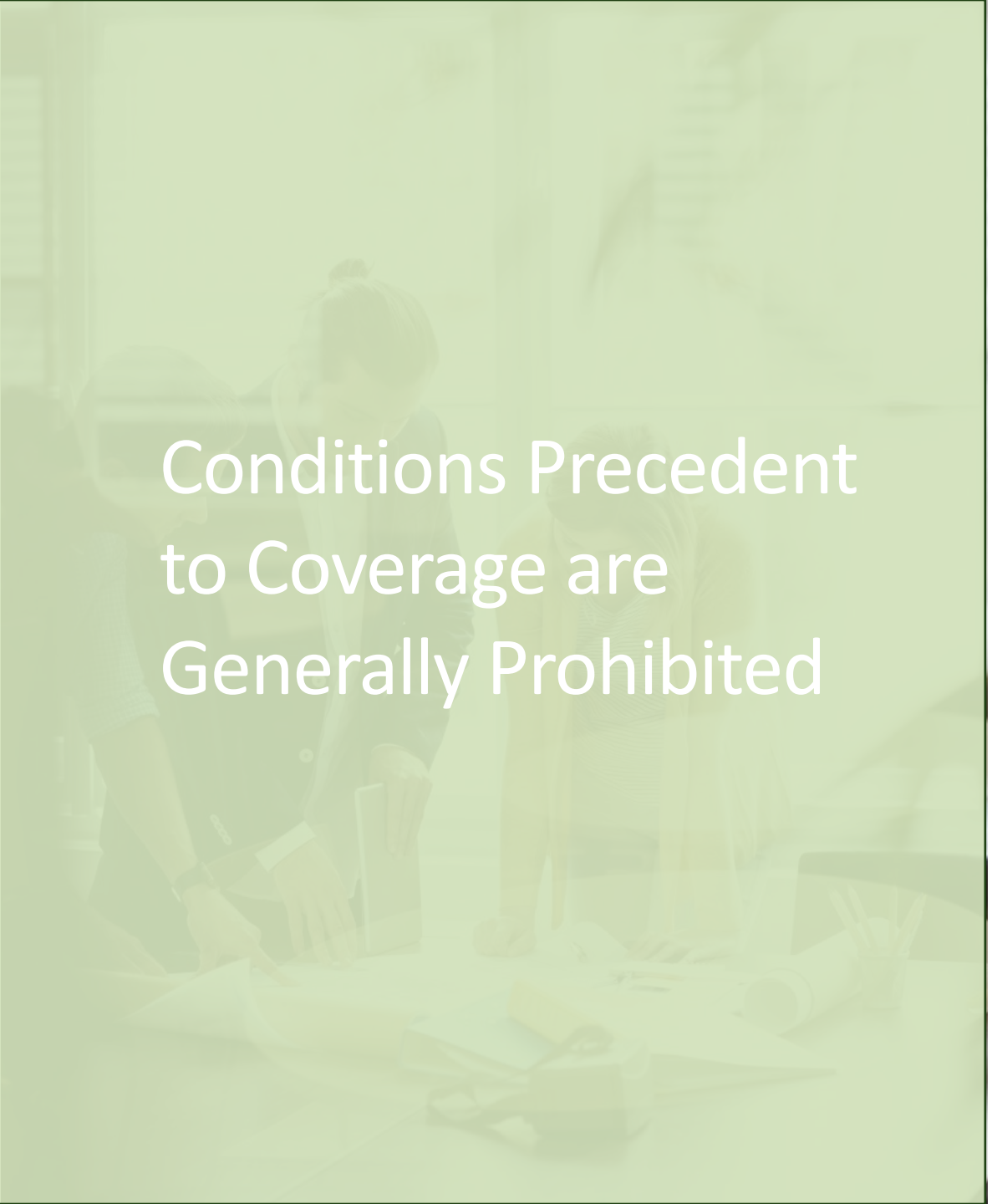
The list of Medicare regulations referred to is not exhaustive



CMS 2024 Final Rule

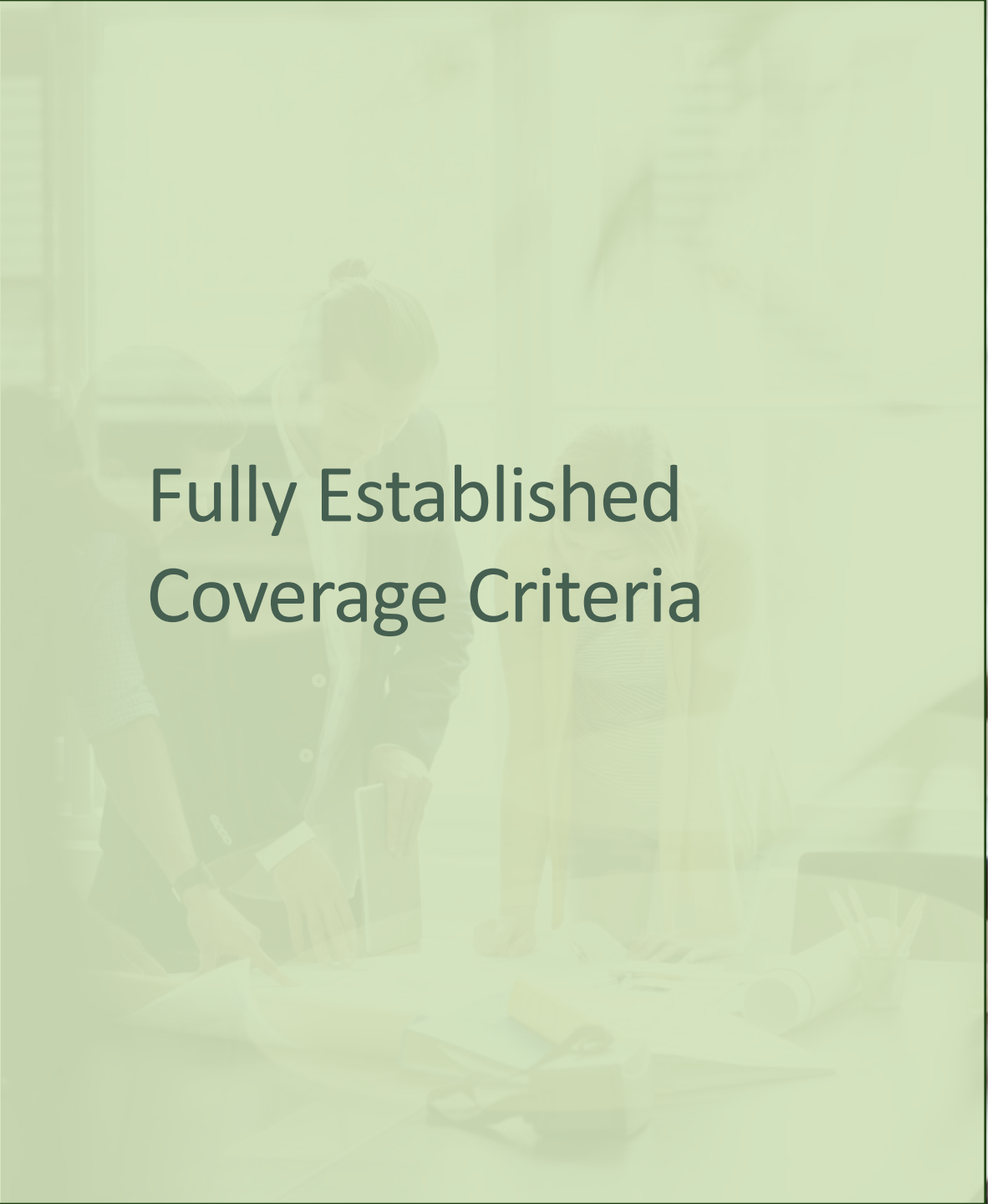
- Benefits cannot be denied on the basis of coverage criteria that do not meet updated, clarified language
- While the language is new, the underlying policy is not

> 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



Conditions Precedent to Coverage are Generally Prohibited

Utilization management processes not specified under an LCD or NCD requiring step therapy or other services to be furnished before receiving the requested item or service would violate the proposed requirements at § 422.101(b) and (c), and thus, **their use by an MA organization would be prohibited**



Fully Established Coverage Criteria

Inpatient only list (p. 22192)

Inpatient criteria (p. 22194)

SNF (p. 22194)

Home health (p. 22194)

Inpatient rehab (p. 22194)

Description of When Coverage Criteria are *Not* Fully Established

When not fully established under traditional Medicare, MA plans can use internal criteria to determine coverage, but must follow narrow parameters in their policies.

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

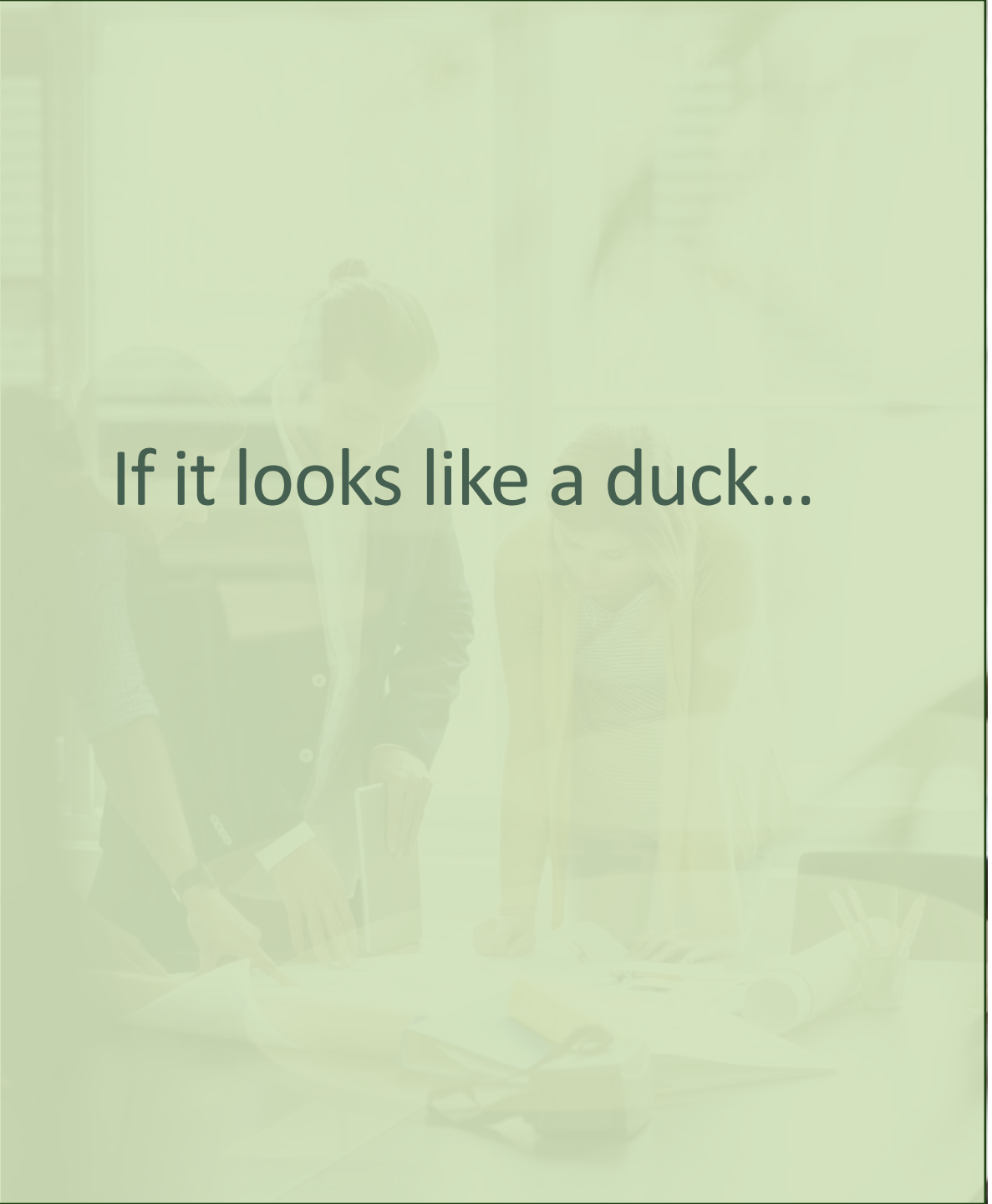
(A) additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including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

Substance Over Form (or Title)

"[W]hether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity"



If it looks like a duck…

Clinical Validation

“Any policy purporting to define a diagnosis using certain criteria is subject to these rules”

National standard code sets for ICD-10 codes and CPT/HCPCS codes, along with respective coding guidelines, as required under HIPAA, must be followed

Limitations on MA Plan Internal Coverage Criteria

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

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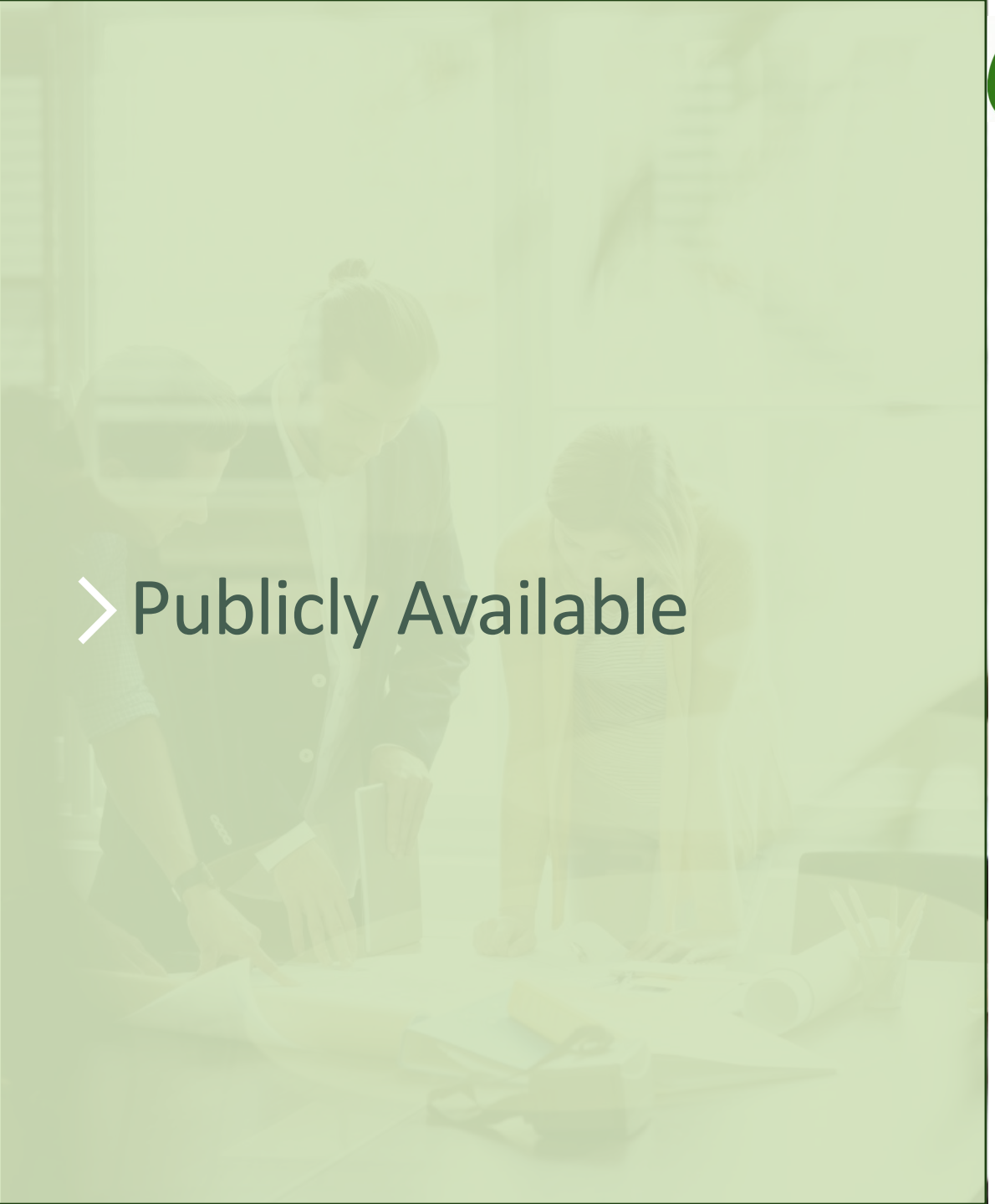
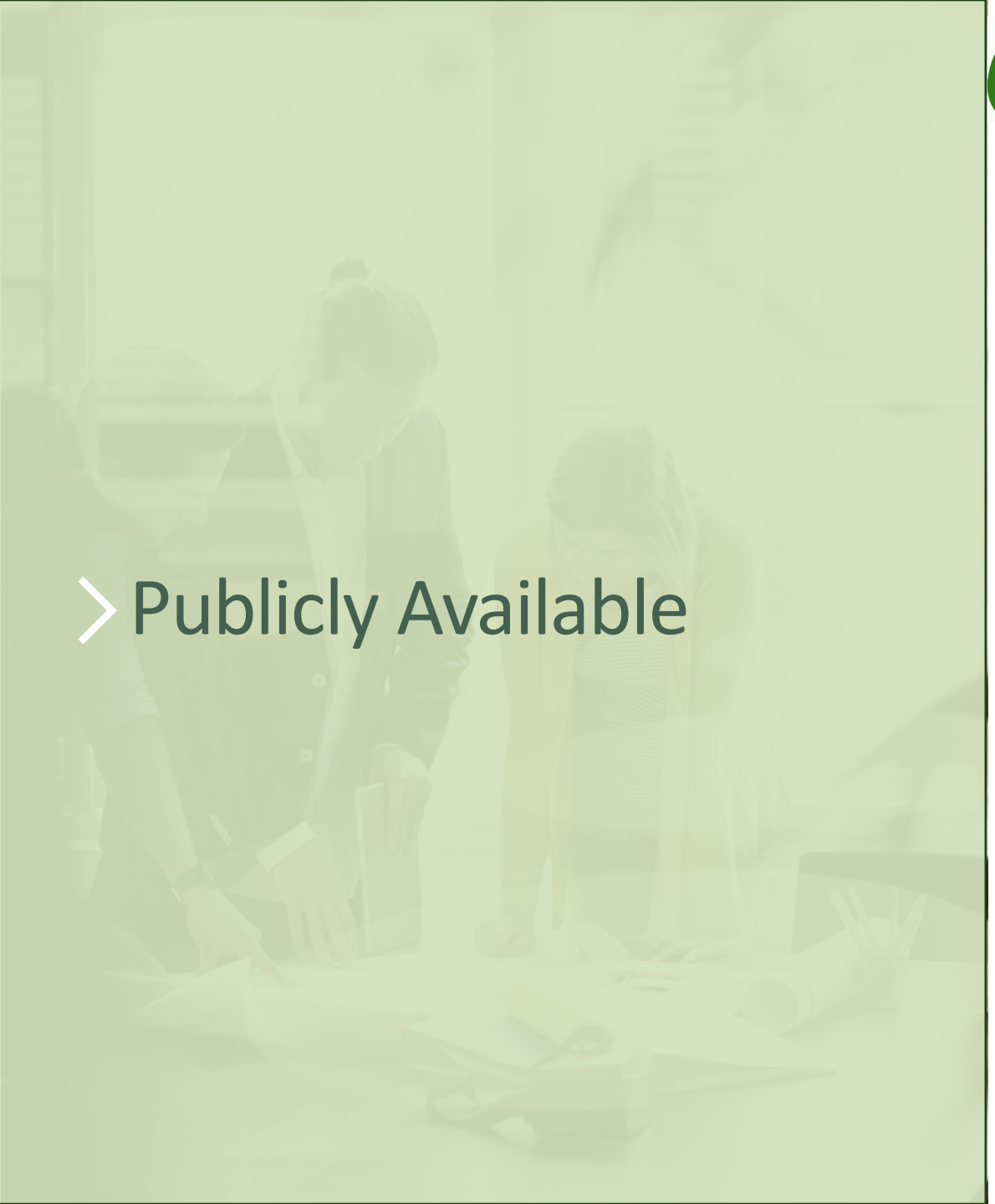


Publicly Available

We believe that the benefits of transparency in the development of internal coverage criteria balances out that [increased] Burden [on MA organizations]

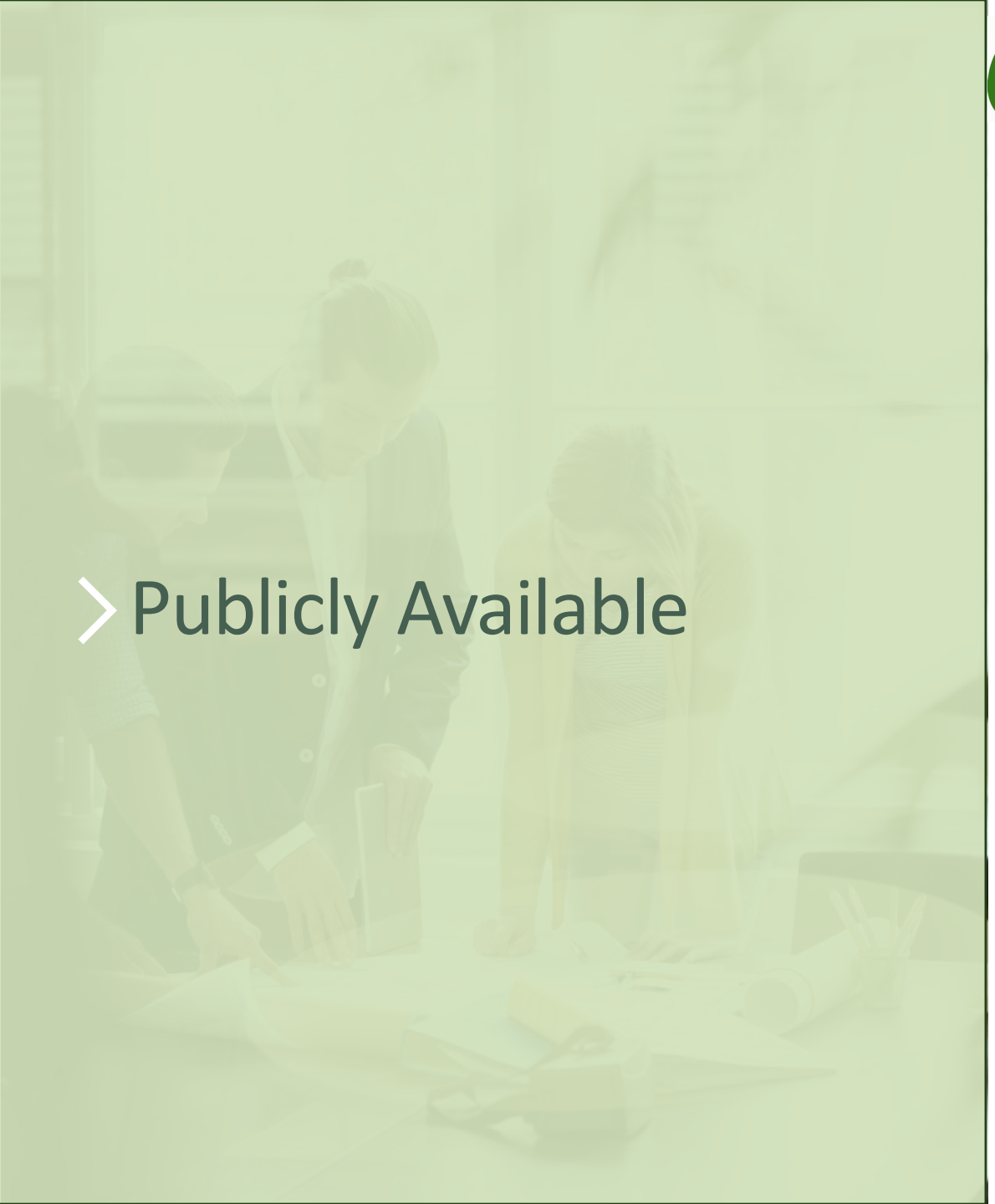
- Evidence that supports criteria must be made publicly available by the MA plan
- MA organizations must provide information discussing the factors the MA organization considered in making coverage criteria for medical necessity determinations
- Explanation of how the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms



Publicly Available

> We believe that permitting the use of publicly accessible internal coverage criteria in these limited circumstances and contexts is necessary to promote transparent, and evidence based clinical decisions by MA plans that are consistent with Traditional Medicare.

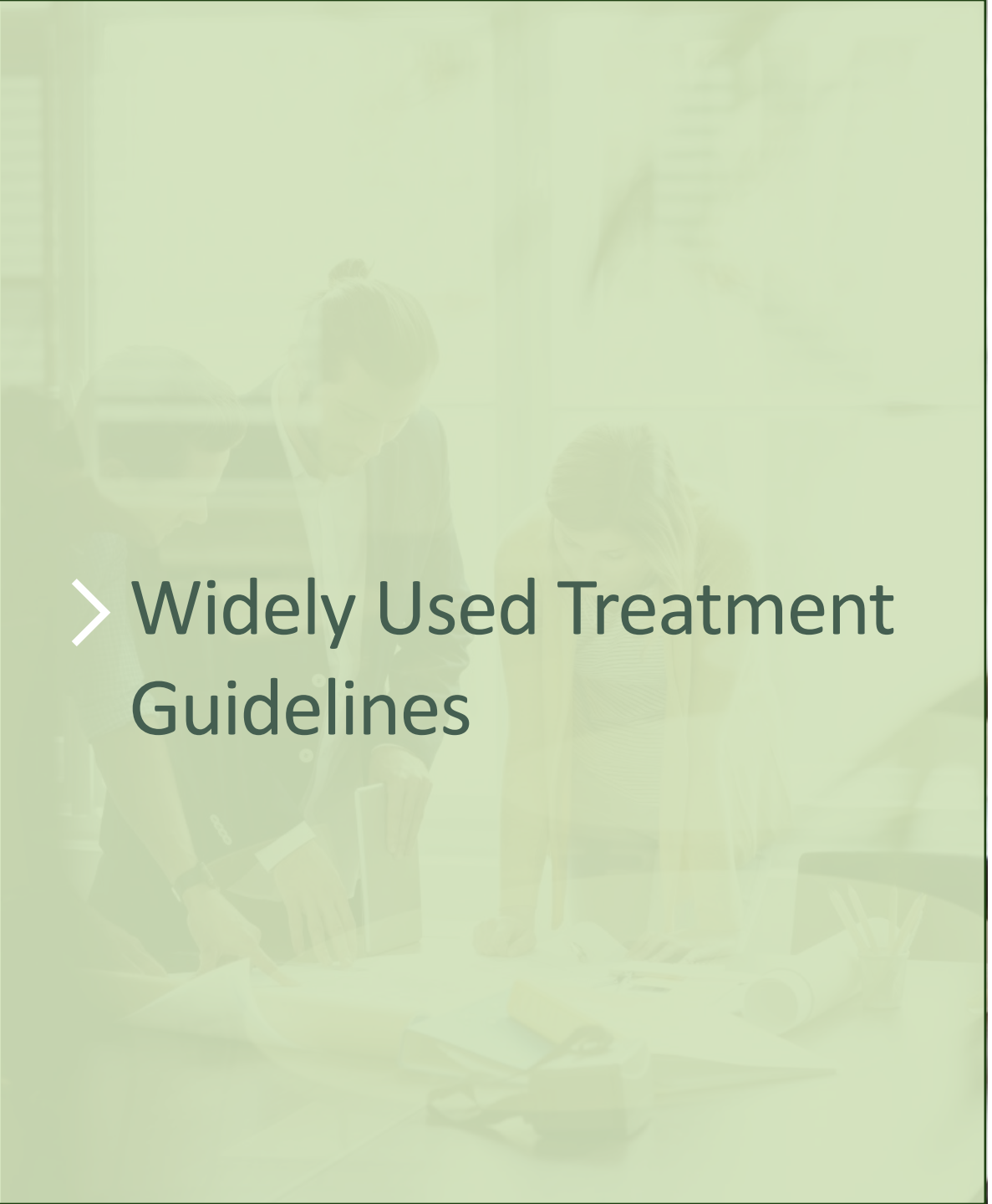
- MA organizations must provide publicly available information that discusses the factors the MA organization considered in making coverage criteria for medical necessity determinations
- identification of the general provisions that are being supplemented or interpreted
- a list of the sources of such evidence



Publicly Available

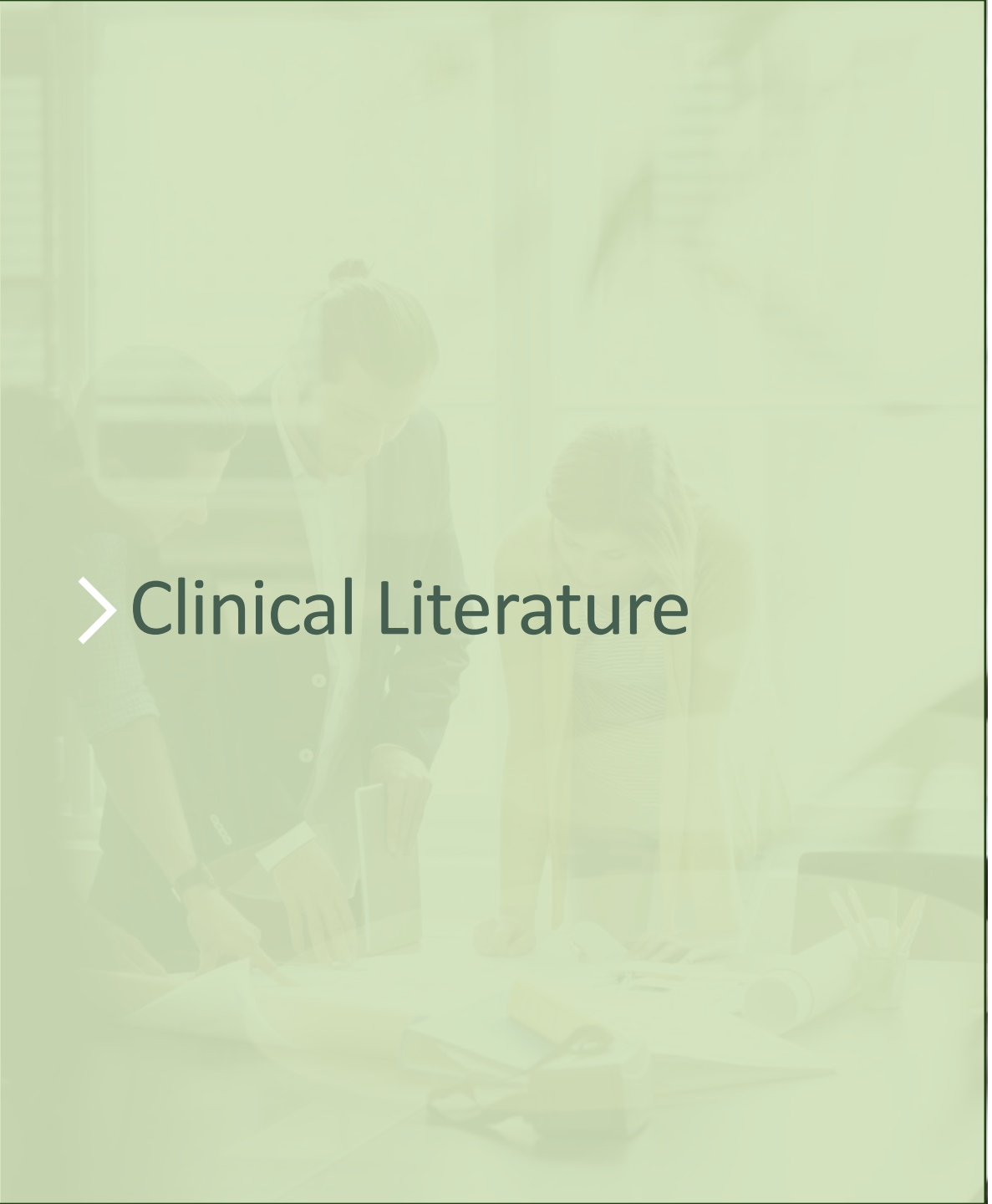
> We do recommend MA plans refer to the coverage criteria and summary of evidence presented by MACs as a guide and best practice for how to present this information publicly

- MA organizations may cite to policies or publicly available evidence that is behind a paywall without having to provide access to the policy directly
- Does not require MA plan provide direct access to the source



Widely Used Treatment Guidelines

- Developed by organizations representing clinical medical specialties
- Guidelines for the treatment of specific diseases or conditions



Clinical Literature

Large, randomized controlled trials

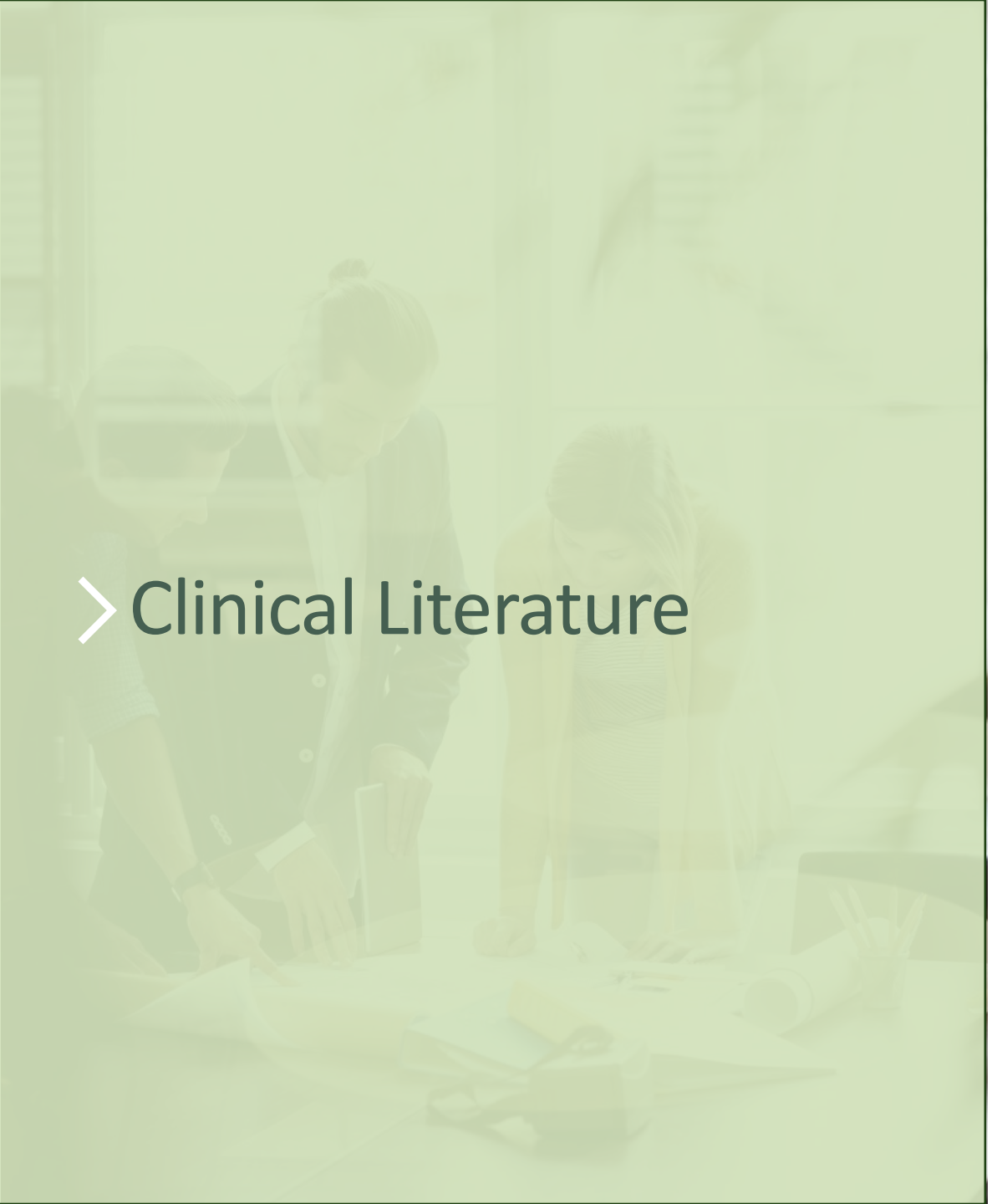
Prospective cohort studies with clear results

Published in a peer-reviewed journal

and

Specifically designed to answer the relevant clinical question

Large systematic reviews or meta-analyses summarizing the literature of the specific clinical question



Clinical Literature

Example: Infectious Diseases Society of America for the Treatment of Clostridium Difficile (p. 22197)

Examples That Do Not Qualify:

- Evidence that is unpublished
- Case series or report
- Derived solely from internal analyses within the MA organization

MA plans' permitted use of prior authorizations have become much more limited

PRIOR AUTHORIZATION

Prior Authorizations

Only Two Permitted Uses

1) confirm presence of a diagnosis or other medical criteria; or
2) 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

Non-Discrimination

PA is benefit design. Processes cannot be used to discriminate or direct enrollees away from certain types of services

Revocation

If approved by prior authorization, MA plan cannot deny coverage later on the basis of lack of medical necessity

Authorizations

Prohibition on authorization for emergency conditions includes retrospective review

CMS emphasizes this applies "regardless of the final diagnosis" and "the services needed to treat the emergency medical condition as presented therefore may not be retrospectively denied payment by the MA plan"

Authorizations

MA PFFS plans may not use prior authorization processes at all and that MA PPO plans may not use prior authorization processes for out of network services.

Authorizations

The UM committee is required to, at least annually, review the policies and procedures for all utilization management, including prior
authorization, used by the MA plan.

This means that any UM policy or procedure that is used by the plan, whether developed or managed by a third-party entity, must be reviewed and approved by the UM committee

Traditional Medicare regulations at 42 CFR 412.3 apply to Medicare Advantage plans also

TWO MIDNIGHT RULE

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

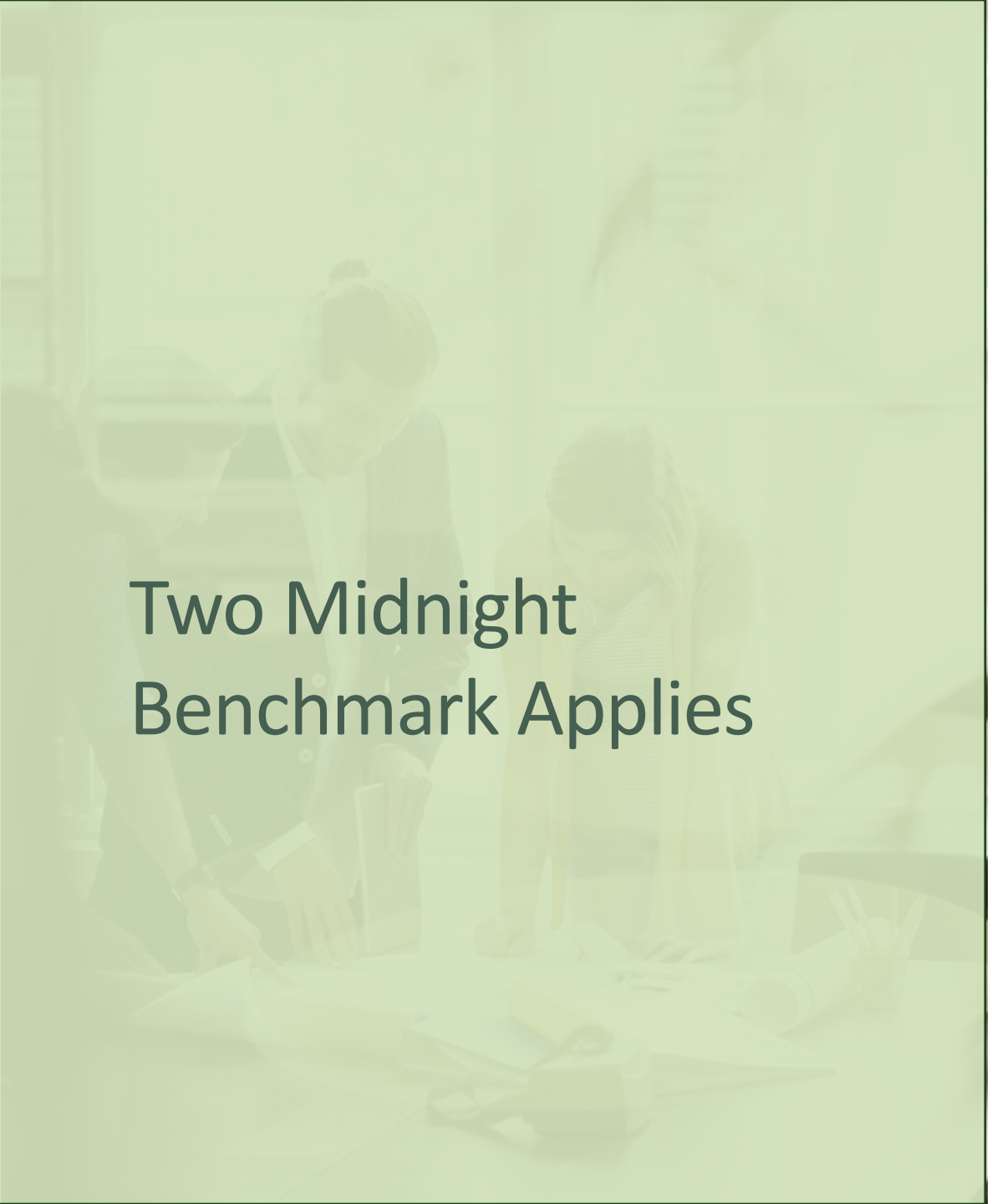
Unexpected Short Stay

Unexpected death, other circumstances can still qualify; defer to initial expectation

Inpatient Only

Accreditations

Patient specific clinical factors



Two Midnight Benchmark Applies

Two-Midnight Benchmark Applies

Two-Midnight *Presumption* is a medical review instruction from CMS to MACs, RACs, QIOs; does not apply to MA

Knowing rules for Medicare Advantage plans will help you level the playing field and protect your revenue cycle

DENIALS

Denial Requirements

Patient, Provider Notice

MA organizations must give enrollees written notice of a denial and the notice must state the specific reasons for the denial.

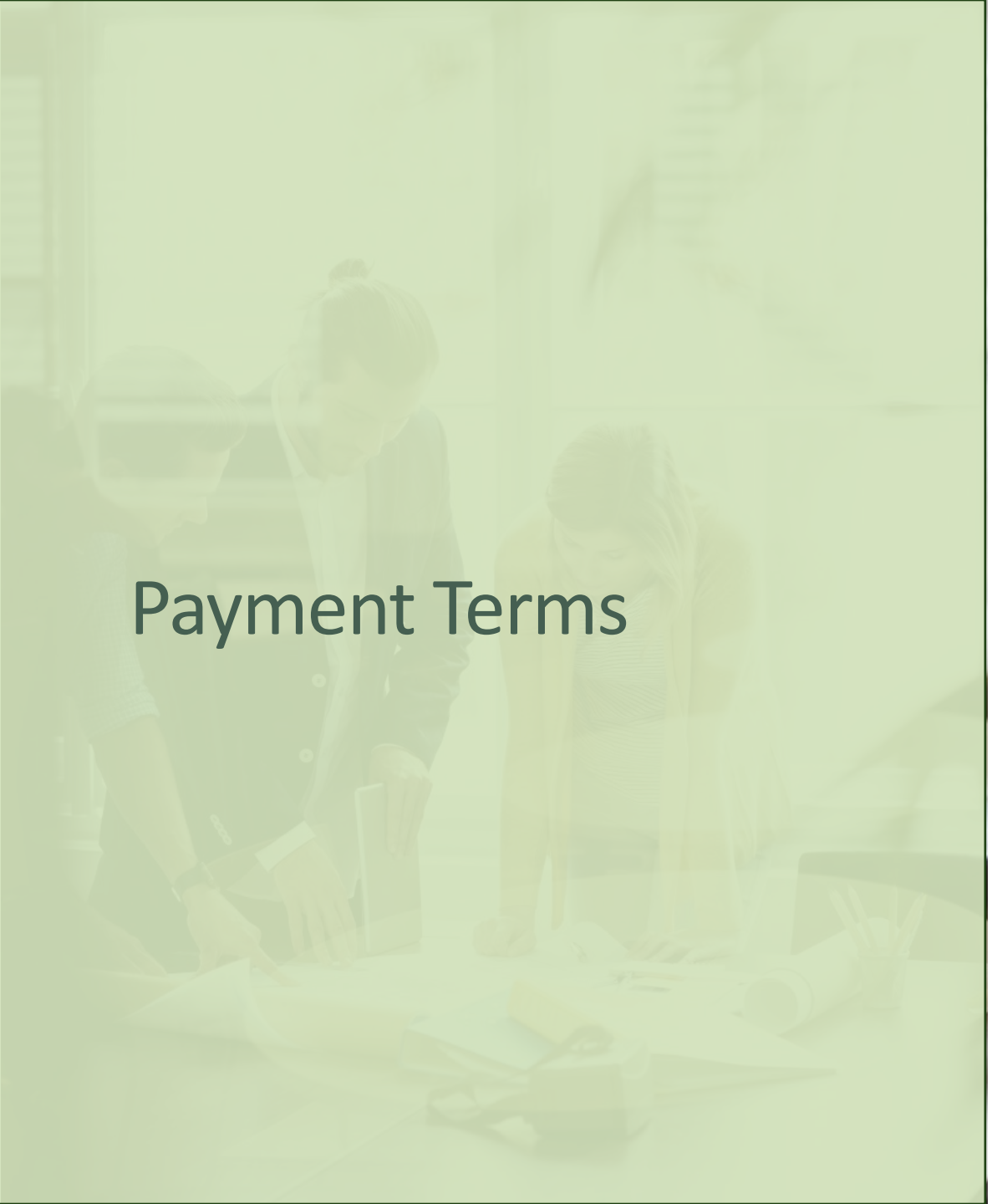
Identify Internal Criteria

If based on internal criteria, clearly identify and state the criteria in the notice

Who Decides?

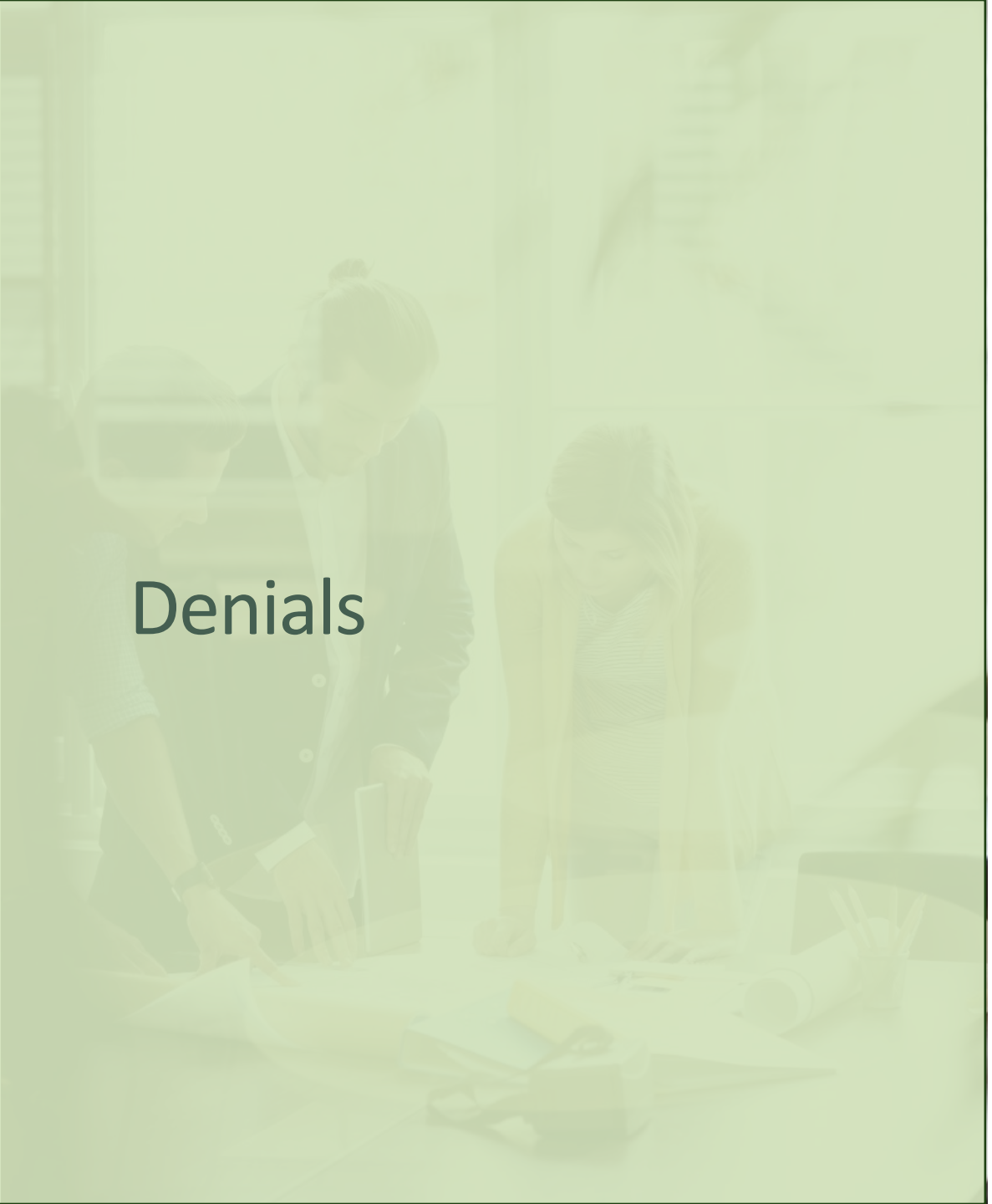
Denials based on medical necessity are based on a thorough clinical review by someone with sufficient expertise so that enrollees receive the benefits to which they are entitled

> “Communicating all necessary information needed for the enrollee or provider to effectively appeal the decision, including the evidence used to support the internal coverage policy when applicable, is one of the purposes of the denial notice.”



Payment Terms

- OON and deemed acceptance of Medicare allowable; higher patient cost sharing
- Pay 95% of clean claims within 30 days
- Must pay interest on clean claims (422.520)
- Contract with provider must address prompt payment (discuss interest)



Denials

- MAOs should refer to Medicare Program Manuals
- MA organizations must give providers written notice of a denial containing **specific reasons** for the denial, giving **all necessary information** needed for the provider **to effectively appeal** the decision **including evidence used** to support the MA plan's policy

Questions

Richelle Marting, JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I
rmarting@richellemarting.com