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Medicare Advantage Coverage Denials: Strategies and Considerations for SNFs

American Health Care Association
February 27, 2024

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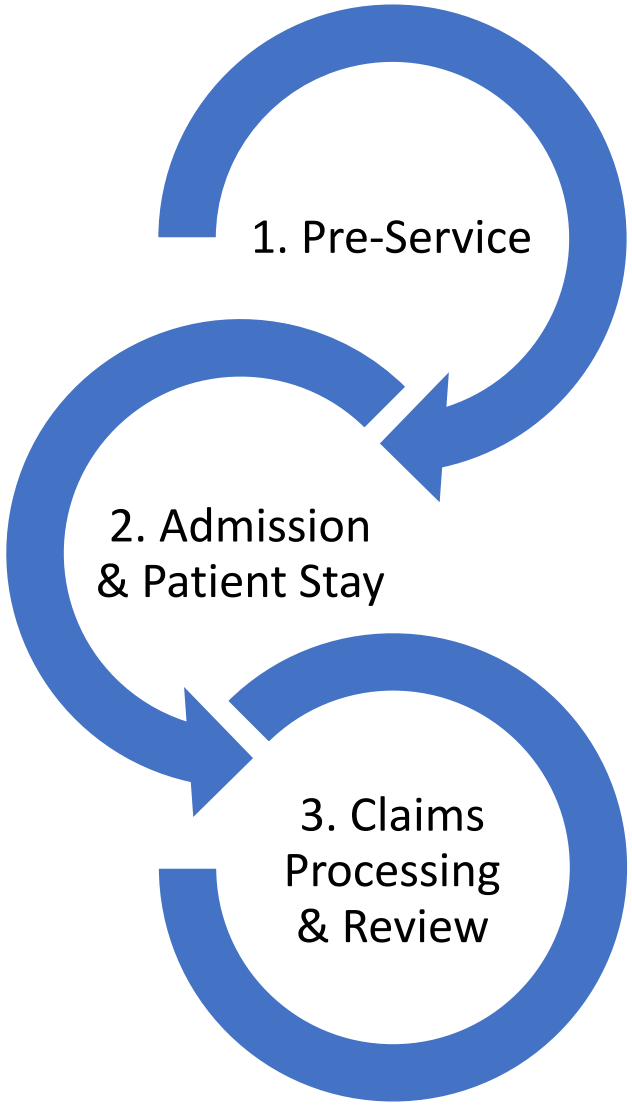
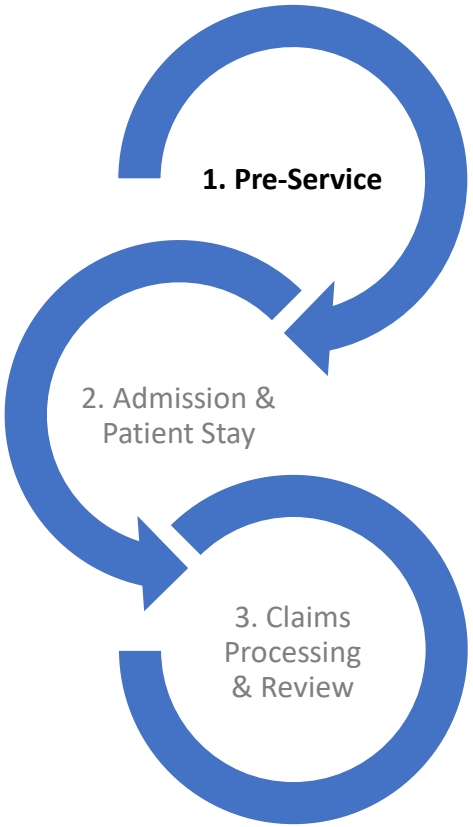
Introduction & Structure



Pre-Service: **Prior Authorization**

New limitations on prior authorization

- Common tool to provide pre-service coverage determination
- Can only be used to confirm medical/clinical criteria are satisfied.
- Cannot be used to steer patients to lower-cost post-acute settings
  - e.g., cannot be used to steer patients to home health instead of SNF



[42 CFR 422.138, 422.112(b)(8)]

Pre-Service: **Prior Authorization**

Limited bases for MA organizations to deny prior authorization

- Medical necessity determinations for admission and length of stay must be based on:
  - Coverage criteria
  - “Reasonable and necessary” requirement
  - Enrollee’s medical history, physician recommendations, and clinical notes
  - Involvement of the MAO’s medical director where appropriate

[42 CFR 422.101(c)]

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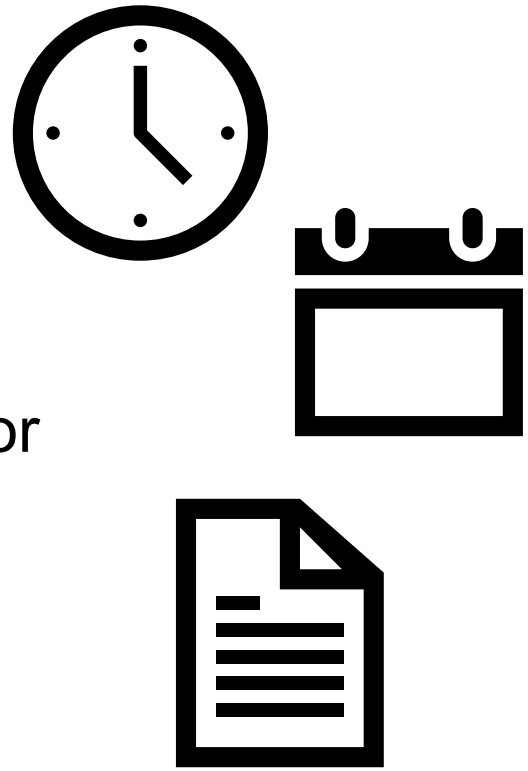
Pre-Service: **Timing and Form of Prior Authorizations**

Clear expectation for timing and format of MA organization's decisions

- Timing:
  - Regular requests: 14 calendar days
  - Expedited requests: "as expeditiously as the enrollee's health condition requires," but no more than 72 hours after the request
- A denial notice must state the "specific reasons for the denial"
- If a denial is based on medical necessity, it must have been reviewed by an appropriate health professional



[42 CFR 422.566, 422.568, 422.570, 422.571]

Pre-Service: **Did the MAO Apply Appropriate Coverage Criteria?**

New limitations on when an MA organization can supplement Medicare coverage rules

- MAOs *must* follow traditional Medicare criteria (unless superseded by laws applicable to MA plans), including:
  - NCDs
  - Applicable LCDs
  - General coverage and benefit conditions in Traditional Medicare laws
- Traditional Medicare Criteria for SNF care
  - Prior qualifying hospital stay
    - (3-day qualifying stay may be *waived* by MA plan)
  - Requires skilled nursing/rehabilitation services on a daily basis
  - Furnished for a qualifying condition
    - (In the case of a waiver of the 3-day qualifying stay, a physician determined direct admission would be medically appropriate)
  - Services are ones that, as a practical matter, can only be provided in a SNF on an inpatient basis

[42 CFR 422.101(b), (c); 42 CFR 409.30-36; CMS Feb. 6, 2024 FAQ, Q7]

Pre-Service: **Did the MAO Apply Appropriate Coverage Criteria?**

New limitations on when an MA organization can supplement Medicare coverage rules

When can an MAO apply internal coverage criteria?

Not Fully Established

- Traditional Medicare criteria must be not fully established
- For inpatient SNF care, would need to establish that:
  - Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; and
  - Clinical benefits are highly likely to outweigh any clinical harms, include from delayed or decreased access to item or services

Based on Current Evidence

- Criteria must be based on current evidence in widely used treatment guidelines or clinical literature

Publicly Accessible

- Criteria in use
- Summary of evidence considered and list of sources
- Explanation of rationale that supports the adoption of the coverage criteria (including benefits/harms)

MA Coverage Criteria

Tips and key points

- Internal coverage criteria ***cannot replace or overwrite*** Traditional Medicare criteria
- ***Artificial intelligence*** cannot be used to shift coverage criteria over time (must be static)
- Must be ***supported by current evidence*** in widely used treatment guidelines (developed by organizations representing clinical medical specialties) or clinical literature (peer reviewed)
- ***Patient safety*** is paramount:
  - Must "systematically explain the harms and benefits and use appropriate clinical evidence and citation of current, widely used treatment guideline or clinical literature."
  - If no guidelines/literature suggest that the clinical benefits are highly likely to outweigh the clinical harm, the criteria cannot be adopted
- ***Setting of care and costs***:
  - Can only deny a request for Medicare covered SNF services if the MA organization determines that the Traditional Medicare coverage criteria or internal coverage criteria (if applicable and authorized) for the services cannot be satisfied in the SNF
  - The flexibility for MA plans to cover and deliver care in cost-effective approaches does not replace the obligation for MA plans to cover all basic benefits consistent with the established coverage criteria for Traditional Medicare
  - (But, MA plan may discuss other treatment options that are covered by the MA plan with the enrollee.)

Admission & Patient Stay: **UM During Patient Stay**

- Concurrent review is still permissible
  - Must apply permissible coverage criteria
- Interrupted Stays
  - “An interruption in a stay within the scope of the SNF PPS interrupted stay policy does not change or alter the scope of the prior authorization approval” (FAQ 10)
  - “Approval of a prior authorization request for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation.” 42 CFR 422.112(b)(8)(i)(A)
- Addressing the problem of short MA authorizations?

Admission & Patient Stay: **Discharge**

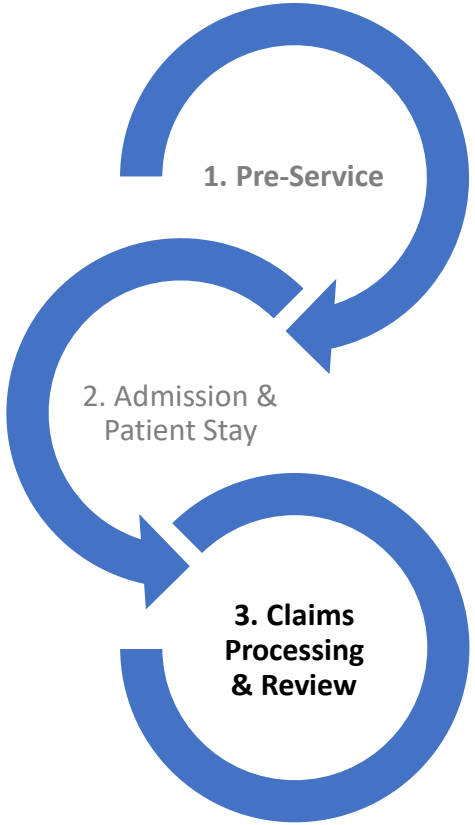
Length of Stay Issues

- May only terminate SNF coverage based on permitted coverage criteria
- Algorithms and software tools:
  - May be used to assist MA plans in *predicting* a length of stay
  - But, the prediction alone must not be used as the basis to terminate SNF services
- Requirement of individual assessment:
  - To determine that the patient no longer meets the level of care requirements at the time services are being terminated, the MA plan must *reassess the individual patient's condition* prior to issuing the notice of termination of services
- No changes to NOMNC requirement and timing

Claims Processing & Review: **Claims Review**

Post-Claim Review Audits and Examinations

- Post-claims reviews are organization determinations
  - Any refusal to provide or pay for services, in whole or in part, is an organization determination by the MA plan under 422.566(b)(3)
  - Must be reviewed by a physician or other appropriate health care professional with expertise
- Post-claims reviews after Prior Authorization
  - An MA organization generally cannot deny coverage (or payment) later based on lack of medical necessity
  - Exceptions: May reopen for—
    - "Good cause" (42 CFR 405.986)
      - Either there is new and material evidence or the evidence that was considered "clearly shows on its face that an obvious error was made"
      - A change in CMS legal interpretation or policy is not good cause
      - Third party error is not good cause
    - With reliable evidence of fraud or similar fault (per 42 CFR 422.616)
      - Evidence must be relevant, credible, and material

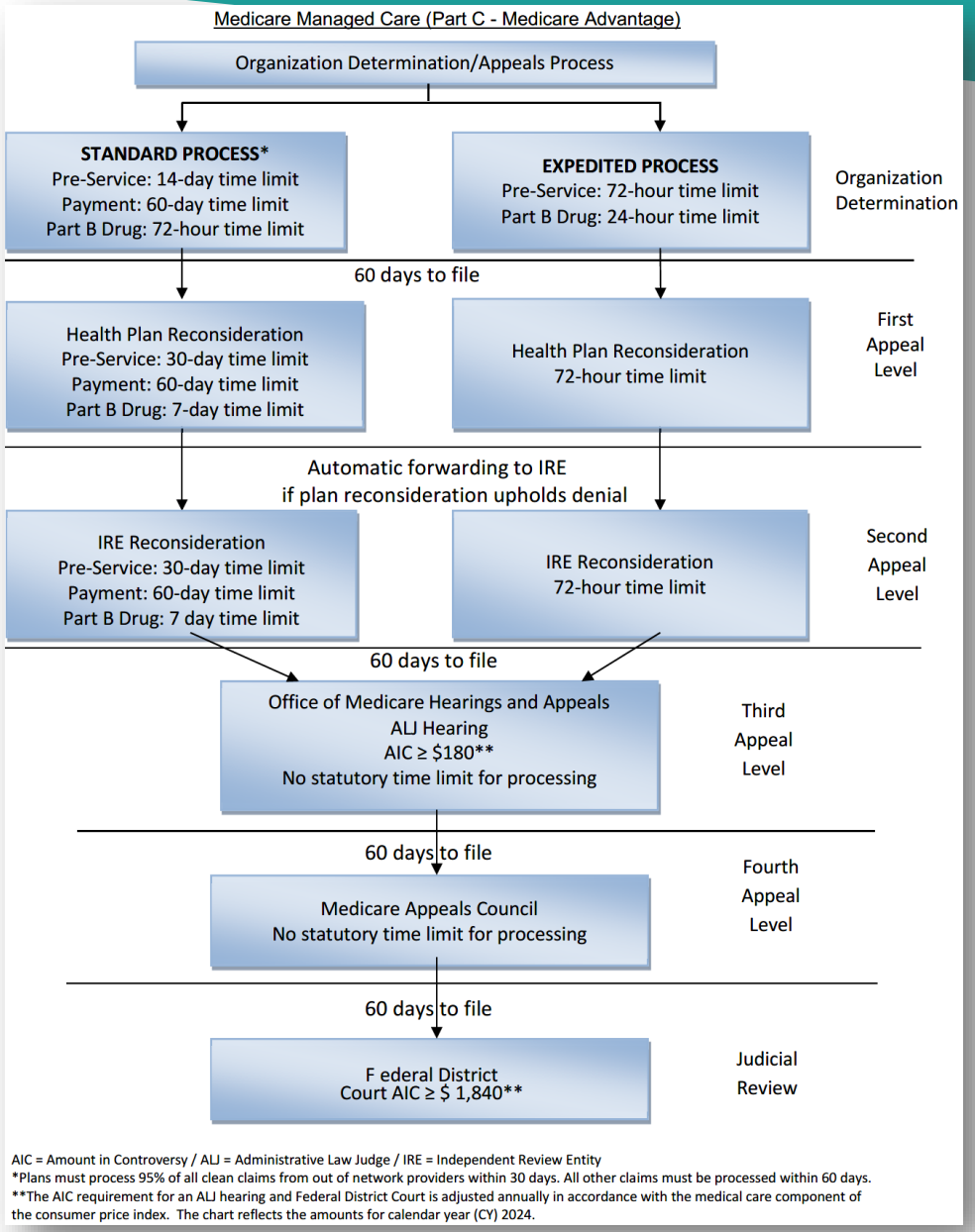


Claims Processing & Review: **Disputes**

Contractual Disputes and Beneficiary Appeals

- MAO Dispute. Review your contract with the MAO to identify the dispute resolution process
  - Notice of dispute timing and content
  - Meet and confer requirements
  - Timely initiation of formal dispute resolution (e.g., arbitration)
- Beneficiary Appeal. Layers of administrative and judicial appeal are available (https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/managed-care-appeals-flow-chart-.pdf)
  - With authorization from the beneficiary, a representative (such as a provider authorized by the beneficiary) can carry out appeals on his or her behalf
  - Beneficiaries may also fast-track an appeal of non-coverage of SNF services to the Quality Improvement Organization (QIO) if they file by noon the first day after the Notice of Medicare Non-Coverage (NOMNC)
  - Beneficiary assistance is available from 1-800-MEDICARE, the local SHIP program, or the Medicare ombudsman

[42 CFR 422.560 et seq.]



Claims Processing & Review: **CMS Oversight & Outlook**

CMS announces renewed attention to plan practices

- Recent CMS guidance announces routine and focused program audits of Medicare Advantage organizations
  - *Through this combination of routine and focused audits in 2024, CMS expects to evaluate the UM-related performance of plans serving approximately 88% of people with MA… During both the routine and focused program audits, CMS will utilize physician reviewers to review denied requests to assess whether MAOs are meeting new clinical coverage requirements, such as following coverage and benefit conditions included in Medicare laws, NCDs, or LCDs, and when permissible, applying internal coverage criteria...*
- Enforcement tools include compliance actions and enforcement actions

Resources

April 12, 2023 Final Rule: https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf

February 6, 2024 CMS Guidance—HPMS Memo, *Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F):* https://www.documentcloud.org/documents/24410692-cms-memo-2624-faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f

Presenters

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