Experts Discuss the Key Points and Impact of the 2024 Medicare Advantage Final Rule (CMS-4201-F)

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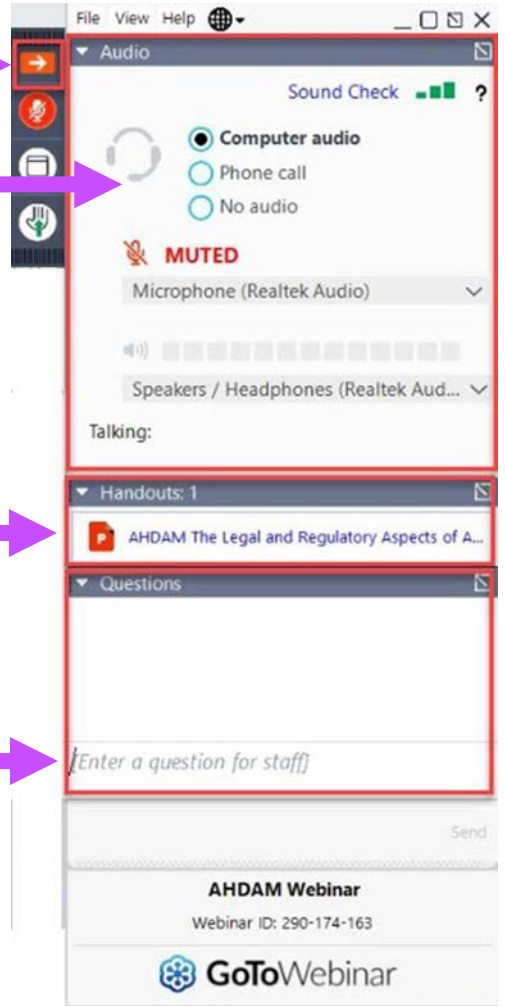

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Denise Wilson MS, RN, RRT

Senior Vice President, PayerWatch/AppealMasters; President, AHDAM

Denise has over thirty years of experience in healthcare, including clinical management, education, compliance, and appeal writing.

Denise has extensive experience as a Medical Appeals Expert and has personally managed hundreds of Medicare, Managed Medicare, and Commercial appeal cases and presented hundreds of cases at the Administrative Law Judge level. Denise is a nationally known speaker and dynamic educator on Medicare and Commercial appeals processes, payer behaviors, standards of care, appeal template development, and building a road map to drive the payer to a decision in the provider's favor. She has educated thousands of healthcare professionals around the country in successfully overturning healthcare denials.

Carolyn Dutton, MD, FACEP, FACP

Senior Physician Advisor, Wound Care Director, Emergency Medicine, Internal Medicine; Atrium Health

Dr. Carolyn Dutton is board certified in Internal Medicine and Emergency Medicine. She completed medical school at St. George's University School of Medicine and her training at Allegheny General Hospital where she served as Chief Resident. She has worked both in emergency medicine and as a hospitalist with Atrium Health since 2006. She continues to work clinically as the Medical Director for University City Wound Care Center and serves as the Director of Operations for Atrium Health Physician Advisor Services.

Dr. Dutton is also board certified in health care quality and management. She is Chair of the American College of Physician Advisors (ACPA) Government Affairs Committee and serves on the ACPA Board of Directors.

Kendall Smith MD, SFHM

Chief Medical Officer, Chief Physician Advisor

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

Bill Haynes, Esq.

Bill serves as the Legal Director of the Clinical-Legal Unit and as Managing Attorney for PayerWatch – AppealMasters. Bill is a member in good standing of the Maryland Bar, a member of The Association for Healthcare Denial and Appeal Management, and a member of the American Health Law Association.

Bill has experience in healthcare law, including managed care contract analysis, payer-provider arbitrations, and the independent review processes.

Bill personally manages a team of attorneys who do legal research, answer legal questions, and draft language for Medicare, Managed Medicare, Medicaid, and Commercial appeal cases, independent reviews, and arbitrations.

Learning Objectives

At the conclusion of the webinar, the learner will be able to:

Self report they can summarize 2 major provisions of the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F), how the final rule will impact their work, the effective date for most services, and how to provide feedback regarding MAO noncompliance.

At the conclusion of the webinar, at least 90% of participants will share on the evaluation:

1. The ability to identify 3 ways to provide feedback regarding MAO noncompliance with CMS 4201-F.
2. Identification of 2 major provisions to the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) that impact case managers, utilization management nurses, and nurse appeal writers.
3. When the final rule goes into effect.

Overview of the CMS 4201-F rule

- 4/2/2022 - The Office of Inspector General (OIG) issued a report on Medicare Advantage Organizations (MAO)
- 8/1/2022 – CMS issued RFI on proposed rule – almost 4000 comments submitted
- 12/27/2022 – Proposed rule published
- 4/5/2023 – CMS issued final rule

- *Effective date:* June 5, 2023
- *Applicability date*: applicable to coverage beginning January 1, 2024, except as otherwise noted

Overview of the CMS 4201-F rule

- The final rule reaffirms that MA organizations (MAO) cannot limit or deny coverage for services that would be covered under Traditional Medicare.
- The CMS inpatient-only list applies to MAOs
- MAOs must follow the “two midnight benchmark” as well as the “case-by-case exception”
- 2-midnight rule, presumption versus benchmark

Impact of 4201-F on UM functions

- 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)
  - Include coverage criteria for Part A inpatient admissions, Skilled Nursing Facility(SNF) care, Home Health Services, and Inpatient Rehabilitation Facilities (IRF)

Impact of 4201-F on UM functions

- Prior Authorization §422.138(b)(1)
  - To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service
  - To ensure basic benefits are medically necessary based on standards specified in §422.101(c)(1)
  - To ensure furnishing of supplemental benefits is clinically appropriate §422.138(b)(3)
- Not be used as a barrier to accessing medically necessary services
- Approval of PA request should be approved for treatment course as long as medically necessary to avoid disruption in care

Impact of 4201-F on UM functions

- If the plan has approved a prescribed or ordered course of treatment or service for which the duration is 90 days, then the PA approval must apply to the full 90 days
- Prohibited for a minimum 90-day transition period for any enrollee currently undergoing an active course of treatment when the enrollee switches to a new MA plan

Impact of 4201-F on UM functions

- Require MAO to establish a Utilization Management (UM) committee §422.137
  - Employ a medical director to ensure clinical accuracy of all organization determinations and reconsiderations involving medical necessity
  - At least annually, reviews the policies and procedures for all UM, including prior authorizations and coverage decisions and guidelines for original Medicare including NCDs and LCDs
  - Majority are practicing physicians
    - at least one who is independent and free of conflict relative to the MAO
    - at least one who is an expert regarding care of the elderly or disabled individuals
  - Encourage inclusion of an enrollee representative
- MA plans may not use any policies that have not been reviewed or approved by the UM committee on or after January 1, 2024

Impact of 4201-F on Coverage Criteria

- CMS clarifies rules related to acceptable coverage criteria for basic benefits by requiring that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare regulations.
- CMS is also finalizing that when coverage criteria are not fully established, MA organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.
- In the final rule, CMS more clearly defines when applicable Medicare coverage criteria are not fully established by explicitly stating the circumstances under which MA plans may apply internal coverage criteria when making medical necessity decisions.

Impact of 4201-F on Authorization Denials

- CMS specifically states that “the ‘2-midnight presumption’ (the presumption that all inpatient claims that cross two midnights following the inpatient admission order are ‘presumed’ appropriate for payment and are not the focus of medical review absent other evidence) **does not apply to MA plans**.”

Noncompliance with 4201-F

- Responding to non-compliance by the MAOs
- 3 ways to provide feedback:
  - File a grievance with the plan.
  - Encourage the enrollee to call 1-800-MEDICARE.
  - Submit your inquiry to the Part C and D mailbox at https://appeals.lmi.org/dapmailbox

Regulatory Impact of the CMS 4201-F Rule

- 4201-F codifies a significant amount from pre-existing guidelines, but with clarifying language.
- Of particular note is the update to Requirements relating to basic benefits, 42 CFR 422.101(b).
  - Prior 422.101(b)(2): “General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions”.
  - New 422.101(b)(2): “General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example,” (Payment criteria for inpatient admissions, inpatient care, SNF care, Home Health Services, IRF).
    - Draws from MMCM Ch.4, 10.2: “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…”.

Regulatory Impact of the CMS 4201-F Rule

- New 42 CFR 422.101(b)(6) – creation of **publicly accessible** internal coverage criteria when **coverage criteria not fully established** – bold terms are defined.
  - Draws from MMCM Ch.4, 90.5: Creating New Guidance – internal coverage criteria, “In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals…”, not defined.
    - No publicly accessible requirement

Questions and Answers

References

Centers for Medicare and Medicaid Services. (page last modified 5/12/2022). File a Complaint. CMS.gov.

https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/FileaComplaint

Office of Inspector General. (2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (Report No. OEI-09-18-00260), United States Department of Health and Human Services.

https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Centers for Medicare and Medicaid Services. (8/1/2022). A Proposed Rule. CMS.gov. HHS.gov.

https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-for-information-on-medicare

Centers for Medicare and Medicaid Services. (12/27/2022). A Proposed Rule. CMS.gov. HHS.gov.

https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Centers for Medicare and Medicaid Services. (4/12/2023). A Final Rule. CMS.gov. HHS.gov

https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

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Thank you for attending today's event!

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