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Proposed Rules: MA Plans Must Follow Two-Midnight Rule, IPO List and Expedite Prior Auth

By Nina Youngstrom

In a Dec. 14 proposed regulation, CMS put teeth into the requirement that Medicare Advantage (MA) plans follow traditional Medicare's two-midnight rule, inpatient-only (IPO) list and case-by-case exception, experts say.[1] It's one of two rules CMS proposed in the space of 10 days that potentially would curb some of what providers consider the excesses of MA plans.

The rule, which also addresses prior authorization, utilization review and other areas, proposes to codify regulatory language that would explicitly require MA plans to live by coverage criteria for inpatient admissions under Part A (42 C.F.R. § 412.3), said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in North Carolina.

"In general, CMS has published a resounding 'no' as to whether Medicare Advantage organizations can rely on internal coverage criteria to be more restrictive than traditional Medicare, with the only exception being areas where Medicare lacks clear policy coverage and high-quality evidence-based literature exists to guide coverage," Hu noted. "Not only does this apply to services received by a beneficiary, but also the setting of care that traditional Medicare would cover it in, and the payment to the provider for those services."

Although CMS doesn't specifically mention the two-midnight rule, it's clearly stating it believes MA plans should be following traditional (fee-for-service) Medicare inpatient status regulations, he explained.

Of equal importance, Hu said, CMS repeatedly asserts that MA plans must stick to the rules on two-midnights, the IPO list and case-by-case exceptions (which allow hospitals to bill for inpatient admissions even when physicians don't expect a two-midnight stay in rare and unusual circumstances). According to the proposed rule, "MA organizations may not limit coverage through the adoption of policies and procedures – whether 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 – when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item or service furnished to the beneficiary. In addition, this means that limits or conditions on payment and coverage in the Traditional Medicare program—such as who may deliver a service and in what setting a service may be provided, the criteria adopted in relevant NCDs and LCDs, and other substantive conditions—apply to set the scope of basic benefits as defined in § 422.100(c)." If finalized, CMS is, among other things, putting an end to prior authorization denials based on MA internal criteria that goes beyond Medicare coverage rules.

It will be enormously helpful for hospitals and other providers if there's one Medicare standard, said Ronald Hirsch, M.D., vice president of R1 RCM. "This will be a huge burden off the shoulder of hospitals across the country," he said. "Right now, they're dealing with myriad sets of rules about who can be an inpatient and who can't. It varies by patient, by day, by which medical director you talk to." He noted, however, that confusion will continue because providers have to abide by criteria from an abundance of commercial plans.

The proposed rule sends a message to MA plans. "It tells the MA plans that CMS is listening to complaints from providers and patients about lack of access to necessary care," Hirsch said. "CMS is taking it very seriously that MA plans appear to be depriving patients of care they would receive if they were in traditional Medicare and they feel that warrants codifying the rules." CMS cited two examples in the rules that seemed to inform its thinking. "For example, if an MA patient is being discharged from an acute care hospital and the attending physician orders post-acute care at a SNF [skilled nursing facility] because the patient requires skilled nursing care on a daily basis in an institutional setting, the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for SNF care in §§ 409.30-409.36 and proposed § 422.101(b) and (c)."

OIG Report is 'Overarching Theme'

Hu said the "overarching theme" of this and other proposals in the rule is CMS's response to an April report from the HHS Office of Inspector General (OIG) on MA plan denials of prior authorization requests.[2] OIG concluded that MA plans deny 13% to 18% of requests for prior authorization and payment for services that are covered by Medicare and that the services denied by the MA plans probably would have been approved if the beneficiaries were in traditional Medicare.

The proposed rule also has new requirements that will take effect in 2024 if finalized, Hu said. For one thing, CMS would require MA plans to have a utilization management committee "to review all utilization management, including prior authorization, policies annually and ensure they are consistent with current, traditional Medicare's national and local coverage decisions and guidelines," the rule stated. "These proposed changes will help ensure enrollees have consistent access to medically necessary care, without unreasonable barriers or interruptions."

The proposed rule seems to be grounded in Chapter 4 of the *Medicare Managed Care Manual*, Hu said. Generally, when talking about prior authorization, CMS just refers to Chapter 13, which is the chapter on Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.[3] "I think it is noteworthy that CMS is codifying Chapter 4, 10.16, which is the section that says you can't go back and deny for medical necessity something you've already approved absent fraud, misrepresentation, etc.," Hu said. "CMS also notes another Chapter 4 concept, which is that emergency services, urgently needed services, and stabilization services cannot require prior authorization. Chapter 4 is beneficiary protections, but contains clauses that protect both patients and providers, and kudos to CMS for linking existing concepts from different areas of the statute/regs/manuals."

Another CMS Rule Expedites Prior Authorization

The other proposed rule affecting MA plans, announced Dec. 6, has different requirements for prior authorization.[4] The rule, which advances interoperability, was originally proposed only for certain payers, such as Medicaid and the state Children's Health Insurance Program, but CMS rescinded it. This new version adds MA and new provisions, including faster turnaround times for MA prior authorization.

"The current requirement for Medicare Advantage organizations is to respond to 'urgent' requests for prior authorization within 72 hours and within 14 days for standard requests. The proposal is to change standard requests to 'as expeditiously as a patient's health condition requires, but no later than seven calendar days for standard requests' and leave the 72-hour time frame for 'urgent' requests as is," said attorney Ariana Fuller, with King & Spalding in Los Angeles. CMS is asking for comments on whether to go even further with prior authorization, changing the urgent request deadline to 48 hours and the standard request deadline to five calendar days, she said.

The rule also would mandate electronic prior authorization, said Peggy Tighe, a principal in Powers, Pyles, Sutter and Verville in Washington, D.C. And there's a transparency requirement, she said. MA plans would have to post certain prior authorization metrics on their website or via publicly accessible hyperlink(s) annually.

The provisions are mirrored in a bill, the Improving Seniors Timely Access to Care Act (H.R. 3173), that was passed by the House of Representatives in September, Tighe said.[5] That bill is still necessary because it codifies the prior authorization improvements, she noted. "Any new administration could reverse them" in another regulation.

The rule, which was published in the *Federal Register* Dec. 13, would not take effect until 2026 if it's finalized, Fuller said. The attorneys explained that the technology challenges prompted CMS to give the industry an unusually long runway. Requiring payers and certain providers to implement electronic application programming interfaces (APIs), which are electronic methods of communication, will take time, Fuller said. "There's concern about getting them up and running."

Contact Hu at edward.hu@unchealth.unc.edu, Hirsch at rhirsch@r1rcm.com, Fuller at afuller@kslaw.com and Tighe at peggy.tighe@powerslaw.com.

1 Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications," proposed rule, December 14, 2022, https://bit.ly/3uSY7dt.
2 Nina Youngstrom, "OIG: MA Plans Deny Payment for 18% of Medicare-Covered Services," *Report on Medicare Compliance* 31, no. 16 (May 2, 2022), https://bit.ly/3hxnDBK.
3 Nina Youngstrom, "CMS Gives Providers More Elbow Room to Fight MA Denials in Update to Appeals Guidance," *Report on Medicare Compliance* 31, no. 30 (August 22, 2022), https://bit.ly/3V1wXf6.
4 Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76,238 (December 13, 2022), https://bit.ly/3uW6XXR.
5 Improving Seniors' Timely Access to Care Act of 2021, 117th Cong. (2021), https://bit.ly/3FtahP0.