CAC-PIAC Annual Report

Source of Coverage – Medicare

- In 2021, 17.5% of individuals received Medicare coverage in whole or in part through Medicare
- In 2022, more than 28 million people are enrolled in Medicare advantage plans, accounting for nearly half or 48% of the eligible Medicare population.
    - 4.62 million enrollees are in Special Needs Plans
    - 5.1 million are in employer group Medicare Advantage plans

Medicare Advantage Market

- United Health Care, Humana, Blue Cross Blue Shield, Aetna (now owned by CVS Health) and Kaiser Permanente account for more than 75% of the market
- United Health Care is the largest with 28%, followed by Humana with 18%, CVS Health has 11%, Kaiser Permanente 6% and all Blue Cross Blue Shield plans combined have 14%

No Surprises Act

- Part of the Consolidated Appropriations Act of 2021
- Requirements limiting consumer liability and increasing cost transparency.
- The act ensures patients are not obligated to pay more than the in-network cost sharing under their commercial health plans in certain situations when out of network providers furnish services and sets forth a process for noncontract providers and insurers to come to agreement on payment amounts.
- The Act is off to a slow and rocky start with litigation and enforcement delays and final rules still pending.

No Surprises Act – Good Faith Estimates

- The NSA also imposes a requirement for providers to provide good estimates of costs of receiving care.
- For uninsured/self-pay patients, GFE is provided directly to the patient. In instances in which there is more than one provider or facility involved the provider scheduling the service or getting the request for the GFE is responsible for obtaining estimates from the other providers and including them in the GFE.
- Effective January 1, 2022 providers were required to provide GFE's to:
    - Uninsured and self-pay individuals scheduling an item or service at least 3 business days in advance. This includes insured individuals scheduling non-covered items or services.
    - Uninsured and self-pay individuals who have not scheduled an item or service but request a GFE or otherwise inquire about costs for items or services they haven't yet scheduled.

Timing for Providing GFEs

- When an item or service is scheduled at least 10 business days before it will be furnished, the provider must furnish the GFE no later than 3 business days after the date of the scheduling.
- When the item or service is scheduled at least 3 business days before it well be furnished, the provider must furnish the GFE no later than 1 business day after the date of the scheduling.
- When the uninsured or self-pay individual requests a GFE, the GFE must be provided no later than 3 business days after the date of the request.

What if the Patient Receives Recurring Services?

- If the patient receives recurring services for which a GFE must be provided such as non- covered routine care, the provider may issue a single good faith estimate (GFE) if both of the following requirements are met.
- The GFE includes the expected scope of the recurring items or services (such as time frames , frequency, and total number of recurring items or services) in a clear and understandable manner; and
- The scope of the GFE does exceed one year

GFE Notification Requirements

- Providers must orally furnish information concerning the availability of a GFE to a self-pay or uninsured individual when scheduling an item or service or when questions about the cost of the items or services occur.
- Providers must also post a written notice of the availability of a GFE for uninsured or self-pay individuals that is written in in a clear and understandable manner.

What if the GFE is Wrong?

- A patient provider dispute resolution (PPDR) process is available for individuals who get a bill for an item or service that is $400 or more in excess of the expected charges on the GFE.
- In the case of the GFE's that include co-providers, the $400 amount is determined for each provider or facility on the estimate.
- An independent reviewer makes the decision
- In 2022 , a $25 administrative fee will be assessed to the non-prevailing party to the PPDR process. Providers cannot send a bill to collection or threaten to do so while the PPDR process in pending.

Medicare Advantage Issues

- April 2022 OIG report on Medicare Advantage Denials
- Findings
    - 13% of prior authorization denials were for service requests that met Medicare coverage rules.
    - 18% of payment denials were for claims that met Medicare coverage rules and MAO billing rules.
    - Imaging services, stays in post-acute facilities and injections were three prominent types among denials that met Medicare coverage rules.

Recommendations for CMS

- Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews
- Update its audit protocols to address the issues identified in the report
- Direct MAO's to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

May 2022 Final Rule

- Beginning for plan years effective 2024 (applications filed in 2023) CMS will revert to its policy of requiring MA plans to meet network adequacy requirements before awarding new contracts or approving service area applications.

Medicare Advantage (MA)Appeal Process

- Appeals for contracted Providers
    - Prior Authorization- Regulatory ("member") process (30 days)
    - Post Service appeals- Plan Process
- Appeals for Non-Contracted Providers
    - Regulatory process- simply a disagreement regarding the amount due for the service (30 days)

- Both Contracted and Non-Contracted
    - Expedited Appeals - regulatory process - only pre-service appeals (72 hours). Available in situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

Addressing Services you Believe will be Inappropriately Denied - Pre-Service

- Ask for prior authorization- a treating physician may ask on behalf of a patient. A member has a has a right to a prior authorization decision whether or not prior authorization is required for the service. Except for expedited determinations plan has 14 days to make decision.
- If you receive a denial, you have two choices:
    - You can see if the beneficiary wants to pay out of pocket and can bill.
    - You can appeal, using member appeal process. A treating physician may as for an appeal on behalf of the patient.
- If the plan wishes to uphold the denial in whole or part, it must forward the case to an independent review entity(IRE).
- IRE overturns count against the plans star rating.

Denials of Claims for Basic Benefits

- If the denial was after the services was furnished: Contracting providers must appeal using the process set forth in their contract or the plan's policies or procedures
- Non-contracting providers may use the member appeal process if they are willing to sign a waiver of liability stating that, regardless of the outcome, they will hold the member harmless.
    - Trade off- if the plan upholds the denial, the appeal automatically goes to an independent review entity.
    - Because overturns by the IRE count against the plan star ratings, plans seek to avoid them.

Denials of Claims for Basic Benefits

- Both contracted and non-contracted providers can support their claims by submitting FFS remittance notices that are BLINDED (take out all PHI) showing that FFS Medicare pays for the service at issue
- Include any supporting LCD is also helpful
- CMS has created a data base of IRE decisions. It can be searched by procedure or code or other key words. May be sued as support where local IRE made decision.
    - https://www.cms.gov/qic-decision-search

Appeals for Administrative Denials

- If based on a rule different than Medicare
    - Contracted providers - Look at provider contract
        - Does it say anything about coding modifiers
        - Does it refer to policies and procedures that support the plan position?
        - What does the payment terms say? Does it say you will be paid based on fee for service.
    - Non-contracted Providers – Should expect to be paid the same amount they would be paid under FFS Medicare

Medicare Advantage Appeals

- Medicare Advantage Organizations make a substantial amount of their own decisions, particularly when the appeal is through the regulatory process.
    - IRE overturns against the plans star ratings.

Respectfully Submitted,

Martin Lesnak DPM
Ohio PIAC Representative