Education 2025

Hot topics & Potential Impacts to The Revenue Cycle

AR Systems, Inc.

Day Egusquiza, President
AR Systems, Inc. & Patient Financial Navigator Foundation, Inc.

Day's Revenue Cycle Motto:

My patient did not ask to get sick. My patient did not ask to have their bill be so high. My patient did not ask for their insurance to pay so little or deny their claim. My patient did not ask to have their life disrupted by this unexpected illness. How can I help? You are scared and sick.
Let me be the Patient Financial Navigator!

AND START WITH A LITTLE "PAYER FUN"

THANKS, WARREN K/REGION 8 HFMA MEETING, 2022

U	usually
N	nine
I	in
T	ten
E	experience
D	denials…..

Medicaid Redetermination

C	called
I	in
G	got
N	no
A	answer

++All time favorite: Singing the"Blues "

"Medicare and Medicaid turn 60: What's changing - and what it means for hospitals." Becker Hospital 7-25

- **July 30, 2025 marks the 60th Anniversary of Medicare and Medicaid – which have grown to cover about 140 million people combined, including older adults, people with disabilities and low-income families.**
- **Medicare insures more than 68 million people**
- **Medicaid insures approx. 71 million people.**
- **This safety net is under pressure. Millions are projected to lose their health insurance in the coming years due to Medicaid cuts AND Affordable Care Act/ACA reforms as outlined in the One Big Beautiful Bill. The Congressional Budget Office estimates these changes will increase the uninsured by 10 million by 2034.**

"Before Medicare and Medicaid, tens of millions of Americans lived in fear of illness. Sixty years ago, that all changed with the new law that brought peace of mind and a new era of access to medical care. In the decades since, our nation has proudly built on the promise of care for our most vulnerable, but today that is under threat."Chip Kahn, President and CEO of the Federation of American Hospitals.

"Cuts to Medicaid, the expiration of the ACA's enhanced premium tax credits at the end of 2025 and threats to Medicare reductions are placing millions of American's coverage and access to care at risk."

End of 2025: Loss of lower insurance premiums on the Exchange/Marketplace due to lower incomes -is slated to be gone. Now people who have coverage on the Exchange will pay FULL Monthly premiums - which are increasing per the insurance plans. Will they be able to pay? Or drop coverage? Now self pay with increase in ER visits. What is the aggressive strategy to address this large group is newly underinsured? (*Sen Schumer has introduced legislation to re-instate the Tax subsides and reverse healthcare cuts. S.2556 Protecting Health Care and Lowering Costs Act. 7-30-25)*

OIG Auditing MA plans PLUS AI payer concerns ++ MA enrollment has exploded by 337% from 2006-2022.

- OIG completes audit of specific dx codes that Excellus Health Plan, Inc submitted to CMS. 7-2023
- Under the MA program, CMS makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee.
- MA are paid more for enrollees with dx associated with more intensive use of health resources.
- OIG audited 210 unique enrollee high-risk dx submitted that did NOT comply with federal requirements.
- Specifically 202 of 210 sampled, the medical record did not support the dx codes, resulting in $479K overpayments.
- Estimated Excellus received approx. $5.4M in overpayments 2017-2018. Too early to make them pay back which recently changed.
- Beginning 2024, recoupment. Not since 2007.
- Excellus disagreed with all, but OIG confirmed

- **Cigna sued following ProPublica report on unreviewed batches of denied claims. 7-23**
- Two Cigna members have filed a class-action complaint against their insurer for allegedly denying large batches of member's claims without individual review- thereby denying them coverage for certain services.
- Many states require physicians to review pt files and coverage polices BEFORE denying claims for medical reasons.
- The suit alleges that Cigna has bypassed these steps by having an **Algorithm called " PXDX"** complete the review and then having physicians sign off on groups of denied claims. Drs instantly rejects for MN w/o ever opening a file.
- "Relying on the PXDX system, Cigna's doctors instantly reject claims on medical grounds (med necessity sound familiar?) without ever opening a pt file, leaving thousands of patients effectively without coverage and with unexpected bills. The scope of this problem is massive."

CMS: MA insurers can't use AI, algorithms to deny care

- ***The CMS sent a memo clarifying that Medicare Advantage insurers are not allowed to use algorithms or AI-powered tools as basis for denying care or coverage. Algorithms and AI tools can be used only to support coverage decisions, and insurers must ensure that the tools they are using comply with the CMS' coverage decision requirements. 2-24 ** see slide 52***

And a little bit more specifically for Medicare Advantage Plans

- **Insurers brought in $50Billion through 'questionable' Medicare Advantage coding: Wall Street Journal. July 2024**
- Think 'risk adjustment notices to facilities' that they need unlimited records 'per CMS' (Nope!)
- **HHS announces investigation of MA prior authorization use for post-acute care.** AHA

  The Dept of Health and Human Services is investigating MA organizations use of prior auth for post-acute care after hospital stays.

  The focus is on the authorization processes and the frequency of denied requests for care in long-term acute care hospitals, inpt rehab facilities, and skilled nursing facilities.
- **Footnote: Remember - Prohibit MA organizations from limiting or denying coverage when the item or service would be covered under TM. Applies to all, not just Inpt vs obs.**

- **CMS's 2024 MA rule brings some improvements but falls short of addressing all providers' concerns.** (Medicare payment & Reimbursement.)
- **Medicare Advantage Final Rule (CMS-4201-F)**. The rule represents CMS's efforts to refine the practice of MA organizations by placing limitations on prior authorization, elevating requirements for provider directories and making comprehensive adjustments to the MA and Part D quality rating systems.
- Nonetheless, some providers continue to express frustration with the challenges posed by MA and the final rule does not allay all of their concerns.
- Provider frustration has led to an appreciable shift in practice – with some hospitals opting to discontinue their participation in MA plans due to the adverse consequences on patient populations.
- Among the final rule's notable provisions, four most important with the determination around prior authorization having raised the most questions and concerns.
- Prior authorization, advancements in quality rating systems, promotion of health equity and applicability of the 2-midnight rule.

"UnitedHealthcare launching national gold-card program." Becker 8-24

UnitedHealthcare will launch its national gold-card program on Oct 1, 2024

(Impacts the prior authorization of services)

- The program will reward **contracted provider group** that **'consistently adheres to evidence-based care guidelines,' according to an Aug 1st policy update**.
- The payer said that details on how to determine whether a provider group has qualified for the programs will be published Sept 1st. Additional details will be available on UHCprovider.com.
- UnitedHealthcare first floated plans for a national gold-card in March 2023 when it also aid it would cut 20% of its prior authorization requirements. The cuts took effect in two phases, the first in Sept 2023 and the second in Nov 2024.

Wow- whose 'evidence-based care guidelines?' Many payers have hired companies to determine what is appropriate for certain dx. Then they declare: Evidence based says this is not appropriate for __ based on the payer's specific 'evidence-based."

Little Northwest History:

- This has been done in the past by other payers- mostly directed at the provider offices and their request for simple dx testing-especially MRI
- If they found the provider (EX: BX) history of adhering to BX's coverage issues, then they had a reduction in requests for prior authorization.
- Did it really happen? When asked about same issue with hospital with inpatient coverage, they said –no, this only applies to provider offices.

SUPER IMPORTANT: Clearly outline the reason for the higher level imaging- MRI. (ex)

- EX) Neck pain vs xray shows C5-7 collapsing on top of each other, considerable pain.
- EX) Shoulder pain vs xray shows some damage but also 'eye balling' can see the bicep is 'hanging.'

And what else is happening in the payer world?

Court blocks Medicare Advantage broker fee caps. (Becker) OVERTURNED/NO limits 8-25

- Judge O'Conner /Texas judge put a 'pause' on the implementation of the CMS regulations capping the amount Medicare Advantage companies can pay their brokers that sell their plans.
- In April, CMS issued a final rule capping the total compensation MA plans can pay brokers at $611 for a new member, and $306 for a renewal. These caps include payments for administrative costs, which were previously excluded for limits.
- CMS raised the compensation limit by $100 to account for the removal of separate adm costs.
- Broker group sued and won/said they will be hurt with the arbitrary cap. It was intended to close any 'loophole' to get higher compensation from the plans and prevent 'anti-competitive and anti-consumer steering incentives.'
- Smaller plans have argued previous broker compensation made it difficult to compete with larger insurers that had a larger budget to pay brokers for enrolling beneficiaries.

Five payers recently fined by states. (Are you reporting them?)

- Payers have faced state penalties in 2024 for slow reimbursement, improper claims denials, or the sale of unapproved products.
- Anthem BCBS Virginia: will pay $3263,000 to settle allegations that it violated state law, including improper denial of claims and incorrect reimbursements
- Cigna was fined $600,000 by Texas in June for failing to comply with multiple independent claims dispute resolution requirement under state law.
- United Healthcare was fined $546,500 by Utah in May for selling unapproved health plans to state residents.
- Molina Healthcare of Washington was fined $100,000 for enrollment and billing errors in March.
- Anthem BC of CA was fined $690,000 in Jan for failure to reimburse providers and members in a timely manner. (Anthem is now Elevance Health/2022)

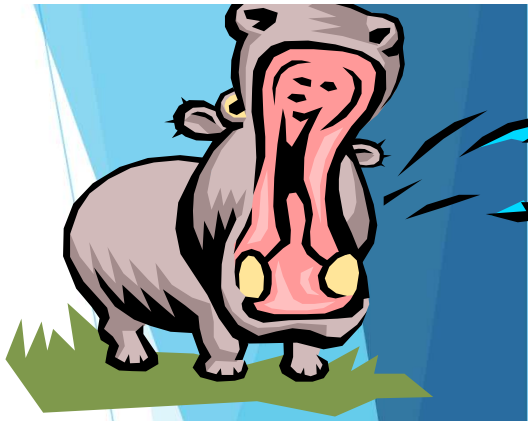
Labor intensive, but it is **critical to track and trend abuse by payer and report them accordingly.**

Now hot in 2025 – A little tiny bit of 'maybe good news' with the MA plans: *"While Adm values the work that MA plans do, it is time CMS faithfully executes its duty to audit plans and ensure they are billing accurately…" June 2025 Becker Payer Issues*

- *"The Trump administration's approach to Medicare Advantage as of May 2025"*
- **1) May, CMS said it plans to audit each of the 500 MA plans for potential overpayments annually.**
- **Currently the agency reviews about 60 plans each year. To support the effort, CMS plans to expand its team of medical coders from 40 to around 2000 by Sept 1st.**
- **United liked. "We look forward to working with CMS to develop an accurate methodology and appropriately using advanced technology to greatly enhance the auditing process."**
- **May, the Justice Department filed a sweeping lawsuit against Humana, Aetna and Anthem/Elevance (all for-profit) and multiple brokers. The Govt alleges the insurers and brokers engaged in a multi-year scheme involving unlawful kickbacks and discriminatory practices against DISABLED MA enrollees.**

- Final rate notice for 2026 keeps in place the 3-yr phase-in of risk adjustment changes from V24 to V28 model. Many MA plans – will result in reduced payments.
- Final rule/April for MA and Part D prescript drug. CMS included measures to streamline prior authorization and increase oversight of supplemental benefits.
- Did not cover weight loss drugs GLP-1 . AUG –YES/4-26 thru Jan 27. designated period. Not final yet.
- Did not finalize rules to place guardrails around how plans can use AI in prior authorization decisions.
- CMS re-branded the health-equity index reward program. Beginning in 2027, the program will be called the "Excellent Health Outcomes for all." The change 'better captures the goal of ensuring exceptional care for all enrollees.- included in Final Rule 2026
- **COMING UP: Lawmakers contine turning their eyes toward MA. Senators have floated including provisions of the "No UPCODE Act" as part of a budget megabill.** The bill, first introduced in 2023, is intended to crack down on improper payments from 'multiple additional code' resources – ie home payer visits with no MD validation. ON HOLD FOR NOW.

Big Audits and Proposed Review "No Upcode Act"- Medicare Adv



- Proposal introduced on March 25th in an effort to find additional ways to reduce the $2.4 Trillion to the national debt over the next decade (CBO). Senate Republicans are looking for cost-saving measures within Federal Health Programs. (This is beyond the huge Medicaid cuts.)
- "There is a lot of concern on Capital Hill about Medicare Advantage" –which is 55% of all Medicare. Legislation introduced, w/bipartisan support – aims to tighten DIAGNOSIS coding regulations and could yield up to $275Billion in savings over 10 years.'
- Humana and United indicated support for increased auditing of accuracy of a NURSING's home visit that adds diagnosis codes without physician involvement and must have any new DX code related to ongoing treatment.
- PUT ON HOLD… No appetite to cut"Medicare". *Will begin AGGRESSIVE MA audits/500 plans, to add 2000 coders/auditors

The proposal seeks to:

A. Use two years of diagnostic data in risk (payment) adjustment, rather than one.

B. Limit use of outdated or unrelated conditions when assessing care costs.

C. Ensure Medicare (Adv) only pays for treatments related to clinically relevant conditions.

D. Align assessment methods between traditional Medicare and Medicare Advantage.

NEW COSTS TO PROVIDERS: Just say NO but be prepared

Ensure there is a contractual limit for # of records that will be sent for any request.

The MAs will continue to have to support their adding of a DX. Payers told: the correct DX codes were submitted with all claims. Use this history to find codes related to relevant care.

More Updates Impacting the Revenue Cycle

- ***"We have heard similar commitments before; CEOs demand action, not promises on Prior Auth." Becker's Hospital July 25***
- Health insurers covering more than 250 M have unveiled a sweeping plan to streamline and reduce prior auth requirements – a long-standing source of frustration and burnout for providers and patients.
- The voluntary reforms, hailed as a modernization effort by payers, aim to accelerate approvals, simplify processes and reduce administrative burdens across commercial, Medicare Advantage and managed Medicaid plans.
- But many hospital leaders argue they have heard promises before. Skeptical that these will have meaningful change.
- Health system CEOs – 'a step in the right direction' but warn that without accountability, the effort could simply accelerate denials or sihft administrative hurdles elsewhere in the revenue cycle. (Lack of trust??)

- ***CMS – Short-stay reviews shift to PrePayment with chance to 'cure a problem; No AI Use. Move from QIOs to MACs, effective Sept 1, 2025.***
- With change to MACs, hospitals may have a better chance of workshopping problems and preventing denials, CMS officials said.
- With the shift from the QIO/Lavinta for short stay (0 to 1 MN stay), the review is under the TPE – Targeted Probe & Education--- Instead of POST payment.
- MACs can help cure a problem during the pre-payment review process—pick up phone and call the site to avoid the denial.
- Determining whether a claim complies with the Two –MN rule won't be left to AI. 'There will be human reviewers. **MACS WON'T use admission screening tools, such as IQ and MCG, in their short-stay reviews**. The MAC will rely on the documentation and clinical expertise to determine if Part A payment is appropriate.
- Request happens after claim submitted but before payment.

More provider and patient challenges

- ***"More than half of patients report health insurance denied drugs and chronic or rare diseases: Poll" Healthcare Dive 8-25***
- The survey also found high rates of alternative funding programs, controversial arrangements in which employers outsource access to pricey specialty drugs to third parties.
- More than ½ of adults with Commercial Insurance were informed by their plan that it would NO LONGER cover their medications for Chronic or rare disease, according to a new survey.
- The poll from healthcare advocacy group, the PAN Foundation, found high prevalence of cost-saving tacti from employers called Alternative Funding Programs/AFP in which plans outsource funding programs, in which plans outsource access to high-cost medications instead of covering them on their own.
- ARPs are frequently targets of advocacy groups as they hinder access to medication. They save employer-sponsored plans money. Pts may have to agree to restrictive terms; delays compared to regular insurance coverage; higher pt liablity.

- ***"Soaring Charity Care grabs hospital leaders' attention." HFMA July 2025***
- **Uncompensated surge. Large hospitals (200 beds or more) have seen big increases in their bad debt and charity care costs since the lull of COVID-19 pandemic.**
- **2022: BD $15.3M Charity $21.4M**
- **2023: BD $16.8M Charity $24.2M**
- **2024: BD $18.1M Charity $27.9M**
- **Full year charity care deductions for hospitals with more than 200 beds SURGED more than 30% from 2022 to 2024 according to Strata Decision Technology data published in HFMA's newsletter.**
- **Meanwhile Bad Debt rose 18% during the same period.**
- **Thought/Kaufman Hall - "So I think the hospitals are continuing to pursue - or aim to collect- on those accounts to a longer degree than they have in the past." Grows the AR.**

Last but not least:
Huge change Aetna is implementing in determination of an inpt.
Medicare Advantage 8-25

https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-august-2025-olu-pdf

- ***Announcement from Aetna.com (Aetna NJ Network)***
- ***"Aetna is not currently pursuing short stay/level of care audits for Medicare Advantage membership that became effective for dates of service Jan 1, 2024 and after." Provider - "There should be no INPT short stay Aetna MA pre or Post payment audits by Cotivit or HMS for DOS after 1-1-24."***
- Aetna provided notice that effective 11-1-25 they will start approving all inpt admissions that encompass at least one midnight. GOOD? Not so fast
- Because what Aetna will do next for those inpt admission is to run the MCG criteria on the case.
- If the case meets MCG inpt criteria, they will pay the hospital at their contracted inpt rate.
- If the case does not meet MCG, they will continue to allow the admission but will only PAY the hospital ' at a lower level of severity rate' comparable to the hospital's observation services.
- This is a devised clever way to get around the Medicare 2 MN rule, which CMS codified 42 CFR 422.101 to require MA plans to follow the same standards as Traditional Medicare. Rather than deny Short inpt stays and allow hospitals the chance to appeal or conduct peer-to-peer reviews, Aetna is opting to approve all inpt admissions that cross at least 1 MN.
- Kicker: **The 835 RA will show the reduced payment as 'payment in full' meaning no denial, no P2P, no appeal rights, no denial letter - JUST a quiet underpayment masked as a Contractual Adjustment.**
- **Tactical steps for hospitals:**
- Alert CFO and Appeal team- Demand a review of Aetna MA contract language. Insist legal counsel weigh in/violates
- Cash Receiving/835 team. Revise software to REJECT auto write-off contractual codes. Force into manual work-Ques
- File complaint with CMS Send to: part_c_part_d-audits@cms.hhs.gov

Thanks to Dr Ron Hirsch for his ALERT! CALL TO ACTION! Thanks to RAC RELIEF for their input. It takes a village!

Letter sent to providers from an eastern hospital association in response to the Aetna announcement. 8-25

- We strongly oppose the new payment policy set to take effect Nov 15, 2025 because it alters how urgent and emergent inpatient hospital admissions are reviewed and reimbursed.
- While Aetna staff say the policy removes initial medical necessity reviews for stays exceeding one midnight and results in fast payments, they fail to mention that it also effectively eliminates the collaborative processes that ensures appropriate patient care and fair provider reimbursement.

Key Policy Changes:

1) Elimination of initial medical necessity review for inpt admissions expected to exceed one midnight

2) Removal of Peer-to-peer (hospital doc to payer doc that is in the specialty) clinical reviews, ending physician –to-physician discussions that often result in case overturns.

3) Use of MCG Criteria, bypassing consideration of the federal 2 MN rule, which bases inpatient status on medical necessity beyond midnight – not solely on Milliman/MCG Guidelines

4) No Pre-Service appeal process before a down grade occurs.

SUMMARY:

Significant effect on 2MN rule cases

Admissions downgraded to obs status without consideration of physician judgement or patient-specific factors.

Loss of current overturns achieved thru P2P, replaced by unilateral determinations that are expected to have a much lower appeal success rate

Risk of "Silent downgrades" to observation payment without formal hospital notification; resulting in reduced hospital reimbursement.

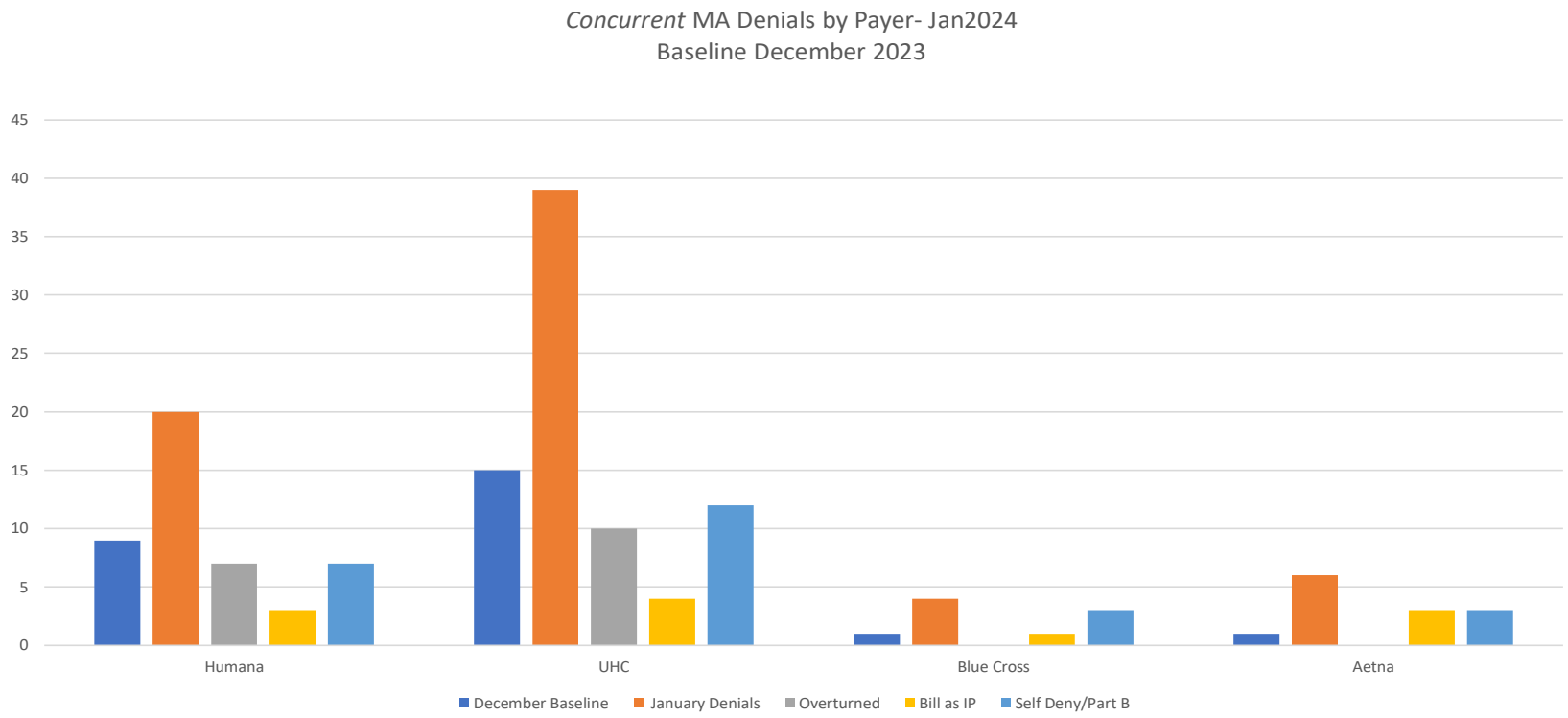
Time to act is now!

A CFO's Analysis of 'Long Length's of stay" with the Medicare Advantage plans. Real CASH opportunities Before 1-24 and post 1-24 Denials for inpt

- As all providers are hoping for a much smoother process to have an inpt approved with the MA plans due to the 1-24 implementation of the 2 MN rule – it is important to have historical information and then track and trend to see success with massive reduction in the long OBS stays.

Analysis of 2023.	Stays over 2MN 140 ADC
Medicare traditional	33 of 165 OBS pts stayed over 2 MN (did not covert to inpt as the 2nd MN approached and the pt needed necessary in-hospital care.)
Aetna MA	26 of 43 OBS patients stayed over 2 MN
BCBS MA	64 of 86 OBS pts stayed over 2 MN
Humana MA	180 of 251 OBS pts stayed over 2 MN
United Healthcare MA	285 of 389 OBS pts stayed over 2 MN
TOTAL MA MARKET	**588 of 934 OBS pts stayed over 2 MN. 63%**

Managed Medicare Status Disputes January 2024



NEW WORLD WITH MA's.

As we all prepare for the implementation of the 2MN rule with the Medicare Advantage plans, it is time to do a refresher of the 2014 2 MN rule for Traditional Medicare. A++ game on.

Know Traditional Regulations with references. Don't shoot from the hip.

WITH 10 YEARS OF NON-AUDITING OF A 2 MN PRESUMPTION STAY/FROM AND THRU DATES ON THE UB/BILLING DOCUMENT FOR TRADITIONAL MEDICARE, IT WILL BE THE FIRST TIME ROUTINE AUDITING CAN OCCUR ON 2 MN PRESUMPTION==FROM THE MEDICARE ADVANTAGE PLANS

BAD HABITS OF CHARTING: COPY FORWARD, COPY & PASTE – WILL BE EVIDENT IN THE NEW MA AUDITING WORLD.

Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**
- "***Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.***

Pg 50959

Key provision for the Exception for the Medicare Adv plans. "Don't have to follow the 2 MN presumption."

- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

Pg 50956

More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)

- 1 midnight after 1 midnight OBS = at risk for inpt **audit but still an inpt.**

Pg 50946

- ..*the judgment of the physician and the physician's order for inpt admission should be based on the* ***expectation of care surpassing the 2 midnights*** ***with BOTH the expectation of time and the underlying need for medical care*** *supported by* ***complex medical factors such as history and comorbidities, the severity of signs and symptoms , current medical needs and the risk of an adverse event.*** *Pg 50944*

Key elements for defining what is an inpt! = Plan!!

STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- After the 1st MN as an outpt – anywhere – or the first MN in another facility and transferred in –
- "The decision to admit becomes easier as the time approaches the 2nd MN, and the beneficiaries in *necessary hospitalization* should NOT pass a 2nd MN prior to the admission order being written.' (IPPS Final rule, pg 50946)
- Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert or discharge. If clinical care is occurring, convert to inpt-no longer obs.
- As the 2nd MN approaches – is there a clinical reason to be in the hospital? Yes = convert to inpt with a PLAN. No= discharge.

"Meeting Criteria" – means Traditional Medicare ?

- It never has and never will mean – "meeting clinical guidelines" (Interqual or MCG/Milliman)
- It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet "Criteria"/Medical necessity not met – this means: Doctor cannot attest to a medically appropriate 2 midnight stay with a plan for 2 MN or additional 2nd MN after a 1st outpt MN– right?
- **11/1/2013 Section 3, E. Note: "It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate"**
- **Hint: 1st test: Can provider attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with PLAN – trumps any Clinical Guideline criteria.**

Wow! Hot off the press – CMS Final rule with regard to Medicare Advantage Prior Authorization, Utilization Management, Traditional Medicare Coverage, etc.
Effective 1-2024 WELCOME TO THE 2 MN RULE, MA plans!!

- On April 5, 2023, CMS issued a final rule /2024 that revises the MA /Part C, Part D , Medicare Cost Plan and Programs of all-inclusive Care for the Elderly (PACE) regulations to implement changes related to:
  - Star Ratings
  - Marketing and Communication
  - Health Equity
  - Provider Dictionaries
  - Coverage Criteria **
  - Prior Authorization *
  - Network Adequacy
  - And other programmatic areas.

- Ensuring timely access to care: Utilization Mgt

This final rule clarifies clinical criteria guidelines to ensure people with MA receive access to the same medical necessary (subjective) care they would receive in Traditional Medicare/TM

CMS clarifies- MA plans must comply with national coverage determinations/NCD and LCD and general coverage and benefit coordination included in TM.

When applicable criteria are not fully established, a MA may create internal criteria based on current evidence in widely used treatment guidelines. Coverage not explicitly when MA use publicly accessible internal coverage criteria IN LIMITED circumstances is necessary to promote transparent, and evidence-based clinical decisions by MA plans that are consistent with TM. Must disclose what was used.

THIS IS THE KEY PIECE OF DISPUTE WITH THE MA DENIALS. Complex medical factors -inpt defined in final 2014 regs.

MA Plans can offer more than Traditional Medicare, not less! ***2024 Final Rule is even more clear.

- 42 CFR 422.101 states:
- "…each MA organization must meet the following requirements:
- (a) Provide coverage of, by finishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare…that are available to beneficiaries residing in the plan's service area…
- (b) Comply with-
- (1) CMS's national coverage determinations
- (2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations…"

- This regulation essentially states that MAO's may not be more restrictive than Medicare FFS/Traditional Medicare.

Now we are live, what is happening when inpts are requested using the 2 MN rule? What type of 2 MN?

- **Denial of inpt request: United**
  - *Determination rationale:*
  - *This determination is based on Medicare and HEALTH PLAN criteria that states **a member must show signs and/or symptoms severe enough to need services that can only be provided safely and effectively on an inpt basis**. Please visit UHC.Provider..com/policies to review the UHC MA Coverage Summary for Hospital Services.*
  - *Based on my review, these criteria may NOT have been met. To help you understand more about this determination, here is my medical rationale:*
  - ***"This patient was admitted to the hospital on 1-9-24 with colitis. We reviewed the provided clinical information based on traditional Medicare and health plan criteria for inpt admission.***
  - ***Our findings indicate that this stay does not meet criteria for inpt admission. The medical record does not document COMPLEX FACTORS that support an inpt admission is reasonable and necessary..***
  - ***The reason is a 3-week hx of diarrhea with colitis noted on CT abdomen. CDiff negative. Responded to ER initiated ceftriaxone . No dehydration or electrolyte imbalance deny. Consequently, the admission does not meet criteria for inpt stay."***

- **Denial of inpt request: Humana**
  - We denied the medical services/items . The request for inpt hospital level of service of care to be covered does not meet the requirements for approval. (Directed toward the pt)
  - Humana has reviewed this request against its Inpt Hospital Medical Coverage Policy which can be found at www.humana.com/coverage policies, which includes the inpt admission criteria as outlined by CMS.
  - In order for an inpt hospital admission to be appropriate for coverage under Medicare Part A, CMS requires that the admiitting physician **have a reasonable expectation that the pt requires medically necessary hospital care that crosses 2 MN, based on complex medical factors supported by the medical record documentation.**
  - **The information in the medical record documentation does not** support the admitting physician's expectation , based on COMPLEX MEDICAL FACTORS, that your hospital stay will require 2 or more MNs.
  - ***"Our physician reviewed your records, and they show you were admitted to the hospital with trouble breathing because of a lung problem (COPD-Chronic Obstruction Pulmonary Disease). You were evaluated for blood tests and pictures of your chest. You were treated with breathing medicine and medicines in your vein that fight infection and inflammation. Your records do not show that you have the complex medical conditions to support an inpt stay.***

Additional MA payer denials for inpt. Wow!

Aetna: A decision denying coverage. 4-6-24

"A physician with expertise in the field of medicine or health care that is appropriate for the services at issue reviewed the request taking account of appropriate coverage and benefit criteria, whether the requested item or service is reasonable and necessary as defined by Medicare, the Aetna policy stated below (speaks directly to clinical guide criteria) and the member's complex medical factors.

Denied for the below reasons: (A full page of narrative speaking to Medicare's rules; regs listed in many areas). "We used Medicare guidance and Aetna Supplemental guidance and Aetna Supplemental guidelines for General Recovery Care, Body System General Recovery Guidelines, Systemic or infections condition. (It goes on to outline all the 21 factors for coverage. Stating: The patient does not meet any of these factors.

NO REFERENCE TO THE 2 MN RULE other than to list the 42 CFR

Humana- Denial of Medical Coverage 4-8-24

"Humana has reviewed this request against its Inpatient Hospital Services Medical Coverage Policy which can be found at www.Humana.Com/coveragepolicies which includes the inpt admission criteria outlined by CMS.

"The information in the medical record documentation does not support the admitting physician's reasonable expectation that the pt's care will cross two midnights, **based on complex medical factors that your hospital stay requires two or more midnights."**

'Your records do not show that you have the following signs, symptoms, comorbidities, complex medical condition or other factors that would require treatment in the inpt setting such as: (Lists 5 items –Their own clinical guidelines.)

"Based on the documentation provided, the request for an inpt **level of care is NOT MEDICALLY NECESSARY.**

You did not appear to have complex medical factors that would require a prolonged workup and tx in the hospital to support a reasonable expect you would require medically necessary hospital care that spans 2 MN.

NO REFERENCE TO THE 2MN RULE other than to list it as reference.

More MA Denials. *What about 2 MN benchmark? 1 outpt MN = 1 more = 2 MN inpt. All same complex medical factors but as the 2nd MN approaches..new plan for why 2nd MN is clinically necessary 'in-hospital' and convert*

United Healthcare 2-27-24

"This is a follow-up to an inpt admission. Based on the clinical information provided, the member may not meet the criteria for an inpt stay."

"This determination is based on Medicare and health plan criteria that states a member must show signs and/or symptoms severe enough to need services that can only be provided safely and effectively on an inpt basis. Please visit UHCProvider.com/policies to review the UHC Medicare Advantage Coverage Summaries for Hospital care."

This pt was admitted to the hospital on 2-20 with erythema intertrigo. We reviewed the provided clinical information based on Traditional Medicare and health plan criteria for admissions. **The medical record does not document complex medical factors. The reason is patient had a clinical condition as indicated by the need to establish a dx and tx in a lower level of care."**

NO REFERENCE TO THE 2MN rule..Not even as a reference.

United Healthcare 3-12-24

Same two initial statements. Part of template for all denials of inpt.

Still referencing Medicare Criteria but no mention of the care requiring a 2 MN or a 2 MN benchmark.

Short and sweet with the rationale:

'This pt was admitted to the hospital on 3-8-24 with cerebral infarction unspecified. We reviewed the provided clinical information based on Traditional Medicare and health plan criteria.

"Our findings indicate that this stay does not meet criteria for an inpt admission. The medical record does not document complex medical factors that support an inpt admission is reasonable and necessary.

"The reason is member stable and not hypoxic." Nothing more!

NO REFERENCE TO THE 2 MN RULE – not even as a reference.

CMS Contacts for Regions 1-10 (7-21)

File complaints – squeak – with excellent examples of abuse. IT CANNOT BE FOR A PAYMENT/CONTRACTUAL ISSUE
Will require the provider try to work it out with the payer first. Then file.. NOT FOR MA ISSUES /New one 8-24

Region 1	Robosora@cms.hhs.gov	CT, ME, MA, NH, RI, VT
Region 2	Ronycora@cms.hhs.gov	NJ, NY, Puerto Rico, Vir Islands
Region 3	Rophiora@cms.hhs.gov	DE, Dis of CO, MD, PA, VA, WV
Region 4	Roatlora@cms.hhs.gov	AL, FL, GA, KY, MS, NC, SC, TN
Region 5	Rochiora@cms.hhs.gov	Ill, IN, MI, MN, OH, WI
Region 6	Rodalora@cms.hhs.gov	Ark, LA, NM, OK, TX
Region 7	Rokcmora@cms.hhs.gov	IA, KS, MO, NE
Region 8	Roreaora@cms.hhs.gov	CO, MT, ND, SD, UT, WY
Region 9	Rosfoora@cms.hhs.gov	AZ, CA, HI, NV, Pacific Territories
Region 10	Rosea_ora2@cms.hhs.gov	AK, ID, OR, WA

But what if the MA plans are not complying as outlined by the law or as interpreted by the provider? What recourse does the provider have?

- **American Hospital Association/AHA**, letter to CMS, Oct 13, 2023 (references a previous letter on MA issues in Aug 22 and Feb 23)
- "We urge the Agency to rigorous oversight to enforce the policies and safeguards included in the rule and to ensure that appropriate action is taken in response to any violations." Providers/many examples
- CMS is prohibited from doing intervention with Contracting Payment issues.
- A) MAO are retroactively reviewing inpt stays that received prior auth citing that they are NOT doing so as a medically necessary audit but rather under a SHORT STAY audit that is performed on any Medicare stay that is less than two days. We understand that the 2 MN presumption does not apply, but the criteria by which the plan is required to review the inpt stay (specifically the 2 MN rule)- NOT THE CRITERIA OF A SHORT STAY POLICY OF THE PLAN's OWN MAKING!
- Focus on the payers – known bad actors.
- Presents Recommendations: Data collection & reporting, Routine auditing, Pathways to report suspected violations, Enforce penalties.

- B) In other cases, the terminology stating that denials of inpt care are **PAYMENT REVIEWS**, and not level of care reviews, medical necessity audits or organizational determinations – even when the audit is EXPLICITLY evaluating whether the inpt level of car was appropriate and results in care delivered being downgraded to observation status and payment.
- A 3rd party vendor, for a short stay audit-noting that they were conducting a '**payment integrity administrative review,** not a level of care or a medically necessary review, focused on payment of services.
- **"We urge CMS to issue clarifying directives to MAOs regarding the applicability of the Two-MN rule and the obligations for MAOs to provide PAYMENT for covered services. We also urge CMS to close loopholes in terminology or practice that allow MAOs to deny services or payment in a way that circumvents establish processes for adjudicating adverse organizational determinations."**

Mmillerick@aha.org **No reply as of 11-11-23**

Full report aha.org

Another CMS communication 2024 Oversight

- CMS has sent a memo to all MA plans announcing its plan to use audits to ensure compliance with the new requirements under the 2024 MA final rule. Issued in April, the rule includes new requirements concerning coverage criteria, the use of prior authorization and other utilization management techniques.
- Specific provisions:
  - Prohibit plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria if such restrictions do not exist in traditional Medicare.
  - Requires adherence to the '2 MN Rule' for coverage of an inpt admission
  - Limits plan's ability to apply service restrictions not found in Traditional Medicare.

Beginning in Nov, CMS will conduct strategic conversations w/MA plans to ensure they have a comprehensive understanding and implementing pf coverage criteria. (Thanks, E Sullivan, RAC Relief for sharing)

AHA Member Advisory: "New Medicare Advantage Question and Complaint Process for Provider Organizations." 8-20-24

- A new complaint form has been created with instructions on resolving MA claims issues.
- The complaint form is a cover pg to a password-protected file along with the requested documentation as indicated
- To the new CMS Drug & Health Plan Operations (DHPO) email at MedicarePartCDQuestions@CMS.hhs.gov
- **ALL MA inquiries and complaints from providers thru this centralized email. NEW – not regional CMS offices**
- In addition to the DHPO email, hospitals and health systems may also send complaints ***about inappropriate utilization management criteria or claims processing approaches that they believe do not comply with CMS requirements*** to CMS Part Cand D audit email at: part_c_part_d_audit@cms.hhs.gov
- This may include practices **related to prior authorization concurrent review or retrospective review to deny or downgrade coverage or payment that the provider believes is not permitted under CMS rules.**
- These complain types can be submitted to both the Part C & D Audit and the DHPO emails. Note there is no cover sheets required for Part C & D Audit email submission.

For CMS to act upon cases submitted thru the new email, the provider must:

- Include all information and documentation requested on the cover pg.
- Refrain from providing additional info not requested on the cover pg.
- Certify that an effort was made to resolve the issue with the MA plan before contacting CMS.
- CMS reminds providers that its role is not to determine medically necessity or payment amounts for disputed cases, CMS will seek to identify trends in provider complaints to investigate and address broader issues with MA plans where appropriate.
- Determine to add to CMS's Complaint Tracking Module.
- As appropriate – be sure to reference 42 CFR 422.101 (b) (2) and 42 CFR 412.3. (2 MN rule)

Now what is the Revenue Cycle Leadership's Strategy for each of the multiple areas?

Brainstorm as a group and report back so we can learn together

- Ideas for preparing for _____ . New issue
- Current strategies for _____.
- Ongoing challenges with _____ and strategies taken to 'take your power back"

Our Healthcare Revenue Cycle Family is Strong..just getting tired…

Thank You for Joining Us in this Educational Journey

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