Charles N. Kahn III
President and CEO

December 11, 2024

Via email

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: Provider concerns with out-of-network MA appeals

Dear Administrator Brooks-LaSure:

We are writing to alert you to operational details regarding the reconsideration of out-of-network Medicare Advantage appeals and to urge the Center for Medicare & Medicaid Services (CMS) to take prompt action that will ensure transparency, accountability, and accuracy in the reconsideration process through MAXIMUS, the Part C Independent Review Entity (IRE), and promote full coverage of Medicare benefits for Medicare Advantage (MA) enrollees.

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH continues to commend recent efforts by CMS to ensure that MA enrollees receive full coverage for Medicare-covered items and services, including the key reforms and clarifications in CMS's 2024 Policy and Technical MA Final Rule "designed to prohibit MA organizations from limiting or denying coverage when the item or service would be covered

under Traditional Medicare."[1] Despite these clarifications and associated accountability and transparency measures, however, providers continue to report issues with access to Medicare coverage and the resolution of appeals involving out-of-network MA benefits. In particular, our members report deficiencies in the transmission of out-of-network appeals to MAXIMUS that could be addressed with appropriate transparency measures, as well as cases where the IRE has not fully applied Medicare fee-for-service coverage and payment criteria to these appeals. The FAH therefore urges CMS to work with MAXIMUS to implement operational improvements that allow the prompt detection and amelioration of MA organizations' deficiencies in the reconsideration process and to provide MAXIMUS with appropriate guidance on the requirement that Medicare basic benefits be provided by MA organizations consistent with Medicare fee-for-service coverage criteria.

Following an adverse organization determination, an out-of-network provider may initiate an appeal by seeking reconsideration by the MA organization. For hospitals, the vast majority of these cases represent emergency department patients that are treated and often admitted for stabilization. If the MA organization affirms its adverse organization determination at this first level, the reconsideration is automatically elevated for review and resolution by an independent, outside, CMS-contracted entity, which is MAXIMUS. 42 C.F.R. § 422.592(a). As part of this process, MA organizations are obligated to send a written explanation and the entire case file to MAXIMUS for reconsideration, *id.* at § 422.590(a)(2), (b)(2), (e)(5). This case file would include the evidence and allegations of fact or law previously submitted to the MA organization by the provider as a party to the reconsideration. *Id.* Further, section 422.562(d) incorporates appropriate provisions of 42 C.F.R. Part 405, which in turn provide an opportunity to submit evidence and be satisfied that the case record is complete. *See* 42 C.F.R. § 405.966 (permitting a provider to present evidence both at the time of and after filing a request for reconsideration); 42 C.F.R. § 405.968(a) (an IRE reviews the evidence and findings upon which the initial determination and redetermination were based, including any additional evidence the parties submit at the IRE Reconsideration stage). These regulations are designed to ensure that MAXIMUS can undertake the reconsideration with a fulsome record that appropriately presents the provider's reconsideration request and evidentiary record.

In practice, however, the case file is directly transmitted by the MA organization to MAXIMUS without copying the provider, and providers do not otherwise have access to the reconsideration portal for an appeal, such that the provider has no opportunity to detect and cure any gaps in the transmitted appeal and record. Manuals describe a process in which the MA Plan is wholly responsible for submitting the case file to the IRE, while the provider cannot see these submitted case files or upload their own.[2] As a result of this operational reality the IRE may

[1] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120, 22,187 (Apr. 12, 2023).

[2] CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance § 50.12 (Nov. 18, 2024), *available at* https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf (the MA plan submits the entirety of the case file directly to the IRE); Maximus Medicare Health Plan Reconsideration Process Manual § 6.3.3 (Nov. 2022), *available at* https://www.medicareappeal.com/sites/default/files/Documents/New-Manual-November-2022_FINAL002.pdf (articulating opportunities for enrollees and their representatives, but not providers appearing as parties in a case, to submit additional information to the IRE case file).

unwittingly make reconsideration determinations based on an incomplete record, risking erroneous determinations. Additionally, there is no transparency into the timing of the MA plans reconsideration and submission of the appeal to the IRE – leaving providers in limbo for sometimes months at a time. This in turn increases the costs and burdens for out-of-network providers seeking appropriate payment for the covered benefits they furnished and for the Office of Medicare Hearings and Appeals, which must process appeals that should have been appropriately resolved on reconsideration at the IRE.

The FAH believes that these issues can be appropriately addressed through straightforward transparency and accountability measures that would facilitate the smooth operation of the reconsideration process in accordance with the appeals scheme laid out in CMS's regulations. In particular, providers should be copied on all reconsideration communications between the MA organization and the IRE and should be provided with access to the case file on the MAXIMUS appeals portal and the ability to address gaps in the case file. Transparency on its own will create appropriate incentives for MA organizations to carefully and faithfully transmit the case file, and to the extent that any gaps remain even with this transparency measure, providers would have some opportunity to detect and cure the issue so that the IRE has the benefit of the complete case file—as required by CMS regulations—when making its determination.

Finally, providers report issues with the failure to fully apply Medicare fee-for-service (FFS) payment and coverage criteria in reconsiderations by the Part C IRE. Because out-of-network providers are guaranteed the FFS rate for MA covered services pursuant to 42 C.F.R. § 422.214(b), Medicare FFS coverage and payment requirements apply with unique force to out-of-network MA services. MA plans, however, often deny inpatient level of care for services that would have been covered and paid as inpatient based on the Two-Midnight Rule, Inpatient Only List, and case-by-case exception policies, notwithstanding the MA's financial liability for such services under 42 C.F.R. § 422.113(b) and (c) or otherwise. Additionally, plans often inappropriately downgrade DRG assignments, even though FFS Medicare would pay the assigned DRG following general coding guidelines supported by the medical record. Our members have reported challenges where the FFS coverage and payment criteria are not applied in appeals involving out-of-network emergency, post-stabilization, or other covered care. Whether this a problem with the information the plans are providing the IRE, or whether MAXIMUS is not fully applying the FFS criteria, is unclear.

With the 2024 amendments to 42 C.F.R. § 422.101(b)(2), CMS has clarified that MA organizations must comply with general FFS Medicare coverage and benefit conditions included in, whether those criteria are characterized as Medicare coverage or payment criteria. The regulation makes the application of this requirement to inpatient hospital benefits plain and explicit by requiring compliance with the payment criteria for inpatient admissions at 42 C.F.R. § 412.3. The 2024 Policy and Technical MA Final Rule, including amended 42 C.F.R. § 422.101(b)(2), promotes equitable beneficiary access to basic Medicare benefits, as required under section 1852(a)(1) of the Social Security Act. Following publication of the 2024 Final Rule, CMS has undertaken to further educate MA organizations regarding their coverage obligations, including by publishing "Frequently Asked Questions related to Coverage Criteria

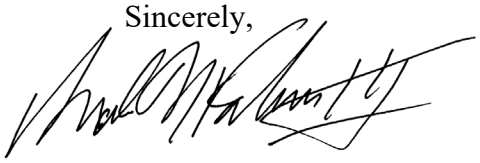
and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)"[3] for Medicare organizations through CMS' Health Plan Management System. At this time, however, the FAH is not aware of any targeted guidance provided to CMS' Part C IRE.

To promote consistent application of Medicare coverage criteria consistent with section 422.101(b)(2), the FAH urges CMS to issue guidance and educational materials directly to MAXIMUS as the Part C IRE instructing them to apply FFS coverage and payment rules for out-of-network services and appeals. In particular, such guidance should address the criteria for inpatient admissions, which include the two-midnight benchmark (§ 412.3(d)(1)), the case-by-case exception (§ 412.3(d)(3)), and the inpatient only procedure rule (§ 412.3(d)(2)).

****

The FAH appreciates the opportunity to share our concerns on this important issue to providers and the Medicare Advantage patients we serve. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,



cc: Dr. Meena Seshamani, M.D., Ph.D., Deputy Administrator and Director, Center for Medicare
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Cheri Rice, Deputy Director, Center for Medicare

[3] *Available at* https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-2-february-5-9 (Feb. 6, 2024).