Guidance on the MA Prior Authorization Tool for Skilled Nursing Facilities

Background

Despite playing a critical role in the care continuum, Medicare Advantage (MA) plans reduce beneficiaries' access to Skilled Nursing Facilities that are covered under traditional Medicare (TM). Prior research has shown that MA enrollees are less likely to use institutional post-acute care (PAC) than TM beneficiaries, raising concern that this difference in institutional PAC use may reflect barriers in access to PAC faced by MA beneficiaries.

Over the years, we have shared critical feedback with the Centers for Medicare & Medicaid Services (CMS) on MA's prior authorization processes and have documented prior authorization denials erroneously preventing Medicare beneficiaries' ability to access medically necessary and appropriate post-acute care. On April 5, 2023, CMS issued its Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs Final Rule (CMS-4201-F). This rule took significant steps towards ensuring timely access to care.

Effective January 1, 2024, the agency implemented this final rule which amended regulatory language and clarified that MA plans are required to comply with general coverage and benefit conditions included in TM statutes and regulations. CMS further clarified that under the rule, the prior authorization processes can only be used to confirm the presence of diagnoses or other medical criteria that is the basis for coverage of a certain item or service or ensure an item or service is medically necessary. And in addition, prior authorizations are required to cover a "course of treatment" with the goal of reducing the need for constant re-authorization requests for the same episode of care.

Request

We invite you to participate in this initiative to track MA prior authorization denials. We will not attribute the information to your SNF(s). We ask that you report monthly MA data in one of the spreadsheet tabs described in more detail below.

Your answers will help us assess the extent to which SNFs have benefited from the final rule (CMS-4201-F) and will be shared with policymakers to advocate for further Medicare Advantage reforms and to ensure beneficiaries' access to post acute care.

Overview of Medicare Advantage Plans Pre-Service Authorization Appeals Process

Most Medicare Advantage (MA) plans require post-acute care (PAC) services to be authorized prior to the service being provided. The Centers for Medicare & Medicaid Services (CMS) provides an appeal process for MA enrollees and their providers to challenge denial of services decisions. The appeal process consists of the following steps:

(1) Initial Determination – Request Pre-Service Authorization for Patients
(2) Peer-to-Peer Conversation (Optional) (Part of the Initial Determination)
(3) Level 1 Appeal – Request Reconsideration by the MA plan
(4) Peer-to-Peer Conversation (Optional)

(5) Level 2 Appeal – External Review by the Independent Review Entity (IRE). This appeal is automatic; the MA plan must transmit the entire case to the IRE within 24 hours of an MA plan upholding its denial during the Level 1 Appeal process.

This data tool collects information on MA prior authorization and re-authorization (also known as concurrent review) denials and level 1 appeals.

Step 1. Initial Determination

First, an MA plan will make an organization determination ("initial determination") to either allow or deny services at a skilled nursing facility after submission of a request for pre-service authorization for the plan member. The plan member, their representative, or the physician can request the initial determination. If the initial determination decision is a denial, the MA plan must submit in writing to the plan member the reasons for the denial and information on how to appeal the denial. After the initial determination decision to deny has occurred, a plan member and/or the attending or treating physician can appeal the decision. The physician who would be treating the patient at the SNF ("treating physician") may appeal the decision.

Step 2. Peer-to-Peer Conversation (**Optional**)

A conversation between a physician representing the patient and a physician representing the MA plan regarding the medical necessity of sending the patient to the SNF. This may be arranged as part of the initial decision, but may also take place as part of the Level 1 Appeal. **This step is optional and may or may not occur during your appeal process. We do not collect any information related to the peer-to-peer conversation in this tool.**

Step 3. Level 1 Appeal

The Level 1 Appeal is an appeal to the MA plan to reconsider its initial decision. Information on how to initiate this step should be included in the Notice of Denial of Medicare Coverage (NDMC)/Integrated Denial Notice (IDN), but it is best to submit a written request.

The decision timeframe for a standard Level 1 Appeal is 30 days. However, an expedited Level 1 Appeal only takes 72 hours. It is best if a physician signs the appeal letter and requests an expedited timeframe (72 hours). This can be the attending physician who would be treating the patient. If an MA plan agrees with the patient's appeal, the patient will receive a notice of a decision change. If the plan makes a determination against the patient, either fully or partially, the appeal must be automatically sent to the IRE as a Level 2 Appeal. The patient will receive a written notice if the appeal moves up to Level 2, but the MA plan will usually tell the proposed service provider if the Level 1 Appeal is denied.

Step 4. Level 2 Appeal

The Level 2 Appeal is a review by CMS' Independent Review Entity (IRE) to decide if the MA plan made the correct decision. The beneficiary will receive a written Reconsideration Determination with the IRE's decision. When a decision letter is sent to the beneficiary:

- If the IRE disagrees with the MA plan (overturns the plan's denial), then the IRE will send a letter to the beneficiary and a letter to the health plan telling the health plan to authorize and pay for the service,
- If the IRE agrees with the health plan (upholds the plan's denial), then the letter includes instructions on how to further appeal the decision.

We do not collect any information related to Level 2 Appeals in this tool.

Submitting Data through the MA Prior Authorization Tool for Skilled Nursing Facilities (SNFs)

What data are we asking for. We are asking our members to submit data on prior authorization and re-authorization requests and appeals for one month of 2024 (i.e., June, July, August) but would be happy to accept additional months, if you are able and willing. This will provide us with a snapshot of how the prior authorization and re-authorization processes and corresponding appeals play out monthly in post-acute care.

Why are we asking for this data. LeadingAge along with its Post-Acute Care(PAC) Coalition partners committed to work with CMS to ensure MA plans are following the new rules related to prior authorizations. Each participating post-acute care association is seeking similar data from their members so we can identify continuing issues and trends related to beneficiaries' access to care and provider burden resulting from these authorizations. We know that this is extra work but also believe this data is critical to help us advocate for changes to MA policies related to prior authorizations including minimizing the administrative burden of this process.

How the data will be used. First, the data you submit will be aggregated by provider type, filtered by plan and/or state and we will report out trends. We will not share organizational level data publicly. Nonetheless, we request that you very carefully review all data to be submitted to ensure no personal health information (PHI) or personally identifiable information (PII) is included in your submission. We will not be able to accept spreadsheets with this information included.

How to approach submitting your data. As a SNF admission progresses through the MA prior authorization process, person-level information can be captured in a log and recorded in the Claims log and then rolled up to the plan level (see "Claim Log" tab for an example). Our goal is to aggregate this data to the MA plan level reported by month. **Individual cases which do not meet your internal criteria for admission should not be included in any counts in this document.** Below we explain the two ways you can report this data to us.

First, we ask all providers to complete the "Organizational Contact Info" tab in the spreadsheet. While LeadingAge will not be sharing organizational level data with policymakers or other outside groups, it will help us to know a little bit about your SNF including the state where services are provided and who to contact if we have questions about the data.

Next SNFs can select from two ways to submit your data to LeadingAge, based upon what is easiest for your organization:

1. **Claims Log Tab –** This data submission option allows the SNF organization to enter each authorization request and its outcome for a person in your care for a given month. We are looking for a snapshot of what happens in one month for those MA enrollees in your SNF. You are welcome to submit more than one month of data. Therefore, this data is more at the individual level but the preferred approach for conducting analysis on the data.

   By submitting this data, LeadingAge will be able to calculate how long it is taking for decisions to be made by plans, how many re-authorization (concurrent review) requests you must submit in a month and for a particular individual, how many days are approved initially and for the re-

authorizations, the main reasons for denial and what happens at that initial level 1 appeal level. In addition, we will be able to examine if there are differences among plans or states. This data will show us where additional regulatory policies are needed and assist us in our Medicare Advantage reform advocacy efforts. Below is an explanation of what information is sought for each cell in the spreadsheet.

Step 1. Click on the Organizational Contact Info tab and complete the following information.

Organization/Provider Name
State(s) for which data is reported (Ideally, please submit data separately for each state)
How many SNFs are represented in this datat?
How many SNF beds are represented in this data?
Contact name for data submission
Contact email for data submission

Step 2. If using the **Claims Log tab**, click on this tab and then please go to the top of the spreadsheet and select the month (from the drop-down list) for which you are submitting data.

Note: Data highlighted in yellow on the spreadsheet are examples of how one should approach completing the spreadsheet.

Step. 3. Then follow the instructions below to fill in the requested data for each cell in the spreadsheet on the Claims Log tab. This can be done throughout the month as authorization requests are made. Or if you have all of this data from a prior month, it could be entered all at one time.

Field Name	Description
Unique ID	This number refers to a single patient but does not include protected health information (PHI) or personally identifiable information (PII) such as a social security number
Medicare Advantage Plan	Here you enter the name of the Medicare Advantage or Special Needs Plan that the individual is enrolled in. Full name is not required. For example, enter United Healthcare instead of the full plan name for AARP Medicare Advantage from UHC. If you don't know the parent organization, the plan name can be entered
Authorization Type	You will select from a drop-down menu to indicate whether this is the initial prior authorization request to initiate services or if this request is to continue care and services, referred to as a re-authorization or concurrent review.
Date Authorization Requested	This is the date you or the hospital/physician submit a request for prior or re-authorization for SNF care.

Date Authorization Decision Received from the Plan	This is the date you or the requesting entity received a decision to approve or deny the requested SNF services.
Plan Authorization Decision	Enter whether the plan approved or denied the request for SNF services.
Denial Reason	There is a drop-down menu of the most common reasons provided by the MA plan for denying the authorization request from which you can select.
Number of Days Authorized	If the authorization was approved, enter the number of SNF days the plan approved.
Level 1 Appeal Decision	If the authorization request was denied and then was resubmitted to the MA plan for reconsideration, was the original plan decision to deny care upheld or overturned upon appeal. Only complete this if the original decision was denied and a level 1 appeal was sought.
Admission Status	For initial prior authorizations, enter whether the individual was admitted to your SNF or not admitted. For-re-authorization (concurrent review) requests, indicate whether care continued or the person was discharged.
Provider Notes Claim Denied Post-Discharge	DO NOT INCLUDE ANY PHI/PII. This is an optional area where you can provide additional brief comments about the situation. This is not required. If you know at the time of submission, let us know if the claim for these approved services was denied after the person was discharged.

Step. 4 Review your data to ensure no PHI or PII is included. We ask that prior to submitting your monthly data on MA plan authorizations that you review the data that has been entered and remove any PHI or PII prior to sending to LeadingAge.

Step. 5. Submit your data. Once you've completed one of the tabs for a given month, please email your data to Nicole Fallon at LeadingAge at: nfallon@leadingage.org .

2. **Monthly Summary:** The second option for submitting data is to complete the tab entitled, "Monthly Summary." This may work best for organizations who already have monthly reports that track individual prior authorization and re-authorization requests information and therefore, can easily provide summary data for a given month.

   In this case, we ask organizations to report the following information at the Medicare Advantage Organization level, which means all individual plans that are under Aetna, Humana, United Healthcare, or a regional plan, would be included in a single line.

   Step 1. Click on the **Organizational Contact Info tab** and complete the following information.

Organization/Provider Name
State(s) for which data is reported (Ideally, please submit data separately for each state)
How many SNFs are represented in this datat?
How many SNF beds are represented in this data?
Contact name for data submission
Contact email for data submission

Step 2. If using the **Monthly Summary tab**, click on this tab and then please go to the top of the spreadsheet and select the month (from the drop-down list) for which you are submitting data.

Note: Data highlighted in yellow on the spreadsheet are examples of how one should approach completing the spreadsheet.

Step. 3. Then follow the instructions below to fill in the requested data for each cell in the spreadsheet on the Monthly Summary tab. This can be done at the end of the month or if you have all of this data from a prior month, it could be entered all at one time.

Field Name	Description
Medicare Advantage Plan	Name of the Medicare Advantage plan you contacted for prior-authorization (i.e., United Healthcare, Aetna, etc.)
Total Number of Initial Prior Authorizations Requested	In this month, enter how many prior authorizations were sought on behalf of individuals in your SNF for each MA plan
Total Initial Prior Authorizations Denied	Number of prior authorization requests initially denied by this Medicare Advantage plan
Total Prior Authorization Level 1 Appeals	Number of requests for redetermination (Level 1 appeal) when the initial prior authorization request is denied.
Prior Authorization Level 1 Appeals Denied	Number of denials that remained after request for redetermination (Leve 1 appeal) when the initial prior authorization request is denied.
Admissions	Number of SNF admissions following the prior authorization process
Top Reason for Denial	Select the primary reason provided by the MA plan for the initial denial from a pre-set list
Average number of days approved for Initial Prior Authorization	For this plan, using the claims log, sort the claims for this plan and enter the average number of SNF days approved
Re-Authorizations Requested	Number of re-authorization (concurrent review) requests submitted to this Medicare Advantage plan to obtain approval to continue care and services

Re-authorizations Denied	Number of re-authorization (concurrent review) requests denied by this Medicare Advantage plan
Top Reason for Re-Authorization Denial	Select the primary reason provided by the MA plan for the denial to continue care from a pre-set list
Level 1 Appeals	Number of requests for redetermination (Level 1 appeal) when the re-authorization request is denied.
Level 1 Appeals Denied	Number of denials that remained after request for redetermination (Level 1 appeal) when the re-authorization request is denied.
Average Number of Days Approved Per Re-Authorization	For this plan, what was the average number of days approved for the re-authorizations requested
Discharges Due to Denied Re-Authorization	Number of SNF patients discharges resulting from plan refusal to re-authorize care and/or services
Number of Claims Denied Post-Discharge	Number of claims for authorized services that were later denied for payment by the MA plan.

Step. 4 Review your data to ensure no PHI or PII is included. We ask that prior to submitting your monthly data on MA plan authorizations that you review the data that has been entered and remove any PHI or PII prior to sending to LeadingAge.

Step. 5. Submit your data. Once you've completed one of the tabs for a given month, please email your data to Nicole Fallon at LeadingAge at: nfallon@leadingage.org.

Any questions about the tool or the data request can be submitted to Nicole Fallon at: nfallon@leadingage.org .