

# Medicare Advantage Plans: Recent Tactics and Responses



Idaho Hospital Association

Kim C. Stanger

(9.26)



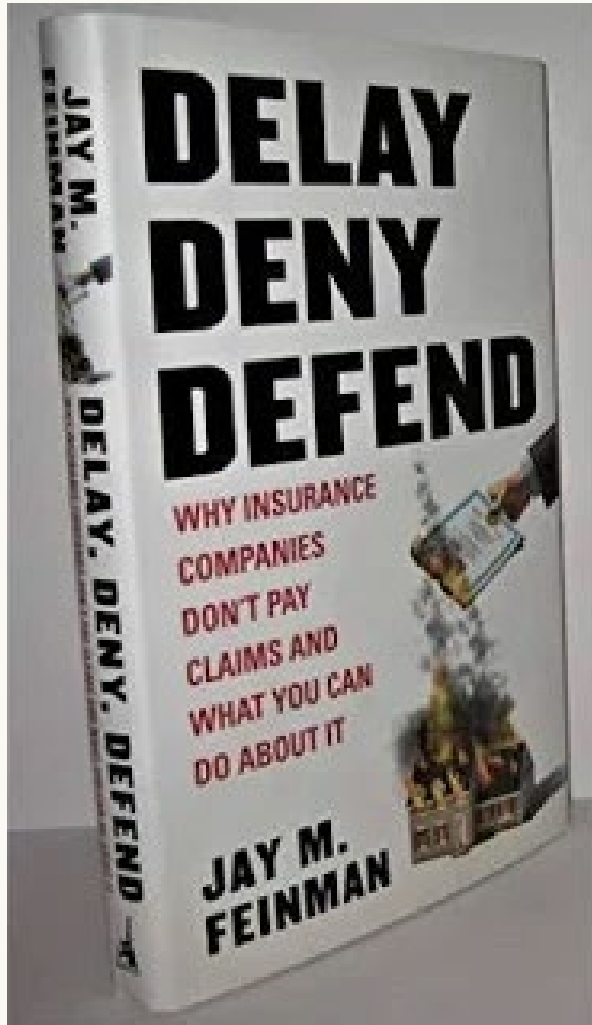
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# Medicare Advantage



- MA plans contract with CMS to provide Part A, B and supplemental coverage for Medicare beneficiaries.
- About 50% of Medicare beneficiaries are enrolled in MA plans.

# Medicare Advantage: Claims Context



- MA plans are paid a capitated rate on member lives; thus, MA plans have incentive to reduce costs to increase profits.
- Uneven playing field:
  - Small savings on numerous claims may result in significant profits for insurers.
  - Administrative hassle and burden on providers may outweigh the benefit of challenging insurers or pursuing claims.
  - Providers are dealing with multiple different payers each with their own requirements, policies, contracts, etc.

# Medicare Advantage: General Rules



- Obligations of MA plan and contracted provider are largely governed by the contract,  
**BUT...**
- MA plans must provide coverage and make payment for all services covered by Medicare Part A and Part B.
  - When MA plans cover and pay for benefits, MA plans must do so in a way that is no less restrictive than traditional Medicare.  
(42 USC 1395w-22(a)(1)(A); 42 CFR 422.101(a))
- MA plans must comply with coverage guidelines issued by CMS for original Medicare.  
(42 CFR 422.101(b))
- MA plans must comply with CMS regulations governing MA.  
(42 CFR part 422)

# Issues to Address

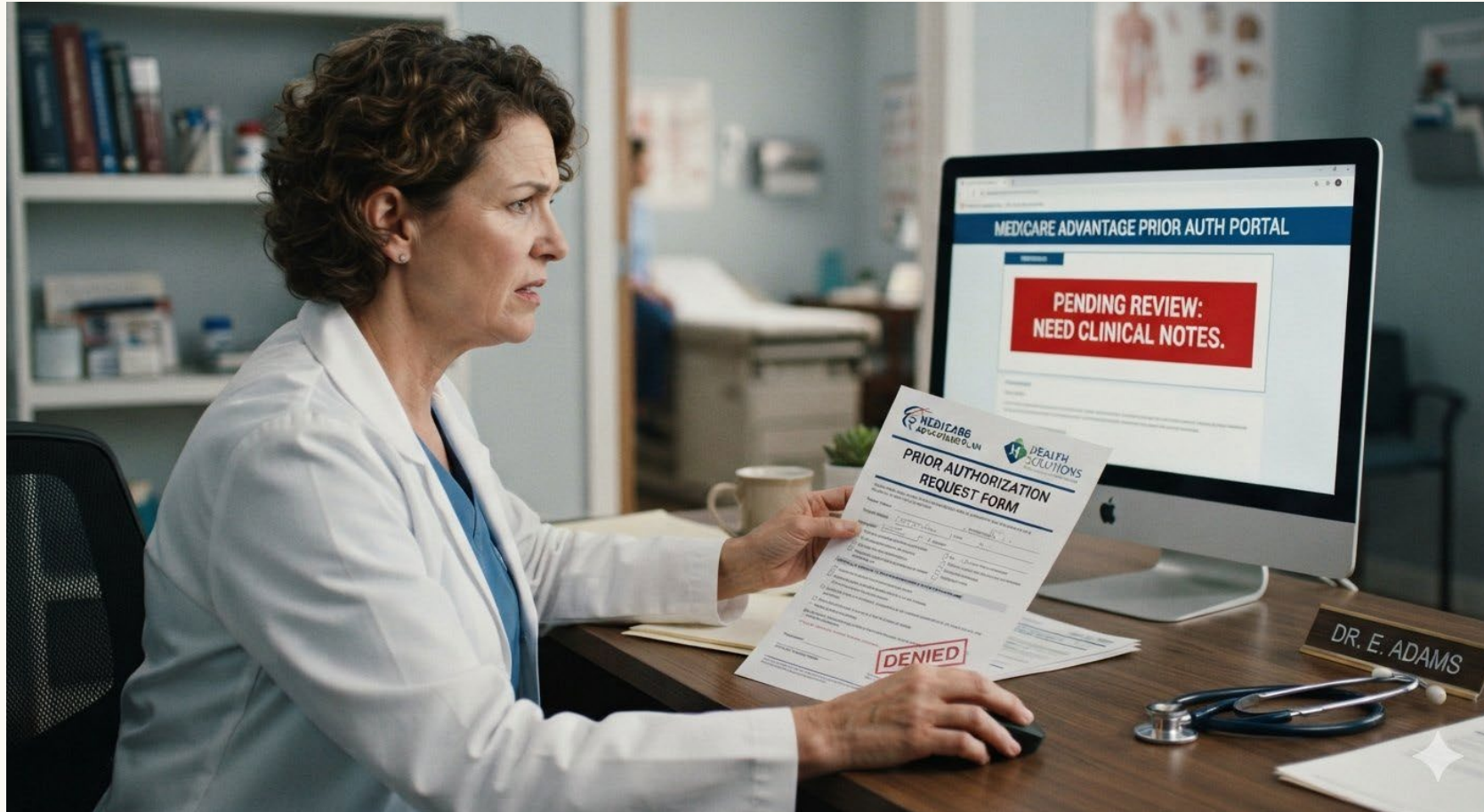
- Prior authorization
- Automatic downgrading or downcoding
- Internal coverage criteria
- AI in claims decisions
- Payment policies to deny or reduce coverage
- Payment delays



## Others:

- Administrative burdens / claims obstruction.
- Appeals obstruction.

# Prior Authorization



# Prior Authorization: Denials

According to Kaiser Family Foundation study published on 1/28/26:

- In 2024, Medicare Advantage insurers fully or partially denied 4.1 million prior authorization requests.
  - Only 11.5% of Medicare Advantage prior authorization denials were appealed in 2024.
  - On appeal, 80.7% of Medicare Advantage denials were partially or fully overturned in 2024.
- “Across all years examined, more than eight in ten appeals overturned the initial denial. These requests represent medical care that was ordered by a health care provider and ultimately deemed necessary but was potentially delayed because of the additional step of appealing the initial prior authorization decision. Such delays may have negative effects on a patient’s health.”

(<https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a>).

# Prior Authorization: Denials

According to OIG Report published in 6/8/26 concerning SNFs:

- 18% of denials were appealed.
- 95% of denials were overturned on appeal.
- Navihealth processes a large number of MAO preauthorizations. Navihealth's denial rate is higher than most other MAOs.
- “MAO's use of prior authorization can in some cases result in denials and delays in access to needed care for enrollees. MAOS that inappropriately deny care are not delivering the full value that taxpayers pay them to provide.”

(OIG Data Brief OEI -09-24-00331, available at <https://oig.hhs.gov/documents/audit/11694/OEI-09-24-00331.pdf>).

# Prior Authorization: MA Plan Pledge (6/25)

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**FOR IMMEDIATE RELEASE**

**June 23, 2025**

**Contact: HHS Press Office**

202-690-6343

[Submit a Request for Comment](#)

Aetna  
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BCBS Association  
CareFirst  
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Highmark Health  
Humana  
Kaiser Permanente  
United Healthcare

## HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System

**WASHINGTON, DC—JUNE 23, 2025**—U.S. Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. and Centers for Medicare & Medicaid Services (CMS) Administrator Dr. Mehmet Oz today met with industry leaders to discuss their [pledge](#) to streamline and improve the prior authorization processes for Medicare Advantage, Medicaid Managed Care, Health Insurance Marketplace® and commercial plans covering nearly eight out of 10 Americans.

In a roundtable discussion hosted by HHS, health insurers pledged six key reforms aimed at cutting red tape, accelerating care decisions, and enhancing transparency for patients and providers. Their commitments reinforce the role of CMS in monitoring outcomes and promoting accountability. Companies represented at the roundtable included Aetna, Inc., AHIP, Blue Cross Blue Shield Association, CareFirst BlueCross BlueShield, Centene Corporation, The Cigna Group, Elevance Health, GuideWell, Highmark Health, Humana, Inc., Kaiser Permanente, and UnitedHealthcare.

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# Prior Authorization: MA Plan Pledge (6/25)

“Participating health insurers have pledged to:

- **Standardize electronic prior authorization submissions** using Fast Healthcare Interoperability Resources (FHIR®)-based application programming interfaces (APIs).
- **Reduce the volume of medical services subject to prior authorization by January 1, 2026.**
- Honor existing authorizations during insurance transitions to ensure continuity of care.
- **Enhance transparency and communication around authorization decisions and appeals.**
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
- **Ensure medical professionals review all clinical denials.”**

(<https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html>).

# Prior Authorization: OIG Compliance Program Guide (2/26)



“MAOs must, at a minimum, provide their members all benefits covered under Medicare Parts A and B.... MAOs’ compliance programs, therefore, should evaluate whether utilization management tools, such as prior authorization, could inappropriately limit or impede access to medically necessary covered services...”

“OIG oversight has highlighted serious concerns about improper denials or delays in care resulting from prior authorization programs.

CMS regulations require that MAOs base medical necessity determinations on the individual patient’s circumstances, including the patient’s medical history, physician recommendations, and clinical notes. MAOs must act timely and ensure specific practice and utilization management standards are met.....”

# Prior Authorization: Regulations

- MA plans may use prior authorizations, but they cannot be used in a way to deny services such that it is more restrictive than traditional Medicare.

(See 42 CFR 422.101)

- Cannot use prior authorization for emergent or urgent services.

(See 42 CFR 422.113)

- If a MA plan approves prior authorization for a service, it cannot later revoke, rescind or deny coverage and payment for that service based on medical necessity criteria.

(See 42 CFR 422.138(c))

# Prior Authorization: Regulations

- “If the MA organization approved the furnishing of a covered item or service through a prior authorization ... or a concurrent determination made during the enrollee's receipt of inpatient or outpatient services, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except [i] for good cause (as provided at § 405.986 of this chapter and § 422.616) or [ii] if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616.”

(42 CFR 422.138(c))

- “If the MA organization approved an inpatient hospital admission under the rules at § 412.3(d)(1) and (3) of this chapter, any additional clinical information obtained after the initial organization determination cannot be used as new and material evidence to establish good cause for reopening the determination.”

(42 CFR 422.616)

# Prior Authorization: Regulations

- “(a) **Establishing good cause for reopening.** Good cause may be established when—
- (1) There is new and material evidence that (i) was not available or known at the time of the determination...; and (ii) may result in a different conclusion; or
  - (2) The evidence that was considered in making the determination ... clearly shows on its face that an obvious error was made at the time of the determination....
- “(b) **Change in substantive law or interpretative policy.** A change of legal interpretation or policy by CMS ... is not a basis for reopening a determination ....
- “(c) **Third party payer error.** A request to reopen a claim based upon a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its system of records or on the claim form does not constitute good cause for reopening.”

(42 CFR 405.986, emphasis added)

# Prior Authorization: CMS Letter (2/24)

**“9. Question: Are plans able to do post-claim audits and deny payment and still be compliant with the effect of a prior authorization or pre-service approval rule at 422.138(c)**

**“Answer: ... 422.138(c) states that if an MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at 42 CFR § 405.986) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616. This means that if the MA organization pre-authorized the inpatient admission, it would be a violation of § 422.138(c) to later deny payment based on a determination that the level of care was not medically necessary.”**

(CMS letter to MA Plans (2/6/24))

**DATE:** February 6, 2024

**TO:** All Medicare Advantage Organizations and Medicare-Medicaid Plans

**SUBJECT:** Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the “[Medicare Program, 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](#)” final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

**1. Question: When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?**

**Answer:** For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at § 422.101(c)<sup>1</sup>; based on the circumstances of each specific individual, including the patient’s medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).

<sup>1</sup> MA organizations must make medical necessity determinations based on all of the following:  
(A) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).  
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.  
(C) The enrollee’s medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.  
(D) Where appropriate, involvement of the organization’s medical director as required at § 422.562(a)(4).

# Prior Authorization: Regulations

- CMS Interoperability and Prior Authorization Final Rule (1/17/24)
  - By 1/1/26, MA plan sponsors must respond to prior auth request—
    - Expedited requests: within 72 hours.
    - Standard requests: within 7 calendar days.
  - By 1/1/27, MA plans and providers must implement FHIR-based APIs for electronic prior authorization.

(42 CFR 422.122 and .568)

- Hospitals and MIPS providers are required to implement electronic prior authorization or face reduced interoperability score.

(<https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/implementation-guides-standards/application-programming-interfaces-apis-relevant-standards-implementation-guides-igs>)

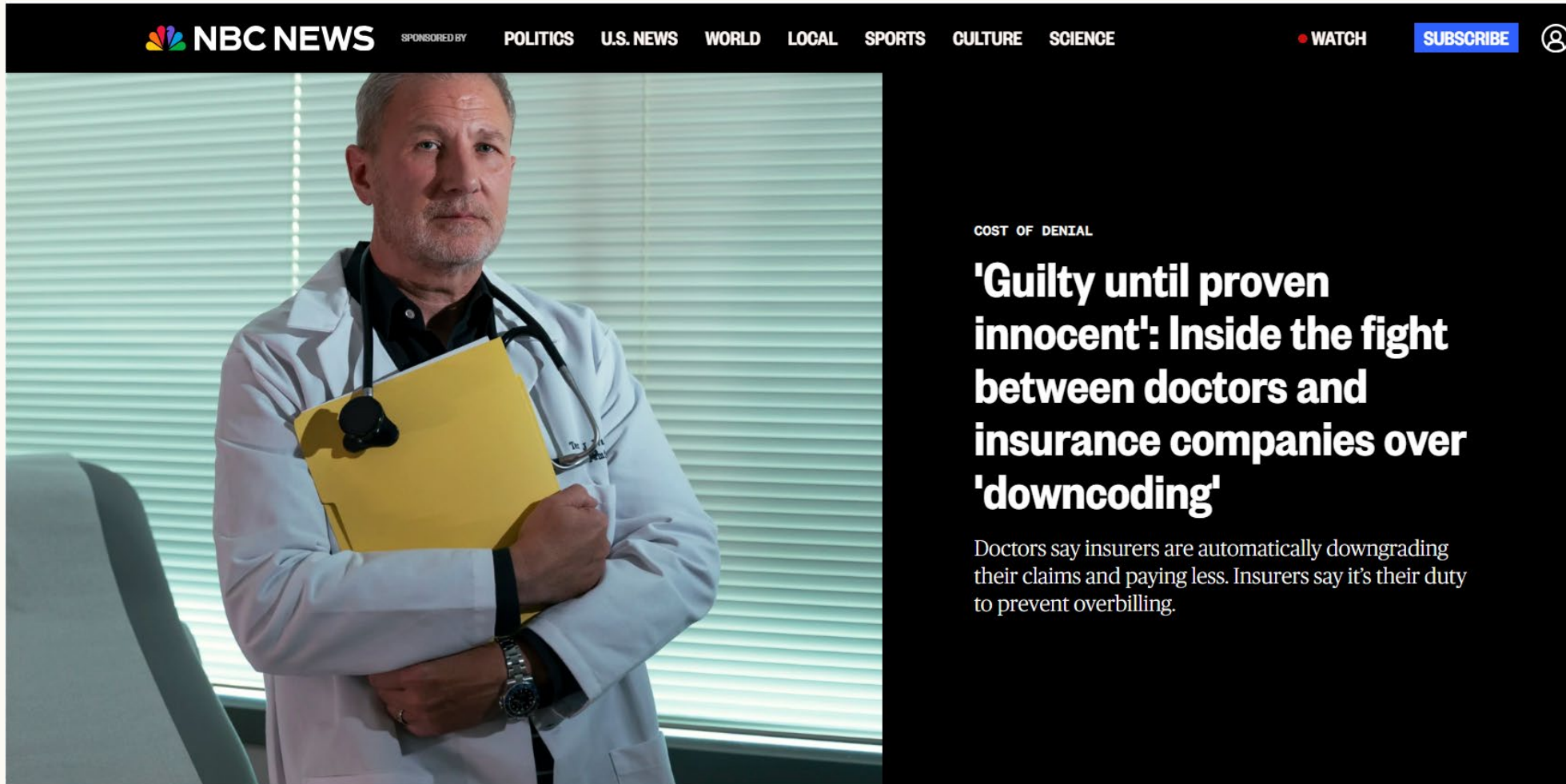
# Prior Authorization: Proposed Legislation

- Improving Seniors' Timely Access to Care Act (HR 3514/S 1816)
  - MA plans must adopt standardized electronic prior authorization process.
  - Timelines for prior authorization decisions:
    - Urgent requests: 72 hours
    - Standard requests: 7 calendar days
  - Once a service is approved, coverage cannot be retroactively denied.
  - MA plans must publish their prior authorization approval/denial rates and resolution timelines.
  - Addresses use of AI in deciding prior authorizations.
- *Bill has very broad bipartisan support.*

# Prior Authorizations: Suggestions

- ✓ Create a robust authorization tracking system that captures authorization confirmations, reference numbers, time stamps and dates, names of plan representatives who granted authorization, method of authorization (phone, portal, fax).
- ✓ Follow up all verbal authorizations in writing immediately; send confirmation to MA plan and retain copy.
- ✓ Challenge retroactive denials aggressively.
- ✓ Document the legal basis for challenges, specifically referencing:
  - 42 CFR 422.101 (coverage requirements no more restrictive than traditional Medicare).
  - 42 CFR 422.113 (prohibition on prior authorization for emergent/urgent services).
  - 42 CFR 422.138(c) (prohibition on retroactive denial after authorization).
- ✓ Track denial rates and overturn rates for use against insurer.
- ✓ Challenge AI-based denials (see discussion below).
- ✓ File complaints with CMS and state insurance commissioner.

# Automatic Downgrading

A screenshot of an NBC News article. The top navigation bar is black with the NBC News logo on the left, followed by 'SPONSORED BY', and then links for 'POLITICS', 'U.S. NEWS', 'WORLD', 'LOCAL', 'SPORTS', 'CULTURE', and 'SCIENCE'. On the right side of the bar are links for 'WATCH', 'SUBSCRIBE' (in a blue button), and a user profile icon. The main content area features a large photo of a middle-aged man with grey hair and a beard, wearing a white lab coat over a dark shirt. He has a stethoscope around his neck and is holding a large yellow folder. He is standing in front of a window with horizontal blinds. To the right of the photo, the article title is displayed in large, bold, white text. Below the title is a short paragraph in smaller white text. The background of the article text is black.

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COST OF DENIAL

## **'Guilty until proven innocent': Inside the fight between doctors and insurance companies over 'downcoding'**

Doctors say insurers are automatically downgrading their claims and paying less. Insurers say it's their duty to prevent overbilling.

# Automatic Downgrading: Evolution of MA Plan Reviews

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- **Post pay review:** payors would pay, payor would audit, and payor would adjust payment if documentation did not support the claim.
- **Prepay review:** payor plan requires documentation to justify claim before payment.
- **Auto downcoding/downgrading:** some payors have begun automatically downgrading claims based on initial claim forms even though claim forms lack documentation necessary to support downgrade, e.g.,
  - E&M codes
  - Inpatient to observation
  - Replacing billed CPT codes with lower-value codes
  - Denying comorbidities or complications
  - Others?

- Maybe using AI or similar algorithms to project likely payment.
- MA Plan may think providers are less likely to appeal if provider is paid something.

# Automatic Downgrading: Example

[Current News](#)

[Archived News](#)

## New resource: Questions & Answers for E/M overcoding program



February 25, 2026

This article is for contracted professional providers caring for our members

As you know, effective for dates of service on or after November 3, 2025, Blue Cross has expanded our pre-payment claims editing to review professional services for evaluation and management (E/M) overcoding. We will assess level 4 and 5 E/M codes to determine if the level of service billed is appropriate for the severity of the member's condition as reported on the claim. If we identify overcoding, we may adjust reimbursement to a lower-level E/M.

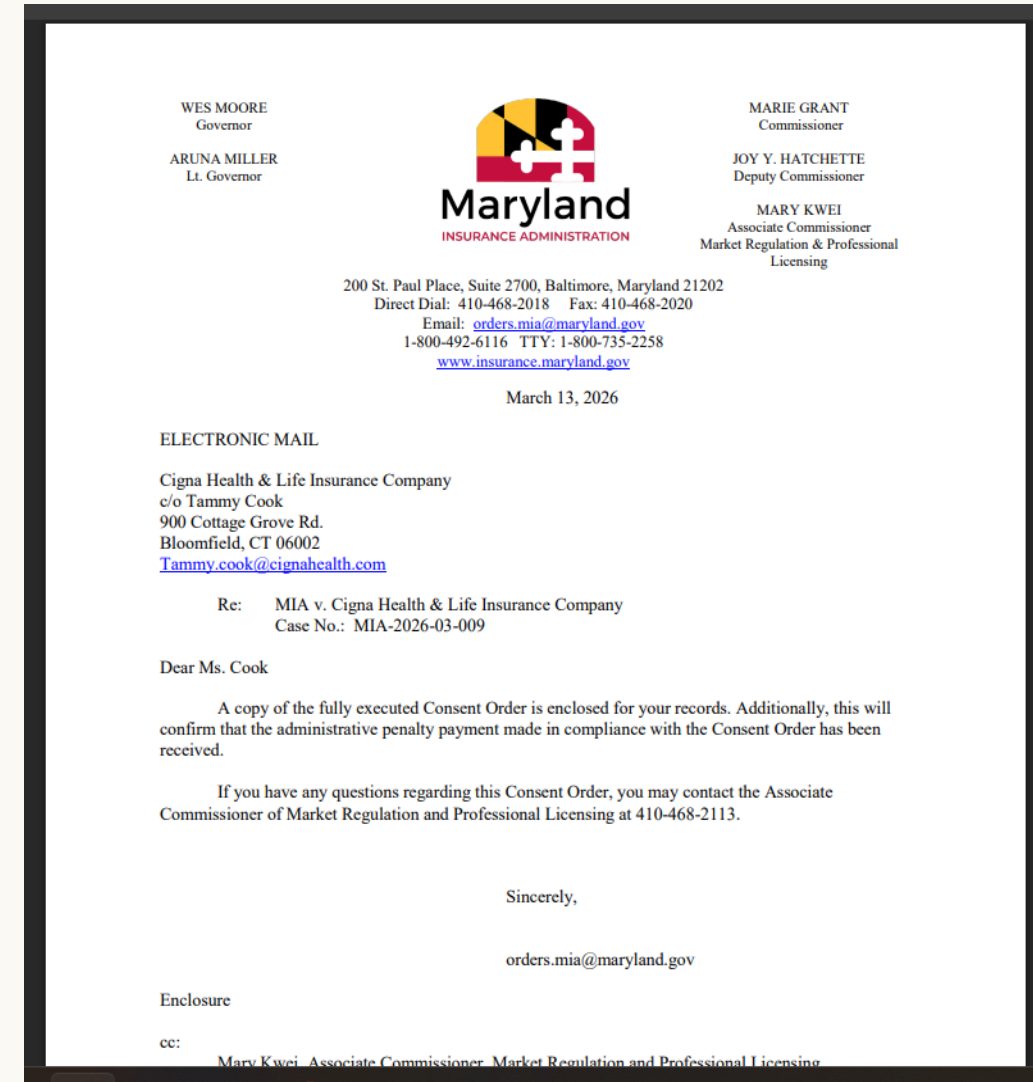
This program applies to:

- Office visits for new and established patients and emergency department visits
- Commercial, Federal Employee Program (FEP), and Medicare Advantage members
- Professional services only, and is different from the Optum® Emergency Department Claim (EDC) Analyzer tool for facility claims

To better support you, we've compiled a list of [Questions & Answers](#) that provides additional information and explores

# Automatic Downgrading *Maryland v. Cigna* (3/26)

- Cigna had a “policy and practice ... to adjust the coding based on their internal assessment only and issue payment for the lower-level code, requiring the provider to appeal the decision by providing additional information if they disagree...”
  - Maryland Insurance Administration determined this violated Maryland’s law.
  - Cigna agreed to pay \$80,000.
- (Consent Order, available at <https://www.medchi.org/Portals/18/MIA-2026-03-009%20Letter%20%26%20Order.pdf>).



# Automatic Downgrading

## *Maryland v. Cigna (3/26)*

- Maryland law requires that, w/in 30 days of receipt of claim, insurer must:
  1. Pay,
  2. Dispute amount of reimbursement and provide reason, or
  3. If claim is not clean, identify additional info needed for a clean claim.(Md. Ins. Art. 15-1005)
- Maryland law did not allow insurer to automatically downgrade without providing notice or specifying additional information needed.

- *Maryland's law is very similar to most other state laws.*
- *Maryland's analysis may apply to other state laws.*

# Automatic Downgrading: Idaho Law

Idaho law:

“(2) If a [provider] submits an electronic claim to an insurer within thirty (30) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than thirty (30) days after receipt of the claim.

(3) If a [provider] submits a paper claim for payment to an insurer within forty-five (45) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than forty-five (45) days after receipt of the claim.

(4) If an insurer denies the claim or needs additional information to process the claim, the insurer shall notify the [provider] in writing within thirty (30) days of receipt of an electronic claim or within forty-five (45) days of receipt of a paper claim. The notice shall state why the insurer denied the claim.

(5) If the claim was denied because more information was required to process the claim, the notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing.”

(IC 41-5602)

- Arguably, like Maryland’s law, Idaho law does not permit MA plan to simply pay a lower rate based on its internal assessment of the claim.
- But consider federal preemption

# Automatic Downgrading: Example



| Level of Severity Inpatient Payment Policy |                                                                                                                                                                                                                                                                                  |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Policy Type:</b>                        | New                                                                                                                                                                                                                                                                              |
| <b>Applies to:</b>                         | <ul style="list-style-type: none"><li>• Medicare Advantage Products including all Special Needs Plans (SNPs) types (coordinated and integrated D-SNPs, I-SNPs, and C-SNPs)</li><li>• All participating DRG facilities with a Medicare Allowable/DRG contracting method</li></ul> |
| <b>Policy Implementation:</b>              | Date of Service                                                                                                                                                                                                                                                                  |
| <b>Policy Revision Date:</b>               | <a href="#">Click Here</a>                                                                                                                                                                                                                                                       |
| <b>Last Review Date:</b>                   | November, 2025                                                                                                                                                                                                                                                                   |
| <b>Next Review Date:</b>                   | November, 2026                                                                                                                                                                                                                                                                   |

Our payment policies ensure that we pay providers based on the code that most accurately describes the procedure performed. We include CPT/HCPCS, CMS or other coding methodologies in our payment policies when appropriate. Unless noted otherwise, payment policies apply to all professionals who deliver health care services. When developing payment policies, we consider coding methodology, industry-standard payment logic, regulatory requirements, benefits design and other factors.

This Payment Policy expresses Aetna's determination of whether or how certain services or supplies are reimbursed. Payment Policies include references to standard HIPAA compliant code sets to assist with search functions and to facilitate billing and payment for services. New and revised codes are added to the policies as they are updated. When billing, you must use the most appropriate code as of the effective date of the submission. Unlisted, unspecified and nonspecific codes should be avoided when a more specific code exists for the service. **Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.** If there is a discrepancy between this payment policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the following website: <http://www.cms.hhs.gov/center/coverage.asp>. More stringent State requirements may supersede the requirements of this policy.

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| <a href="#">Policy Revision Date</a>  |

- Aetna Level of Severity Policy
  - If inpatient stay greater than 1 but less than 5 midnights, Aetna reviews the stay under its level of severity standards.
  - Net effect: Aetna automatically approves stay but downgrades status and pays the rate for observation status.
  - Inpatient stays above 5 midnights are paid at higher severity rate without mandatory review.
- Aetna claims it is a “payment policy” that will allow faster payment

# Automatic Downgrading

## *Jefferson Health v. Aetna* (4/26)

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF PENNSYLVANIA

Thomas Jefferson University dba Jefferson  
Health and Lehigh Valley Physician Hospital  
Organization, Inc.,

Plaintiffs,

v.

Aetna Health Inc.,

Defendant.

Civil Case No. \_\_\_\_\_

COMPLAINT

Plaintiffs Thomas Jefferson University dba Jefferson Health ("Jefferson Health") and Lehigh Valley Physician Hospital Organization, Inc. ("LVPHO") (collectively, the "Hospitals" or "Plaintiffs"), by and through their attorneys, by way of Complaint for Declaratory and Injunctive Relief against the Defendant Aetna Health Inc. ("Aetna" or "Defendant") allege as follows:

INTRODUCTION

1. This dispute arises from Aetna's violation of federal law and failure to comply with the terms of the written agreements between Jefferson Health and Aetna and LVPHO and Aetna through its implementation of the Aetna "Level of Severity Inpatient Payment Policy" (the "Policy").

2. Beginning on January 1, 2026, pursuant to the "Policy," Aetna has engaged in improper denials and/or underpayments for inpatient hospital care that the Hospitals have provided and continue to provide to members of Aetna Medicare Advantage plans.

3. The contracts require Aetna to comply with all applicable laws and regulations. But Aetna's "Policy" violates the Centers for Medicare & Medicaid Services' ("CMS") Two Midnight

- *Jefferson Health v. Aetna*, No. 5:26-cv-02215 (E.D. Pa. 4/6/26) alleges:
  - CMS's 2-midnight rule clearly establishes when admissions must be paid as inpatient stays for purposes of medical necessity. Aetna policy violates Medicare 2-midnight rule by paying stays between 2- and 5 midnights as observation stays.
  - Aetna policy violates parties' negotiated contract, which did not include a two-tiered rate for inpatient services.
- May violate prior authorization requirements?
- May violate state laws that prohibit unilateral contract amendments?

# Automatic Downgrading: CMS Letter (2/24)

“8. Question: Does the CY 2024 final rule mean that MA organizations must follow the Medicare “two-midnight rule”?

Answer:

- MA plans must follow the 2-midnight “benchmark,” i.e., inpatient admission criteria.
  - Depends on admitting physician’s expectation and medical records.
- MA plans are not required to follow the 2-midnight “presumption”, i.e., medical review instructions given to Medicare post-payment audit contractors that they do not need to review medical necessity if satisfy 2-midnight rule.

(CMS letter to MA Plans (2/6/24)

➤ *MA Plans may confuse the “benchmark” with the “presumption.”*

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C4-21-26  
Baltimore, Maryland 21244-1850



**DATE:** February 6, 2024

**TO:** All Medicare Advantage Organizations and Medicare-Medicaid Plans

**SUBJECT:** Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the “[Medicare Program; 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](#)” final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

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**Answer:** For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at § 422.101(c)<sup>1</sup>; based on the circumstances of each specific individual, including the patient’s medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).

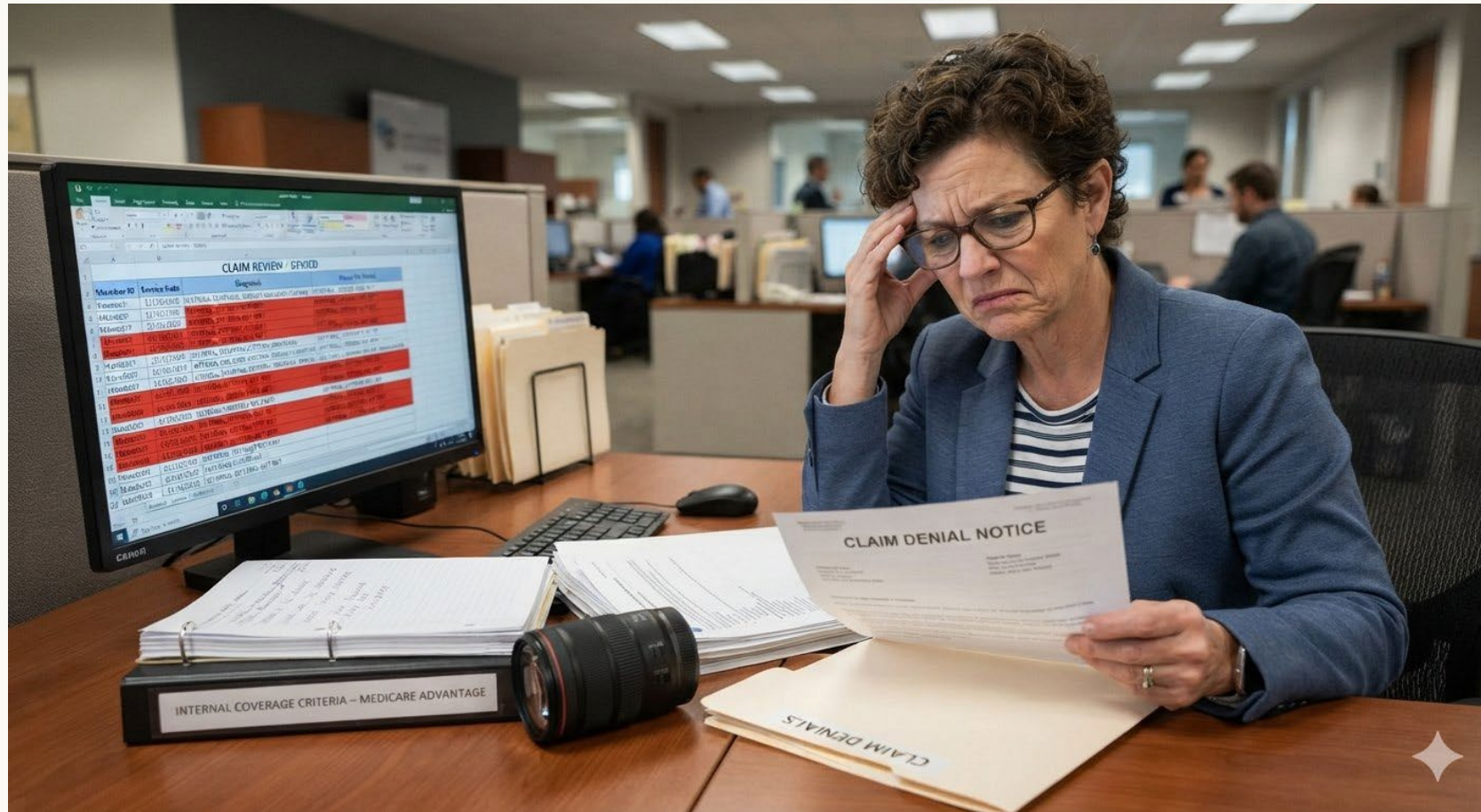
<sup>1</sup> MA organizations must make medical necessity determinations based on all of the following:

(A) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).  
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.  
(C) The enrollee’s medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.  
(D) Where appropriate, involvement of the organization’s medical director as required at § 422.562(a)(4).

# Automatic Downgrading: Suggestions

- ✓ Ensure all submitted claims are clean and supported by documentation before submitting.
- ✓ Review and know plan terms, including provisions re contract amendment, binding effect of payment policies, process for disputing claims, etc.
- ✓ Implement a claims monitoring system to identify when MA plans are automatically downgrading claims, tracking:
  - Frequency of downgrades by payer
  - Types of codes being downgraded
  - Whether downgrades occur pre- or post-payment
- ✓ Demand written justification for any downcoding or downgrading, requiring the plan to identify specifically what additional information is needed.
  - See state law.
- ✓ Monitor and use *Jefferson Health* and similar decisions as appropriate.
- ✓ Appeal on timely basis.
- ✓ Develop and leverage template forms.

# Internal Coverage Criteria



# Internal Coverage Criteria re Medical Necessity

- MA plan may use internal coverage criteria only if:
  - Coverage criteria not fully established by traditional Medicare, i.e., not already covered by Medicare statutes, regulations, NCDs or LCDs.
    - *Cannot contradict established rules for traditional Medicare.*
  - Based on evidence from widely used treatment guidelines or clinical literature, e.g., peer-reviewed studies, specialty organization publications, etc.
  - Publicly accessible, i.e., MA plan must publish the internal coverage criteria and summary of evidence supporting criteria to make medical necessity determinations; list of sources of such evidence; and explanation of the rationale used to make a medical necessity determination.

*Cannot conflict with Medicare statute, regulations, NCDs or LCDs.*

(42 CFR 422.101(b)(6))

# Internal Coverage Criteria re Medical Necessity

**“1. Question: When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?**

**“Answer: For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with [i] all medical necessity determination requirements, outlined at § 422.101(c); [ii] based on the circumstances of each specific individual, including the patient’s medical history, physician recommendations, and clinical notes; and [iii] in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).”**

(CMS letter to MA Plans (2/6/24), available at <https://calhospital.org/wp-content/uploads/2024/02/HPMS-Memo-FAQ-on-CC-and-UM-020624.pdf>).

# Internal Coverage Criteria: LCDs

**“6. Question: Can MA organizations apply coverage criteria from a Traditional Medicare Local Coverage Determination (LCD) that is not applicable to the service area where the MA plan is available?**

**“Answer:** If the LCD is not from the applicable service area, use of the LCD is use of internal coverage criteria and all associated requirements would still apply; an MA organization is not exempted from the requirements of § 422.101(b)(6) by using an LCD adopted in a geographic area that is not the MA plan’s service area. **MA organizations must follow all Traditional Medicare NCDs, LCDs applicable to the MA plan’s service area, and general coverage and benefit conditions included in Traditional Medicare per 42 CFR § 422.101.** In situations where Traditional Medicare coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs (applicable to the applicable service area), MA organizations may create internal coverage criteria as long as they comply with rules at § 422.101(b)(6). An MA plan’s internal coverage criteria may be similar or the same as criteria found in LCDs that are applicable outside of the MA plan’s service area, but **the MA organization must still ensure that the criteria are based on current evidence in widely used treatment guidelines or clinical literature and is made publicly available**, as required by § 422.101(b)(6).”

(CMS letter to MA Plans (2/6/24))

# Internal Coverage Criteria: Suggestions

- ✓ Train staff on limits in 42 CFR 422.101(b)(6).
  - Know Medicare statutes, regulations, NCDs and LCDs.
- ✓ Demand specific coverage criteria used to deny claim, including elements required by 422.101(b)(6).
- ✓ Maintain library of applicable NCDs and LCDs.
- ✓ Document patient-specific clinical circumstances relevant to claims.
- ✓ Others?

# Use of AI in Claims Decisions



# Use of AI in Claims Decisions

**“2. Question: Do the new rules on clinical coverage criteria for basic Medicare benefits mean that MA organizations cannot use algorithms or artificial intelligence to make coverage decisions?”**

**“Answer... An algorithm or software tool can be used to assist MA plans in making coverage determinations, but it is the responsibility of the MA organization to ensure that the algorithm or artificial intelligence complies with all applicable rules for how coverage determinations by MA organizations are made. For example, compliance is required with all of the rules at § 422.101(c) for making a determination of medical necessity, including that the MA organization base the decision on the individual patient’s circumstances, so an algorithm that determines coverage based on a larger data set instead of the individual patient’s medical history, the physician’s recommendations, or clinical notes would not be compliant with § 422.101(c). [For example], for inpatient admissions, algorithms or artificial intelligence alone cannot be used as the basis to deny admission or downgrade to an observation stay; the patient’s individual circumstances must be considered against the permissible applicable coverage criteria under § 422.101(c).”**

(CMS letter to MA Plans (2/6/24))

# Use of AI in Claims Decisions

**“2. Question: Do the new rules on clinical coverage criteria for basic Medicare benefits mean that MA organizations cannot use algorithms or artificial intelligence to make coverage decisions?**

...

**“MA organizations may only deny coverage for basic benefits based on coverage criteria that are specified in § 422.101(b) or (c) or for other expressly permissible bases, such as network limitations or failure to comply with prior authorization requirements. Therefore, the algorithm or software tool should only be used to ensure fidelity with the posted internal coverage criteria which has been made public under § 422.101(b)(6)(ii).... [P]redictive algorithms or software tools cannot apply other internal coverage criteria that have not been explicitly made public and adopted in compliance with the evidentiary standard in § 422.101(b)(6).”**

**(CMS letter to MA Plans (2/6/24))**

# Use of AI in Claims Decisions



“CMS has warned that MAOs must ensure that they are making medical necessity determinations based on the circumstances of the specific individual as opposed to solely using an algorithm or software that does not account for an individual's circumstances....

“[S]uch algorithms may also present potential compliance risks when used in making prior authorization and other coverage decisions. CMS regulations require MAOs to make medical necessity determinations based on the individual patient's circumstances. Accordingly, an algorithm may not be compliant with those regulations if it determines coverage based on a larger data set instead of the individual patient's medical history, the physician's recommendations, or clinical notes.”

# Use of AI in Claims Decisions: Litigation



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## Law firm suing three major health insurance companies for 'wrongfully' rejecting claims with AI

CASE 0:23-cv-03514 Doc. 1 Filed 11/14/23 Page 1 of 46

UNITED STATES DISTRICT COURT  
DISTRICT OF MINNESOTA

The Estate of Gene B. Lokken and The Estate  
of Dale Henry Tetzloff, individually and on  
behalf of all others similarly situated,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC.,  
UNITEDHEALTHCARE, INC.,  
NAVIHEALTH, INC., and DOES 1-50,  
inclusive,

Defendants.

Civil File No.

CLASS ACTION COMPLAINT

**DEMAND FOR JURY TRIAL**

PLAINTIFFS' CLASS ACTION COMPLAINT

Plaintiffs, the Estate of Gene B. Lokken and the Estate of Dale Henry Tetzloff ("Plaintiffs"), individually and on behalf of all others similarly situated (the "Class" or "Classes"), by and through their attorneys, bring this class action against Defendants UnitedHealth Group, Inc., UnitedHealthcare, Inc., naviHealth, Inc., and Does 1-50, inclusive (collectively, "Defendants" or "UnitedHealthcare") and allege as follows:

INTRODUCTION

1. This putative class action arises from Defendants' illegal deployment of artificial intelligence (AI) in place of real medical professionals to wrongfully deny elderly patients care owed to them under Medicare Advantage Plans by overriding their treating physicians' determinations as to medically necessary care based on an AI model that Defendants know has a 90% error rate.

# Use of AI in Claims Decisions: State Legislation\*

## STATES THAT LIMIT OR ADDRESS USE OF AI IN CLAIMS

- **Alabama:** establishes parameters for use.
- **Arizona:** must involve medical director in any denial of claim or preauthorization.
- **California:** must involve licensed healthcare professional; may use AI, but cannot supplant provider decision-making.
- **Indiana:** limits use of AI to automatically downcode.
- **Maryland:** must have human oversight of medical necessity determinations and other decision that could delay, deny or alter patient care.
- **Nebraska:** individuals must make decisions to deny, delay or modify a health care claim.
- **Texas:** addresses use of AI in determinations.
- Others?

## LEGISLATION PROPOSED

- **Florida**
- **Hawaii**
- **Kentucky**
- **New Hampshire**
- **Oklahoma**
- **Pennsylvania**
- **Virginia**
- **Others?**

# Use of AI in Claims Decisions: Proposed Legislation

- Improving Seniors' Timely Access to Care Act (HR 3514/S 1816)
  - Requires physician reviewers to confirm they exercised independent medical judgment and that denial was not solely generated or dictated by AI.
  - MA plan must report number and % of prior authorization requests approved or denied using AI.
  - Authorizes HHS to audit and inspect use of AI in prior authorization determinations.
- *Bill has very broad bipartisan support.*

# Use of AI in Claims Decisions: Suggestions

- ✓ Request disclosure of the MA plan's use of AI in claims process.
- ✓ Look for patterns, e.g., high volumes of identical denial language; denials issued unusually quickly; denials that do not reference patient-specific clinical information.
- ✓ Challenge non-compliant AI use, e.g.,
  - AI/algorithms cannot be the sole basis for denying inpatient admission or downgrading to observation.
  - Coverage decisions must be based on the individual patient's circumstances, including medical history, physician recommendations, and clinical notes.
  - Algorithms cannot apply internal coverage criteria that have not been made publicly available.
- ✓ File CMS and state insurance commissioner complaints.
- ✓ Lobby for AI limits in Idaho.
- ✓ Track national developments.

# Using Payment Policies to Deny or Reduce Coverage



# Using Payment Policies to Deny or Reduce Coverage

- MA plans may recharacterize coverage criteria as payment policies and use the payment policies to deny or reduce payments.
- MA plans may argue that providers have agreed to the criteria as a matter of contract.

# Using Payment Policies to Deny or Reduce Coverage

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C4-21-26  
Baltimore, Maryland 21244-1850



**DATE:** February 6, 2024

**TO:** All Medicare Advantage Organizations and Medicare-Medicaid Plans

**SUBJECT:** Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the "[Medicare Program; 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](#)" final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

1. **Question:** When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?

<https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>

benefits based on coverage criteria not specified in § 422.101(c) or (e).  
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the

- CMS has said that if the payment policies have the effect of denying coverage or payment, it is a coverage issue and subject to Medicare regulations that prohibit denying or reducing benefits available under traditional Medicare.

# Using Payment Policies to Deny or Reduce Coverage

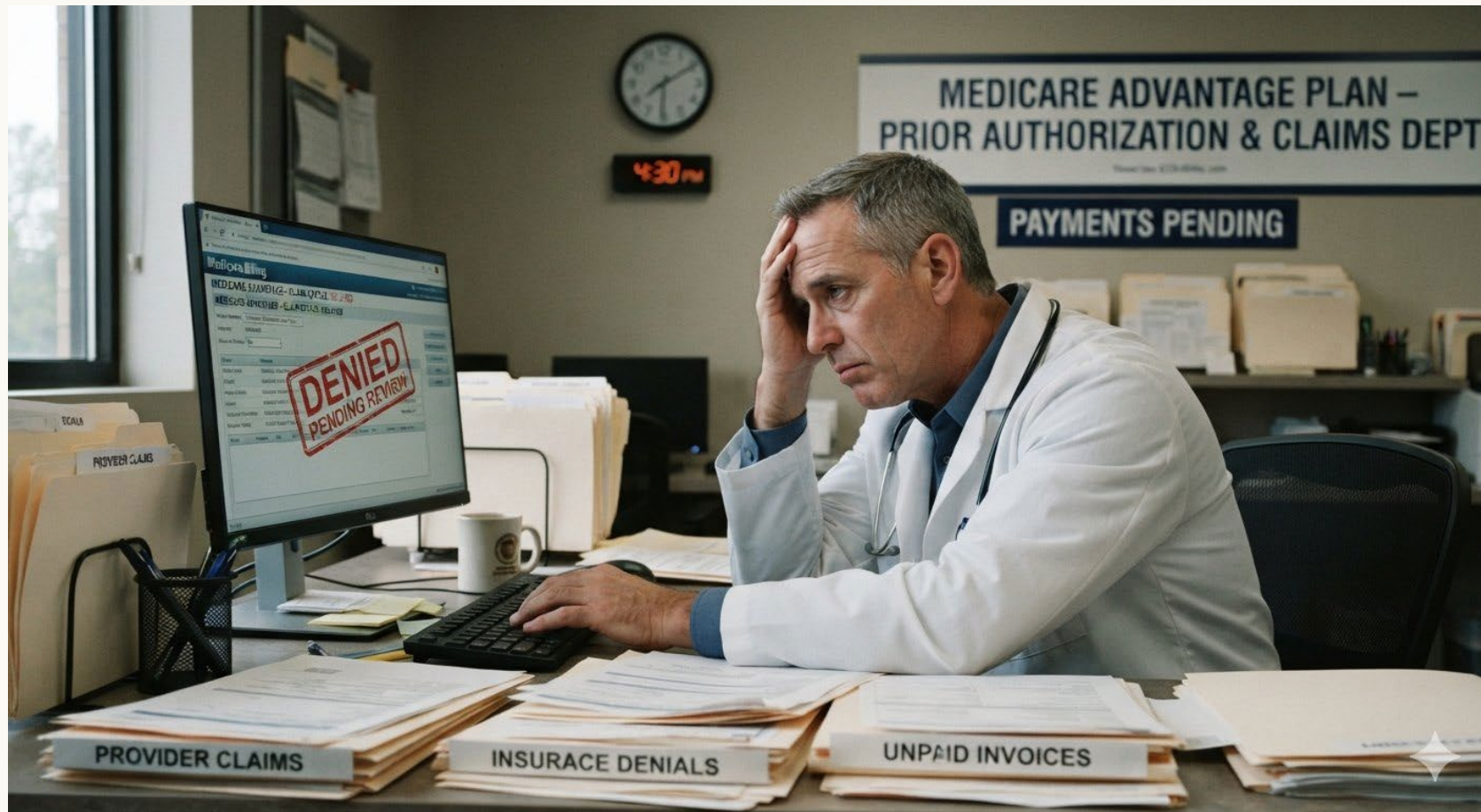
“We have heard frequently that MA organizations utilize post-claim review audits and examinations that routinely result in the denial of payment for the inpatient care that was provided to the enrollee. Further, we have heard that MA organizations characterize these reviews as “payment” reviews and that these reviews are “not organization determinations” or “level of care or medical necessity reviews.” We disagree with those characterizations of decisions that are denials of coverage or otherwise a refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization. We reiterate here that the refusal to provide or pay for services, in whole or in part, including the type or level of services (e.g., inpatient services versus outpatient services) is an organization determination by the MA plan under § 422.566(b)(3). Therefore, if the MA organization expects to issue a partially or fully adverse decision about whether the services are or were medically necessary, that decision – meaning that organization determination – must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare coverage criteria, before the MA organization issues the organization determination decision. See 42 CFR § 422.566(d).”

(CMS letter to MA Plans (2/6/24))

# Using Payment Policies to Deny or Reduce Coverage

- ✓ Challenge the characterization of coverage denials as "payment policies", citing CMS's explicit statement that any refusal to pay for services constitutes an organization determination subject to Medicare regulations.
- ✓ Demand physician review of any adverse determination, citing 42 CFR 422.566(d), which requires review by a physician or appropriate healthcare professional with expertise in the relevant field before an adverse organization determination is issued.
- ✓ Review contracts carefully re provisions that purport to incorporate MA plan payment policies.
- ✓ Negotiate explicit contract language preserving your right to challenge payment policy changes and requiring advance notice of any policy changes.
- ✓ Challenge unilateral payment policy changes mid-contract as contract amendments requiring mutual agreement.
- ✓ Treat post-claim audit denials as organization determinations and invoke the full Medicare appeals process.
- ✓ File CMS complaints when MA plans characterize coverage denials as payment reviews to avoid Medicare appeals obligations.

# Delays



# Delays: Idaho Law

“(2) If a [provider] submits an **electronic claim** to an insurer within thirty (30) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than **thirty (30) days** after receipt of the claim.

(3) If a [provider] submits a **paper claim** for payment to an insurer within forty-five (45) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than **forty-five (45) days** after receipt of the claim.

(4) If an insurer **denies the claim or needs additional information** to process the claim, the insurer shall notify the [provider] in writing within **thirty (30) days of receipt of an electronic claim** or within **forty-five (45) days of receipt of a paper claim**. The notice shall state why the insurer denied the claim.

(5) If the claim was denied because more information was required to process the claim, the notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing.”

(IC 41-5602)

# Delays: Idaho Law

“(1) [DOI] shall enforce the provisions of this chapter and shall review and, if appropriate, investigate complaints ... related to noncompliance with the provisions of this chapter.

(2) If [DOI] determines an insurer has violated the provisions of this chapter, [DOI] may impose an administrative fine not to exceed **five thousand dollars (\$5,000)** based upon an enforcement action.

(3) [DOI] shall not suspend or revoke an insurer’s certificate of authority for violation...

(4) No administrative penalty shall be imposed against an insurer ... for failure to comply with this chapter if, in the calendar year it has paid ninety-five percent (95%) or more of all claims subject to this chapter to or on behalf of beneficiaries within the time periods set forth in [IC 41-5602].

(5) This section shall **not create a private cause of action** by or on behalf of a beneficiary or practitioner or facility against an insurer.”

(IC 41-5606)

# Delays: Federal Preemption?

- But federal regulations governing MA plans likely preempt state laws.
- "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part."

(42 USC 1395w-26(b)(3); see also 42 CFR 422.402)



# Delays CMS Regulations

- MA regulations require:
  - Contracted providers: contracts between MA plan and providers must contain a provision developed and agreed by the parties.
    - *Check your contracts.*
  - Non-contracted providers:
    - Clean claims: contract with CMS requires that MA plan will pay 95% within 30 days of receipt. Must pay interest on late claims.
    - Other claims: MA plans must pay or deny within 60 days.
- If MA plan violates the regulations, CMS may authorize direct payment to providers and reduce payments to MA plan.

(42 CFR 422.520)

# Delays: Proposed Legislation

- Medicare Advantage Act (HR 5454/ S 2879)
  - Would require MA plans to pay at least 95% of clean claims:
    - In-network claims: within 14 days.
    - Out-of-network claims: within 30 days.
  - Plans that violate deadlines may be subject to civil monetary penalties.
  - MA plans must report compliance data, including number of claims paid on time.
- *So far, it appears to have bipartisan support.*

# Resources



# CMS Online Form re MA Plans



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## Provider Complaints Form

### Warning

Data entered into the provider complaint form must not include special characters such as quotes or accents. These non-standard characters may be inserted by Microsoft Word or other rich text editors. If you encounter an error, use Notepad to remove special characters from your content.

Complaint information

Complainant First Name (Required)

Providers may submit complaint about  
MA plan.

<https://www.cms.gov/medicare/health-drug-plans/provider-s-form>

Feedback

# Idaho Insurance Code: Unfair Claim Settlement Practices

Generally prohibits:

- “(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- “(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- “(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- “(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;...”

(IC 41-1329)

# Idaho Insurance Code: Unfair Claim Settlement Practices

(continued...)

“(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed....”

“(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

“(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;...”

(IC 41-1329)

# Idaho Insurance Code: Unfair Claim Settlement Practices

(continued...)

“(11) ... [Adopting a] policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

“(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician ... to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

...

“(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.”

(IC 41-1329)

# Idaho Insurance Code: Penalties

- The director, if he finds after a hearing, that an insurer has violated the provisions of [IC 41-1329] may, in his discretion, impose an administrative penalty not to exceed ten thousand dollars (\$10,000) to be deposited by the director as provided in [IC 41-406] and may, in addition to the fine, or in the alternative to the fine, refuse to continue or suspend or revoke an insurer's certificate of authority.”

(IC 41-1329A)

# But Beware: Federal Preemption

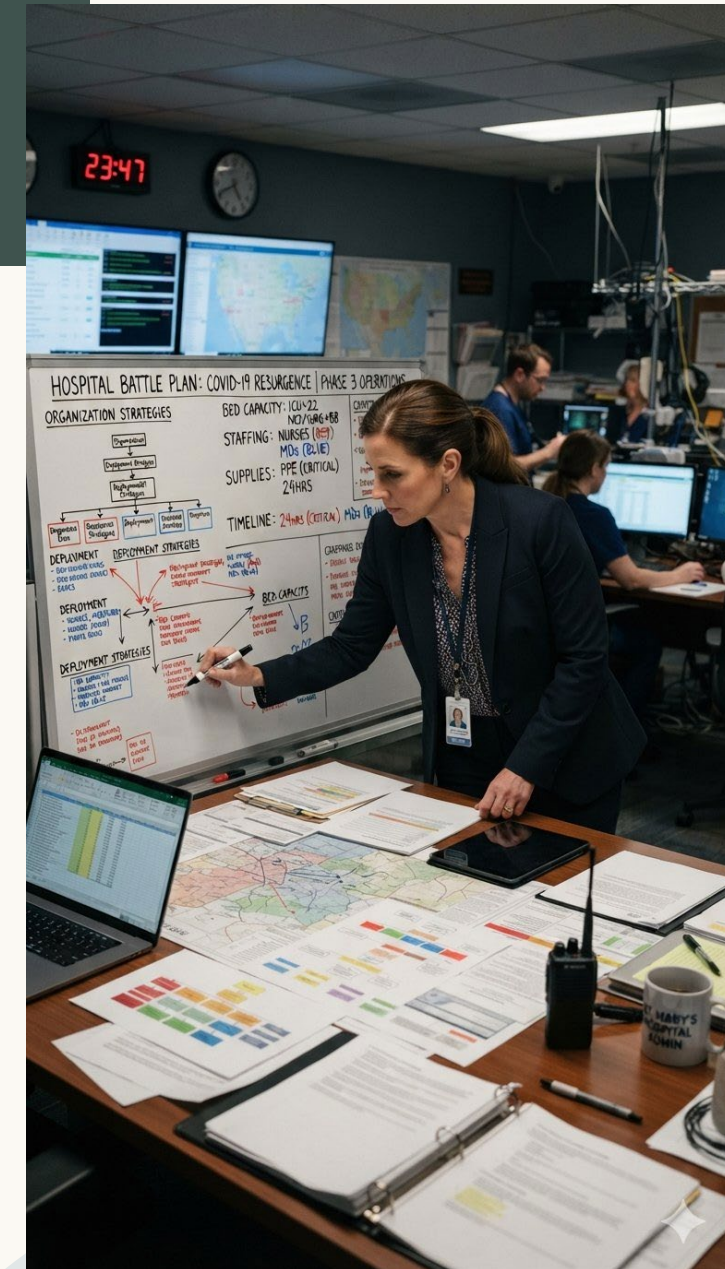
- But federal regulations governing MA plans may preempt state laws.
- "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part."

(42 USC 1395w-26(b)(3); see also 42 CFR 422.402)



# Action Plan

- ✓ Know the limits to MA plan authority and discretion and train your people. *See 42 CFR part 422 and CMS/OIG Guidance.*
- ✓ Review and negotiate key contract terms. *E.g., protect against unilateral payment policy changes, advance notice, preserve dispute rights.*
- ✓ Appeal MA plan decisions. *Recent reports suggest high % of success.*
- ✓ Track data and build coalitions. *E.g., denial rates by payers.*
- ✓ Complain to CMS. *See online process.*
- ✓ Complain to Idaho DOI. *See Idaho Unfair Claims Practices Act.*
- ✓ Litigate overreaching. *See Jefferson Health v. Aetna; Maryland v. Cigna.*
- ✓ Watch other pending litigation. *See cases re use of AI in claims.*
- ✓ Advocate for legislative changes. *E.g., AI in claims decisions.*



# Resources

- MA plan rules, 42 CFR part 422
- MA plan final rule (2024), 88 FR 22120 (4/12/23), <https://www.federalregister.gov/documents/2023/08/01/2023-16307/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program>.
- Medicare Advantage Internet-Only Manuals, <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms>
- CMS letter to All Medicare Advantage Organizations and Medicare Advantage Plans (2/6/24), <https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf>

# Questions?



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