NEW ENROLLEE RIGHTS, NEW PROVIDER RESPONSIBILITIES IN MA PROGRAM

Introduction

As of January 1, 2004, enrollees of Medicare Advantage (MA) plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulations in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

What is "Grijalva"?

"Grijalva" is Grijalva v. Shalala – a class action lawsuit that challenged the adequacy of the Medicare managed care appeals process. The plaintiffs claimed that beneficiaries in Medicare managed care plans were not given adequate notice and appeal rights when coverage of their health care services was denied, reduced or terminated. Following extended legal negotiations -- and significant changes to appeals procedures that resolved many issues -- CMS reached a settlement agreement with plaintiffs and published a proposed rule based on that agreement in January 2001, and the final rule in April 2003.

New Regulations

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that State and the enrollee's MA plan must furnish a detailed notice explaining why services are no longer necessary or covered. The review process generally will be completed within less than 48 hours of the enrollee's request for a review. The new SNF, HHA, and CORF notification and appeal requirements distribute responsibilities under the new procedures among four parties:

1) The *MA organization* generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, MA organizations may choose to delegate these responsibilities to their contracting providers.)
2) The *provider* is responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to all enrollees no later than 2 days before their covered services end.
3) The *patient/MA enrollee* (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the QIO (within the specified timelines) if they wish to obtain an expedited review.

4) The *QIO* is responsible for immediately contacting the MA organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

Again, these new notice and appeal procedures went into effect on January 1, 2004. You should be aware that the Medicare law (section 1869(b)(1)(F) of the Social Security Act) establishes a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries, and we expect to implement similar procedures for these beneficiaries in the near future.

What Do the New SNF, HHA, and CORF Notification Requirements Mean for Providers?

Notice of Medicare Non-Coverage (NOMNC)
The NOMNC (formerly referred to as the Important Medicare Message of Non-Coverage) is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider must fill in.

When to Deliver the NOMNC
Based on the MA organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than 2 days before the end of coverage. If services are expected to be fewer than 2 days, the NOMNC should be delivered upon admission. If there is more than a 2-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. We encourage providers to work with MA organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to Deliver the NOMNC
The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented, and the notice must be mailed to the representative.

Expedited Review Process
If the enrollee decides to appeal the end of coverage, he or she must contact the QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The QIO will inform the MA organization and the provider of the request for a review and the MA organization is responsible for providing the QIO and

enrollee with a second notice, the Detailed Explanation of Non-Coverage (DENC). The MA organization may need to present additional information needed for the QIO to make a decision. Providers should cooperate with MA organization requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

Importance of Timing/Need for Flexibility
Although the regulations and accompanying CMS instructions do not require action by any of the four responsible parties until 2 days before the planned termination of covered services, we want to emphasize that it's generally in everyone's best interest for an MA organization and its providers to work together to deliver the advance termination notice to enrollees as soon as the provider knows when the MA organization will terminate coverage. Doing so will allow the patient more time to determine if they wish to appeal and may permit more time for providers and MA organizations to furnish any needed records.

In some cases, we recognize that permitting flexibility in the timing of notice delivery may result in an early, and possibly premature, enrollee request for a QIO review. In these situations, the QIO will immediately notify the MA organization of the appeal request but all parties will need to exercise judgment in determining when it makes sense for the MA organization and/or provider to furnish any needed medical records or other documentation to the QIO. Although an MA organization should provide the enrollee (and the QIO) with a DENC as soon as it learns of the appeal request, it may be appropriate to delay providing the enrollee's medical records until shortly before the planned coverage termination, when the record is presumably complete enough to permit an informed QIO determination. Keep in mind that the overall deadline for record provision remains close of business of the day before the planned termination.

We strongly encourage providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible. For example, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate financial liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance, facilitating a faster, simpler discharge.

We recognize that these new requirements will be a challenge--at least at first – and that there may be unforeseen complications that will need to be resolved as the process evolves. We intend to continue working together with all involved parties to identify problems, publicize best practices, and implement needed changes.

More Information
Further information on this process, including the required notices and related instructions can be found on the CMS website at www.cms.hhs.gov/healthplans/appeals. (Also, the regulations are at 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the MA Manual includes information on the process.)