Federal Issues Update: Health Plan Accountability

AAHAM Legislative Day
May 4, 2023
Agenda

• End of the PHE is May 11 / Medicaid Redetermination
• Health Plan Accountability
• Medicare Advantage
  ➢ Trends in growth and enrollment, CY24 Final MA and Part D Rule
• Prior Authorization
  ➢ Proposed Prior Authorization Rule, Seniors Timely Access to care Act
• Patient Billing Guidelines
PHE Comes to an End May 11

Changes in payment, coverage, regulatory requirements

• Several policies/programs expire May 11, others extended through rulemaking

• HHS-issued Transition Roadmap lists what's affected, what's not

• AHA letter to HHS Sec. with recommendations for “glide path”

• CMS hosting office hours with the AHA (members only) to answer questions on May 5 at 3pm
Medicaid/CHIP Coverage Post-PHE

Working to Mitigate Coverage Loss

• Consolidated Appropriations Act: states permitted to begin disenrollment (after eligibility redetermination) on Apr. 1
  ➢ Likely to take up to a year to complete
• State Medicaid agencies and stakeholders play pivotal roles
  ➢ Resources at Medicaid.gov/unwinding
  ➢ AHA working with CMS, stakeholder community
    ▪ See AHA resources on aha.org
Advancing the Health Plan Accountability Agenda

“Lawmakers and regulators should increase their oversight of commercial health plans and enact fair and patient-friendly reforms,” writes AHA President and CEO Rick Pollack in an advertorial published today in the Wall Street Journal.”
New Infographic:
Prior Authorization Denials & Payment Delays

Survey:
Commercial Health Insurance Practices that Delay Care, Increase Costs

Real people, Real stories

A cancer patient was scheduled to receive an infusion, but their health plan required the supportive care drug to be supplied by the plan’s specialty pharmacy. When the drug was shipped, it was left overnight in the truck, rendering it unusable; subsequent delays continued. While the hospital staff pressured the health plan to approve using the hospital’s...
And it is only getting worse.

78% of hospitals and health systems report that their experience with commercial insurers is getting worse.

<1% said it’s getting better.

Inappropriate prior authorization and payment denials result in significant disruption for hospitals and health systems, challenging their ability to continue caring for their communities.
Prior Auth Denials & Payment Delays

**Member Survey Results**

- **7 in 10 Hospitals** report having an outstanding claim from 2016 or older.
- **55%** of hospitals and health systems reported their oldest Medicare Advantage claim is from 2016 or older.

- **50%** of hospitals and health systems report having more than $100 Million in accounts receivable for claims that are older than 6 months.
- **STATUS DELAYED**
  - This amounts to $6.4 billion in delayed or unpaid claims that are 6 months or older among 772 hospital survey responders.

- **35%** of hospitals and health systems report $50 Million or more in foregone payments as a result of denied claims once appeals have been exhausted.
Policy Solutions

- Provide lists of services subject to PA in a standardized format
- Streamline the format for PA requests and responses
- Require plans to have 24/7 PA processing capability
- Establish more timely PA response requirements
- Require full and complete denial notices
- Standardize appeal processes
- Improve data collecting/reporting on plan performance
- More frequent/targeted audits of plans based on data collection
- Apply financial penalties for inappropriate levels of denials
- Ensure adequate provider networks
Medicare Advantage

• Growth & Enrollment Trends
• CY2024 MA Final Rule
The share of eligible Medicare beneficiaries enrolled in MA has more than doubled since 2007.

- **12M enrollees in 2011 to **28.4M** in 2022
- Currently **48%** of all Medicare beneficiaries are enrolled in MA
- CBO projects MA enrollment will reach **61%** of MA enrollees in 2032
There are more MA plans available than ever before

More Medicare Advantage plans are available in 2023 than in any other year going back to 2010

Number of Medicare Advantage plans generally available by plan type, 2010-2023

- HMO
- Local PPO
- PFFS
- Regional PPO
- MSAs

The average consumer can choose from 43 Medicare Advantage plans in 2023

Figure 2

NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans and MMPs. Numbers may differ from previous publications in cases where the Landscape File for the year was updated after initial publication.

SOURCE: KFF analysis of CMS Landscape files for 2010-2023. • PNG

MA enrollment grew at a slower pace between 2022-2023 (+5.5%) than in recent prior years (+8-10%).

https://www.chartis.com/insights/shifting-market-medicare-advantage-shows-continued-growth
United and Humana account for nearly half of all MA enrollees nationwide in 2022

Figure 8
Medicare Advantage Enrollment by Firm or Affiliate, 2022

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are about 2% of total enrollment.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022. • PNG
CY24 MA Final Rule: Highlights

- Increases **health plan oversight** and accountability
- Requires greater **alignment with Medicare FFS**
- Regulates plan use of **prior authorization**
-Strengthens **behavioral health** network adequacy standards
- Restricts **MA plan marketing** and increases **consumer protections**
- Expands plan requirements for culturally appropriate care and provider directories
- Includes **quality** and **health equity** provisions

The problematic proposal regarding overpayments was NOT finalized.
Coverage Requirements for Basic Benefits

- Codifies standards for coverage criteria to ensure that basic benefits coverage for MA enrollees are no more restrictive than Traditional Medicare.

- Explicitly requires that:
  - MA plans provide coverage of all basic benefits (services covered under Medicare Parts A and B)
  - MA plans must comply with Traditional Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) applicable in the MA plan’s service area.
  - Access to post-acute care (SNFs, HH, IRFs) must be the same for both Medicare FFS and MA
Medical Necessity Criteria

- MA plans must follow Medicare FFS NCDs, LCDs, statutes and regulations when making medical necessity determinations
  - MA plans **cannot limit or deny coverage for a Medicare-covered service based on their own internal or proprietary criteria** if such restrictions don’t exist in Medicare FFS
  - MA plans **cannot apply site of service restrictions** that are not found in Medicare FFS
Criteria for Inpatient Admissions

- MA plans are required to adhere to the Two-Midnight rule, the Inpatient Only List and the Case-by-Case Exception criteria

- However, MA plans are not required to follow the Two-Midnight presumption
  - Under the presumption, hospital stays that cross two-midnights after a patient has been admitted as an inpatient generally are considered payable under Part A and are insulated from Medicare reviews.

- MA plans may still use PA or concurrent case management review of inpatient admissions based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission, under either the Two-Midnight Rule or the Case-by-Case Exception
Prior Authorization

- MA plans may only use PA policies to confirm the presence of diagnoses or other medical criteria and/or ensure that a service is medically necessary.

- PA must be valid for an entire course of approved treatment and for a 90-day transition period if an enrollee undergoing treatment switches to a new MA plan.

- If an MA plan approves an item or service through a PA or preservice determination of coverage or payment, it may not deny coverage later based on lack of medical necessity.

- MA plan clinicians reviewing PA requests required to have expertise in relevant medical discipline for the service being requested.
Utilization Management Committee

- Requires MA plans to establish a UM Committee to review policies annually and ensure consistency with Medicare FFS NCDs, LCDs, and guidelines

- Must be led by the plan’s medical director and including the following:
  - a majority of members who are practicing physicians;
  - at least one practicing physician who is independent and free of conflict relative to the MA organization and MA plan;
  - at least one practicing physician who is an expert regarding care of elderly or disabled individuals; and
  - members representing various clinical specialties (for example, primary care or behavioral health)
**Behavioral Health**

- Adds **clinical psychologists** and **licensed clinical social workers** as specialty types for network standards and make these types eligible for the 10-percentage point telehealth credit;
- Amends **general access to services standards** to explicitly include behavioral health services;
- **Codifies standards for appointment wait times** for primary care and behavioral health services;
- Clarifies that emergency behavioral health services are not subject to prior authorization;
- Requires MA plans to **notify enrollees** when the enrollee’s behavioral health or primary care provider(s) is dropped midyear from networks; and
- Requires MA plans to **establish care coordination programs** to help move toward greater parity between behavioral and physical health services.
Health Equity

- Expands the **list of populations to which MA plans must provide culturally competent services**. The list now includes people:
  - with limited English proficiency or reading skills;
  - of ethnic, cultural, racial or religious minorities;
  - with disabilities;
  - who identify as lesbian, gay, bisexual or other diverse sexual orientations;
  - who identify as transgender, nonbinary and other diverse gender identities or people who were born intersex;
  - who live in rural areas and other areas with high levels of deprivation; and
  - otherwise adversely affected by persistent poverty or inequality.

- Requires **enhancements to provider directories** to include providers’ cultural and linguistic capabilities
Other Notable Provisions

- Establishes **strict marketing restrictions** for MA plans and their vendors that may be confusing or misleading to beneficiaries
- Changes to **MA plan Star Ratings**
  - Eliminate Reward Factor
  - Replace with Health Equity Index
- Makes LI NET program (low-income newly eligible transition program) permanent
- Expands low-income subsidies under Part D
Recap: Key Accomplishments

• Prevents MAOs from limiting/denying coverage for a FFS-approved service, including based on their own internal or proprietary criteria, if such restrictions don’t exist in FFS

• Explicitly states MAOs must follow FFS rules for IP Admission including the Two Midnight Rule and inpatient-only list

• Limits MAO ability to apply site of service restrictions not found in FFS

• Restricts MAO ability to issue denials for emergency services based on medical necessity reviews

• Requires health plan clinicians reviewing PA requests to have expertise in the relevant medical discipline for the service being requested

• Adds specific BH provider types to network adequacy requirements

• Requires PAs to be valid for an entire course of approved treatment

• Requires MAO to establish a UM oversight committee
The Need for Rigorous Enforcement

- Focus shifts to ensuring that new rules are rigorously enforced to achieve MA plan compliance with federal regulations

- AHA Asks:
  - Complaint pathway for patients and providers
  - Data collection and reporting on plan performance
  - More frequent and targeted plan audits
  - Enforcement penalties

- AHA resources to support members in preparing for the rules to take effect and hold payers accountable
Next Steps on MA

- Provisions of the MA final rule apply to the plan year beginning January 1, 2024
- Closely monitoring for a possible second final rule from CMS to address proposed provisions that were not finalized
  - Advocacy to reinforce concerns re: proposed overpayment provision
- Additional AHA resources to support members in preparing for rules to take effect in 2024 and hold payers accountable
Prior Authorization
Prior Authorization Standardization Rule

- **Automated/Standardized process to:**
  - Learn whether PA is required for a service
  - Determine what needs to be sent to the plan to receive approval
  - Ability to complete PA documentation directly from EHR

- **Timelines**
  - Reduces the maximum time from 14 days to 7
  - Sec. may further shorten this timeframe

- **Reporting**
  - Increases plan PA reporting requirements, which should enable more focused enforcement
Alignment with Key Legislation

• Proposed rule largely aligns with what the “Improving Seniors Timely Access to Care Act” seeks to do via legislation
  ➢ Applies to additional plans: Medicaid, CHIP, and Federal Exchange Plans
  ➢ Some differences related to data collection and reporting
  ➢ May reduce legislation’s prohibitively high CBO score

#FixPriorAuth
Patient Billing Guidelines
Patient Billing Guidelines

- **AHA Engagement**
  - Identifying and promoting best practices in patient billing: adopting and updating guidelines for the field from 2003 to the present.
  - Asking hospital members to affirm commitment

- **Core principles for engaging with patients on financial matters:**
  - Treating all people equitably, with dignity, respect and compassion;
  - Serving the emergency health care needs of all, regardless of a patient’s ability to pay; and
  - Assisting patients who cannot pay for part or all of the care they receive.
Patient Billing Guidelines Overview

- Helping Patients with Payment for Hospital Care
  - Helping Patients Qualify for Coverage
  - Helping Patients Qualify for Financial Assistance
  - Providing Financial Assistance to Patients

- Ensuring Fair Billing and Debt Collection Practices
  - Communicating Effectively with Patients
  - Oversight of Third Party Debt Collection
  - Protecting Patients from Certain Debt Collection Practices

- Ensuring Accountability
  - Approval of Financial Assistance and Debt Collection Policies

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