Federal Issues Update

Medicare Advantage Final Rule, Prior Authorization NPRM, No Surprises Act GFEs & AEOBs

AAHAM Quarterly Meeting
July 26, 2023
Medicare Advantage Final Rule
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
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**.
  - The MA plan may not reopen the decision for any reason except for good cause or if there is reliable evidence of fraud or similar fault.

- **MA plan clinicians reviewing PA requests required to have expertise in the 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)
Prior Authorization Proposed Rule

Advancing Interoperability and Improving Prior Authorization Processes Notice of Proposed Rulemaking (NPRM)
Current Landscape

- Intent: to improve patient and provider access to health information and to streamline processes related to prior authorization for medical items and services

- Previous Related Rules
  - CMS Interoperability and Patient Access Final Rule (finalized March 2020)
  - CMS December 2020 Interoperability Proposed Rule
Overview

Provisions
- Patient Access Application Programming Interface (API)
- Provider Access API
- Payer-to-Payer Data Exchange API
- Prior Authorization Requirements, Documentation, and Decision API
- Improving Prior Authorization Processes
- New MIPS measures for Electronic PA

Impacted Payers
- Medicare Advantage
- State Medicaid & CHIP agencies
- Medicaid & CHIP Managed Care Plans
- Qualified Health Plans (QHPs) on the Federally-Facilitated Exchanges

Impacted Providers
- Hospitals and Critical Access Hospitals (CAHs) eligible under the Medicare Promoting Interoperability Program
- Clinicians eligible under the Merit-Based Incentive Program (MIPS)

Requests for Information (RFIs)
- Accelerating the Adoption of Standards Related to Social Risk Factor Data
- Electronic Exchange of Behavioral Health Information
- Improving the Electronic Exchange of Information in Medicare FFS
- Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health
- Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)
Improving Prior Authorization

- CMS proposes a three-pronged approach:
  1. Requiring impacted payers to implement an API to support functions of electronic prior authorization
  2. Standardizing prior authorization decision timeframes
  3. Bringing transparency to prior authorization through metrics for providers and payers
Requiring Impacted Payers to Implement an API to Support Electronic Prior Authorization

- CMS proposes use of the Prior Authorization Requirements, Documentation, and Decision (PARDD) API
  - The FHIR PARDD API would be populated with the payer’s list of covered items and services for which prior authorization is required and the required documentation. The API would also be used to communicate prior authorization decisions

- Payers also required to include a specific reason for a prior authorization denial
Standardizing Prior Authorization Time Frames

- Impacted payers required to send prior authorization decisions within 7 days and expedited prior authorization decisions within 72 hours.

- Existing regulations allow Medicare Advantage organizations and other plans up to 14 days for standard prior authorizations.
Prior Authorization Metrics for Providers

- CMS proposing to add a new measure to the hospital Medicare Promoting Interoperability Program and MIPS titled Electronic Prior Authorization
  - Numerator: # of PA requests requested for items/services from a PARDD API using data from CEHRT
  - Denominator: # of Pas requested for items/services ordered by the MIPS eligible clinician/ordered for patients discharged from the eligible hospital, CAH inpatient, or ED during the performance period
- CY 2026: required but unscored
- CY 2027+: CMS to propose scoring methodology for future program years in subsequent rulemaking
Prior Authorization Metrics for Payers

- Impacted payers would be required to publicly report aggregated data about their prior authorization process on an annual basis. This would include:
  - % of prior authorization requests approved, denied, and approved after appeal
  - Average time between submission and decision
**Requests for Information**

**Improving the Electronic Exchange of Information in Medicare FFS**
- How Medicare FFS could support improved medical documentation exchange between and among providers, suppliers, and patients. CMS believes it could enable better care for beneficiaries if covered services are not delayed by administrative inefficiencies.

**Accelerating Adoption of Standards Related to Social Risk Factor Data**
- Seeking information on barriers to adopting standards, and opportunities to accelerate standards adoption related to social risk data. Given the importance of these data, CMS looks to understand how to better standardize and liberate these data to address social determinants of health.

**Electronic Exchange of Behavioral Health Information**
- Seeking comment on how CMS might leverage APIs to facilitate electronic data exchange between and with behavioral health care providers and community based organizations, who have lagged behind other provider types in EHR adoption.

**Advancing Interoperability and Improving PA Processes for Maternal Health**
- Seeking comment on how health IT standards, such as FHIR, can be used to promote interoperability with, for instance, human services to improve maternal health outcomes. Also interested in comment on special considerations for prior authorization in maternal healthcare.

**Advancing TEFCA**
- Seeking comment on how to encourage providers and payers to enable exchange under TEFCA to make patient information available to providers and support the transmission of coverage and prior authorization requests from providers.

- Good Faith Estimates for Uninsured/Self-Pay Patients
- Patient/Provider Dispute Resolution Process
- Advanced Explanation of Benefits
Broader Price Transparency Landscape

- Numerous price transparency resources available:
  - Hospital machine readable files
  - Insurer machine readable files
  - Provider patient cost estimators
  - Insurer patient cost estimator
  - Third Party cost estimators
  - Good Faith Estimates/ AEOB

- Which should the patient rely upon as the “source of truth”?
  - What to do if numbers are inconsistent between estimator tools

- Could the processes be better aligned to limit overlap/duplicate efforts for plans/providers?
Good Faith Estimates for Uninsured/ Self-Pay Patients

- Good faith estimates required for **all** uninsured/self-pay scheduled services (3+ days out) AND when requested by a uninsured/self-pay patient
- One provider ("**convening provider**") required to coordinate estimates across all providers and deliver one good faith estimate to the patient
- The good faith estimate should cover all items/services from admission to discharge (e.g., all items/services that wouldn’t be scheduled on their own)
- The estimates should be the **cash pay rate or uninsured/self-pay rate**, reflective of any discounts available to the patient (e.g., financial assistance)

**Convening Provider** is defined as the provider/facility responsible for scheduling the primary item/service or that receives the request for an estimate; they will **not** be responsible for the accuracy of other provider’s estimates.
Uninsured/Self-Pay Good Faith Estimates: Convening Provider Process

- HHS has delayed the Convening Provider requirement

- New process/workflow
  - Administrative standard transactions do not carry information between providers
  - Infrastructure not in place
  - Provider technical sophistication varies widely
  - Provider services (and their GFEs) are very interdependent on one another

- Timing Concerns
  - Providers must deliver comprehensive estimate to patient within 1 or 3 days of scheduling.
<table>
<thead>
<tr>
<th>Service Scheduled</th>
<th>Deadline to Return Estimate to Patient</th>
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<tbody>
<tr>
<td>3-9 days in advance</td>
<td>1 business day after scheduling</td>
</tr>
<tr>
<td>10+ days in advance OR by request (service not scheduled)</td>
<td>3 business days after scheduling/request</td>
</tr>
</tbody>
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The convening provider must request good faith estimates from the co-providers within **one business day**; the request must include a deadline for when the convening provider would like the co-providers to respond.
Patient-Provider Dispute Resolution Process

Uninsured/self-pay patients can initiate the patient-provider dispute resolution process in instances when a provider or facility’s total bill is $400+ more than the provider or facility’s total good faith estimate.

<table>
<thead>
<tr>
<th>PROVIDER 1</th>
<th>PROVIDER 1</th>
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<tbody>
<tr>
<td>Service</td>
<td>Good Faith Estimate</td>
</tr>
<tr>
<td>Service A</td>
<td>$500</td>
</tr>
<tr>
<td>Service B</td>
<td>$1,000</td>
</tr>
<tr>
<td>Service C</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$1,500</td>
</tr>
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Note: Each provider is responsible for the accuracy of their own estimates.
Advanced Explanation of Benefits

- Health Plan Requirement: Plans will need to provide an “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients seeking more information prior to scheduling. The Advanced EOB requirement is triggered by the provider sending a “good faith estimate, and must include:
  - Provider network status
  - Contracted rate if the provider is in-network
  - How the patient could obtain information on in-network providers if the provider is out-of-network
  - The provider’s “good faith estimate”
  - A “good faith estimate” of the plan’s payment responsibility, the patient’s expected cost-sharing amount, and where the patient is in meeting their deductibles and out-of-pocket maximums
  - Whether the service(s) are subject to any medical management processes
  - Disclaimer that information is subject to change
**Advanced EOB Process Flow**

1. **Provider receiving request** alerts all other providers involved in the episode of care.
2. **Providers** submit good faith estimate(s) (expected charges, billing codes) to insurer:
   - 1 day if service is in <10 days; 3 days if service in is 10+ days.
3. **Insurer** utilizes good faith estimate(s) to create Advanced EOB:
   - 1 day if service is in <10 days; 3 days if service in is 10+ days.
4. **Patient** receive Advanced EOB.

**Considerations:**
- How should information be shared with payers?
  - X12 837?
  - HL7 FHIR?
- How to treat procedures that are not routine?
- How to handle when patients have multiple insurers?
- How are GFEs from each provider involved in care delivered to plan?
- What to do with incomplete information (e.g., missing estimates, insufficient data to adjudicate)?
  - In what order should multiple procedures be adjudicated?
  - How will the plan know when all GFEs have been received?
  - How to ensure that AEOB will closely align with ultimate patient bill?
- How should information be delivered to patient?
- Does AEOB need to go to provider?
- Patient expectations?
Contact

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Questions?