HEALTHCARE REGULATORY ROUND-UP #68

Managing Medicare Advantage

April 10, 2024

Introductions

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The State of Medicare Advantage

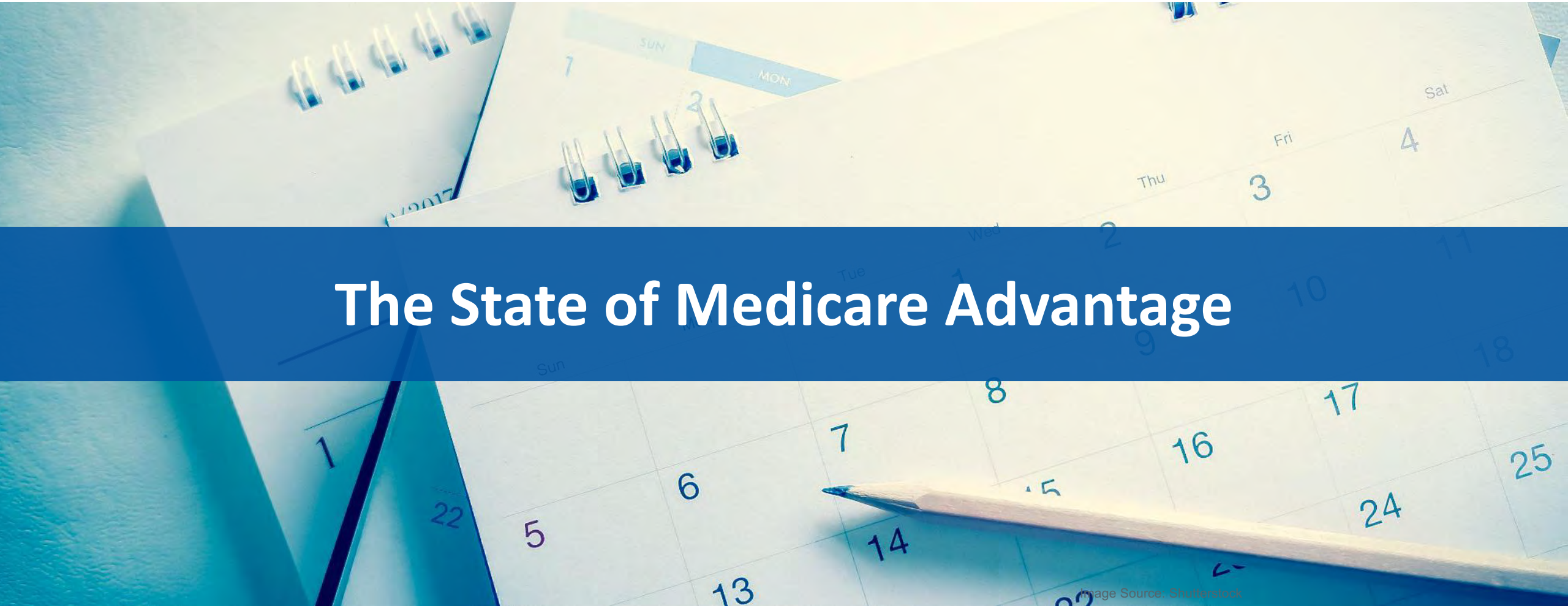


Image Source: Shutterstock

Medicare Advantage – A Brief History

- Bring to Medicare efficiencies and cost savings achieved by private sector managed care
- Medicare Part C
  - Balanced Budget Act of 1997 – Medicare+Choice
  - Medicare Prescription Drug, Improvement, and Modernization Act of 2003
    - Medicare Advantage
    - Part D (prescription drug coverage)

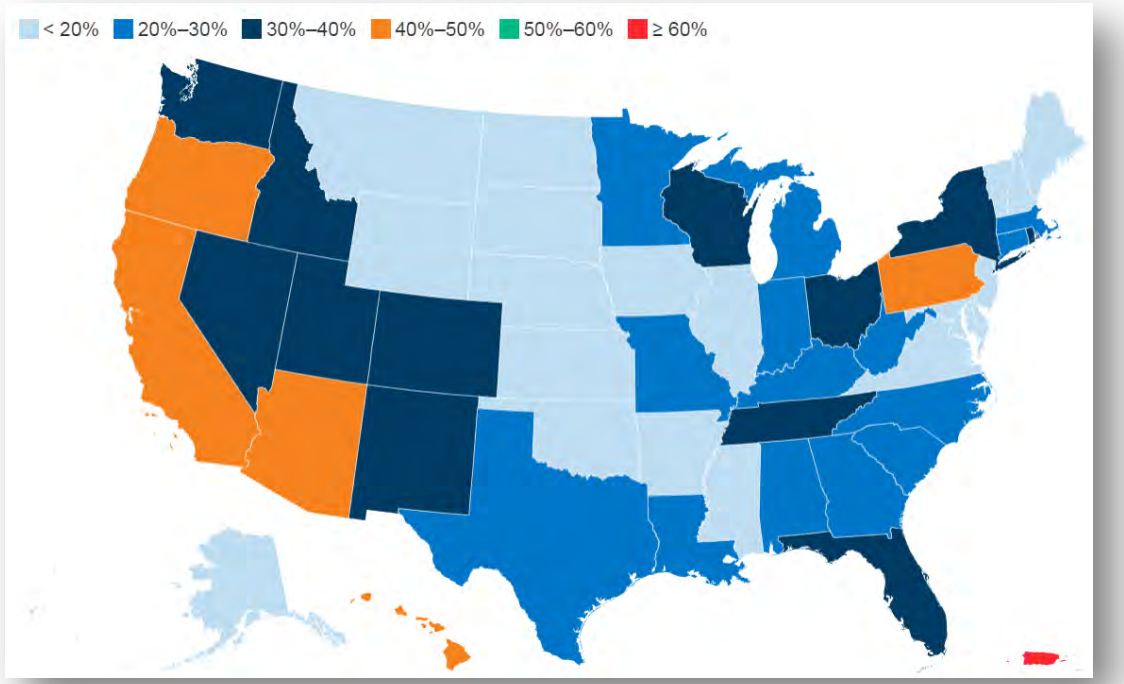
Plan Requirements

- Cover same services as traditional Medicare
- Comply with beneficiary maximum out-of-pocket limits (MOOP) ($8,850 in 2024)
  - Does not include Part B premium ($174.70 in 2024; or higher depending on income) or any non-emergency out-of-network services
- Meet network adequacy requirements
- Reimburse non-contracting providers at least the amount payable under traditional Medicare for Medicare-covered emergency services
  - Including outlier payments, positive and negative adjustments for quality scores, meaningful use, quality reporting; cost-based reimbursement
  - Non-contracted provider can appeal plan decision but must sign waiver of liability
- Provide enrollee appeal process consistent with regulatory requirements (multiple levels of review)

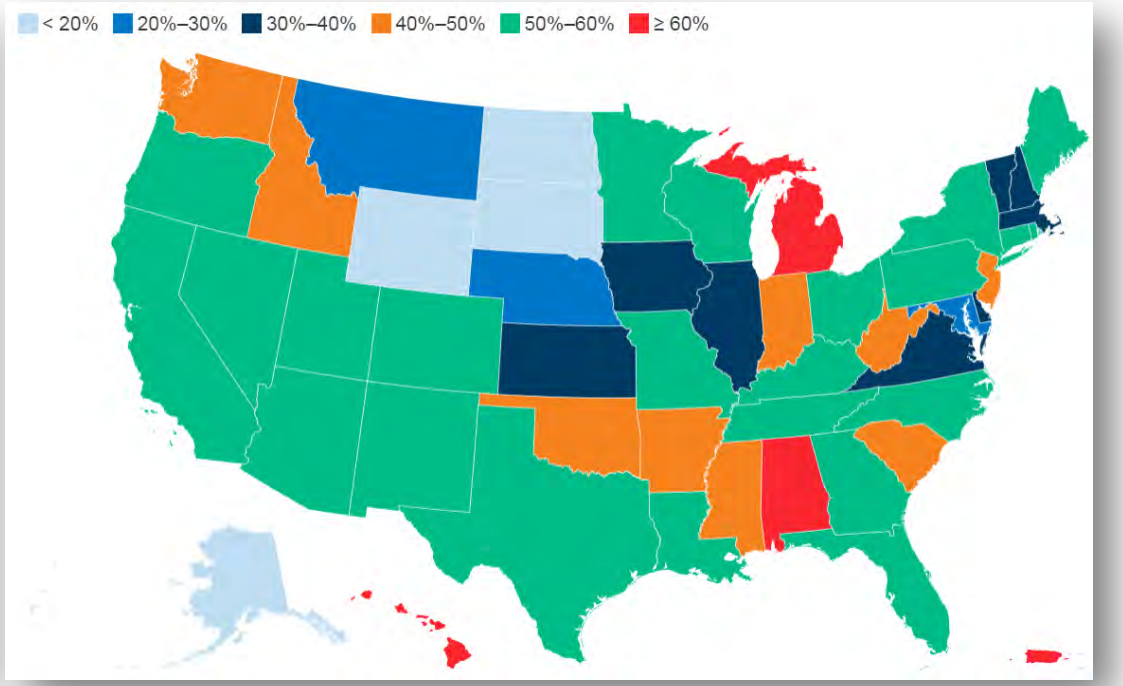
Plan Flexibilities

- Provide permitted supplemental benefits
  - Dental, vision, hearing, fitness programs, food/nutrition programs
  - Supplemental Benefits for the Chronically Ill
- Pay network providers negotiated rates lower than traditional Medicare
- Require prior authorization for specified non-emergency services
- Negotiate grievance/appeal procedures for network providers
  - Denied network provider appeals cannot be appealed to higher levels of review (breach of contract)
- Refuse to pay network providers for services furnished by plan

A Decade of Remarkable Growth



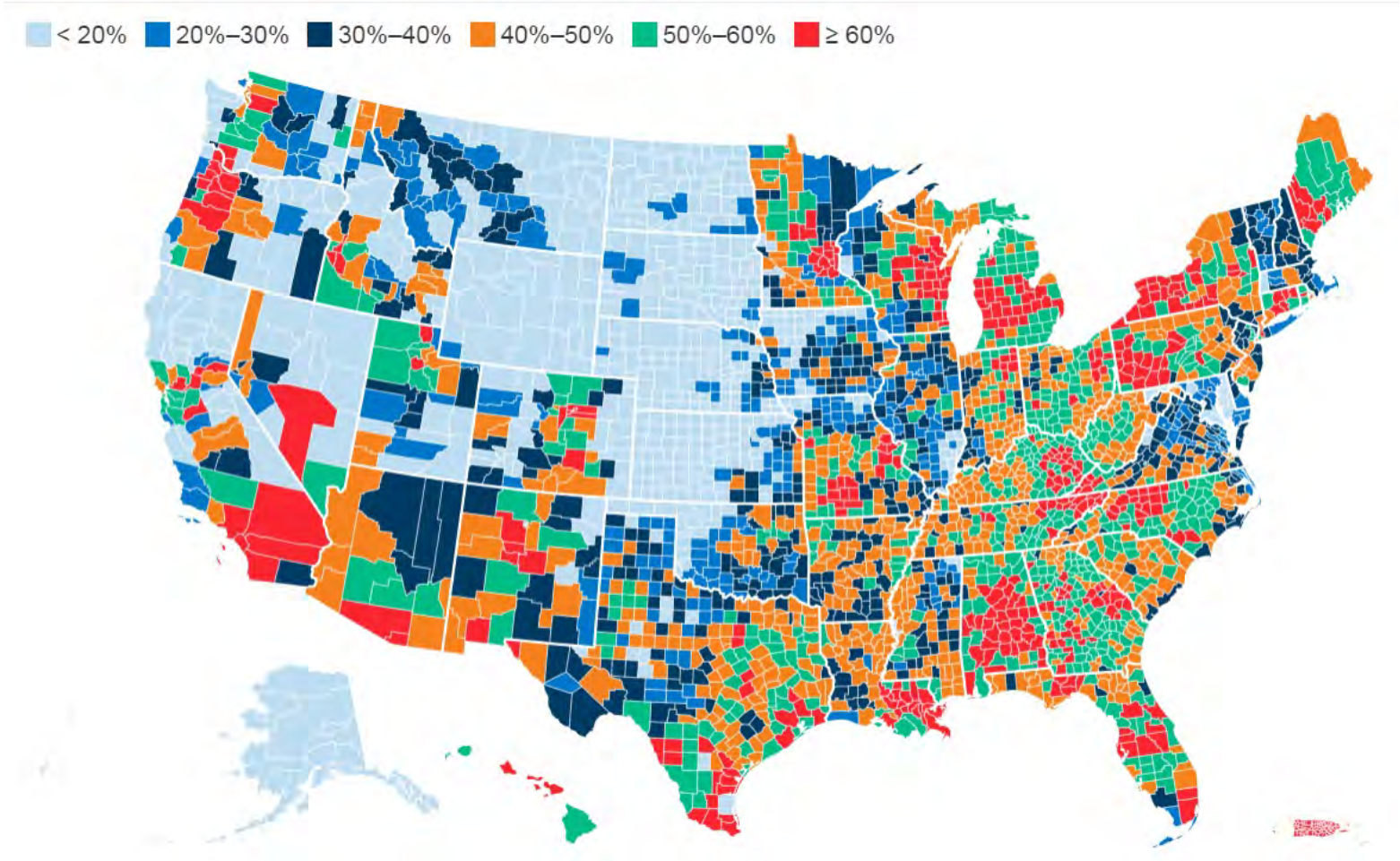
2013



2023

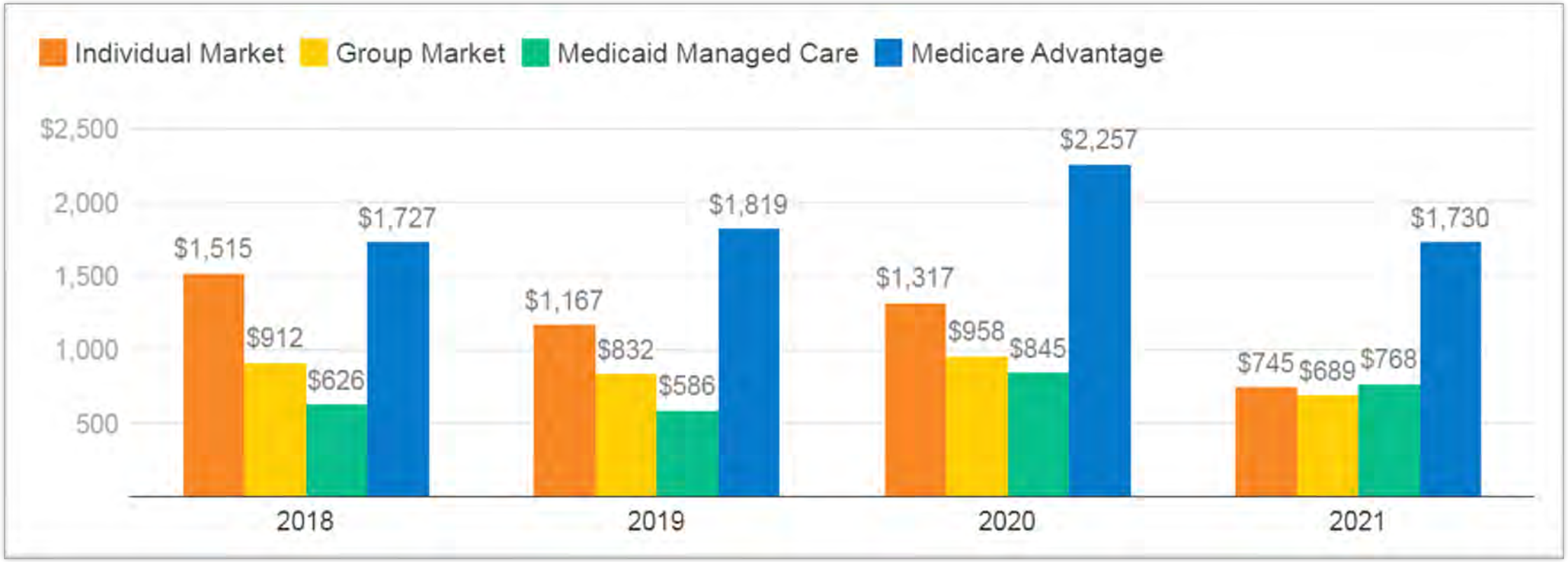
https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

2023 MA Penetration Rates By County



https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

Gross Margins Per Enrollee, 2018-2021



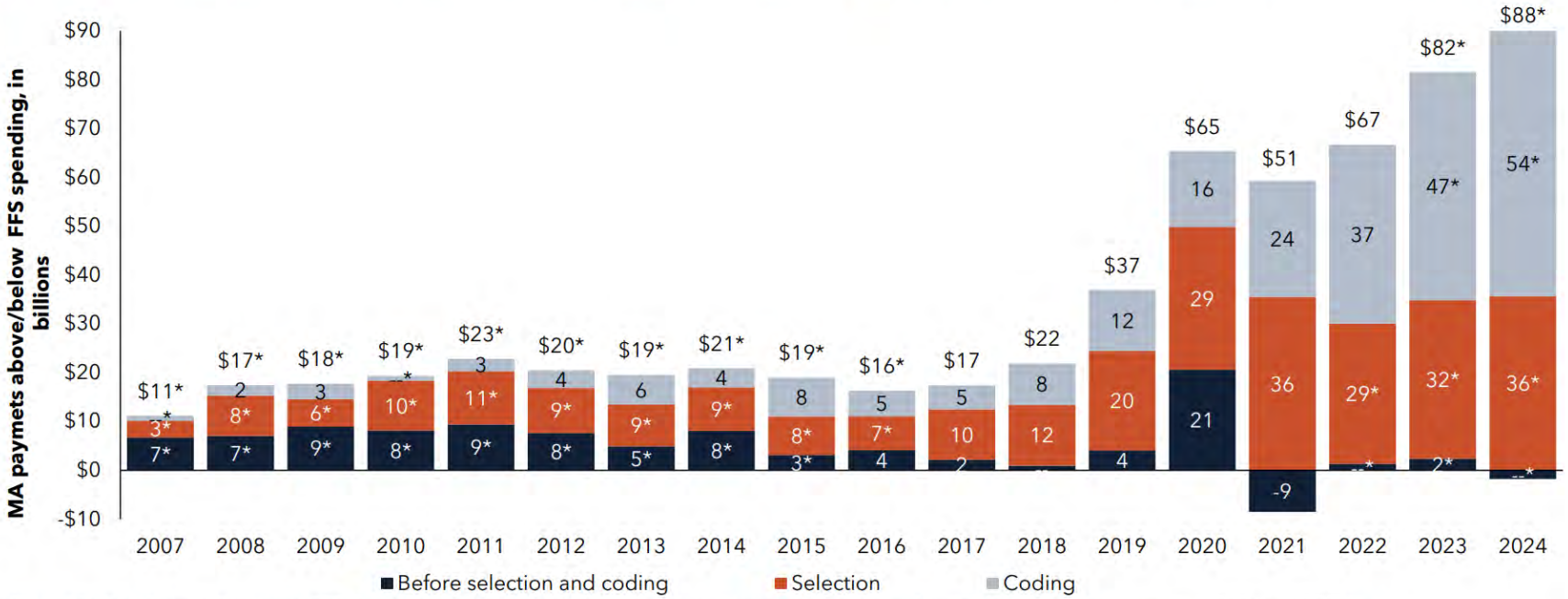
https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

MedPAC 2024 Status Report on Medicare Advantage

- Commission strongly supports the inclusion of private plans in Medicare
- MedPAC estimates that Medicare spends approximately **22% more** for MA enrollees than if those same beneficiaries were enrolled in FFS
  - Equivalent to $83B in 2024
  - Some of these dollars are used for supplemental benefits and better financial protection for MA enrollees
  - Originally, risk-based payment for private plans set at 95% of FFS; averages 122% today
- Calls for “a major overhaul” of MA policies

MedPAC MA Payment Analysis

Coding and selection have driven substantial MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Totals may not sum due to rounding. Estimates from 2017 through 2021 use actual MA and FFS data.
* Specified values used projected data.
--Unidentified values indicate less than $2 billion.
Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf

MedPAC Recommendations

- Replace mandatory minimum coding intensity adjustment (lowers MA risk scores by 5.9%)
  - Develop risk-adjustment model that uses 2 years of FFS and MA diagnostic data
  - Exclude diagnoses that are documented only on health risk assessments from either FFS or MA
  - Apply coding adjustment that fully accounts for remaining differences in FFS and MA
- Improve encounter data accuracy and completeness
- Replace quality bonus program
- Establish more equitable benchmarks

2025 MA Rate Announcement (April 1)

- Includes, as proposed, small decrease in benchmark payments
  - Reduction of 0.16% from 2024 rate
  - Overall revenue expected to be 3.7% higher than 2024
    - Revenue increase tied to increase in risk adjustment payments
- Star Ratings program also expected to reduce quality bonus payments by 0.11%
- Payer “concerns” about maintaining current level of supplemental benefits
  - Sen. Rick Scott (R-FL) *Protect Our Seniors Act* - $33/month reduction in supplemental benefits

Continued Phase-In of Coding Adjustment Changes

- 2024 CMS-HCC model
  - Move from ICD-9 to ICD-10 (finally!)
  - Transition from 2024-2026
  - Blends 67% of risk score using 2024 MA risk adjustment model and 33% using 2020 model
    - Impact of 2025 blended model -2.45% compared to 2024 ($9.2B in savings to Medicare trust fund)
  - Removal of some codes from Hierarchical Condition Categories (HCC) model

Prior Authorization, Coverage Criteria, and Utilization Review

Image Source: Shutterstock

Prior Authorization Statistics - 2021

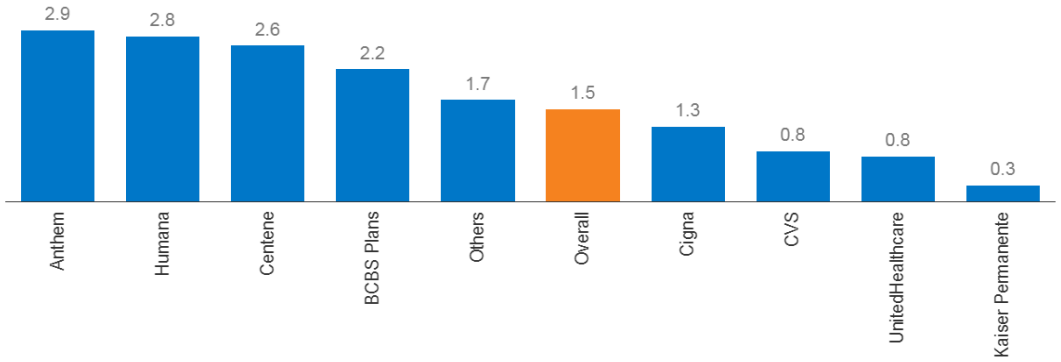
- Based on data from MA plans representing 87% of enrollment, in 2021 –
  - Providers submitted **35M+ PA requests** to MA plans, and average of 1.5 requests per enrollee
  - **2M+** PA requests were **fully or partially denied** by MA plans
  - Only **11%** of PA denials **appealed**
  - **82%** of appeals resulted in **fully or partially overturning** initial PA denial

https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

Prior Authorization Statistics - 2021

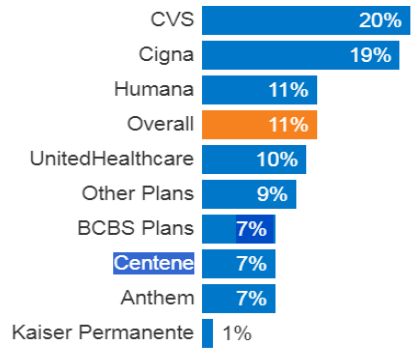
Prior Authorization Requests Are More Common Among Certain Medicare Advantage Firms

Requests for prior authorization of services per Medicare Advantage enrollee in 2021



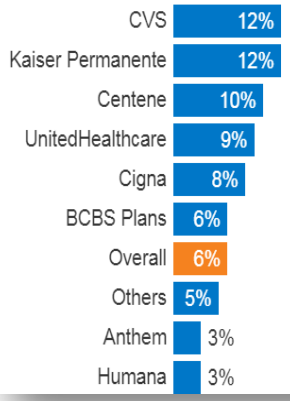
About 1 in 10 (11%) Prior Authorization Request Denials Were Appealed

Share of adverse and partially favorable prior authorization determinations that were reconsidered in 2021



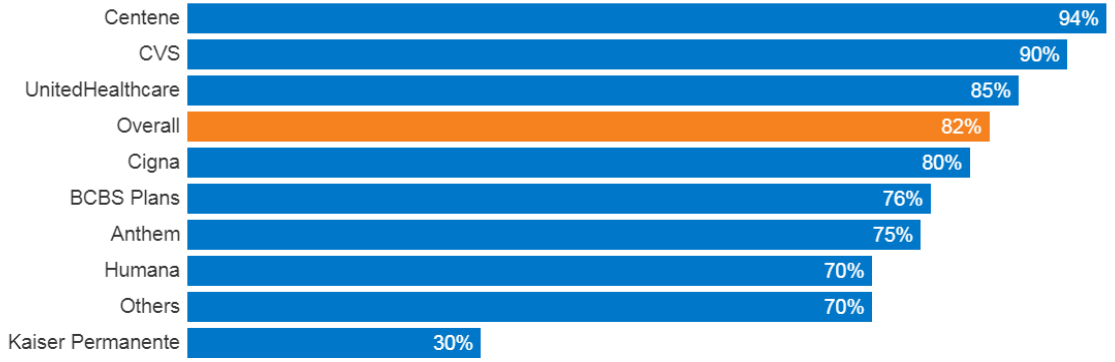
Firms Denied Between 3% and 12% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2021



Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

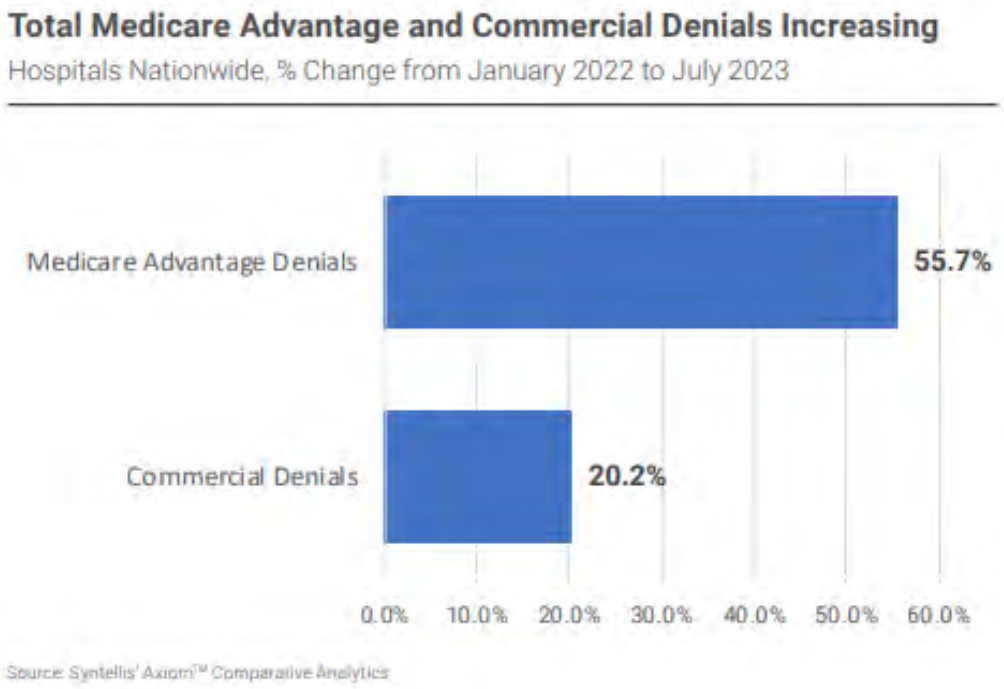
Share of reconsiderations that were fully or partially favorable in 2021

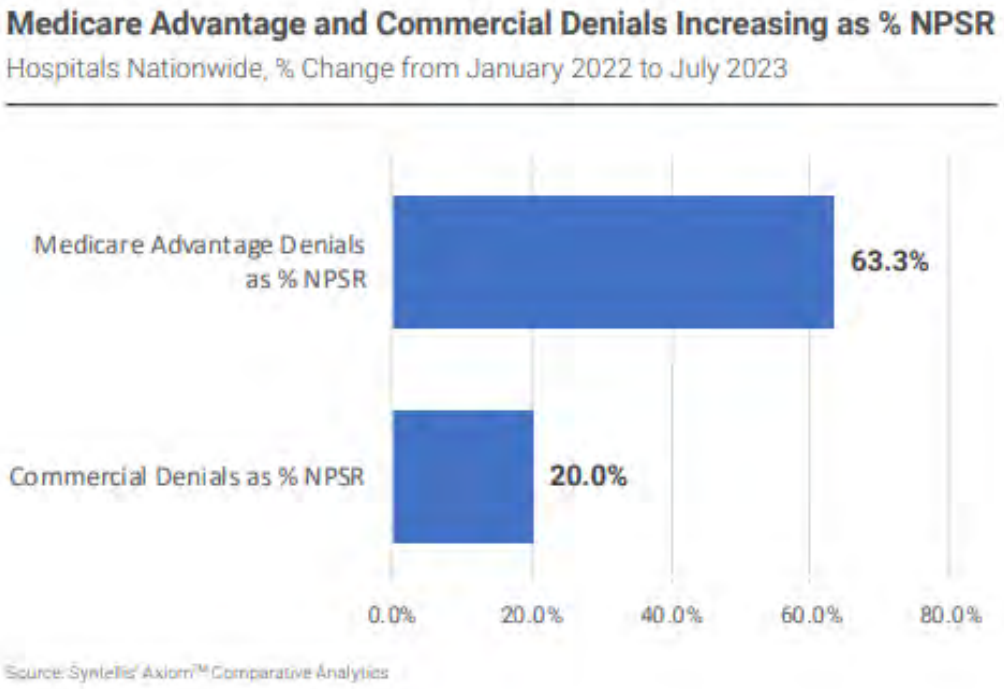


https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

Hospital Vitals: Financial and Operational Trends

Syntellis & American Hospital Association





https://www.syntellis.com/sites/default/files/2023-11/aha_q2_2023_v2.pdf

Impact of Provider Push Back

- Humana discontinued cataract surgery PA policy for MA beneficiaries in Georgia that had been criticized by ophthalmology groups
- UnitedHealthcare abandoned plans to implement gastroenterology endoscopy PA policy in favor of advance notification policy for non-screening and non-emergent GI procedures
- Cigna delayed implementation of policy requiring submission of medical records when using modifier 25 for all E/M claims billed with CPT 99212-99215 + minor procedure
- UnitedHealthcare implemented 20% reduction in PA requirements

U.S. Department of Labor Lawsuit Against UnitedHealth Group Subsidiary

- Lawsuit filed in federal district court on July 31, 2023
  - Pending motion to discuss
- DOL alleges UnitedHealth Group subsidiary UMR incorrectly denied thousands of ER claims based solely on diagnosis codes (vs. applying prudent layperson standard)
  - UMR = TPA that serves 2,000+ self-funded employer health plans

Class Action Lawsuit Against UnitedHealthcare

- Lawsuit filed in federal district court on November 14, 2023, against UnitedHealthcare and its subsidiary NaviHealth
  - Alleges illegal use of algorithm (nH Predict) to deny rehab care despite knowing algorithm has high error rate
  - UnitedHealthcare claims algorithm not used to make coverage decisions

2024 MA & Part D Final Rule (effective 01/01/2024)

1. MA plan must comply with traditional Medicare NCDs, LCDs, and general coverage and benefit conditions
   - Including coverage criteria for inpatient, IRF, and SNF admissions and HHA services
   - Specifically, admissions for surgeries on inpatient only list and admissions meeting two midnight benchmark (but not the two-midnight presumption applied for medical review purposes)
2. If (and only if) coverage criteria not fully defined by above, may establish internal coverage criteria
   - Must be based on current evidence in widely used treatment guidelines or clinical literature
   - Must be publicly accessible (including summary of evidence)
   - Plan must demonstrate additional criteria provide clinical benefits highly likely to outweigh any harm (including delayed/decreased access to care)

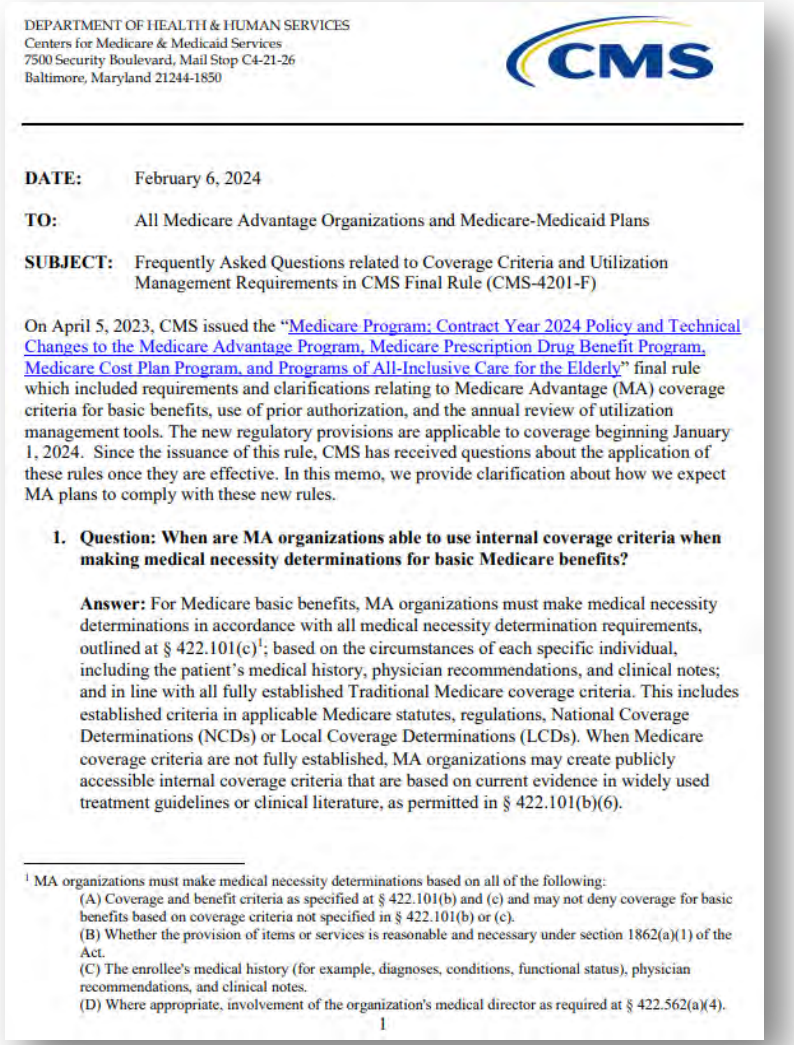
2024 MA & Part D Final Rule

3. Must establish Utilization Management Committee led by Medical Director to review PA policies annually
    - 2025 MA & Part D Final Rule (released 04/04/2024) added new requirements
        - At least one committee member must have expertise in health equity
        - Committee must conduct annual plan-level health equity analysis of PA policies
4. PA approval must remain valid for as long as medically necessary to avoid disruptions in care; must provide minimum 90-day transition period when enrollee undergoing treatment changes coverage

Additional Clarification

FAQs issued February 6, 2024, clarify new regulations

But not on CMS website (or at least we couldn't find it)



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

CMS

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)[1]; 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).

[1] 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).

1

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

Two Midnights – Benchmark vs. Presumption

- MA plans must follow two midnights benchmark (42 CFR 412.3(d)(1))
  - Admitting physician expects patient to require hospital care that crosses two-midnights
- MA plans not required to follow two midnights presumption (CMS medical review instruction)
  - Any claim that crosses two midnights following inpatient admission order are presumed appropriate for payment
- MA plan may evaluate whether admitting physician's expectation was *reasonable* based on complex medical factors documented in medical record

Post-Claim Audits

- If MA plan provided prior authorization, plan cannot later deny coverage for lack of medical necessity and cannot re-open its decision without good cause/reliable evidence of fraud
- Any post-claim review that constitutes a refusal to provide or pay for services = ***organization determination*** that must be reviewed by physician or other healthcare professional with relevant expertise

Use of AI in Coverage Determinations

- CMS allows use of AI in making determinations, but MA plan must ensure that algorithm or AI complies with all applicable rules for medical necessity
  - Looks at individual patient circumstances/medical history
  - Physician's recommendations
  - Clinical notes
  - Cannot be used to deny admission or downgrade an observation stay

Prior Authorization Final Rule (January 17)

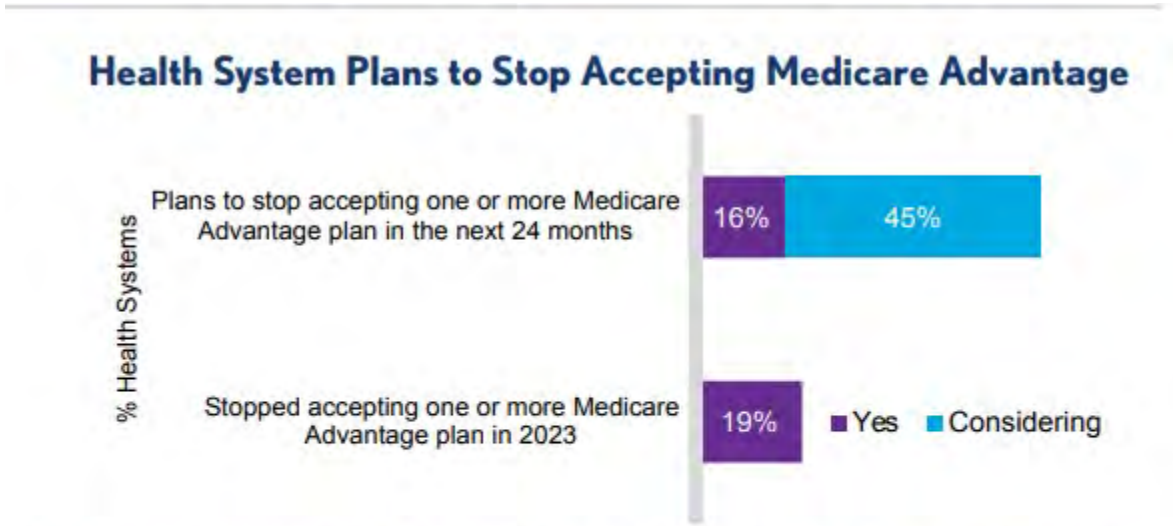
- Applies to MA & Medicaid MCOs
  - Beginning 1/1/2026, plans must send PA decisions within 72 hours for urgent requests and 7 calendar days for standard requests
  - Beginning 1/1/2026, plans must furnish provider with written explanation for PA decision
  - Beginning 3/31/2026, plans must post on their websites specified PA metrics
    - Percent of PA requests approved, denied, approved after appeal
    - Average time between submission and decision
  - By 1/1/2027, plans must implement APIs to facilitate electronic PA process
    - Identify items or services requiring PA, excluding drugs
    - Specify documentation requirements for items and services requiring PA

Going Out of Network

- 69% increase in media-reported provider-payer disputes in 2023*
  - From 51 to 86 disputes; from 24 to 34 states
  - 59% of disputes involved MA
- Examples
  - Baptist Health (KY, IN) – OON for UnitedHealthcare & Wellcare
  - St. Charles Health System (OR) – OON for Humana, HealthNet and WellCare
  - Vanderbilt (TIN) – OON for Humana
  - Bon Secours (VA) – resolved litigation, contract disputes with Anthem
  - Scripps Clinic and Scripps Coastal (CA) – OON for all MA
  - WakeMed (NC) – OON for Humana

*https://fticommunications.com/end-of-year-update-payer-provider-disputes-in-the-public-eye-in-2023/

HFMA Health System CFO Pain Points 2024



- **Between onerous authorization requirements and high denial rates, health systems are frustrated with Medicare Advantage.**
- **19% of health systems have stopped accepting a Medicare Advantage Plan 61% are planning to or are considering.**

Based on feedback from 135 health system CFOs. Summary available at https://www.hfma.org/wp-content/uploads/2024/03/Overview-2024-CFO-Pain-Points-Study.pdf

Impact on Beneficiaries

- Forced to change providers if maintain MA plan (except emergency services)
- Moving from MA to traditional Medicare
  - Higher cost or unavailability of Medigap plan (guaranteed issue vs. medical underwriting)
    - Limited federal guaranteed issue rights
    - Only 4 states prohibit medical underwriting by Medigap plans
  - Loss of supplemental benefits
  - Potential for higher out-of-pocket costs

MA Enrollment and Marketing Restrictions

Image Source: Shutterstock

MA Plan Year 2024 Final Rule –Marketing Restrictions

- 22 new restrictions on marketing activities based on CMS' review of recorded telephone calls and consumer complaints
  - Cannot mention widely available benefits (e.g., dental, vision, hearing, premium reduction, cost savings) in plan marketing unless materials filed/approved by CMS
  - Cannot use superlatives to describe plans unless also providing factual data that supports their usage and meets CMS requirements
  - Cannot tell potential enrollees how much they could save by comparing costs to those who don't have insurance or who have not paid their medical bills
  - Cannot use of Medicare name, CMS logo, and products and information issued by federal government in misleading way

2025 MA & Part D Final Rule (April 4)

1. Broker compensation
   - Broadens definition of ‘compensation’ to prevent add-on payments
   - Replaces compensation limits with flat rate
     - For 2025, $726 for each new enrollee, $313 for each renewal (estimates)
2. Limits on Third Party Marketing Organizations’ sharing personal beneficiary data
   - TPMO may share with another TPMO only with beneficiary’s express written consent to share data and be contacted for enrollment/marketing purposes
3. Mid-year enrollee notification of available supplemental benefits
   - Personalized notice to all enrollees each July with list of benefits not accessed + scope of benefit, costing-sharing, instructions for accessing, and customer service number for additional help
4. Enhanced beneficiary appeal rights for termination of SNF, CORF, or HHA services

CMS Request for Information - MA Data Transparency

Image Source: Shutterstock

January 30 RFI on MA Transparency

- Requests comments on all aspects of data relating to MA program – due May 29
  - Provider directories and networks
  - Prior authorization and utilization management
    - Denials and appeals
    - Use of algorithms
  - Cost and utilization of different supplemental benefits
  - MA marketing and consumer decision-making
  - Care quality and outcomes
    - Value-based care arrangements
    - Health equity
  - Impact of mergers and acquisitions, high levels of enrollment concentration, effects of vertical integration

https://www.federalregister.gov/public-inspection/2024-01832/request-for-information-medicare-advantage-data

Unreported Data

Type of Data not Reported or Published	Example of Questions that Cannot be Answered Because of Gaps in Data	Status
Use of supplemental benefits and associated spending	What share of Medicare Advantage enrollees use supplemental benefits offered by their plan and how does use vary by race/ethnicity, income, or health condition?	Not reported
Prior authorization data by type of service, beneficiary characteristics, and plan	What services and subgroups of enrollees, such as those with specific health conditions, have the highest prior authorization denial rates?	Not reported
Reason for prior authorization denials	Do certain insurers attribute denials of prior authorization requests to medical necessity more often than others?	Not reported
Timeliness of prior authorization decisions	Do certain insurers respond to prior authorization requests more quickly?	Not reported
Share of Medicare Advantage claims that are denied after service has been provided	How often do Medicare Advantage insureres deny payments for Medicare-covered services?	Not reported
Benefits and cost sharing for employer/union plans	What supplemental benefits are offered by employer and union sponsored plans?	Not reported
Out-of-pocket spending and other payment information for Medicare covered services	What share of Medicare Advantage enrollees reach their annual out-of-pocket limit each year?	Not published

https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/

Our Next Healthcare Regulatory Round-Ups

April 24 – Price Transparency: Are You Ready for July 1?

May 8 – FY2025 Proposed Rules

May 22 – MIPS Refresher Course

June 5 – Getting Paid to Address Social Determinants of Health

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