2nd Annual Legal, Regulatory and Compliance Summit on

Medicare Advantage

Navigating New Limits to the Use of Prior Authorization in Medicare Advantage

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Agenda

- Impact of April 12, 2023 CMS Final Rule on Prior Authorization
  - Coverage Criteria
  - Continuity of Care
  - Utilization Management (UM) Committee
- Interoperability Update
- Perspectives On Why PA Limitations Are Necessary
- Industry Trends for Streamlining PA Process
- Operational Considerations
- CMS Oversight Activities

April 12, 2023 CMS Final Rule – Expansive Interpretation of Requirement to Follow Original Medicare Coverage Policies

- Medicare Advantage (MA) basic benefits must equal those available in Original Medicare
- MAOs must comply with general coverage and benefit conditions included in Original Medicare laws
  - "Payment rules" include coverage criteria
  - Refer to Original Medicare regulations, manuals, and guidance
  - Examples 42 CFR 422.101(b)
    - Two-Midnight Rule in 42 CFR 412.3
    - Skilled Nursing Facility, Home Health, Inpatient Rehabilitation Facilities
- If MAOs exceed Original Medicare coverage, must be structured as supplemental benefits

Impact on MAOs Varies

- Impact of Coverage Criteria interpretation will vary based on
  - Previous structure of provider agreements: Did they incorporate Original Medicare payment policies?
  - Historic reliance on Original Medicare payment guidance versus internal policies
- Original Medicare authorities include:
  - National Coverage Determinations (NCDs); Local Coverage Determinations (LCDs)
  - Coverage instructions and guidance in Original Medicare manuals (e.g. Medicare Benefit Policy Manual, Medicare Program Integrity Manual), regulations, instructions and other guidance documents unless those materials are superseded by regulations in Part 422.

Excerpt from 2019 Article in *The Hospitalist*

"Medicare Advantage plans may or may not follow the two-midnight rule, depending on their contract with the hospital. Which patients are appropriate for inpatient designations are usually determined by the individual contract that the hospital has signed with that payer."

Medicare's two-midnight rule: What hospitalists must know, by Charles Lock, MD; Edward Hu, MD, February 22, 2019, available at https://www.the-hospitalist.org/hospitalist/article/194971/medicares-two-midnight-rule.

Use of MA Internal Plan Coverage Criteria

42 CFR § 422.101(b) and (c)

- If Original Medicare has established coverage criteria, MA plan cannot deny based on its own additional criteria.
- MA plans may use prior authorization and post-claim review to determine <u>if Original Medicare coverage criteria are met</u>
- In <u>absence</u> of fully established Original Medicare criteria, MA plan may create criteria based on current evidence in
  - widely used treatment guidelines or
  - publicly available clinical literature

When Original Medicare Coverage Criteria Are Not Fully Established

42 CFR 422.101(b)(6)(i)

1. Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently;
2. NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or
3. There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

Make Publicly Accessible

42 CFR 422.101(b)(6)(ii)

1. Internal coverage criteria in use and a summary of evidence that was considered during the development of the internal coverage criteria;
2. Listing of sources of such evidence; and
3. Explanation of rationale that supporting adoption of the coverage criteria used to make a medical necessity determination.
   - When Original Medicare coverage criteria are not fully established, MAO must identify the general provisions being supplemented or interpreted and explain how the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

Medical Necessity Reviews

- Must be based on the circumstances of the specific individual, as outlined at § 422.101(c)
- Not solely using an algorithm or software that doesn't account for an individual's circumstances
- Use of software does not absolve MAO of regulatory requirements and is permitted only if
  - MAO understands how clinical evidence relied upon in tools supports the embedded coverage criteria;
  - MAO makes evidence and internal criteria publicly available

Duration of Prior Authorization

42 CFR §422.112

- Approval of a prior authorization for a course of treatment must be valid for as long as medically necessary to avoid disruptions in care, in accordance with
  - applicable coverage criteria,
  - the patient's medical history (for example, diagnoses, conditions, functional status), and
  - the treating provider's recommendation
- No new maximum or minimum number of days of prior authorization
- Cannot be shorter than approval periods in Original Medicare coverage criteria

Continuity of Care – 90 Day Transition Period

42 CFR §422.112(b)(8)

A minimum 90-day transition period for any *active course(s) of treatment* when an enrollee has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider.

- Includes enrollees new to a plan and enrollees new to Medicare
- MAO must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days
  - **"Course of treatment** means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan"
  - "**Active course of treatment** means a course of treatment in which a patient is actively seeing the provider and following the course of treatment."

UM Committee Duties and Composition

42 CFR §422.562(a)

- At least annual review of all policies for UM, including prior authorization, considering:
  - The services to which the utilization management applies;
  - Coverage decisions and guidelines for Original Medicare, including NCDs, LCDs, and laws; and
  - Relevant current clinical guidelines.
- Composition of committee
  - majority of members who are practicing physicians;
  - at least one practicing physician who is independent and free of conflict relative to the MAO;
  - at least one practicing physician who is an expert regarding care of elderly or disabled; and
  - include members representing various clinical specialties to ensure that a wide range of conditions are adequately considered

UM Committee and Policies

- No use of UM policies for basic or supplemental benefits on or after January 1, 2024 unless reviewed and approved by the UM committee
  - May approve on a rolling basis in 2024 and issue during CY 2024
  - Concerns with consistency
- Committee responsible for ensuring UM policies including coverage criteria comply with all updated requirements
  - § 422.101(b) regarding CMS coverage determinations;
  - § 422.138(a)–(c) regarding prior authorization;
  - § 422.202(b)(1) regarding practice guidelines and utilization management guidelines; and
  - § 422.101(c)(1) for medical necessity criteria
- Remove any policies that do not comply fully

Interoperability Proposed Rule

The CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P) was published December 6, 2022

- Prior Authorization Requirements, Documentation and Decision (PARDD) API - Payers will need to maintain an **electronic interface that creates an automated process** for providers to
  - determine whether a prior authorization is required,
  - identify the prior authorization documentation and requirements, and
  - facilitate the exchange of prior authorization information within a provider's organization.
- The Proposed Rule would require prior authorization decisions within **72 hours for expedited requests and 7 calendar days for standard** requests.
- Payers would be required to **publicly report prior authorization metrics annually**. Reported metrics would include:
  - A list of all items and services that require prior authorization
  - The percentage of standard prior authorization requests that were approved and denied
  - The average and median timeframe for standard and expedited decisions

Perspectives On Why PA Limitations Are Necessary

OIG

- Improperly applied Medicare coverage rules to deny 13% of prior-authorization requests and 18% of payments

CMS

- High overturn rates
- Inappropriate denials
- Low appeal rates potentially due to insufficient details in denial letters

Kaiser Family Foundation

- 6% service requests were denied
- Only 11% were appealed
- 82% were fully or partially overturned by the MAO

Industry Trends for Streamlining PA Process

Actions Taken

- Eliminated many procedure code requirements for prior authorizations
- Eliminated pre-certification for certain outpatient therapies e.g., PT
- Eliminated pre-certification for durable medical equipment
- Eliminated prior authorization for certain surgeries e.g., cataract, spine

Impact of Actions Taken

- United Health: reduced nearly 20% of their prior auth requirements for various treatments & equipment
- Cigna: Only 6% of medical services go through the prior auth process
- Aetna: Eliminated prior auth for cataract surgery (except for GA & FL). Ceased prior auth for PT in 5 states

Operational Considerations

UM Committee Review and Approve On a Rolling Basis

- Determine whether to use an existing committee or form a new committee to review all medical policies.
- If UM is delegated to a TPA or IPA, should there be a process for these policies to be reviewed and approved by the MAO's UM Committee?

Make publicly accessible summary of evidence considered in developing internal coverage criteria, including a list of the sources and rationale

- How can a MAO comply with this requirement, when using proprietary guidelines like InterQual and MCG?

Operational Considerations (con't)

Continuity of Care – 90 Day Transition Period

- What systems and process changes are needed to recognize new members to a plan or new to Medicare to support a course of treatment for 90 days?

Denial Reason Requirement

- What systems and process changes are needed to better facilitate communication between the MAO and provider so that the denial reason contains sufficient specificity and additional information needed to promote successful resubmission of the prior authorization>

CMS 2024 Oversight Activities

Strategic Conversations

- CMS Account Managers will be conducting strategic conversations with MAOs to ensure your understanding and implementation of these coverage criteria and UM requirements. The strategic conversations will begin in November 2023.

Routine Program Audits

- Starting in January 2024, the Medicare Parts C and D Oversight and Enforcement Group will begin conducting both routine and focused audits of organizations to assess compliance with the UM requirements finalized in CMS-4201-F. Routine program audits will be conducted as we have conducted them in the past.

Focused Audits

- Will only test the Compliance Program Effectiveness (CPE) and Organization Determinations, Appeals, and Grievances (ODAG) program areas during focused audits.
- CMS will provide selected organizations with additional instruction and guidance after CMS initiates the focused audit.
- Organizations offering MA and Medicare Advantage-Prescription Drug Plans (MAPD) may be subject to a focused audit even if the organization completed a 2021 or 2022 routine program audit.
- Organizations audited in 2023 and undergoing a **CMS-led audit validation** may be subject to a review of the new UM requirements during their validation audit.

HAVE A QUESTION?