# 2024 Updates for Medicare Inpatient and Outpatient


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# Objectives

- Attendees will familiarize themselves with key Medicare proposed rules and how they may impact their revenue cycle
- Understand how CMS 4201-F final ruling will impact Medicare Managed care workflows CY2024 and beyond
- Be aware of what’s happening around the country with the No Surprises Act Independent Dispute Resolution workflow

# CMS Proposed 340B Underpayment Remedy for CY 2018–2022

**CY2018 final rule paid 340B covered entities less money under OPPS for 340B drugs**

- CMS estimates a $10.5 billion underpayment in 340B drug payments

**American Hospital Association et al sues CMS**

- CMS appeals to Supreme Court and loses

**Two decisions made in court**

- Payments must be corrected immediately
- Prior 4 years of underpayments need to be addressed and remedied

# CMS Proposed 340B Underpayment Remedy for CY 2018–2022

**CMS began reprocessing claims effective September 27th, 2022, forward; repaying the statutory rates of ASP +6%**

**A one-time lump sum payment to each 340B covered entity that was underpaid**

- Lump sum amount includes the beneficiary cost-sharing amount so hospitals will not need to collect it from patients, particularly since the time range for the services goes back several years

**Offset future non-drug items and services payment by adjusting the OPPS conversion factor minus 0.5% in CY 2025 until the estimated $7.8 billion in non-drug items and services overpayment is recouped from impacted providers**

- CMS estimates it could take up to 16 years

# Medicare Prescription Payment Plan

**The Medicare Prescription Payment Plan under the Inflation Reduction Act, gives people with Medicare prescription drug coverage (Medicare Part D) the option to pay out-of-pocket costs in monthly payments spread out over the year, starting in 2025.**

**The new plan helps those who struggle the most with high upfront prescription drug costs and provides a way to ensure people with Medicare can get the life-saving medications they need.**

# Medicare Prescription Payment Plan

**Part 1: Helping Medicare Part D plan sponsors and pharmacies by:**

- Identifying Medicare Part D enrollees likely to benefit from the program
- The opt-in process for Part D enrollees
- Program participant protections
- Provides the data collection needed to evaluate the program

**Part 2: Guidance for Enrollee outreach and education:**

- Medicare Part D plan bid information
- Monitoring and compliance

**Developing calculators to help beneficiaries and their caregivers determine what monthly payments may look like under the new program**

# Medicare Advantage Organizations - OIG Audit
# How did we get here?

- Increase in concerns reported pertaining to the potential incentive of the MAO to deny
- Random sample of 250 prior authorization denials and 250 payment denials
- Health care coding experts conducted case file reviews of all cases, and physician reviewers examined medical records for a subset of cases
- MAOs delayed or denied beneficiaries' access to services, even though the requests met Medicare coverage rules
- MAOs used clinical criteria that are not contained in Medicare coverage rules
- Payment denials caused by human error during manual claim processing (e.g., overlooking a document) and system processing errors (e.g., the MAO's system was not programmed or updated correctly)

# OIG Concerns

- Significant delays in patient access or even prevention of medical care
- Out of pocket costs for covered services for those who can't afford to pay
- Administrative and financial burdens for patients and providers who choose to appeal these denials

# OIG Recommendations

- Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews
- Update audit protocols for use of clinical criteria and/or examining particular service types
- Direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors

# Medicare Advantage Organizations – Final Ruling

- Clinical criteria guidelines to ensure people with an MAO receive access to the same medically necessary care they would receive in traditional Medicare
- Requiring MAO plans to comply with NCD, LCD and general coverage and benefit conditions included in traditional Medicare regulations
- Defines when Medicare coverage criteria are not fully established, the circumstances under which MAO plans may apply internal coverage criteria when making medical necessity decisions

**MAOs internal criteria should not be more restrictive than original Medicare**

# Medicare Advantage Organizations – Final Ruling

- Streamlines prior authorization requirements
- Prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary
- Provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan, during which the new MA plan may not require prior authorization for the active course of treatment
- All MA plans must establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines

**Strengthening protections against denials for medically necessary services ensures MAO enrollees get the medical care they need by adhering to CMS guidelines.**

SOUNDS TOO GOOD...
WHAT'S THE CATCH?

# Medicare Telehealth

## Temporary Medicare Changes Through December 31, 2024

- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services
- Medicare patients can receive telehealth services in their home
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral /mental telehealth services can be delivered using audio-only communication platforms
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required
- Telehealth services can be provided by all eligible Medicare providers

# Medicare Telehealth

## Permanent Medicare Changes

- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services
- Medicare patients can receive telehealth services for behavioral/mental health care in their home
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms
- Rural Emergency Hospitals (REHs) are eligible originating sites for telehealth

# No Surprise Act Details

- Bans surprise patient billing for emergency, air ambulance and out of network services provided at in-network facilities
- Patient cost sharing cannot be higher than in-network
- Creates a consent process
- Providers required to inform the public
- OON payments were based on median in-network rate 2019 – forward
- Dispute process for providers and patients

# Payor Provisions

- **Nearly all private health plans affected**
- **Out of network services automatically processed in-network**
- **Out of network reimbursed at “qualifying rate” without prior authorization**
- **Interim payment or notice of denial 30 days receipt of ‘clean claim’**
  - Plan can extend 15 days for additional information
- **Routine denials not allowed**
- **Payment made to provider, not to patient/subscriber**

# Provider Responsibilities

- Provide Good Faith Estimates for un-insured or self pay patients for scheduled services
- Provide notice of rights to consumers: single page notice and website
- Develop workflow for consent on non-emergent and certain emergent out of network services
- Implement workflow to ensure patients are billed for correct in-network amounts

# Frequently Asked Question #1

**Q. Patient is having elective services (non-emergency services) and facility is out-of-network, may the facility, or the provider balance bill the patient?**

**A. The federal balance billing prohibitions don’t apply to non-emergency services provided by out of-network providers during patient visits to out-of-network facilities. In this setting, the provider does not need to obtain the patient’s consent to bill them directly, or balance bill them**

*CMS No Surprises Act FAQ* https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf

# Frequently Asked Question #2

**Q. The requirement is no balance billing for certain non-emergency services by out-of-network providers during patient visits to in-network health care facilities, unless notice and consent requirements are met. Are there exceptions?**

**A. For purposes of these protections, health care facilities include hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers. These protections do not apply to other types of health care facilities, such as urgent care centers.**

*CMS No Surprises Act FAQ* https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf

# NSA Updates

# NSA Headlines - Advanced EOB Delayed indefinitely

- **AEOB intended as follow up to good faith estimate**
- **September 2022, Request for Information issued by CMS to providers**
- **American Hospital Association & American Medical Association raised concerns via letter to CMS**
  - Differences in information to be collected
  - Standard should follow existing system to avoid costly retraining and programming
  - AEOB applies to >61% of Americans; 1-day requirement unsustainable

# NSA Headlines

- Biden Administration delayed compliance and enforcement to 1/1/2023
- December 2022, HHS released guidance that enforcement delayed where GFE do not include expected charges from co-providers
- New IDR guidance issued by CMS in December 2022
- February 2023, Texas judge ruled IDR process skews arbitration results. CMS instructs IDR agencies to hold determinations until March 10, 2023
- February and July 2023, district courts vacated requirements for IDR entities to use Qualifying Payment Amount to determine payment
- August 2023, final rule released specifying IDR entities should select the offer that best represents value of item or service

# NSA Headlines continued…

- **IDR Fees continue to increase:**
  - Administrative Fee: 2022 $50 | 2023 $350
  - Single Determination Fee: 2022 $200-$500 | 2023 $200-$700
  - Batch Determination Fee: 2022 $268-$670 | 2023 $268- $938
- **Fee increase due to significant backlog of disputes pending eligibility determinations**
  - Contractors and government staff engaged to handle pre-reviews

# Federal IDR Status Update

- **334,828 disputes initiated between April 15 and March 31, 2023**
- **Non initiating parties challenged 122,781 disputes (37%)**
- **39,890 determined ineligible (12%)**
- **42,158 disputes received payment determinations (13%)**
  - Initiating parties prevailed in approximately 71%
- **106,615 disputes have been closed (32%)**

# Resources

- **340B Underpayment** **https://www.forvis.com/alert/2023/07/cms-proposes-340b-underpayment-remedy-cy-2018-2022**
- **Lump sum provider payment estimates - Addendum AAA** CMS website
- **The Medicare Prescription Payment Plan** **https://www.cms.gov/newsroom/press-releases/cms-issues-draft-guidance-new-program-allow-people-medicare-pay-out-pocket-prescription-drug-costs**
  - **Draft Guidance:** https://www.cms.gov/files/document/medicare-prescription-payment-plan-part-1-guidance.pdf
  - **Medicare Prescription Payment Plan fact sheet:** https://www.cms.gov/files/document/medicare-prescription-payment-plan-fact-sheet.pdf
  - **Implementation timeline:** https://www.cms.gov/files/document/medicare-prescription-payment-plan-timeline.pdf
- **CMS Newsroom** **https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f**

# Resources continued…

- Advanced EOB Requirements and CMS Request for Information https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered
- Delayed enforcement for GFEs without co-provider charges https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf
- CMS NSA Resources https://www.cms.gov/nosurprises
- IDR Guidance for Disputing Parties https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf
- CMS No Surprises Act FAQ https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf
- IDR Federal Initial Report https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf
- ANSI Standard remittance codes: https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

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