Medicare Advantage and Prior Authorization Proposed Rules

January 26, 2024

Andrew B. Wheeler, Vice President of Federal Finance

Bill Anderson, Vice President of State Legislation

Agenda

- 102nd General Assembly Update
- 118th Congressional Update
- Hospital Fiscal Status
- Marketplace / Medicaid Dual Enrollment
- Medicare Advantage

State Legislative Update – 102nd General Assembly

- SB 748 – FRA renewal
- HB 1976 / SB 983 – Prior authorization
- HB 1943 / SB 986 – HOPD NPI
- HB 1837 / SB 1212 – Hospital price transparency and medical debt
- HB 2267 / SB 751– White bagging, 340B and biosimilar

Federal Legislative Update – 118th Congress

118th Congress

- Election year
- 1/3 Senate and all House up for election / re-election

Funding the Federal Government

- Funding the government (appropriations and / or continuing resolution)
  - ~~January 19~~ March 1 – VA, HUD, transportation and health extender deadline
  - ~~January 19~~ March 8 – Delayed Medicaid DSH cuts
  - ~~February 2~~ March 8 – DOD, commerce, labor and HHS deadline
    - H.R. 2872 – Further Additional Continuing Appropriations Act, 2024
    - House – 314 yea, 108 nay, 11 not voting; Representatives Alford and Burlison voted nay, Cleaver did not vote and Bush, Graves, Luetkemeyer, Smith and Wagner voted yea
    - Senate – 77 yea, 18 nay, 5 not voting; Senators Hawley and Schmitt voted nay
  - Funding for Israel, U.S. boarder and Ukraine will remain contentious topics

H.R. 5378, Lower Costs, No Surprises Act

- Passed the House by vote of 320 yea, 71 nay, 1 voting present and 41 did not vote
  - Yea – Alford, Bush, Cleaver, Luetkemeyer, Smith and Wagner
  - Nay – Burlison and Graves
- Helpful
  - Transparency requirements for ASCs, health coverage prices and pharmacy benefits (PBM)
  - Delaying Medicaid DSH payment reductions for FFY 2024 and 2025
- Harmful
  - Require each off-campus HOPD to obtain a national provider identifier
  - Reduce Medicare payments when physician-administered drugs are provided in a off-campus HOPD

Missouri Hospital's Fiscal Status - 2022

	Average Operating Margin				
	2018	2019	2020	2021	2022
All MHA Hospitals	1.4%	3.7%	3.1%	2.7%	2.4%
Urban IPPS and CAH	3.9%	5.5%	5.1%	6.6%	1.1%
Rural IPPS and CAH	-1.5%	0.8%	0.3%	-1.6%	2.8%
CAH	-0.6%	-0.9%	-0.8%	0.3%	1.4%
Inpatient PPS	1.3%	4.5%	3.8%	2.6%	2.5%

	Percent of Hospitals Operating With Positive Margins					Percent of Hospitals Operating With Negative Margins				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
All MHA Hospitals	59.2%	63.2%	59.7%	69.8%	57.1%	40.8%	36.8%	40.3%	30.2%	42.9%
Urban IPPS and CAH	83.3%	78.6%	73.2%	88.1%	58.5%	16.7%	21.4%	26.8%	11.9%	41.5%
Rural IPPS and CAH	45.8%	49.2%	46.7%	58.3%	53.4%	54.2%	50.8%	53.3%	41.7%	46.6%
CAH	50.0%	52.9%	50.0%	61.8%	55.9%	50.0%	47.1%	50.0%	38.2%	44.1%
Inpatient PPS	67.0%	66.7%	61.2%	75.0%	55.4%	33.0%	33.3%	38.8%	25.0%	44.6%

Marketplace / Medicaid Dual Enrollment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

Center for Consumer Information and Insurance Oversight

Medicaid Continuous Enrollment Condition Unwinding Marketplace Frequently Asked Questions (FAQ)

This document describes flexibilities for individuals and Marketplaces with regard to Medicaid Continuous Enrollment Condition unwinding operations (Medicaid unwinding) for plan years 2023 and 2024. The guidance referenced in this document is applicable to all Marketplaces on the federal eligibility and enrollment platform and provides specific operational details for enrollees in Marketplaces using the federal platform. State-based Marketplaces (SBMs) using their own platforms have different operational details but can implement applicable changes and policy flexibilities described in this document. This document does not replace or revise previously issued guidance, and references current federal regulations and law, including the recently enacted Section 5131 of the Consolidated Appropriations Act of 2023 (CAA, 2023) and CMS guidance on this provision in the Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) published January 5, 2023, and State Health Official Letter (SHO# 23-002) published January 27, 2023. Additional guidance related to Medicaid unwinding can be found at Medicaid.gov/Unwinding.

Marketplace and Medicaid Enrollment

- Medicaid
  - As a condition to obtain an enhanced Federal Medical Assistance Percentage (FMAP), state Medicaid agencies were required to maintain continuous enrollment
  - Effective for beneficiaries enrolled on or after March 18, 2020
  - Ended March 31, 2023
- Marketplace
  - If a patient was enrolled in a Marketplace product, the annual enrollment could be auto-renewed

Exchange Enigma

- Issue and Identification
  - Found via our No Surprise Act OON meetings.
    - We were unaware of the Exchange Plan.
    - No ID cards scanned- we were told Insurance Cards not sent to patients.
    - Patient conversations identified patients were unaware of Exchange Plan coverage.
  - Denials and $0 pay for hospitals.
  - Likely tax implications for patients.
- Contact
  - MHA
  - MoHealthnet
    - No response
  - CMS
    - Identified likely issue of Broker Fraud & Auto-renewal
    - Asked that we have patients call the Exchange to cancel and possible investigation
      - Exasperated by Public Health Emergency (PHE) due to letters not being sent to patients about dual coverage.
- Meeting with MHA and MO HealthNet
  - Outcome

Medicare Advantage

Prior Authorization Improvements and Electronic Data Sharing

- CMS-4201-F — Medicare Advantage rule
  - Effective for the 2024 contract year
- CMS-0057-F — Interoperability and Prior Authorization
  - Applies to MA, traditional Medicaid, Medicaid MCO and marketplace products
  - Formally withdraws the December 2020 CMS Interoperability and Prior Authorization
  - Application programing interfaces (API)
  - Two pre-publication notices – one 822 pages and a second 728 pages

Interoperability and Prior Authorization Reforms (CMS-0057-F)

- Requires payors to revise APIs
  - Patient Access API – include information about prior authorizations to help patients understand PA processes
  - Provider Access API – includes individual claim data and specific authorization data
  - Payer-to-Payer API
    - information about claims and information about prior authorizations
    - Patient opt-in process
  - Prior Authorization API – include list of covered items and services, identify documentation requirements related to prior authorization requests and denial information

Interoperability and Prior Authorization Reforms (CMS-0057-F)

- Prior authorization reforms
  - Reduce decision timeframes from 14 days to 7 days for standard requests and 72 hours for expedited requests
  - Provide specific reasons for prior authorization denials
  - Payors must include on websites certain metrics
    - List of all items and services that require prior authorization
    - Percentage of standard and expedited requests that were approved
    - Percentage of standard and expedited request that were denied
    - Percentage of standard request that were approved after appeal
    - Percentage of prior authorization requests that the review was extended
    - Average and median time between submission of a request and a determination for standard and expedited requests

Medicare Advantage Rule (CMS-4201-F)

- Utilization management
  - Basic benefits
    - Medical necessity determinations based on coverage requirements that are no more restrictive than traditional Medicare (NCD / LCD and other manuals, guidance or instruction issued by CMS)
    - "May not deny coverage for basic benefits based on coverage criteria"
    - Insurer may create internal plan coverage criteria by providing a publicly accessible summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations
      - Developed by organizations with expertise in specialty
      - Literature to include large, randomized control trials
  - Supplemental benefits

Medicare Advantage Rule (CMS-4201-F)

- MA plan authorization or denial basis limitation
- Prior authorization definition and impact on denials
- Examples of fully established coverage rules

Medicare Advantage Rule (CMS-4201-F)

- Two-Midnight Rule
  - Clarifies that MA plans must adhere to the “Two-Midnight Rule” under traditional Medicare
  - Insurers are creating policies that does not adhere to the Two-Midnight Rule when “not fully developed”
- Inpatient Only List

Inpatient Hospital Services

All hospital services must be reasonable and necessary to be covered. Decisions on the setting for delivery of healthcare services should be based on nationally recognized guidelines and evidence-based medical literature.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,

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including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient; and
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

For coverage to be appropriate under Medicare for an inpatient admission, the documentation must clearly support the member's severity of illness and intensity of service to warrant the need for inpatient medical care

Concurrent review for inpatient admissions is based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission. [42 CFR § 412.3(d)(1) and (d)(3); 88 Fed. Reg. 22191 (Apr. 12, 2023)]

Hospital care that is custodial, rendered for reasons of convenience, or not required for the diagnosis or treatment of illness or injury is not appropriate for coverage or payment. Any extensive delays in the provision of medically necessary services are excluded from time counted towards the two-midnight benchmark. [*Medicare Program Integrity Manual, Ch. 6, § 6.5.2(A)(I)(B)*]

Note: If the physician or healthcare professional is uncertain if an inpatient admission is appropriate, then the physician or healthcare professional should consider placing the patient in observation.

Additional Considerations Supporting Inpatient Stay

- **Medicare's Inpatient-Only List**: Inpatient admissions where a medically necessary inpatient-only procedure is performed are generally appropriate for Medicare Part A payment regardless of expected or actual length of stay.
  - The Social Security Act allows CMS to define services that are appropriate for payment under the Outpatient Prospective Payment System (OPPS). Under this authority, CMS also identifies services that should be performed in the inpatient setting. These services are itemized on the inpatient list, also known as the inpatient-only list. For inpatient only, reference CMS Addendum E. - Final HCPCS Codes that Would Be Paid Only as Inpatient Procedures.
- **Case-by-Case Exceptions to the Two-Midnight Rule**: For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the documentation supporting the severity of illness and intensity of service support medical necessity for inpatient services. [42 CFR 412.3(d)(3)]

Refer to the Medicare Program Integrity Manual Chapter 6, § 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment.

UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding inpatient admissions at 42 CFR § 412.3(d)(1) and (3), *Chapter 1* of the *Medicare Benefit Policy Manual*, and *Chapter 6, § 6.5* of the *Medicare Program Integrity Manual*. UnitedHealthcare uses the criteria noted below in order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision to admit a patient as an inpatient, including factors such as: patient history and comorbidities; the severity of signs and symptoms; the patient's current medical needs; and the risk of an adverse event. Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly

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likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support inpatient admission. Use of this criteria will also further CMS's goal of reducing inpatient admission errors.

- For more detailed elective inpatient hospital services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Elective Inpatient Services.
- For more detailed hospital services definitions/clinical criteria and guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Hospital Services: Observation and Inpatient.
- UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider.

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/macs/hospital-services-01012024.pdf

UnitedHealthcare
MEDICARE & RETIREMENT

Dear Craig: November 13, 2023

Thank you for your inquiry relating to the 2024 MA Final Rule and specifically the Two Midnight Rule. To say that United is not planning to comply with the Final Rule and that it is "just 'guidance'" is inaccurate. The Final Rule is complicated and nuanced.

On November 1, United published an updated version of its Medicare Advantage Coverage Summary for Hospital Services (Outpatient, Observation, and Inpatient), which will be effective January 1, 2024. This Coverage Summary addresses your question and is located at: Hospital, Emergency, and Ambulance Services – Medicare Advantage Coverage Summary (uhcprovider.com)

Moreover:

- The Final Rule expressly allows MA plans to adopt internal coverage criteria when the applicable coverage criteria in Traditional Medicare laws, NCDs, and LCDs are not fully established. (42 CFR § 422.101(b)(6).)
- Coverage criteria are not fully established when, for example, "additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently." (Id., at (6)(i)(A).)
- Coverage criteria are not fully established under the Two-Midnight Rule.
- CMS guidance confirms that the Two-Midnight Rule contains a number of general provisions and that additional criteria are needed to make appropriate coverage determinations.
- The medical record must indicate hospital care was "medically necessary, reasonable, and appropriate" at all times during the stay. (Program Integrity Manual, Ch. 6, § 6.5.2)

United's interpretation of the Final Rule is thus reflected in the Coverage Summary.

We hope this information is helpful.

Melissa W. Holland, MD, FACOG, FASAM, CPE
Chief Medical Officer | DC, MD, NC, VA, WV
UnitedHealthcare, Medicare & Retirement
9020 Stony Point Pkwy, Suite 350 | Richmond, VA 23235
M: (601) 688-0794
P: (763) 348-5867
melissa_holland@uhc.com

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Report Complaints

- Hospitals need to report when insurers are not following CMS guidelines
  - Report to 07CMHPORF@cms.hhs.gov
    - "This is a safe email to send PHI/PII"
    - Include date of submission to CMS, hospital name (CCN), complainant's name and contact information, beneficiary name, MBI, provider name, MAO name, claim number, dates of service, was the provider contracted, has the provider attempted to resolve.
    - *On behalf of [Provider name], please accept this message as a complaint against [Insurer Name] Medicare Advantage Plan for non-compliance with federal regulations to cover Traditional Medicare benefits in a manner that is no more restrictive than traditional Medicare. 42 U.S.C. 1395w–22, 42 CFR 422.101, IOM 100-16, Ch 4, Section 10.2, 88 Fed. Reg. 22120, 22187 (April 12, 2023). We provide an example of a claim for demonstration of [Plan Name]'s conduct only, and are not requesting CMS assistance or intervention on the claim itself.*
  - Send anecdotal stories (no PHI) to: awheeler@mhanet.com
- Participate in the Missouri Insurance Advisory Group

Questions and Comments

Andrew B. Wheeler
Vice President of Federal Finance
573-893-3700, x1336
AWheeler@mhanet.com

Bill Anderson
Vice President of State Legislation
573-893-3700, x1418
Banderson@mhanet.com

Paul Knudtson
Saint Luke's Health
Director, Patient Access
PKnudtson@saint-lukes.org

Richelle Marting
North Kansas City Hospital
Director of Managed Care
Richelle.Marting@nkch.org