CMS Rules That Keep Us Up at Night

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Topics for Discussion

- No Surprises Act | Price Transparency updates
- Telehealth Changes – temporary and permanent
- CMS oversight of Managed Medicare plans

No Surprise Act Refresher

- 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 within 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

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

- 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
- On November 3, 2023, the Departments published the Federal Independent Dispute Resolution Operations proposed rules
- On November 28, 2023, guidance released to clarify how certified IDR entities determine whether a dispute is appropriately batched and how to submit single and batched air ambulance disputes

Independent Dispute Resolution *Proposed* Changes

- IDR Operations 88FR75744
- CMS - not IDR entity- collecting admin fee
- Imposed timeframes for paying admin fee, with consequences
- Reduce admin fee if highest offer made was less than predetermined threshold
  - 50% of full admin amount
- Reduce admin fee for non-initiating parties when dispute is determined ineligible
  - 20% of full admin amount

Independent Dispute Resolution *Proposed* Changes

- IDR Operations 88FR75744 continued
- Included policies to reduce volume of ineligible disputes
- Additional disclosure requirements (CARC/RARC codes)
- Incentivizing good faith conduct

Independent Dispute Resolution Fees

- Final ruling published 12/21/2023; effective 01/20/2024
- Fee ranges apply until another set of fee ranges is proposed and finalized through notice and comment rulemaking
- CMS Final Rule 9890 IDR Fees:
  - Administrative Fee: 2023 $50/$350 | 2024 $115 per party
  - Single Determination Fee: 2023 $200-$700 | 2024 $200 - $840
  - Batch Determination Fee: 2023 $268-$938 | 2024 $268 - $1,173
- Proposed ‘Heightened workload’ (batching) fees:
  - Fixed tiered fee of $75 - $250 for every 25 additional line items

Federal IDR Volume Update

- 490,000 disputes initiated between April 15 and June 30, 2023
- 2023 Q1 and Q2 totals: 136,111 and 152,699 respectively
- 61% remained unresolved as of June 2023
- Reason for delays include:
  - Missing documentation
  - Bifurcation in federal and state authority
  - Difficulties in batching and bundling disputes
  - Few disputes resolved during open negotiation
    - Volume of claims submitted and/or lack of engagement
  - Lack of transparency in QPA calculations
  - Administrative burden

GAO Report to Congressional Committees: https://www.gao.gov/assets/870/864587.pdf

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
- 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
- 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

Medicare Advantage Organizations vs. CMS

- January 2023, Medicare Advantage enrollment reached 30.19M out of 59.82M
- Surpassing traditional Medicare for 1st time in history
- January 2024, enrollment reached 32M people; will exceed 34M by YE

Hospitals Dropping Medicare Advantage Organizations

- Excessive prior authorization denials
- Allegations of billing fraud, payment delays
- Hospital systems not resigning contracts with MAOs
  - Scripps notified in September, affecting 30,000+ seniors
  - St. Charles Health System, dropping 3 of 7 MAOs and discouraged patients to enroll with private plans
  - Nebraska Hospital Association cited negative patient experiences, delays in post-acute placement and administrative and financial burdens

Becker's Hospital CFO Report; https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html

Medicare Advantage Organizations - OIG Audit

- Increase in concerns reported regarding incentive of the MAO to deny or delay payment
- Random sample of 250 prior authorization denials and 250 payment denials
- Coding experts looked at case files and physicians examined medical records for subset of cases

OIG Audit Findings and Concerns

- Delayed or denied access to services when requests met Medicare coverage rules
- Used clinical criteria not contained in Medicare coverage rules
- Payment denials caused by human (e.g., overlooking a document)
- System processing errors (not programmed or updated correctly)
- 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 burden when appealing 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

CMS Final Ruling 4201-F

- 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

Federal Register CMS-4201-F: https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

CMS Final Ruling 4201-F cont.

- 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
- 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
- Establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's guidelines

Resources

- CMS Newsroom https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f
- 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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