MEDPAC

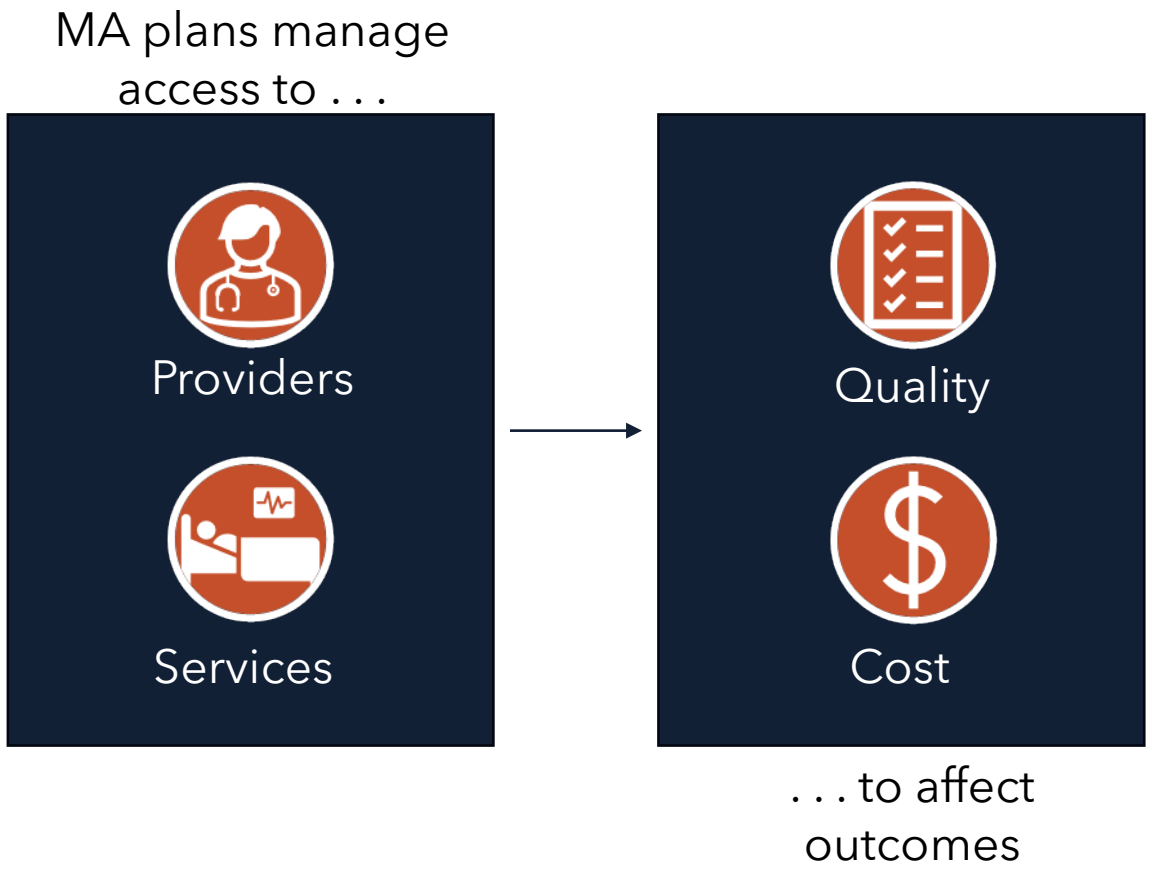
Advising the Congress on Medicare issues

Evaluating access in Medicare Advantage: Network management and prior authorization

Katelyn Smalley & Ledia Tabor

November 3, 2023

Background: Managing access to care in MA



Note: Medicare Advantage (MA).

- MA plans have tools intended to reduce low-value care and improve outcomes:
  - coordination and care management
  - provider and enrollee incentives
  - network management
  - prior authorization
- Stakeholders have raised concerns about administrative burden and barriers to access

Today's presentation

Network management

Prior authorization

Current landscape and future analytic directions

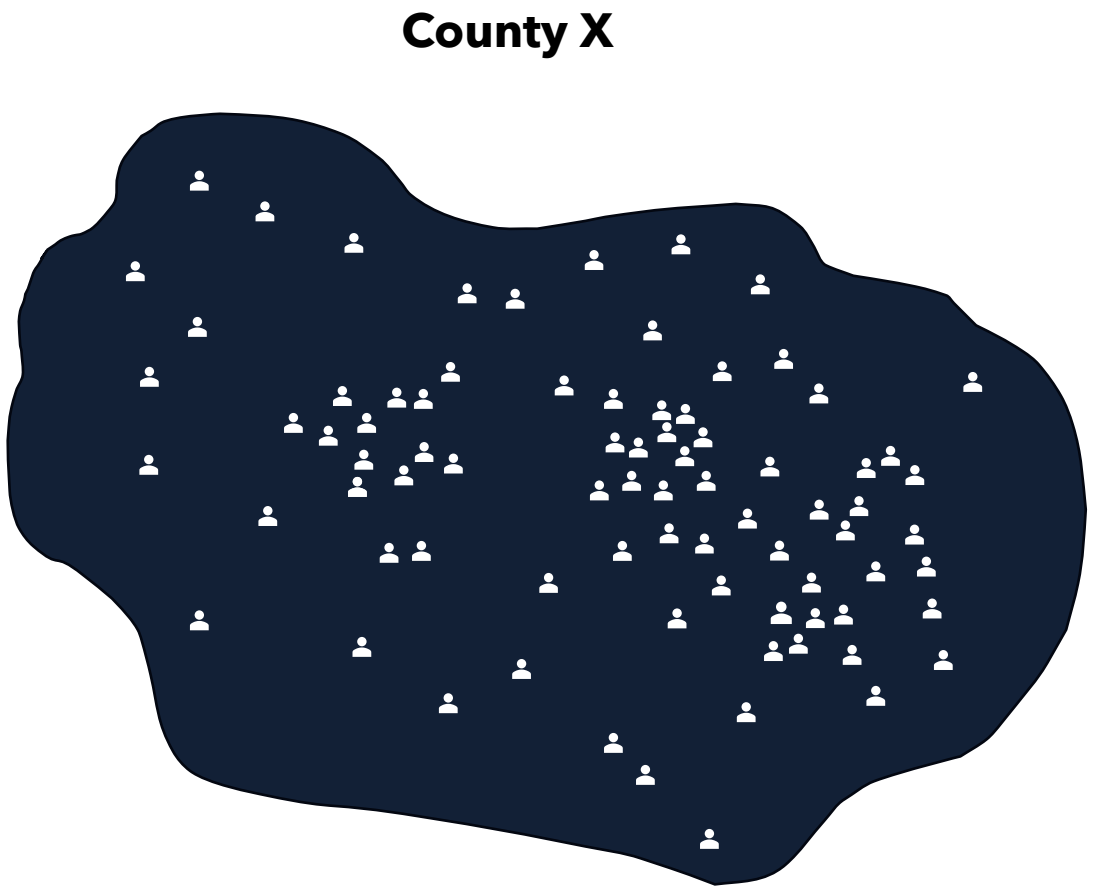
Network management

Provider networks in MA

- Choice of provider is an important factor for Medicare beneficiaries deciding between coverage options
  - Many beneficiaries are willing to trade choice for features like reduced cost sharing, limits on out-of-pocket spending, or additional benefits
  - MA plans can be selective about which providers to contract with, potentially improving value
- Most MA plans are either HMOs or PPOs
  - Parent organizations can aggregate multiple plans under same contract
  - HMO and PPO networks can share the same providers in the same market but differ in rules for cost sharing and out-of-network coverage

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization).

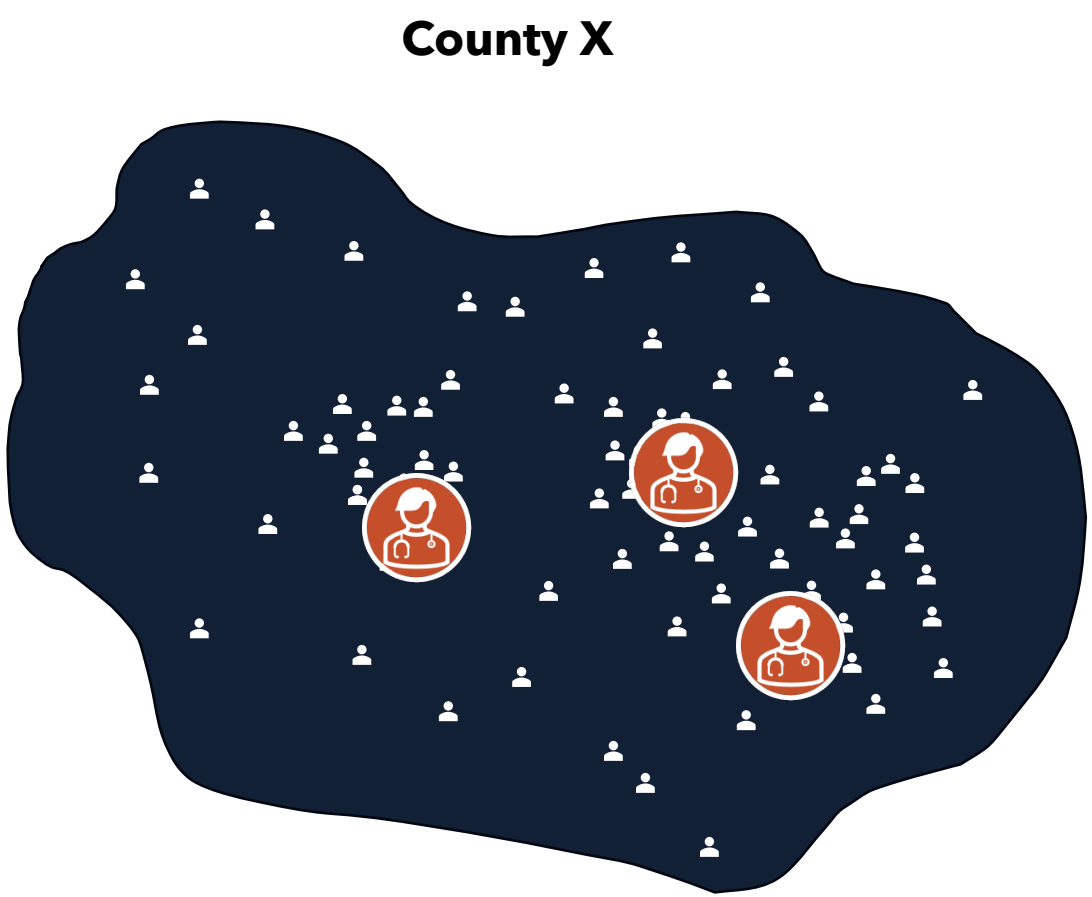
Medicare Advantage network adequacy: Illustrative example



Note: County X is a fictitious county generated for illustrative purposes.

- Network adequacy is assessed at the county level, and standards vary by population:
  - large metro
  - metro
  - micro
  - rural
  - counties with extreme access considerations (CEAC)
- We will use the fictional County X to demonstrate CMS's network adequacy requirements and how they are assessed

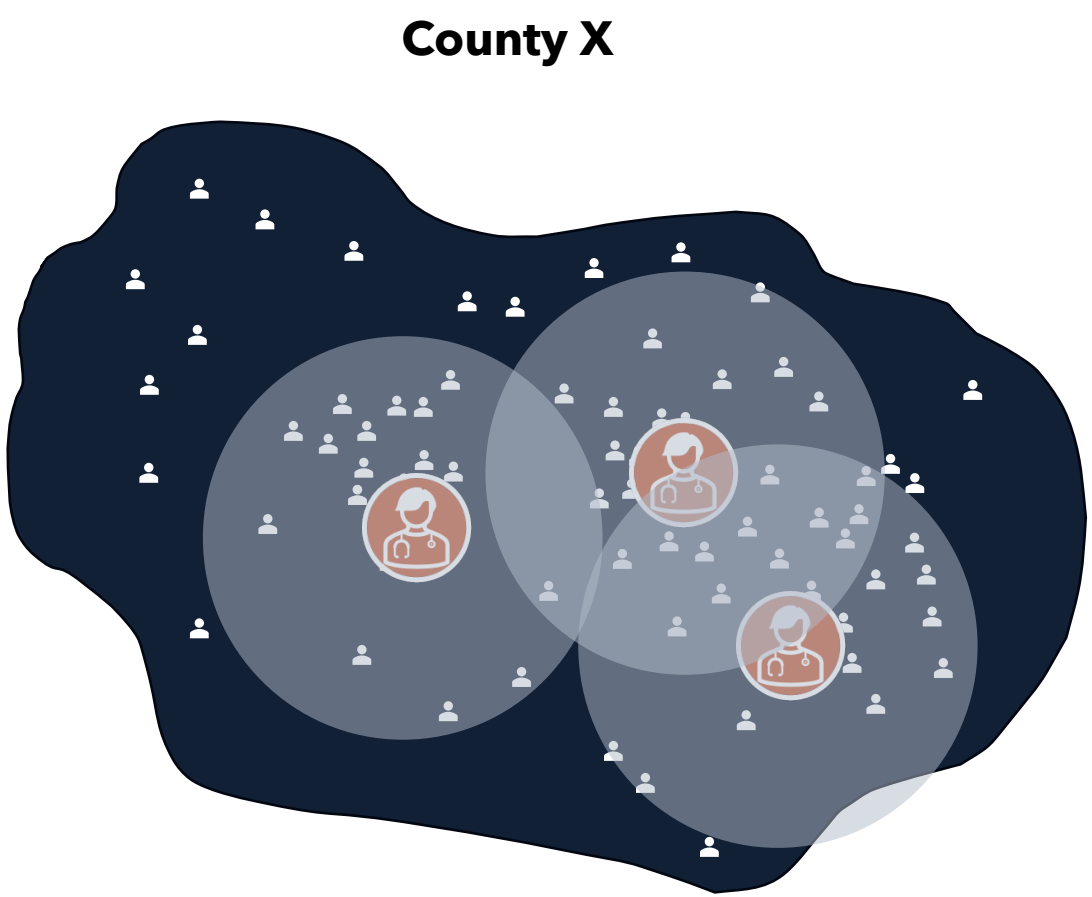
Medicare Advantage network adequacy: Minimum number standard



Note: County X is a fictitious county generated for illustrative purposes.

- CMS has network adequacy standards for 27 provider types and 13 facility types
  - Each specialty and facility type has a national minimum provider ratio
  - Each county has a "number of beneficiaries required to cover"
- Plans in this example county were required to contract with at least 3 gastroenterologists

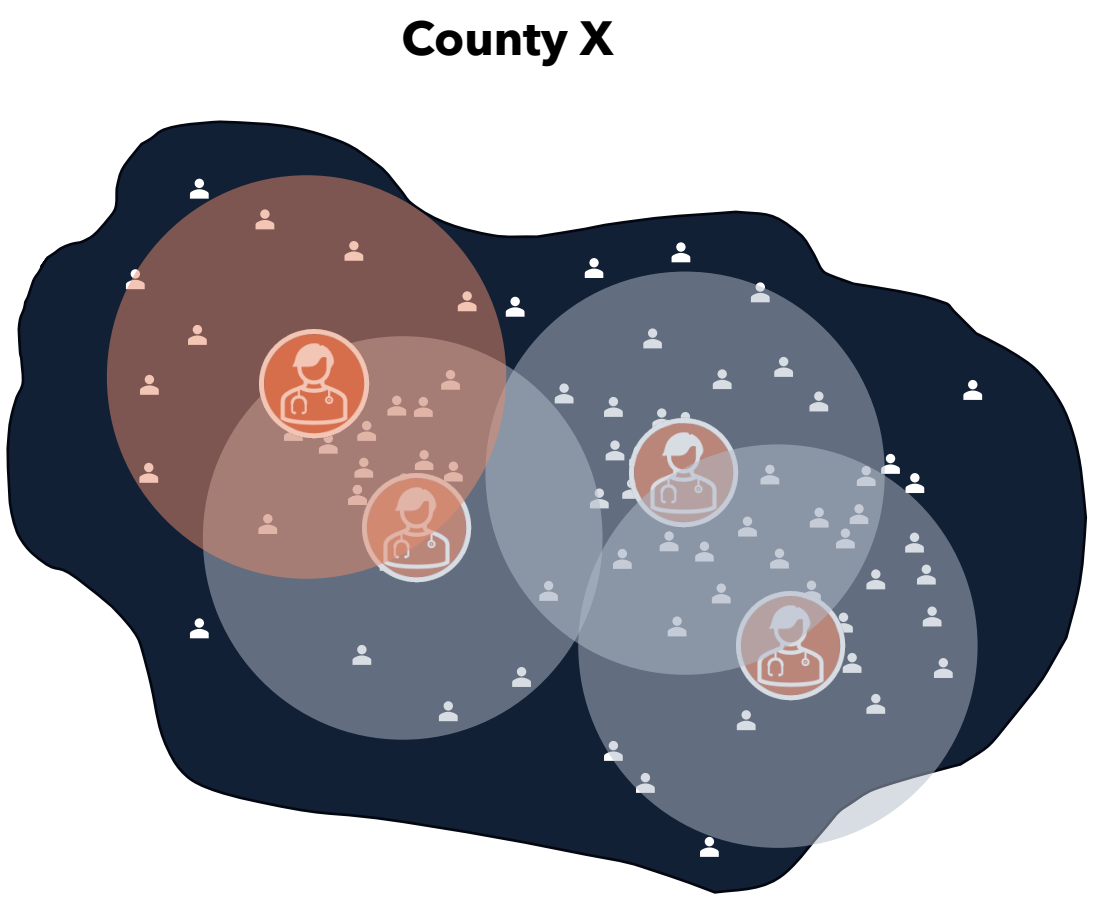
Medicare Advantage network adequacy: Maximum time/distance standard



Note: County X is a fictitious county generated for illustrative purposes.

- The providers that plans contract with must be accessible to enrollees within a reasonable time and distance
- In micro counties like County X, providers must be accessible to at least 85 percent of beneficiaries within 60 minutes or 45 miles

Medicare Advantage network adequacy: Maximum time/distance standard



Note: County X is a fictitious county generated for illustrative purposes.

- In this illustration, the minimum number of three providers was not sufficient to meet the time and distance standards
- The plan serving County X would need to contract with a fourth provider to meet network adequacy standards

CMS's recent changes to network adequacy standards

- Relaxed standards to encourage entry of MA plans in rural areas
  - Reduction in percentage of beneficiaries within time/distance standards from 90 percent to 85 percent in micro, rural, and CEAC counties
- Modified standards for certain specialties
  - Telehealth: 10 percentage point reduction for 12 specialty types
  - States with CON laws: additional 10 percentage point reduction
- Strengthened requirements for timeliness and range of services
  - Maximum wait times
  - Two additional provider types (beginning in 2024)

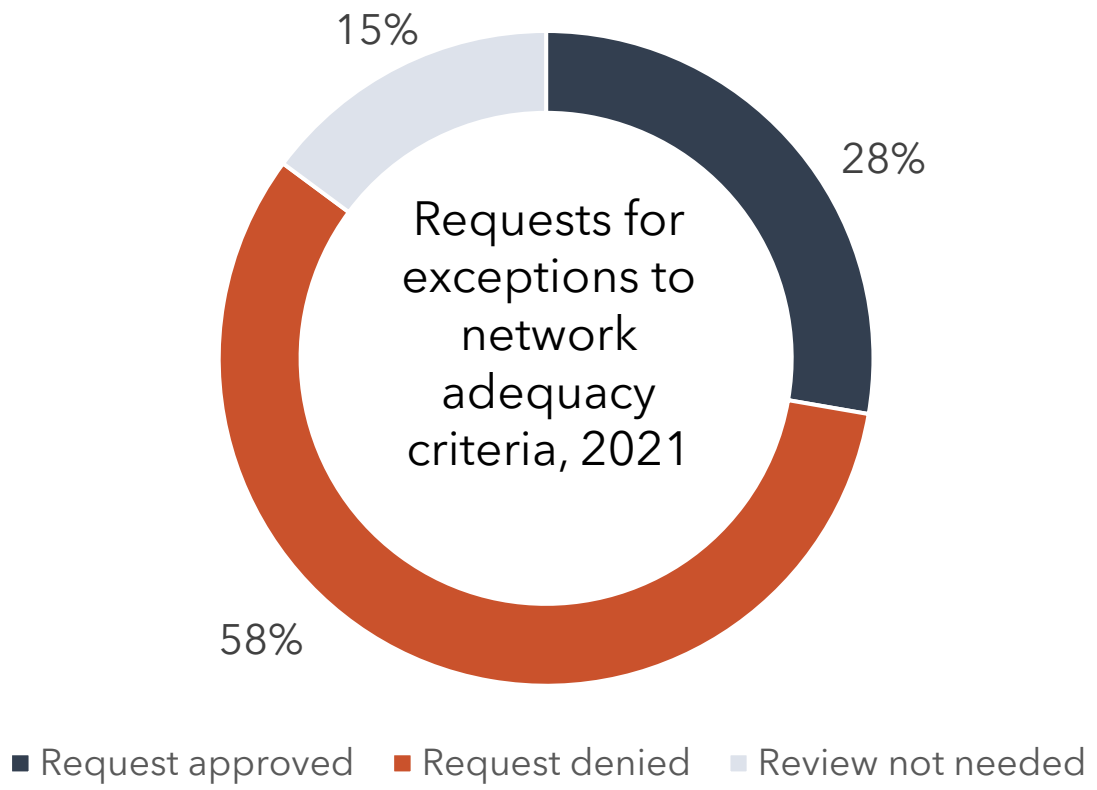
Note: MA (Medicare Advantage), CEAC (counties with extreme access considerations), CON (certificate of need).

CMS audits of MA network adequacy

- MA organizations are audited for network adequacy
  - Routinely on a three-year cycle, such that plans are audited roughly every three years
  - Triggered under special circumstances (e.g., CMS receives a new service expansion application or enrollee access complaint)
- About 25 percent of MA contracts were audited in 2021
  - Audited provider networks covered 75 percent of all counties, across 49 states, Puerto Rico, and the District of Columbia
  - MA organizations must demonstrate adequacy in each county in which they operate, for each of 40 provider and facility types

Note: MA (Medicare Advantage).

Exceptions to CMS's network adequacy criteria



- In 2021, CMS received 448 exception requests
- Of the 183 audited contracts, 64 requested provider-type exceptions, and 33 requested facility-type exceptions
- CMS denied more than half of the requests for network adequacy exceptions that it received

Source: MedPAC analysis of CMS reviews of 2021 network adequacy exception requests and 2022 enrollment data.

Provider directory accuracy and network adequacy

- MA plans must maintain directories of in-network providers
  - Enrollees rely on directories to choose among plans and make care decisions
  - Logistical challenges for plans and providers to keep directories up-to-date
- Access problems from inaccurate directories
  - GAO documented phenomenon of "ghost networks" of behavioral health care providers (2022)
  - Some beneficiaries in our focus groups reported difficulties with inaccurate directories
- Last year, CMS raised the idea of creating a national provider directory to facilitate the maintenance of these documents

Note: MA (Medicare Advantage), GAO (Government Accountability Office).
Source: Government Accountability Office. 2022. Mental health care: Access challenges for covered consumers and relevant federal efforts.

Potential directions for analysis of MA networks

- Characterize MA networks, for example, by size and breadth
  - Variation by plan type, specialty type, geographic designation, or other dimensions
- Explore narrow networks or degree of overlap in local areas
- Analyze utilization of out-of-network services
- Examine MA networks in areas with distinctive market characteristics (e.g., high or low MA penetration)

Note: MA (Medicare Advantage).

Prior authorization

Prior authorization (PA) in MA

- MA plans are permitted to require enrollees to obtain PA to access certain services
- Nearly all MA enrollees are in plans that require PA for some services
- Although MA plans must follow Medicare coverage rules, they are permitted to use additional clinical criteria to determine medical necessity, as long as such criteria are "no more restrictive than original Medicare's national and local coverage policies"

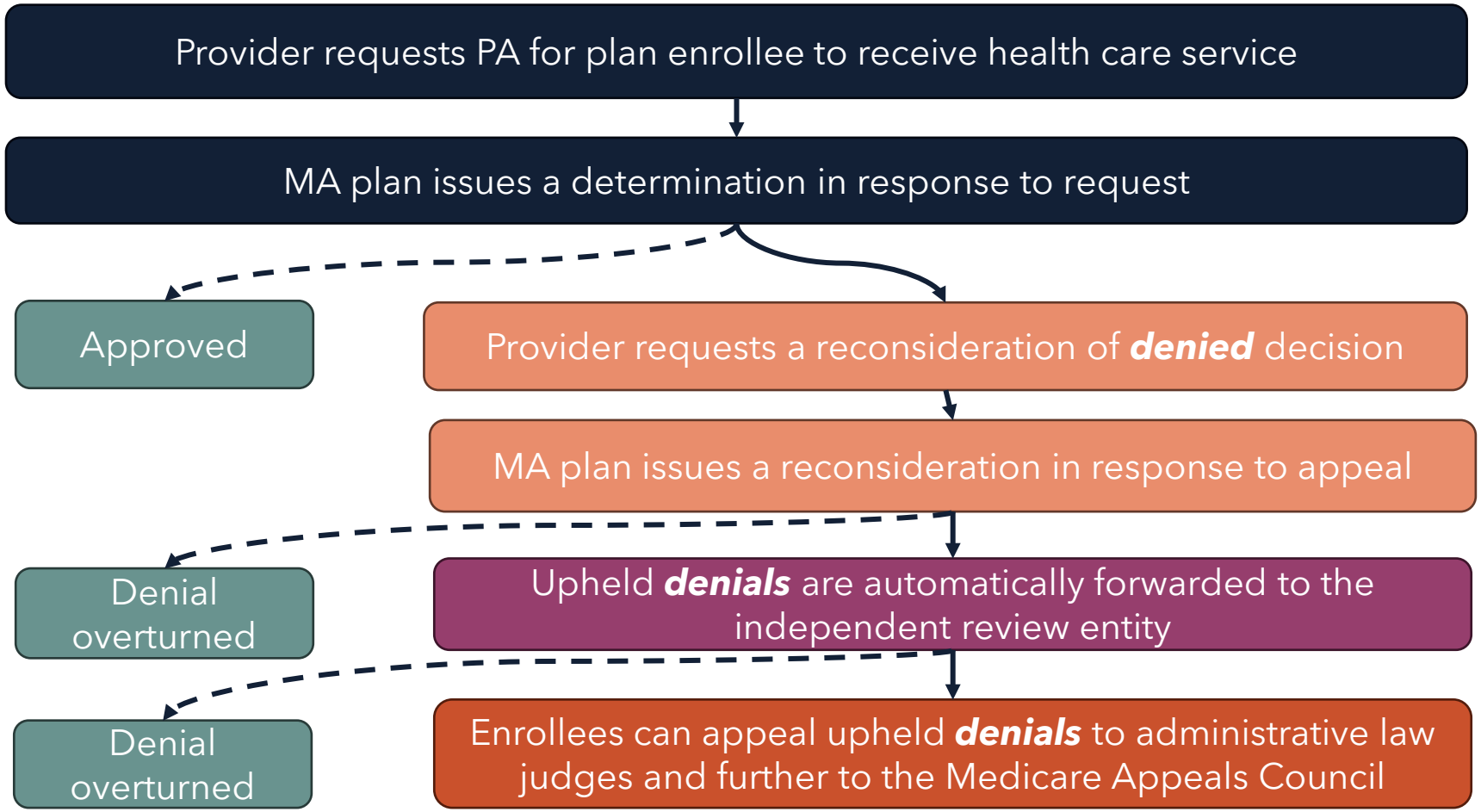
Note: MA (Medicare Advantage).
Source: Ochieng, N., J. Fuglesten Biniek, M. Freed, et al. 2023. Medicare Advantage in 2023: *Premiums, out-of-pocket limits, cost sharing, supplemental benefits, prior authorization, and star ratings*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.
Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2016. Chapter 4: Benefits and beneficiary protections. In *Medicare Managed Care Manual*. Baltimore, MD: CMS.

PA determinations and appeals requirements

- MA plans must establish procedures for making decisions about whether to approve or deny PA requests
- PA requests are reviewed by MA plan clinical staff to determine whether services are medically necessary and reasonable for the beneficiary, and whether they meet Medicare and MA plan coverage rules
- MA enrollees (and providers on their behalf) have the right to appeal a plan's determination to not allow for a service that they think should be covered or provided

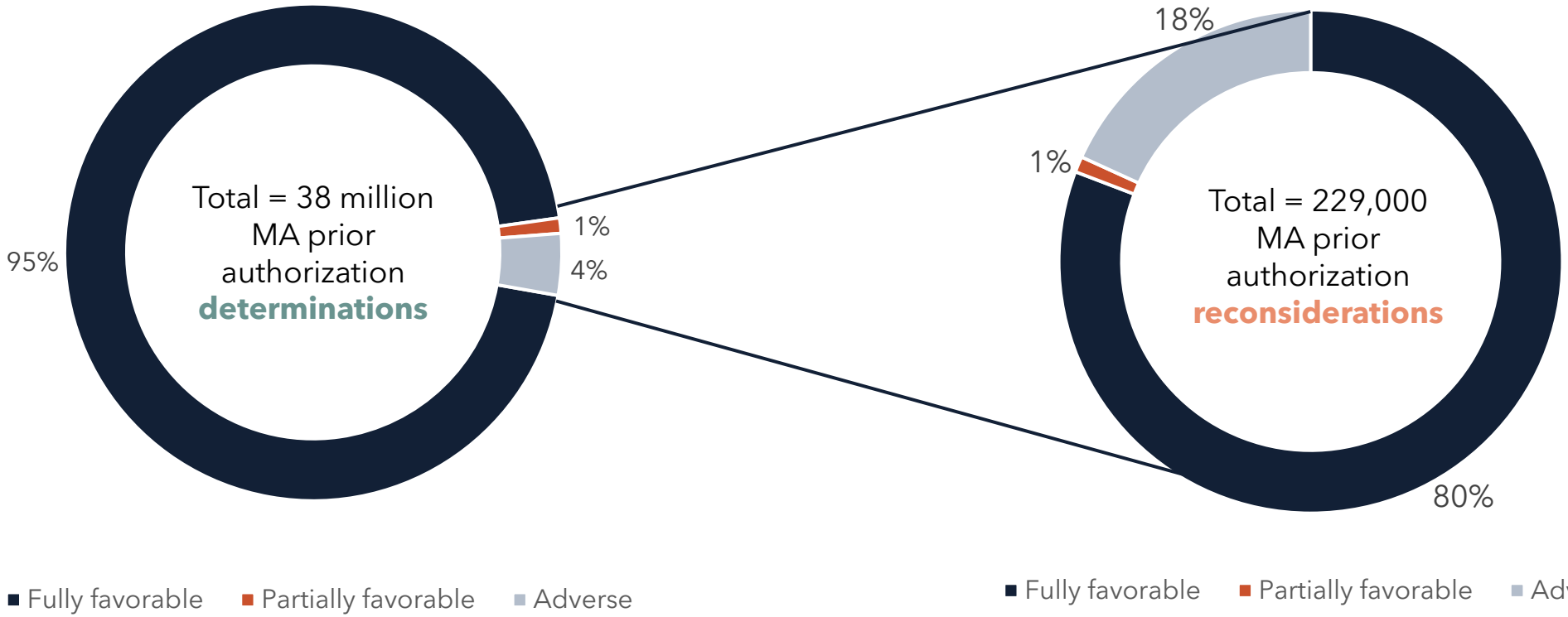
Note: MA (Medicare Advantage), PA (prior authorization).

MA prior authorization and appeals process can involve multiple levels



Note: MA (Medicare Advantage), PA (prior authorization).

Majority of MA prior authorization determinations and reconsiderations were fully approved, 2021



Note: MA (Medicare Advantage). There are three types of determinations resulting from an MA plan's prior authorization review: (1) fully favorable (i.e., service fully approved for coverage and payment); (2) partially favorable (i.e., coverage and payment for service approved at a reduced level or another service approved altogether—for example, 5 therapy visits approved instead of the 10 visits requested), or (3) adverse (i.e., denial of coverage and payment).
Source: MedPAC analysis of determinations and reconsiderations: Part C data from the CMS Part C and Part D reporting requirements public use file for contract year 2021.

Certain beneficiaries and providers/physician specialties are more likely to be affected by prior authorizations

- Most MA plan enrollees are required to receive PA for the highest-cost services such as Part B drugs, skilled nursing facility stays, acute inpatient hospital stays
- Schwartz et al. applied one MA organization's PA rules to FFS Part B claims
  - 41% of FFS beneficiaries received at least one service that would have been subject to PA in the MA plan
  - Largest share of PA services were Part B drugs/injectables, radiology, musculoskeletal
  - Physician specialties varied in rates of services that required PA, from 97 percent (radiation oncologists) to 2 percent pathologists

Note: MA (Medicare Advantage), PA (prior authorization), FFS (fee-for-service).
Source: Ochieng, N., J. Fuglesten Biniek, M. Freed, et al. 2023. Medicare Advantage in 2023: *Premiums, out-of-pocket limits, cost sharing, supplemental benefits, prior authorization, and Star ratings*. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.
Schwartz, A. L., T. A. Brennan, D. J. Verbrugge, et al. 2021. Measuring the scope of prior authorization policies: Applying private insurer rules to Medicare Part B. *JAMA Health Forum* 2, no. 5 (May): e210859.

Independent review entity determinations

- IRE upheld the MA plan's denial in 96% of the roughly 50,000 prior authorization cases it reviewed in 2021
- Certain beneficiaries and providers/specialties are more affected by IRE determinations
  - We reviewed and categorized summaries of the IRE determinations for a snapshot of 2023
  - About half were requests to preapprove acute inpatient rehabilitation facility admissions/services, 20% for DME, and 10% for acute inpatient surgeries

Note: IRE (independent review entity), MA (Medicare Advantage), DME (durable medical equipment). The appeals data that the IRE reports to CMS are structured differently from the determinations and reconsiderations data that MA plans report. The 96 percent are expedited and pre-service cases reviewed by the IRE.

Concerns about PA requirements and processes

- OIG examined a subset of denied PA requests and found examples of MA plans inappropriately denying requests
  - 13% percent of denied requests met Medicare coverage rules
- Some providers report that PA is an increasing burden
  - In MedPAC focus groups they expressed frustration with the number of PA requirements from insurance companies, with several noting that their practices have hired dedicated staff members to manage these requirements
- Stakeholders have voiced concerns that PA may cause enrollees to delay care, abandon care, or pay out of pocket

Note: PA (prior authorization), MA (Medicare Advantage), OIG (Office of Inspector General).
Source: Office of Inspector General, Department of Health and Human Services. 2022. *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care*. OEI-09-18-00260. Washington, DC: OIG.

CMS's recent regulations governing use of PA

- Clarified coverage criteria guidelines to help MA enrollees receive access to the same medically necessary care as FFS enrollees
- When coverage criteria are not fully established, MA plans may create internal coverage criteria based on widely used treatment guidelines/literature and must make those criteria public
- Denials of coverage based on medical necessity must be reviewed by health care professional with relevant expertise
- PA approval given by an MA plan is required to be valid for as long as necessary to avoid disruptions in care

Note: PA (prior authorization), MA (Medicare Advantage), FFS (fee-for-service).
Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. 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. *Federal Register* 88, no. 70 (April 12): 22120-22345.

CMS proposals to make MA PA processes more efficient and transparent

- In December 2022, CMS proposed a number of requirements for MA plans, but these have not been finalized:
  - Build an open-source interface to automate the process for providers to determine whether a PA is required and identify PA documentation requirements (e.g., real-time benefit tools)
  - Include a specific reason why the MA plan denies a PA request
  - Send PA decisions in 7 calendar days for standard requests, as opposed to current 14-day requirement

Note: MA (Medicare Advantage), PA (prior authorization).

Potential directions for analysis of PA

- Consider whether CMS has the plan information necessary to adequately monitor and provide oversight of PA
  - For example, currently plans don't report determinations and reconsiderations by service type
- Analyze the interaction of PA and claims denials
  - If provider does not seek PA before providing a service, then payment denial affects providers and enrollees

Note: PA (prior authorization), MA (Medicare Advantage).

Discussion

- Questions about potential directions for analysis
  - Network management
    - Characterize MA plan provider networks
    - Explore the use of narrow networks
    - Analyze utilization of out-of-network services
    - Examine MA networks in areas with distinctive market characteristics
    - Others?
  - Prior authorization
    - Consider information that MA plans report to CMS
    - Analyze the interaction between PA and claims denials
    - Others?

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