Federation of American Hospitals®

MANAGED CARE COMMITTEE
MEETING AGENDA

Tuesday, October 3, 2023
9:30 am – 11:30 am
Waldorf Astoria Hotel, Washington DC

Conference Call Details for Those Not Attending In-Person:
Phone Number: 301-715-8592
Meeting ID: 857 4810 4392 Passcode: 751980

I. WELCOME/ INTRODUCTIONS / ANTITRUST STATEMENT
   a. Remarks from FAH President and CEO, Chip Kahn

II. SURPRISE BILLING
   a. Status of lawsuits
   b. IDR Proposed Rules
   c. Other

III. MEDICARE ADVANTAGE/MANAGED CARE PRACTICES
   a. Key Strategies
   b. FAH-proposed MA Plan Quality Measure
   c. OIG Work Plan and FAH Engagement
   d. Discussion

IV. MEDICAID MANAGED CARE PROPOSED RULE

V. CMMI / ALTERNATIVE PAYMENT MODELS

VI. **MENTAL HEALTH PARITY PROPOSED RULE**
   a. Discussion of Key Issues for FAH Comment Letter (Due October 17)

VII. NEW BUSINESS

Note: This committee book includes the Managed Care Committee roster, presentation for the meeting, and draft framework for FAH's comment letter on Mental Health Parity proposed rule.

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FAH Managed Care Committee

October 3, 2023

Agenda

1. Welcome and Antitrust Statement
2. CEO Report
3. Surprise Billing
4. Medicare Advantage
5. Medicaid Managed Care Proposed Rule
6. CMMI / Alternative Payment Models
7. Mental Health Parity Proposed Rule
8. New Business/Other
9. Adjourn

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Antitrust Statement

To Be Recited By Chairman

I would like to remind everyone that the Federation, its representatives, and its members, are committed to the continued existence of competitive health care delivery systems and markets, and ongoing compliance with all applicable federal and state antitrust laws.

As such, you are reminded that the Federation will not permit at this meeting, or in any other of its forums, any discussion or remarks that suggest or invite anti-competitive conduct among its member hospitals and/or health care systems.

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Surprise Billing

1. Legal Update – Status of Lawsuits
2. IDR Proposed Rules
3. Other – Member Input

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Medicare Advantage

- **Key Strategies**
  - Leverage 2022 OIG Report on MA Plan Abuses
  - Push Prior Auth Legislation and Congressional Oversight
  - Push for Regulatory Changes and Increased Oversight
  - Develop New Quality Measure on Payment/Authorization Denials and Appeals
- **MA Final Rule for 2024**
  - Coverage Protections
  - Network Adequacy Changes
  - Tightens Marketing Requirements
- **Prior Authorization Proposed Rule**
  - Electronic submission
  - Prior auth reporting and transparency
- **OIG Work Plan for Medicare Advantage**

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Medicare Advantage – Key Coverage Protections

- Requires MA plans to comply with NCDs, LCDs and general coverage and benefit conditions included in Traditional Medicare.
- Affirms that key Medicare coverage requirements for inpatient admissions, i.e., the Two-Midnight Rule and Inpatient-only List, apply to MA Plans.
  - **At the same time, the rule includes language allowing plans to engage in medical review of these admissions.**
- Requires prior auth approvals be valid for the duration of the approved course of treatment, with protections for MA enrollee transition to a new plan.
- Prevents MA plans from denying Medicare coverage based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies.
- Restricts MA plans' internal coverage criteria process and may develop only if
  - there are no applicable Medicare coverage criteria;
  - are based on current evidence in widely used treatment guidelines/clinical literature;
  - are publicly available.
- Clarifies that emergency behavioral health services must not be subject to prior authorization, along with other provisions intended to strengthen network adequacy requirements and improve access for behavioral health.

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Proposed Rule on Advancing Interoperability and Improving Prior Authorization Processes

Provisions

- Patient Access Application Programming Interface (API)
- Provider Access API
- Payer-to-Payer Data Exchange API
- Prior Authorization Requirements, Documentation & Decision API
- Improving Prior Authorization Processes
- New measures for Electronic Prior Authorization for the Merit-Based Incentive Payment System (MIPS) promoting Interoperability Performance Category and Medicare Promoting Interoperability Program

Impacted Payers

- Medicare Advantage
- State Medicaid and CHIP agencies
- Medicaid and CHIP Managed Care Plans
- Qualified Health Plans (QHPs) on the Federally-Facilitated Exchanges (FFEs)

Impacted Providers

- Eligible hospitals and critical access hospitals (CAHs) under the Medicare Promoting Interoperability Program
- Eligible Clinicians under the Promoting Interoperability performance category of the Merit-Based Incentive Payment System (MIPS)

Request for Information (RFI)

- Accelerating the Adoption of Standards Related to Social Risk Factor Data
- Electronic Exchange of Behavioral Health Information
- Improving the Electronic Exchange of Information in Medicare FFS
- Advancing Data and Interoperability of Maternal Health
- Advancing the Trusted Exchange framework and Common Agreement (TEFCA)

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Prior Authorization Improvements

- Requires impacted payers to send information to providers regarding the specific reason for denial when a prior authorization request is denied, regardless of the mechanism used to submit the prior authorization request
- Require response to urgent cases within 72 hours, 14 days for non-urgent requests
- CMS is proposing that payers publicly report annually on certain metrics, including:
  - A list of all items and services that require prior authorization
  - The percentage of standard prior authorization requests that were approved and denied, aggregated for all items and services
  - The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services
  - The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services
  - The percentage of expedited prior authorization requests that were approved and denied, aggregated for all items and services
  - The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard and expedited prior authorizations, aggregated for all items and services

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Medicare Advantage – OIG Workplan

Announced / Revised	Expected	Title/Topic
September 2023	2026	Audits of Medicare Part C Unlinked Chart Review Diagnosis Codes
August 2023	2024	Medicare Part B Payments for Over-the-Counter COVID-19 Tests During the PHE Demonstration
July 2023	2023	Medicare Part C High-Risk Diagnosis Codes Tool Kit
July 2023	2024	CMS May Make Increased Payments to MA Organizations for Diagnoses That Were Reported on Physician's Claims But Were Not Confirmed on a Concurrent Inpatient Stay
July 2023	2024	Medicare Advantage Payments Generated by Health Risk Assessments for 2022
June 2023	2024	Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes
April 2023	2024	Use of Remote Patient Monitoring Services in Medicare
Revised	2025	Medicare Advantage Organizations' Efforts to Reduce Racial and Ethnic Health Disparities
Revised	2024	Availability of Behavioral Health in Medicare Fee-For-Service, Medicare Advantage, and Medicaid Managed Care
Completed (Partial)	2024	Medicare Advantage Risk-Adjustment Data – Targeted Review of Documentation Supporting Specific Diagnosis Codes

Medicare Advantage – Discussion

- **Additional FAH Engagement with OIG**

- **Implementation of 2024 MA Final Rule**
  - How are plans changing their coverage policies?
  - Have you discussed upcoming changes with plans?
  - Are plans beginning to follow Two-Midnight rule or IP Only list?

- **Suggestions for FAH Research**

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Medicaid Managed Care Proposed Rule

- Reporting and transparency of Medicaid plan practices
  - Enrollee experience surveys
  - Establish appointment wait time standards for routing outpatient services
  - Secret shopper surveys
  - Submission of plan provider payment analyses
- Provisions related to State Directed Payments (SDPs)

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Medicaid Managed Care Proposed Rule

- Provisions related to State Directed Payments (SDPs):
  - Requires that states ensure each provider receiving a state directed payment attest that it does not participate in any arrangement that holds taxpayers harmless for the cost of a tax in violation of federal requirements.
  - Requires that provider payment levels for inpatient and outpatient hospital services not exceed the average commercial rate (ACR)
  - Removes unnecessary regulatory barriers to help states use state directed payments to implement value-based payment arrangements
  - Requires states to submit state directed payment evaluations every three years if the SDP costs (as a percentage of total capitation payments) exceed 1.5 percent.

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CMMI – Activity

CMMI Strategy | Overview of Specialty Strategy

The goal is to *"…have 100 percent of beneficiaries in Traditional Medicare and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030…through advanced primary care or ACOs, and these entities are expected to coordinate with or fully integrate specialty care to deliver whole-person care."*

- CMS Innovation Specialty Care Blog, June 2022

To read the white paper, visit innovation.cms.gov

11

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CMMI – Activity

CMMI Specialty Strategy | Overview

1	Enhance Specialty Care Performance Data Transparency	Short-term Long-term
2	Maintain Momentum on Acute Episode Payment Models and Condition-Based Models	Short-term Long-term
3	Create Financial Incentives within Primary Care for Specialist Engagement	Short-term Long-term
4	Create Financial Incentives for Specialists to Affiliate with Population-based Models and Move to Value-Based Care	Long-term

[No Title]

12

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CMMI – Activity

CMMI Specialty Strategy | Element #2. Maintain Momentum on Acute Episode Payment Model

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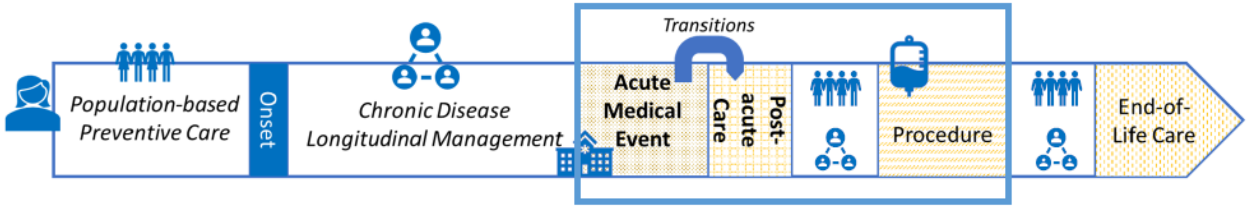

1. **Extend BPCI Advanced** for two years through 2025. 2. **Launch a new model** focusing on beneficiaries with cancer—the Enhancing Oncology Model.	**Short-term**
3. **Test a new mandatory acute episode payment model** that improves acute care and care transitions, while supporting the goals of longitudinal, accountable care.	**Long-term**

14

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CMMI – Activity

CMMI Portfolio | States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

CMS's goal in the AHEAD Model is to collaborate with states to curb health care cost growth; improve population health; and advance health equity by reducing disparities in health outcomes. The model is designed to be a flexible framework that can be adapted across multiple states.

Statewide Accountability Targets

Medicare and All-Payer Cost Growth, Medicare and All-Payer Primary Care Investment, and Equity and Population Health Outcomes through State Agreements with CMS

Components

- Cooperative Agreement Funding
- Hospital Global Budgets (facility services)
- Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration Across Care Settings
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

Visit the AHEAD Model webpage for more information

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CMMI – Activity

How will AHEAD Hospital Global Budgets be Developed?

- Constructed for each hospital based on its own historic FFS (inpatient and outpatient) revenue
- Includes multiple adjustments:
  - **Transformation Incentive Adjustment:** Upward adjustment to invest in infrastructure and capacity development needed for implementation
  - **Effectiveness Adjustment:** Reduction based on portion of calculated avoidable utilization
  - **Quality Adjustment for PPS hospitals:** Downward adjustment based on performance on CMS national hospital quality programs.
  - **Equity Improvement Bonus:** Upward adjustment based on performance on select measures focused on promoting equity
  - **TCOC Performance Adjustment:** Upward and downward adjustments based on TCOC of hospital’s attributed population
  - **Clinical and social risk adjustment:** Upward adjustment, likely based on HCC, ADI, and Part D LIS status
- May include additional adjustments for CAHs and SNHs to encourage participation

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Mental Health Parity Proposed Rule

- Expands current requirements for mental health parity
- Removes some loopholes plans have been using
- Comment period extended to October 17
- *Draft FAH Comment letter outline is included in meeting materials.*

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Requirements Related to the Mental Health Parity and Addiction Equity Act (CMS-9902-P)

Notes for Comment Letter on Proposed Rule

I. Background

Continued noncompliance by plans and issuers, especially with respect to nonquantitative treatment limitation (NQTL) requirements, led Congress in the CAA, 2021 to amend MHPAEA to ensure that limitations on mental health and SUD benefits are no more restrictive than the limitations applicable to medical/surgical benefits. This is done by comparing NQTLs in benefit classifications, which as established in earlier rulemaking are six classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The proposed rules are designed to implement the changes to MHPAEA made by CAA, 2021, to ensure that individuals benefit from the full protections afforded to them under MHPAEA, and to provide clear standards for plans and issuers (hereinafter "plans") on how to comply with MHPAEA. These proposed rules are designed improve the manner in which parity is measured, compared, and demonstrated by plans.

- Strong support for regulatory proposals to hold plans accountable to requirements under the law to ensure parity for mental health care and access to that care with medical/surgical plan benefits, consistent with clear congressional intent; and
- Support the goal of clearer expectations on plans and greater specificity on the manner in which comparative analyses of parity is to be conducted; and
- Express reservation/concerns about the two proposed exceptions to the requirements (described below)

II. Data Collection

Plans must collect and evaluate outcomes data for their NQTLs and take action to address material differences in access to mental health and substance use disorder (SUD) benefits as compared to medical/surgical benefits, focusing on ensuring there are not any material differences in access as a result of the application of their network composition standard. Data includes information on prior authorization requests and decisions, claims denials, data relevant to NQTLs as required by State law or private accreditation standards, utilization rates, network adequacy metrics (see III below), and provider reimbursement rates.

- Strong support for collection of expanded set of plan-specific outcome data to ensure plan NQTLs meet standards as modified by the CAA, 2021
- Encourage careful analysis of data generally and careful scrutiny of any exceptions, if finalized, that plans may claim
- Note that plans have this data and that providers should not incur any new burden by reason of these proposed revised standards and requirements

III. Network Composition

A plan with an NQTL in operation that results in material differences in access to in-network mental health/ SUD benefits compared to in-network medical/surgical benefits in a classification of benefits violates the MHPAEA parity requirements. The determination that an NQTL violates the MEPAEA parity requirements would be based on data collected on in-network and out-of-network utilization (including data related to in-network providers who are actively submitting claims), network adequacy metrics (including time and distance data, and data on providers accepting new patients), provider reimbursement rates (including as compared to billed charges), and other types of data specified by the Departments.

- Strong support—inadequate provider networks restrict access to care, especially for lower income patients
- Substandard provider payment rates limit willingness of qualified providers to join or remain in plan networks; even lower out-of-network provider payment rates imposes severe financial burden on patients and jeopardizes access to care and adherence to treatment plans over time
- Encourage the Departments to consider additional data categories over time designed to provide even greater certainty in conducting comparative analyses of the NQTLs tat plans impose

IV. NQTLs for Mental Health/SUD—Design and Comparative Analysis

NQTLs that fail to meet proposed standards may not be imposed by the plan because they would violate MHPAEA. Standards would include the following:

1) *No more restrictive* (as written or operationalized) than the predominant NQTL applied to substantially all medical/surgical benefits in the same benefit classification under generally recognized independent standards of current medical practice.
    - Support as the proposal is consistent with CAA, 2021 statutory language, and the same standard currently applies under MHPAEA to financial requirements and quantitative treatment limitations

2) *Prohibition on discriminatory factors and evidentiary standards*. A plan may not design or implement an NQTL that relies on any factor or evidentiary standard if it discriminates against mental health/SUD benefits as compared to medical/surgical benefits under generally recognized independent standards of current medical practice. Information is biased or not objective if it results in less favorable treatment of mental health or substance use disorder benefits, based on all the relevant facts and circumstances including, the source of the information, the purpose or context of the information, and the content of the information. Exceptions apply for "Impartially applied generally recognized independent professional medical or clinical standards" and "Standards reasonably designed to detect or prevent and prove fraud, waste, and abuse" (described below).
    - Generally, support prohibition
    - Encourage Departments not to finalize exceptions or, if they finalize exceptions, to narrow them (see below); concern about past documents plan behaviors (note, this applies generally throughout

3) *Design*. NQTLs must be designed to assess impact on access to mental health/SUD treatment (using data described above in section II) using generally recognized independent standards of current medical practice. If there is a material difference in access, plan must "take reasonable action" to address material difference and document actions taken.
   - Support
   - Material action is not defined, so what constitutes a reasonable action in relation to a material difference is unclear. Perhaps Departments should describe material in the preamble to the final rule or in its examples or instead apply a more demanding standard of "any" difference.

4) *Prohibition on separate NQTLs only for mental health/SUD benefits*. NQTLs must apply to mental health/SUD benefits and to medical/surgical benefits in the same benefit classification.
   - Support—consistent with statute and regulations

5) *Effect of Final Determination of Noncompliance*. Final determination of noncompliant NQTL violates statute and regulations, and Secretary "may" direct plan not to impose it until the NQTL is demonstrated to comply with new standards
   - Support generally; helpful to have consequences of violations specified in regulations
   - Perhaps the regulations should "require" the Secretary to direct plans not to impose an NQTL in violation until changes to it have been made to come into compliance as opposed to leaving it to their discretion?

V. Exceptions

Generally under the rule, NQTLs may apply to MH/SUD benefits if: (i) the limitation is "no more restrictive" for MH/SUD benefits than for medical/surgical benefits; (ii) the factors and evidentiary standards relied on in designing and applying the NQTL are not discriminatory against MH/SUD benefits; and (iii) the plan collects, evaluates, and considers the impact of relevant data on access to MH/SUD benefits as compared to access to medical/surgical benefits and takes "reasonable action" to address any material differences. The Departments propose two exceptions as follows:

1) *Exception for Independent Professional Medical or Clinical Standards*. In lieu of an NQTL standard that uses an independent professional medical or clinical standard, a plan could substitute an NQTL that impartially applies generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to medical/surgical benefits and mental health/SUD benefits. Such an NQTL could not deviate from those standards in any way, such as by imposing additional or different requirements.

   - Oppose; the exception could be subject to abuse notwithstanding the Department's intent that the exception be narrow;

- Plans could develop their own recognized clinically appropriate standard of care without input from multiple stakeholders and experts, which could be detrimental to access;
- The Departments previously permitted such an exception but then withdrew it;
- Clinical appropriateness should be part of the NQTL requirements—not an exception to them;
- Use of either exception would appear to exempt a plan from collecting the data necessary to conduct the analyses and comparisons required under the rule;
- Concerns that the proposed rule's description of independence as "independent, peer-reviewed, or unaffiliated with plans and issuers;" could lead to a lack of transparency or the use of proprietary criteria that is created and licensed for sale by entities, which may be advanced for purposes other than ensuring access to mental health/SUD care; and
- These standards should be tied to clinical specialty association guidelines and criteria.

2) *Exception to Detect or Prevent and Prove Fraud, Waste, and Abuse*. Plans may design/implement NQTLs using standards "reasonably designed" to detect or prevent and prove fraud, waste, and abuse. These standards must be (i) based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data, and (ii) be narrowly designed to minimize the negative impact on access to appropriate mental health/SUD benefits.
   - Oppose; concerns include past plan practices of using this as a rationale to (i) deny benefits where no evidence of fraud etc. is present or discernable; and (ii) conduct routine audits for fraud etc., of providers notwithstanding the lack of evidence.
   - Combatting fraud is important; however, this should not be used as an exception to any standard; rather, requirements for fraud detection should be part of any NQTL which is subject to analysis and comparison to the fraud detection that is used for medical/surgical benefits in a benefit classification. The statute does not envision addressing fraud, waste and abuse as an exception, which plans could use to circumvent requirements notwithstanding the proposed criteria for its use as an exception.
   - As noted above, use of either exception would appear to exempt a plan from collecting the data necessary to conduct the analyses and comparisons required under the rule.

VI. Other Issues

1) Sunset election for a self-funded, non-federal governmental plan to opt out of compliance with MHPAEA

Generally, no election to opt out of compliance with the requirements of MHPAEA may be made by a self-funded, non-federal governmental plan on or after December 29, 2022 and that generally no such election with respect to MHPAEA expiring on or after June 27, 2023 may be renewed.

- If a comment is required, support for the same reasons as above.

2) Application to Individual Market

MHPAEA requirements for individual health insurance coverage are found at 45 CFR 147.160. The proposed changes above would also apply in the same manner to health insurance issuers offering individual health insurance coverage.

- If a comment is required, support for the same reasons as above.