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Health Policy Update

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KFF Publishes Research on MA Prior Authorization and Financial Metrics

- On August 8, the Kaiser Family Foundation (KFF) released data on the total number of Medicare Advantage (MA) prior authorization requests that were denied in 2022. The study using the Medicare Limited Data Set found that 7.4% of all requests had adverse determinations out of the 46.2 million requests that year. This number was significantly higher than the 3 previous years (5.7% in 2019, 5.6% in 2020, and 5.8% in 2021). Prior authorization is typically used for high-cost services such as inpatient hospital stays for acute, MRIs and outpatient surgeries. Although traditional Medicare does not require prior authorization for most services nh, MA insurers may impose coverage requirements. In recent years, MA plans have seen new regulations related to the speed and transparency of prior authorization decisions, as well as legislative proposals.
- KFF's research found that the total share of prior authorization denials that were appealed increased to 9.9%, to almost 1 in 10. This rate was higher than previous years despite the fact that the majority of appeals led to the original decision being overturned or partially amended (83.2%). This data was published in the context that slightly more than half of Medicare beneficiaries are now enrolled in MA, with UHC and Humana as the largest insurers.

- Other research recently released by KFF describes the current state of rebates, Part D premiums, out-of-pocket limits, and supplemental benefits for MA plans. The current rebate per enrollee is now $2,329 higher than standard Medicare costs, while 75% are in plans with no additional premiums for Part D drug coverage as part of their supplemental benefits. The enrollment weighted average for out-of-pocket limits for all MA enrollees across HMOs, Local PPOs, and Regional PPOs is $4,882 for in-network care and $8,707 for out-of-network care.

CMS Finalizes Pathway for Coverage of Breakthrough Devices

- On August 7, CMS released the final notice on Transitional Coverage for Emerging Technologies (TCET) for expedited FDA review of certain medical devices. The notice outlines a pathway for new devices that treat severe conditions which typically have an extended time between FDA market approval and CMS coverage decisions and can sometimes take up to 5 years. The rule was originally proposed under the Trump Administration and would have included digital therapeutics, while other similar proposals have been introduced in Congress. The TCET pathway is meant to provide earlier access to medical technologies and encourage evidence development through national coverage determinations supplemented by coverage with evidence development decisions. The program also allows for more transparent communication between CMS and device manufacturers along with more clearly defined timelines. The process includes an Evidence Preview that identifies evidence and coverage gaps, and an Evidence Development Plan for addressing those gaps through study design and real-world data. Industry stakeholders supported CMS's changes but said that the limited

number of devices reviewed each year would limit the impact of the program and recommend that legislators pass more comprehensive reforms.

CMS Releases Medicare Inpatient and Long-term Care Hospital Final Rule

- On August 1, CMS released the Medicare Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule which updates fee for service payments and policies for the 2025 fiscal year. For inpatient stays, hospitals are paid prospectively based on the patient's diagnosis, the services provided, and disease severity based on the discharge information. Hospital rates are updated annually based on the market basket price of goods and services used to treat Medicare patients. This year, IPPS payment rates will increase by ~$2.9 billion after factoring in uncompensated care payments, new technology add-on payments, and subsidies for low-volume hospitals. For LTCH, the 2025 standard payment rate is increasing by 3.0% after adjustments to high-cost outlier payment thresholds. CMS is also extending a temporary policy that increases payments for hospitals in low-wage areas and helps rural hospitals maintain their labor force. The CMS rule also includes a separate payment for independent hospitals to maintain a supply on essential medicines to prevent shortages, new funding for psychiatry residencies in hospitals, technical updates to the Hospital Inpatient Quality Reporting Program (IQR), and other annual updates.

CMS Announces Medicare Part D Bid Information and Part D Stabilization Program

- On July 29, CMS released the annual Medicare Part D bid information for Part D and Medicare Advantage plans for the 2025 enrollment year. As part of the Inflation Reduction Act, Part D enrollees for the 2025 plan year will have their total prescription drug costs capped at $2,000 per year and be able to spread their total costs out over 12 months. As a result, premiums are expected to rise as these higher costs are shared by beneficiaries and plan bids for 2025 have greater variability. Currently, the base premium for Part D plans is expected to increase by $2.08 next year. In response, CMS announced a new voluntary demonstration for plan sponsors to support the costs of the newly redesigned Part D benefit. In response, CMS is introducing a Part D Premium Stabilization program to limit year over year changes. The program will reduce the base premium for standalone prescription drug plans by $15 and limit the yearly increase to a maximum of $35. The program is scheduled to last 3 years but may be modified in future years. In response, Republican legislators wrote a letter to CMS requesting more information on the costs and downstream effects of this program and requested a budgetary analysis as they view the program as sidestepping Congressional authority.

Other Policy News:

- Some states like Colorado move to regulate "algorithmic discrimination" and AI for decision-making in healthcare services and other high-risk industries
- CBO responds to questions from Congress on vertical integration and consolidation in healthcare markets
- Biden Administration announces Medicare Part D negotiated drug prices
- Federal appeals court upholds surprise billing decision favoring providers in the arbitration process
- Commonwealth Fund publishes survey on prevalence of surprise billing and challenges to billing

- Organ Procurement and Transplantation Network reforms face issues with governance decisions and oversight from HRSA