CAPITOL STREET

September 26, 2024

Medicaid MCO Guidance On Prior Auth

Potential Headwind for Medicaid, As MA Questioned

Relevant Companies

Our Take & Next Up

In a potential headwind for Medicaid managed care organizations (Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance, Molina Healthcare, and United Healthcare), CMS guidance today (here) attempts to address prior authorization (PA) practices in state Medicaid programs around EPSDT. We note that guidance documents are generally less enforceable than notice and comment rulemaking per the usual proposed and final rule model for most providers and plans that participate in Medicare & Medicaid. This may be to avoid CRA where a new Administration is able to rescind rules from the last Administration. While the immediate impact of the guidance may be minimal, we expect prior authorization will remain a focus in Washington.

Prior Auth in MA. is a source of consternation to lawmakers. (1) Legislation has stalled after passing the House in June. On MA, we also (2) look to landscape files (2025) that outline benefits, premiums and other characteristics; We anticipate a reduction in benefits due to the payment environment, v28, recently enacted supplemental benefits rules, etc.

Key Points

On Sept. 26, CMS issued a guidance document titled, "Health Coverage Requirements for Children and Youth Enrolled in Medicaid and CHIP" (press release Here; guidance document Here). The guidance appears to include measures to rein in prior authorization practices in state Medicaid programs – an ongoing concern for hospitals and other providers, in commercial and in Medicare Advantage.

The guidance specifically states that CMS's interpretation of the law is that states may not impose prior authorization requirements for screening services under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Under the EPSDT benefit, eligible children and youth are entitled to a comprehensive array of prevention, diagnostic, and treatment services — including well-child visits, mental health services, dental, vision, and hearing services.

While the CMS guidance represents a potential headwind for Medicaid managed care organizations (Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance, Molina Healthcare, and United Healthcare),

we note that guidance documents are generally less enforceable than notice and comment rulemaking. The immediate impact of the guidance may be minimal; however, we expect prior authorization will remain a focus in Washington.

Analyses support policy

- **The CMS guidance follows a recent report (here) from the Government Accountability Office (GAO), which found inconsistent PA requirements administered by Medicaid managed care plans across states.** The GAO report, requested by House Energy & Commerce ranking member Frank Pallone (D-NJ), recommended CMS provide guidelines for states to oversee PA practices of Medicaid managed care plans.
- **Another report from the HHS Office of Inspector General (here) found PA denials by Medicaid MCOs were more than double those in Medicare Advantage.** The OIG report also found that most states don't have a process to consistently review PA denials, which may or may not include machine learning and artificial intelligence algorithms.

Prior authorization practices are also a concern in Medicare Advantage, and the subject of legislation. Rep. Suzan DelBene (D-WA) introduced the "Improving Seniors' Timely Access to Care Act," (link) which passed the House in June. The bill would codify parts of a Biden Administration rule to streamline the use of prior authorization in Medicare Advantage. However, companion legislation (link) from Sen. Roger Marshall (R-KS) remains stalled. It remains unclear if PA reform could squeak its way into a year-end package during the post-election lame duck session of Congress.

Overall, the MA program continues to face headwinds resulting in plans exiting counties and reducing benefits, which we expect to be reflected in Medicare's CY2025 Landscape File, expected later this week or early next week. While plans are unlikely to eliminate key benefits such as dental, vision, and hearing, we have projected that plans will cut things like OTC cards (Amazon gift cards etc) and other optional items like transportation and exercise programs.

Final CY2025 MA rates released in April (see our memo here) were about the same as proposed, a negative for MA plans & VBC providers. Typically, rates improve incrementally between proposed and final. We said that rates would improve approx. +1.0% for 2025, and that CMS would likely provide relief in the form of growth rate given elevated utilization 4Q23. The final notice can be found here with Advanced Notice here.

In a separate CY2025 MA & D-SNP final rule (see our memo here), CMS finalized most MA plan policies as proposed, with supplemental benefit "bibliography" and mid-year benefit notifications being the most onerous to MA plans. The rule also provides policies around dual eligible (D-SNPs), cracking down on aggressive broker/marketing behaviors, mental health, post-acute denials/RADV and biosimilars. There is no significant cost burden accompanying the rules. CMS rules for MA focus on enhanced reporting requirements with an emphasis on health equity and transparency. More importantly, MA plans are gearing up for a 2025 pay cut per the final MA rules released on April 1 (our analysis is here). CMS appears not to believe that plans will reduce benefits in '25, but we very much believe that will be the case, with smaller and mid-sized regional plans being particularly vulnerable in the new rate environment.

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