# ePrior Auth CMS Proposal Aids Hospitals & Docs

## Applies to Med Advantage, Exchange, Medicaid MCOs in 2026

On December 6, 2022, CMS released the long-awaited prior authorization (PA) proposed rule here. This comes as a part of the Biden administration's commitment to increasing health data exchange and interoperability. If finalized, the rule is expected to streamline PA processes for Medicare Advantage, Exchange, Medicaid and CHIP managed care plans, and Qualified Health Plans on Federally Facilitated Exchanges (FFE) and reduce provider administrative burden.

- **Physicians will mainly benefit with ~$15 B savings over ten, Hospitals also gain.** CMS projects that this proposed rule may result in $15 B of savings for physician practices and hospitals over a 10-year period. Hospitals will benefit, as the administrative burden for physicians will be lowered. Physician groups will have $14.7 B in savings, and hospitals added in would bring the total number up to $15.2 B in savings, bringing CMS to the $15 B estimate. An estimated 213 M hours will be saved for physician groups and hospitals, as administrative processes will be streamlined. Provider groups are reacting positively.

- **Does the regulation help push the MA Prior Auth bill forward? Maybe, maybe not**. See bill description below. Some Hill staff may argue that the regulation alone should suffice as it pertains to speedy access to services that typically require PA. CMS provides some detail as to how a more accurate CBO score may be produced. CMS points out in the rule that:
  - MA rebates. If bids rise then the differential between the bids and the benchmarks contracts and therefore rebate dollars go down. It's not dollar for dollar, but this should mute some of the impact of bids going up.
  - Cutting supplemental benfits. To mitigate the impact on supplemental benefits plans might reduce in other areas, including margin and benefits, thus bids would *not* go up materially.

- **The following PA rules start January 1, 2026 and apply to MA, Medicaid, Exchange & CHIP.** If finalized the following would take place:
  - Payers would be required to include information about patients' PA decisions to help better understand the payers' processes. They would use already established Patient Access Application Programming Interface (API)
  - Payers must build and maintain a Provider Access API to share patient data, claims, encounter data, and prior authorization requests.
  - Require payer-to-payer patient data exchange when a patient changes health plan without the patient's permission.
  - Improving the prior authorization process:
    1) Require payers to build and maintain a FHIR API that would automate the process for providers to determine whether a PA is required, identify prior authorization documentation requirements, and facilitate the exchange of PA requests/decisions from their EHRs.
    2) Require payers to include a specific reason a PA request is denied
    3) Require payers (other than QHPs on FFEs) to send PA decisions within 72 hours for expedited (i.e., urgent) requests and 7 calendar days for standard (i.e., non-urgent) requests.
    4) Require payers to report PA metrics by posting on the company's website or publicly accessible hyperlinks annually. The initial set of metrics to be reported March 31, 2026.
  - Require new electronic PA measures for MIPS-eligible clinicians and Critical Access Hospitals (CAHs), this would entice clinicians and hospitals to embrace the technology.


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  - Implement Guides (IGs) proposed in December 2020 CMS Interoperability PA proposed rule, see here, (85 FR 82586) for APIs are NOT being required by this rule.

- **Medicare Advantage prior authorization bill ($16 B price tag) passed the House this fall, proposed rule could renew efforts to include in lame-duck legislation but we look to 2023 for action.** "Improving Seniors' Timely Access to Care Act of 2021," here introduced by Rep. DelBene (D-WA) aims to lessen burden for providers. The bill aids hospitals, physicians & others, while burdening payers (MA Plans). H.R. 3173 had 322 House co-sponsors. It (1) establishes an electronic PA program that can provide "real time decisions" (definition to be updated by HHS every 2 years) (2) report to HHS on use of PA and approval/denial rates and a list of services subject to PA, (3) meet PA technical, quality and timeliness standards set by CMS, (4) share policies with providers and suppliers, and (5) tell beneficiaries criteria used to make determinations.

- **OUR TAKE/ NEXT STEPS:** We think the common sense rule will be finalized, without a need to pass the legislation that may be seen as an incremental negative for plans (Medicaid, MA, etc). The agency also asks stakeholders for feedback in the RFI section of the rule, relating to health equity, etc. We flesh out in the text of this note. We look to the MA and Part D rules (Marketing, Stars, Provider and Network guidelines) over the next week or two. We also expect RADV rules in 1Q2023; See our take in the Background section. 2024 MA proposed rates will be after the start of the year.


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**BACKGROUND**

- **See Request for Information included in the proposed rule below.**
    - **Accelerating the Adoption of Standards Related to Social Risk Factor Data**. RFI on barriers to adopting standards related to social risk data (e.g., housing instability, food insecurity).
    - **Electronic Exchange of Behavioral Health Information**. Reissued RFI on how to advance electronic data exchange among behavioral health providers.
    - **Improving the Electronic Exchange of Information in Medicare FFS.** Improvements to the exchange of medical documentation between and among providers/suppliers and patients.
    - **Advancing the Trusted Exchange Framework and Common Agreement (TEFCA).** How enabling exchange under TEFCA can support this proposal.
    - **Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health**. Evidence-based policies CMS could pursue that leverage health IT, data sharing, and interoperability to improve maternal health outcomes.
    - **Prior Authorization Time Frames**. RFI on alternate time frames with shorter turnaround times, such as 48 hours for expedited requests and five calendar days for standard requests.

***RADV***

- **CMS announced that Part C (MA) net error rates between 2014 and 2020 were in the 1-5% range.** Part C error rates were quietly released by CMS ahead of Thanksgiving (here). Table 1 shows that $11.4 B and 7.2 B were erroneous payments to all MA plans in 2020 and 2019, respectively. The trend over time is likely troubling to CMS and lawmakers, and adds fuel to the RADV fire. We note that the figures include overpayments and underpayments to plans. Improper payment estimates are due to (1) missing or insufficient HCC documentation (2) medical record discrepancies (3) insufficient documentation to determine whether proper or improper.

- **Headline risk for MA plans in 2023 is the long-standing risk adjustment audits that the agency started over a decade ago.** HHS must release final rules by Feb 1, 2023 or request an extension, or even start over. In the Program Integrity Group at CMS, RADV has never been a popular issue among policymakers. RADV audits have taken place over the last decade but significant plan pay recoupments have not.

- **If finalized, we 100% expect industry litigation**. We look at AHIP and BCBSA letters as to areas where the litigation will focus. See here for a blog post on plan perspectives. Issuers want (1) FFS adjuster (FFSA) and (2) No retroactive nature for these audits. (3) CMS should estimate a model based on audited data then determine what payment error is based on audited data then adjust accordingly. We note that program integrity / anti-fraud measures are bipartisan issues.

- **Three policies in the final rule to watch.** HHS is likely to lean on SCOTUS in the final rule. We will be watching for the following three main issues below:
    - FFS Adjuster. CMS has said that the application of the FFSA is not necessary. So, does CMS finalize what they proposed, with no FFSA? CMS performed a study on the topic & subsequently announced it believes there is no need for FFSA, which does not align with MA plans' position.


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- Retroactive (vs. Prospective) audits. There is regulatory text that allows CMS to extrapolate the results from the audits, going as far back as 2011. Some argue the agency has always had the authority to look back. The plan community would have a strong argument, in our view, to solely make RADV prospective, and/or go back only a handful of years.

- Extrapolation. There is n=200 (sample size) for audits. Basically 200 persons are selected and the auditors will ask plans to provide up to 5 medical records to validate whether the Hierarchical Condition Category (HCC) is supported by any of the medical records. Medical records must be from medical providers i.e., from i/p, o/p and physician. A radiology claim, for instance, would not be allowed. The medical record has to be signed. CMS uses a medical record contractor to conduct reviews (not recovery audit contractors, or RACs).

- **FFSA Model that CMS uses to determine payment to health plans used diagnosis codes from FFS Medicare**. The CMS-HCC model allows and includes coding errors, but RADV audit standards hold each code to 100% accuracy. The FFSA accounts for differences in these documentation standards, between FFS data the risk adjustment model is calibrated on and RADV, creating a mismatch.

- **RADV TIMELINE:** As a reminder, here are some key past events shaping the RADV rules.

  - By Nov 1, 2022 – HHS scheduled to release RADV final rules
  - Jun 21, 2022 – Supreme Court declines to hear UnitedHealth appeal on Overpayment Rule litigation (Read here).
  - Oct 21, 2021 – Announcement of one year timeline extension due to exceptional circumstances (1) publication of FFS Adjuster Study and time for public comment, as well as (2) the COVID-19 PHE (Read here).
  - Aug 13, 2021 – Federal appeals court reversed 2018 District Court rulings that sided against CMS on Overpayment Rule (Read here).
  - Jan 10, 2020 – CMS issues Version 2 - Contract-level RADV: Medical Record Reviewer Guidance (Read here).
  - March 20, 2019 – CMS issues Contract-level RADV: Medical Record Reviewer Guidance (Read here).
  - March 6, 2019 – Release of data underlying FFSA Study (Read here).
  - Nov 9, 2018 – DC District Court agrees with UnitedHealthcare suit and vacates CMS's 60-day Overpayment Rule. (Read here).
  - Nov 1, 2018 – CMS released proposed RADV rule (Read here). Agency announced plans of (1) extrapolating data in RADV contract-level audits in RADV contract-level audits going back to 2011 and (2) FFS adjuster to offset error rate would not be applied to audit findings. Since release of the proposed rule, there have been two extensions and HHS has issued provisional data (see above).
  - Oct 26, 2018 – FFS Adjuster Study released by CMS
  - July 19, 2017 – GAO report (Read here) found that (1) the government made $16 billion in improper payments to private MA plans and that (2) RADV audits did not target contracts with the highest likelihood of improper payments. This sparked CMS's reevaluation of RADV rules.
  - Feb 24, 2012 – CMS issues Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Read here). Notice ***proposes extrapolation calculation***, sampling framework, and FFS Adjuster to reduce extrapolation amounts and set a permissible level of payment error.
  - 2012 – CMS gives up on recouping overpayments from 2008 to 2010, although estimated improper payments were more than $32 billion.


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- April 15, 2010 – CMS issues Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule (Read here). Effective date - June 7, 2010. Methodology for selecting "a statistically-valid sample of enrollees from each audited MA contract and extrapolating from the results of that sample audit to calculate a contract-level payment adjustment" proposed.
- 2008 - 2012 – First RADV Audits checked 32 plan contract payments from 2007, CMS recouped $13.7 million in overpayments (Read Fact Sheet here).


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