FDR Compliance Newsletter

Mercy Care Advantage 4750 S. 44th Place, Ste 150 Phoenix, AZ 85040 September 2024 | Issue 2

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Medicare Advantage and Part D Final Rule (CMS-4205-F)

The Centers for Medicare & Medicaid Services (CMS) released the final rule for the 2025 Medicare Advantage (MA) and Part D programs, on April 5, 2024. Outlined below are some key changes included in the rule:

Key areas of focus include:

- Revisions to Annual Health Equity analysis of Utilization Management (UM) policies
- Behavioral Health Provider Network Adequacy,
- Enhancements to the Medication Therapy Management (MTM),
- New standards for Supplemental Benefits for the Chronically Ill,
- New Mid-year Enrollee Notification of available Supplemental Benefits.

Annual Health Equity analysis of UM policies: requires that MA organizations analyze their UM policies and procedures from a health equity perspective annually. For CY2025, the UM committee will have additional responsibilities. They must:

- Include at least one committee member with expertise in health equity,
- Conduct annual plan-level health equity analysis of prior authorization policies and procedures used by the plan, and
- Must make the results publicly available on the plan's website.

The objective of the health equity analysis is to create additional transparency and identify disproportionate impacts of UM policies and procedures on enrollees who.

receive the Part D low-income subsidy, who are dually eligible, or who have a disability.
Delegated entities who review and process prior authorization requests on behalf of Mercy Care Advantage will need to implement and comply with this requirement by January 1, 2025. Mercy Care will be requesting implementation status updates to monitor compliance.

Mid-Year Notice of Unused Supplemental Benefits: Starting CY2026, requires Medicare Advantage plans to issue a "Mid-Year Enrollee Notification of Unused Supplemental Benefits" annually, between June 30 and July 31 of the plan year. The notice must be personalized to each enrollee and include a list of any supplemental benefits not accessed by the individual during the first six months of the year (by June 30th).

This requires accurate tracking of the supplemental benefits offered under the Mercy Care Advantage plans. Mercy Care contracts with various entities for the administration of the Mercy Care Advantage supplemental benefits and may be contacting your organization to discuss the benefit utilization data required to comply with this new member notification requirement.

Reference the final rule for complete details:
https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

The Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) on January 17, 2024. This final rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers.

This final rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care. The rule sets requirements for Medicare Advantage (MA) organizations and Medicaid managed care plans, and CHIP managed care entities, as well as other types of impacted payers.

Quick Links

Medicare Manage Care Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

CVS Code of Conduct
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

The requirements applicable to the prior authorization processes are effective on January 1, 2026, while the API provisions are effective January 1, 2027. See the final rule for more **"effective date"** details.

- The prior authorization requirement includes reducing the decision-making timeframe for standard prior authorization requests to as expeditiously as the enrollee's health condition requires **but no later than 7 calendar days after receiving the request.**
- Impacted payers must provide specific reason for the denial within the decision timeframe regardless of the method used to send the prior authorization request or decision.
- Beginning in 2026, both Medicare Advantage Organizations and Medicaid managed care plans, and CHIP managed care entities to are required to publicly report certain prior authorization metrics annually on their website and the initial set of metrics must be reported by March 31, 2026.

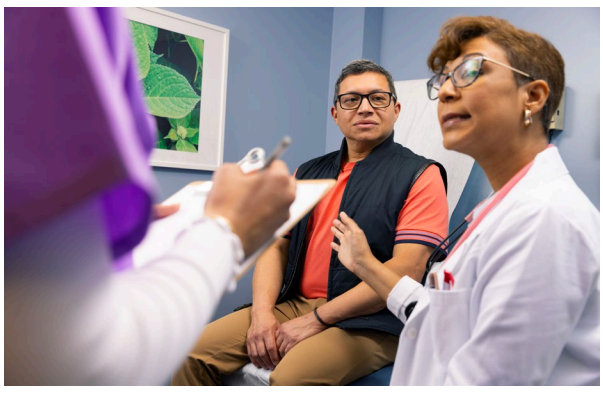
Delegated entities who review and process prior authorization requests on behalf of Mercy Care and Mercy Care Advantage will need to comply with implementing the operational requirements in this final rule by the identified effective dates. Mercy Care will be requesting implementation status updates to monitor compliance.

Reference the final rule for complete details and effective dates:
https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

The Centers for Medicare and Medicaid Services (CMS) issued an update on July 19, 2024, to the Parts C & D Enrollee Grievance, Organization/Coverage Determination, and Appeals Guidance. The updated guidance is **effective immediately**. Updates include incorporating recent changes to 42 CFR § 422.566(d), which requires that a denial based on a medical necessity determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue.

Clarifies who may act or be appointed as a representative, and indicates that enrollees, their representatives, or providers on behalf of enrollees, have the right to voluntarily request plan approval on any service, item, or Part B drug which they believe are, or should be, covered by the plan—including non-covered services, items,



and Part B drugs and those for which the plan does not require prior authorization.

CMS also made certain terminology changes in the manual, such as refraining from using the term **"pre-service"** when discussing authorization requests generally, to ensure consistency with the regulatory terminology of 42 CFR Part 422, Subpart M and to enhance recognition that organization determinations may occur prior to, during, and after a particular benefit is furnished to an enrollee.

The updated guidance is available at:
https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf

Need to report potential fraud, waste and abuse (FWA) involving Mercy Care Advantage or Mercy Care? Visit our website for information about the different ways to report:
https://www.mercycareaz.org/providers/fraud-waste-abuse.html

Need to report identified noncompliance, please contact Chris Macias, Medicare Compliance Officer at MaciasC1@mercycareaz.org or submit to our Medicare Compliance mailbox at: MercyCareAdvantageMedicareCompliance@AETNA.com.