HEALTHCARE ADVOCATE SUMMIT

For Advocates, By Advocates®

SEPTEMBER 2–5, 2025 | CAESARS PALACE | LAS VEGAS

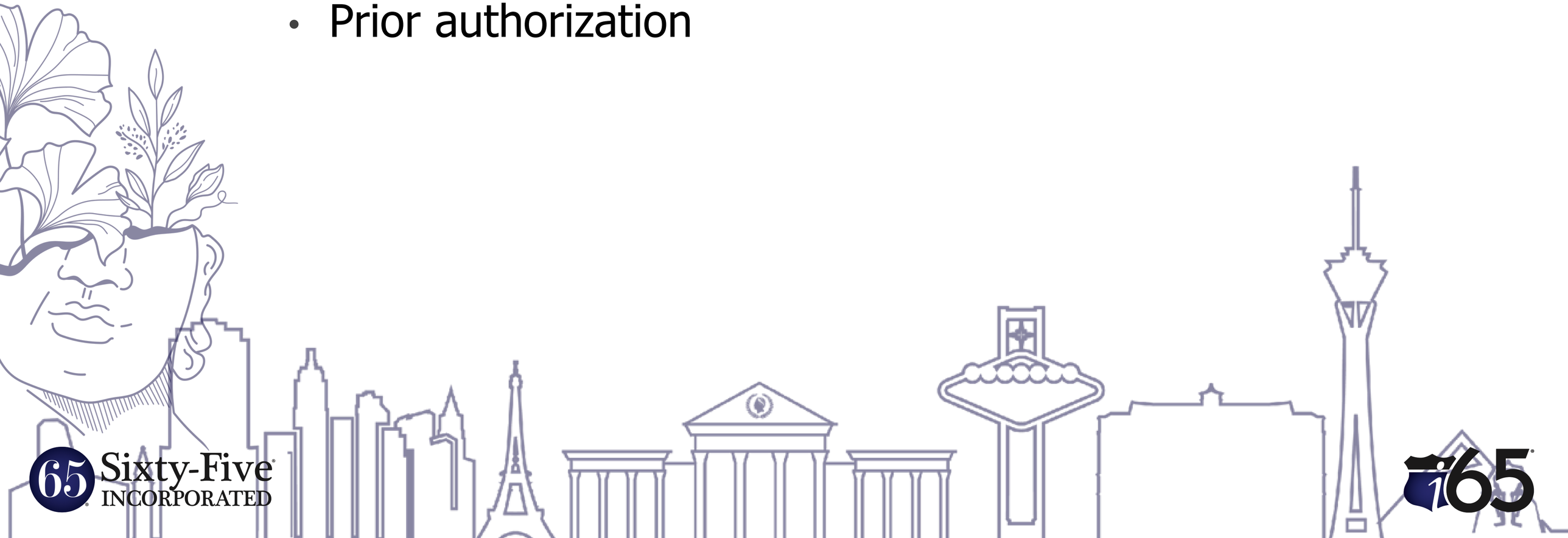
When Medicare's Good Intentions Go Bad

Sixty-Five INCORPORATED

i65

When Medicare's Good Intentions Go Bad or Not Quite as Intended

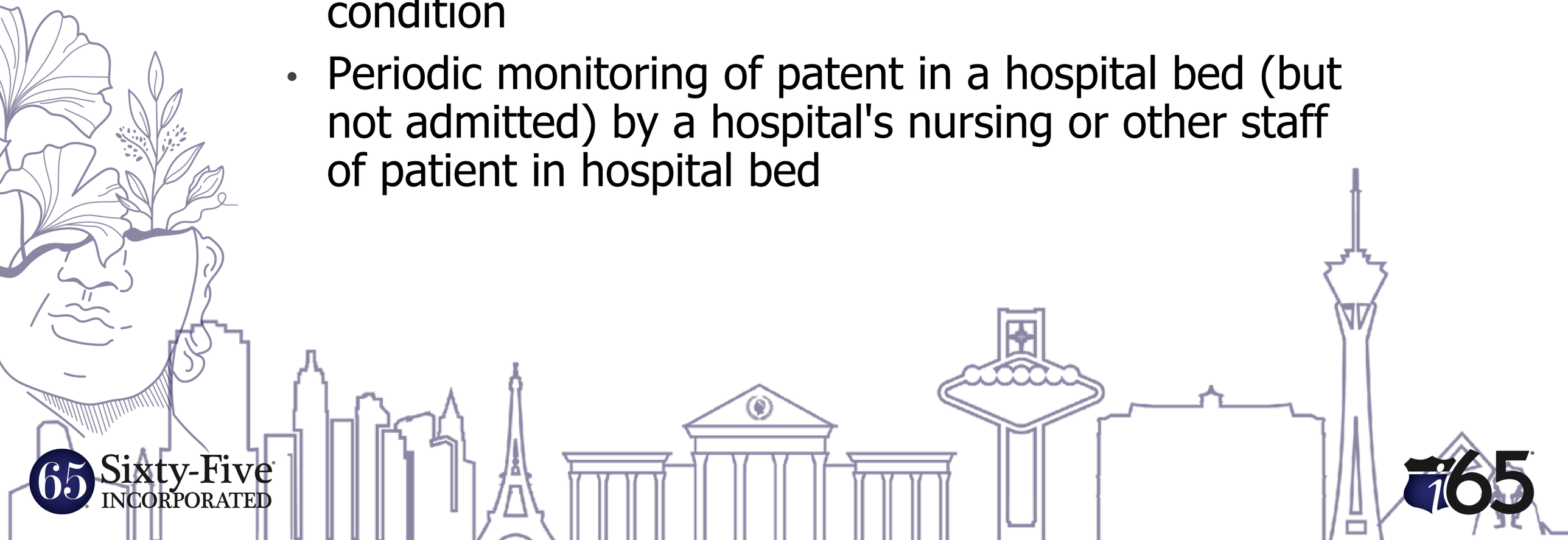
- Outpatient observation stay
- Medicare Prescription Payment Plan
- Prior authorization



Outpatient Observation Stay

Outpatient Observation Stay
What It Is

- First recognized by Medicare in the 1980s
- Hospital service for patient with unstable, uncertain condition
- Periodic monitoring of patent in a hospital bed (but not admitted) by a hospital's nursing or other staff of patient in hospital bed



Outpatient Observation Stay
The Good Intentions

- Determine whether patient with unstable, uncertain condition can be discharged safely to home or require inpatient admission
- Intended for select lower acuity diagnoses that would:
  - Resolve in 24 hours, freeing up ER
  - Save health systems more than $3B per year

Outpatient Observation Stay
What It's Become

- From 2012-2017, observation stays increased by 32%, increasing CMS spending by nearly 20%
- Longer stays, 633,148 in 2014 of three or more days
- Today:
  - Now associated with over 1,000 diagnoses code
  - CMS notes over one million beneficiaries per year
- Medicare numbers projected to increase by 29% between 2024 and 2034*

*Vizient Inc. September 2024

Outpatient Observation Stay
Cost Implications

- Observation stay falls under Part B, medical insurance
- Original Medicare: Part B deductible, 20% coinsurance (covered by Medigap policy)
- Medicare Advantage: Outpatient hospital coverage, $0-$315 (or more) copay per-visit

Outpatient Observation Stay
Cost Implications

- Separate billing codes for physician and practitioner services, evaluation, and other services
- Cost for an individual visit cannot be more than the hospital deductible, but all visits can add up to considerably more

Outpatient Observation Stay

Prescription Drug Implications

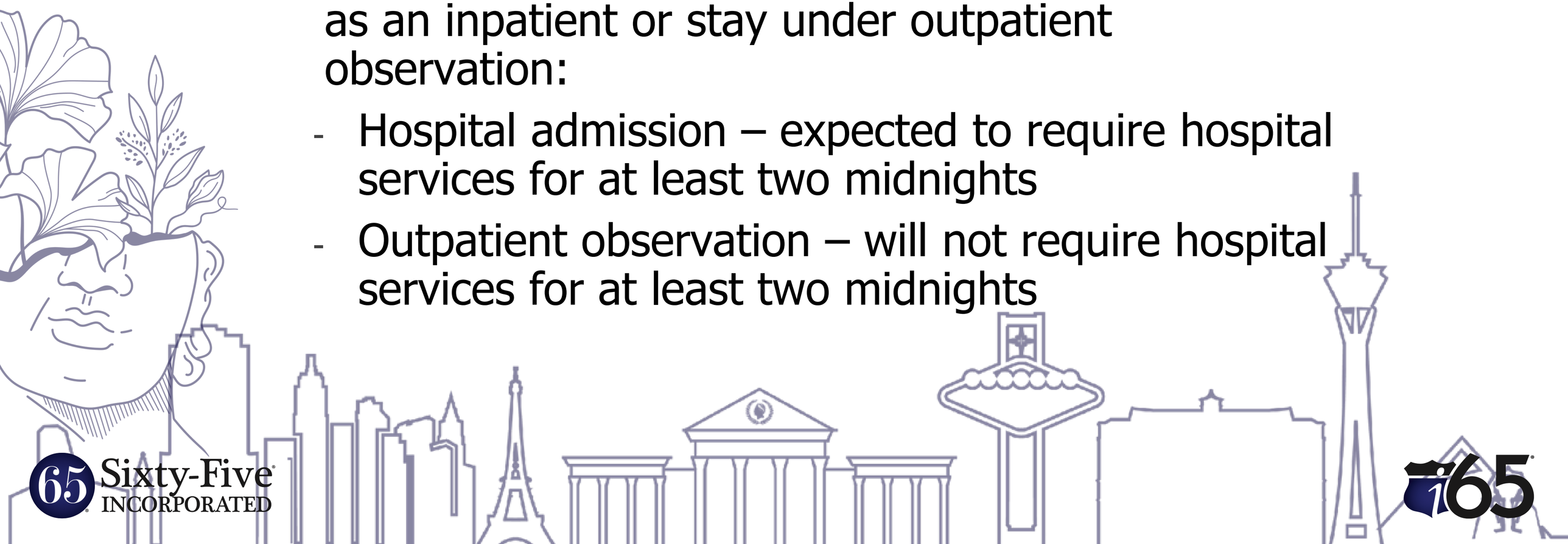
- Part B does not cover drugs during stay
- Hospitals don’t allow medications from home so the hospital pharmacy must supply the drugs
- Hospital pharmacies are out-of-network for Part D:
  - Patient will likely have to pay for drugs, then submit claim for reimbursement using the plan’s form
  - Drugs may not be covered, physician may need to submit formulary exception

Outpatient Observation Stay
SNF Stay Implications

- A three-day hospital admission is necessary to qualify for Medicare coverage:
  - A three-day stay for observation does not qualify
  - Maybe there might still be a Medicare Advantage plan that waives the requirement
- Options:
  - Pay for SNF stay out-of-pocket
  - Go without the care

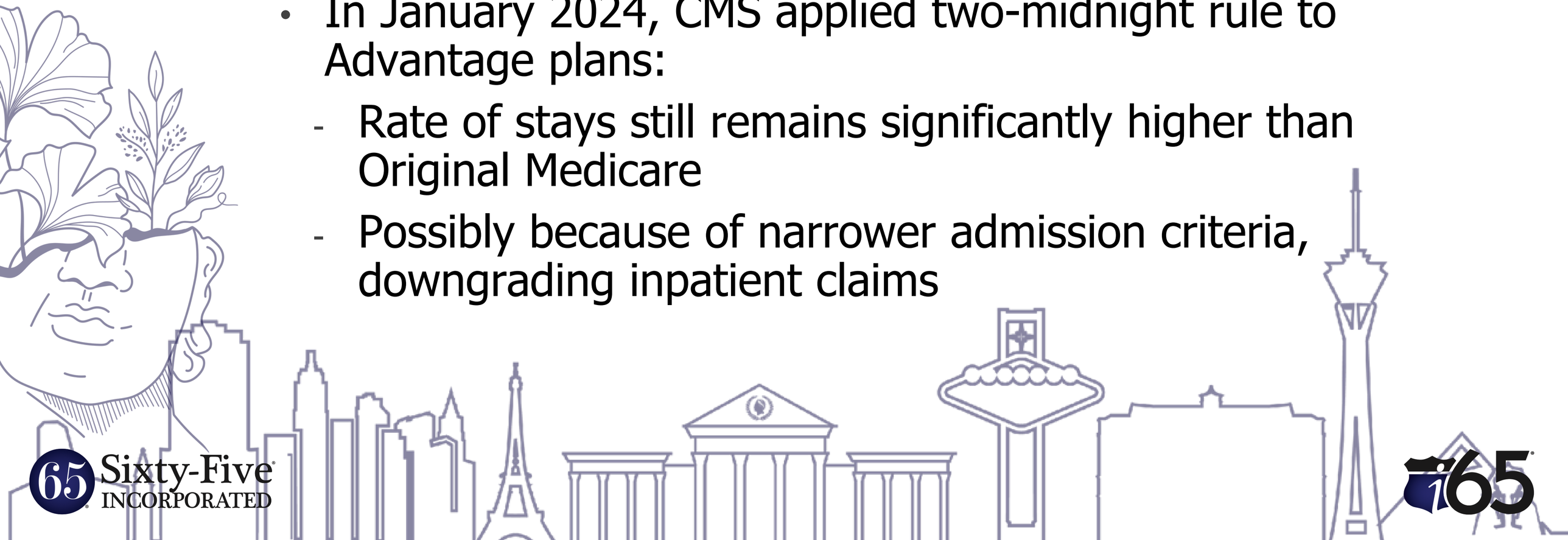
Outpatient Observation Stay
The Two-Midnight Rule

- CMS adopted rule in 2013
- Time-based criteria for deciding whether to admit as an inpatient or stay under outpatient observation:
  - Hospital admission – expected to require hospital services for at least two midnights
  - Outpatient observation – will not require hospital services for at least two midnights

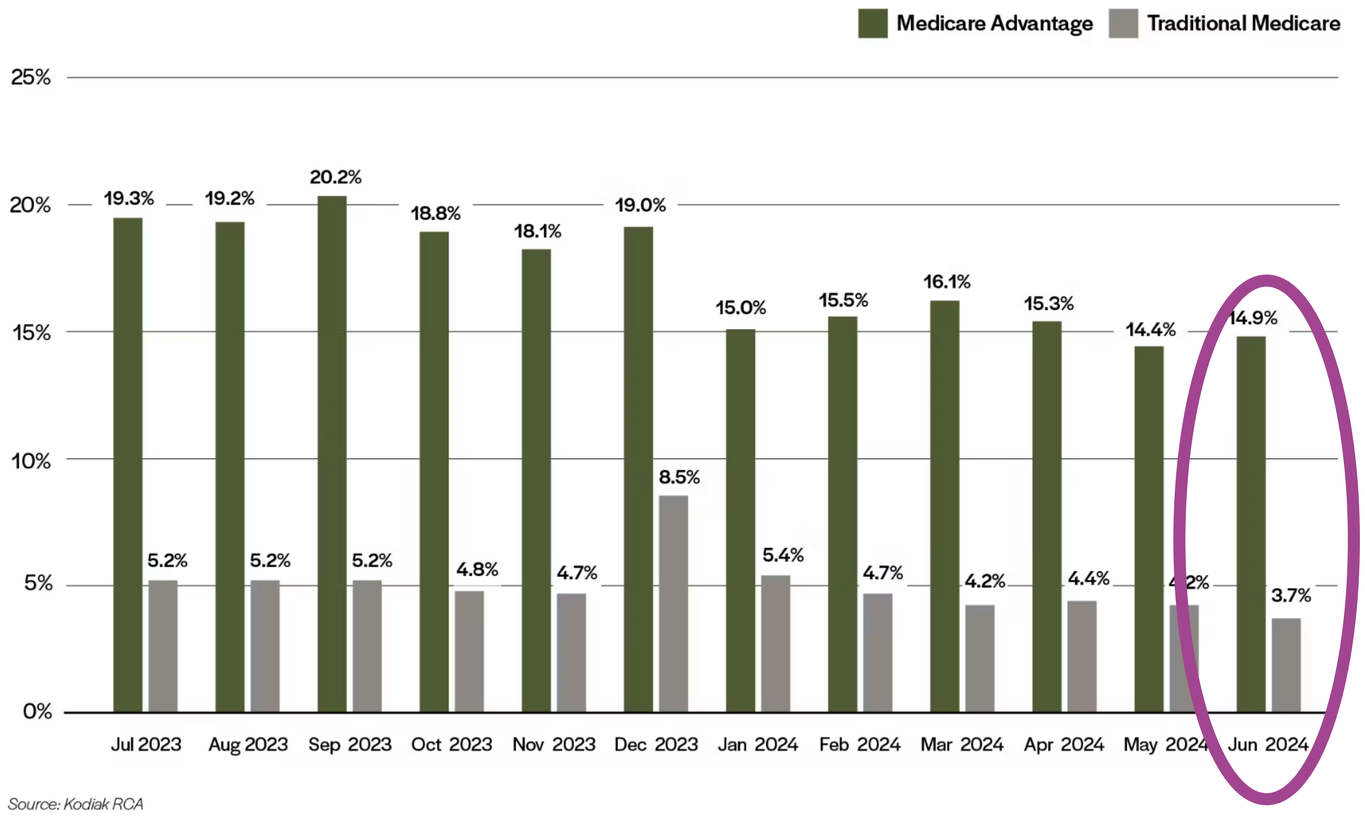


Outpatient Observation Stay
Medicare Advantage

- When implemented in October 2013, two-midnight rule applied only to Original Medicare
- In January 2024, CMS applied two-midnight rule to Advantage plans:
  - Rate of stays still remains significantly higher than Original Medicare
  - Possibly because of narrower admission criteria, downgrading inpatient claims



Medicare Advantage vs. traditional Medicare observation rates July 2023 through June 2024



Source: Kodiak RCA

Kodiak Solutions, "Some payors hit snooze button on Two-Midnight clock," November 2024

Outpatient Observation Stay: How You Can Help

Get to Know The Moon

- Medicare Outpatient Observation Notice (March 2017)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

Outpatient Observation Stay: How You Can Help

Get to Know The Moon

- Medicare Outpatient Observation Notice (March 2017)
- Hospitals must provide notice to those receiving observation services for more than 24 hours:
  - MOON notes the reason for, implications of the stay
  - Must also provide brief explanation
  - Patient can choose to sign or not sign notice
- Most beneficiaries have no idea what to do, may be overwhelmed

Outpatient Observation Stay: How You Can Help
Try to Change Observation to Admission

- Should take action as soon as MOON is issued:
  - Talk to the physician about admitting as an inpatient, especially if an SNF stay is planned
  - 48% conversion rate for Original Medicare
- Even if successful, decision is subject to utilization review change after discharge if stay did not meet criteria for admission

Outpatient Observation Stay: How You Can Help
Know Appeal Rights

- Alexander v. Azar (nine years of litigation) led to two appeals
- Retrospective appeal: For hospitalizations from January 1, 2009–February 13, 2025
- Prospective appeal: Available as of February 14, 2025

Outpatient Observation Stay: How You Can Help
Retrospective Appeal

- Can quality for refund of SNF out-of-pocket costs (no three-day hospital stay)
- Issues with this appeal:
  - How many actually went to an SNF with no Medicare coverage?
  - If they did, how many have the documentation and energy to do this?

Outpatient Observation Stay: How You Can Help
Prospective Appeal

- Criteria:
  - Admitted as an inpatient but reclassified to observation
  - Spends at least three consecutive days (not counting day of discharge) on observation status
- Hospital must provide the Medicare Change of Status Notice (MCSN), stay did not meet criteria for admission

Medicare

Patient name: _____

Patient number: _____

Hospital name: _____

Hospital address: _____

Medicare Change of Status Notice

Important! You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

The box marked below shows what applies to you:

☐ While you're still in the hospital, your hospital stay will now be billed to Medicare Part B instead of Part A.

Your hospital bill may be lower or higher than the Part A inpatient deductible. Your hospital can give you more information about billing.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

☐ While you're still in the hospital, the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

You Can Appeal

- You can appeal your status change to a Quality Improvement Organization right away. Quality Improvement Organizations are independent of Medicare.
- If you decide to appeal, your Quality Improvement Organization will look at your records and give you its decision about 2 days after you ask for an appeal.
- Call your Quality Improvement Organization to appeal at:

  _____
- You should ask for an appeal as soon as possible and before you leave the hospital.
- After you leave the hospital, you still have appeal rights. Call your Quality Improvement Organization.

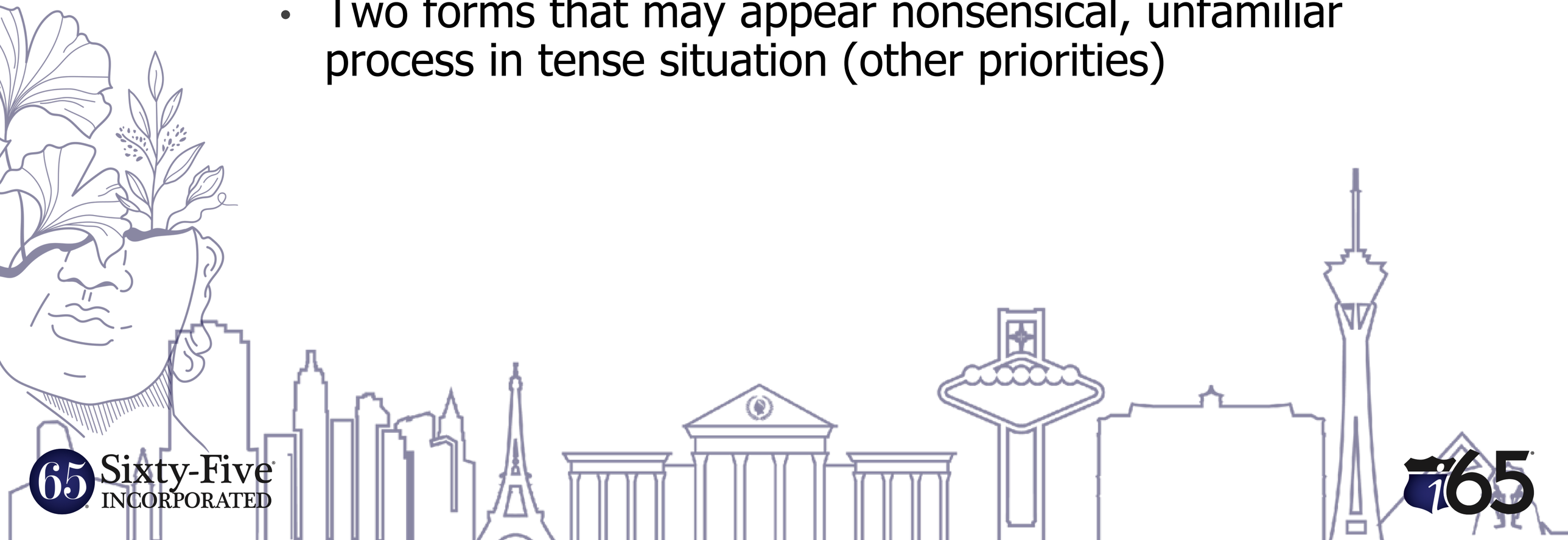
Outpatient Observation Stay: How You Can Help
File a Prospective Appeal

- Advocate can assist or serve as Patient Representative (another form)
- Patient must call the Quality Improvement Organization (QIO) before leaving the hospital
- QIO will review records, ask for patient and hospital views, issue decision within one calendar day
- If denied, the appeals process applies

Outpatient Observation Stay

A Prospective Appeal Sounds Great, But Is It?

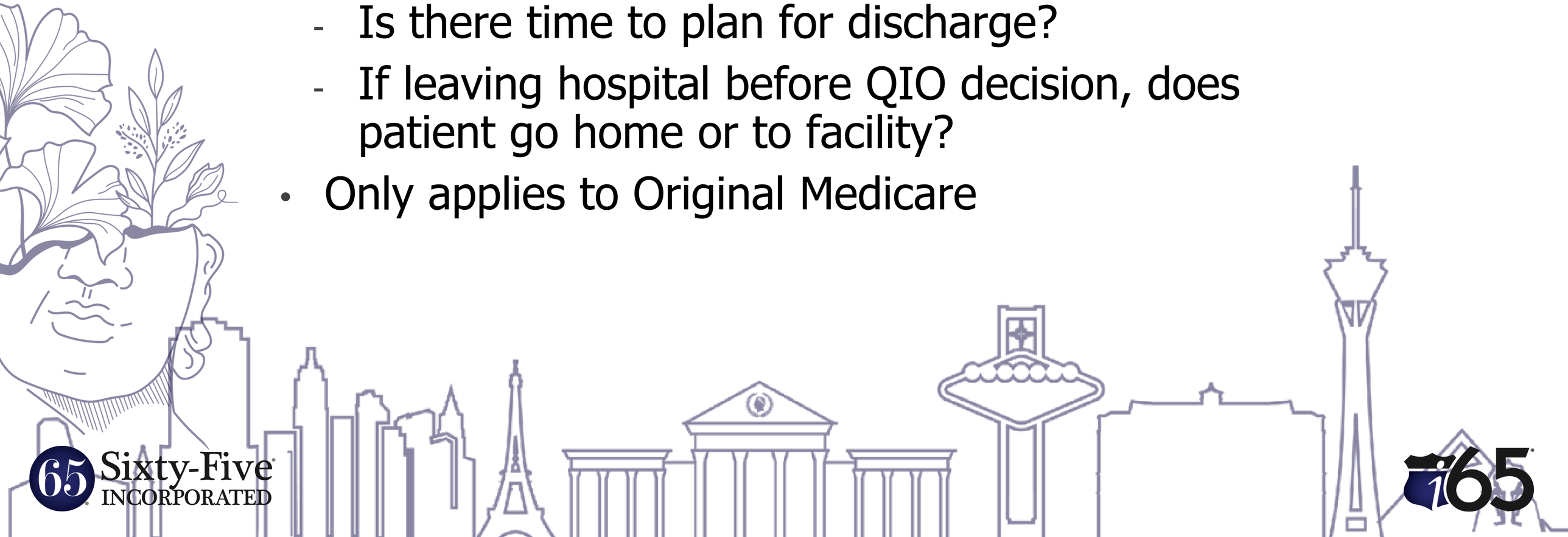
- Limited to observation stay of three or more days after inpatient admission (maybe five days total)
- Two forms that may appear nonsensical, unfamiliar process in tense situation (other priorities)



Outpatient Observation Stay

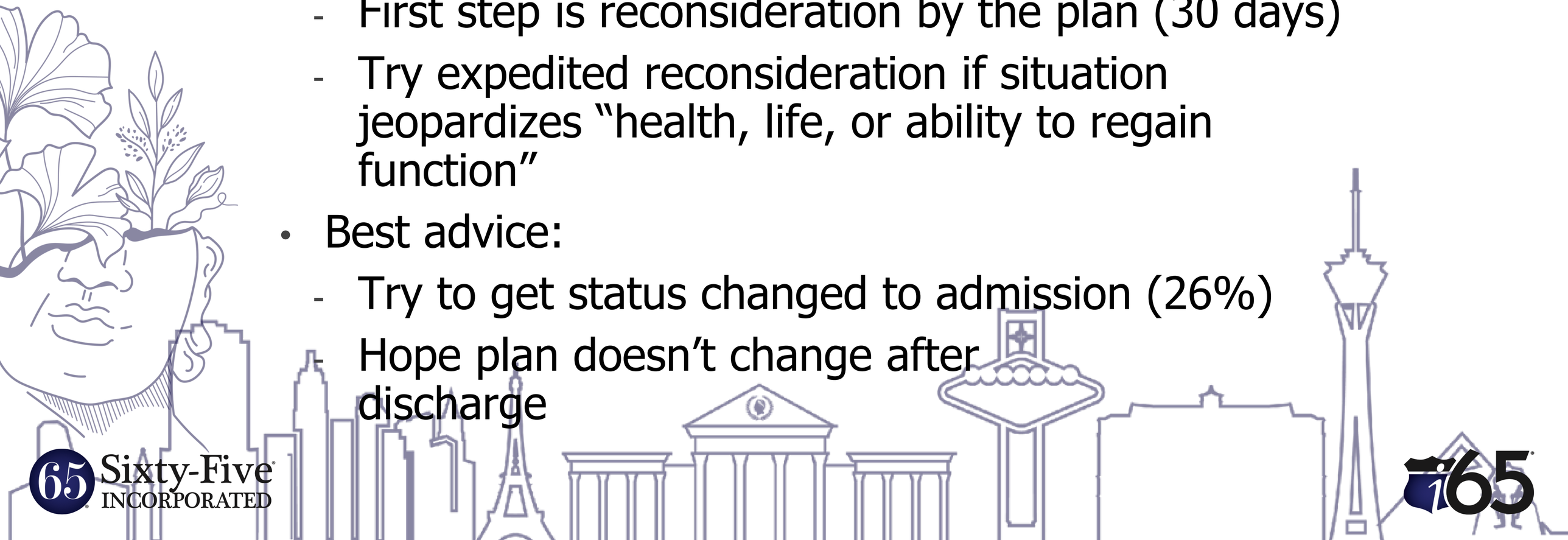
A Prospective Appeal Sounds Great, But Is It?

- Uncertain discharge plan:
  - Does patient need an SNF stay?
  - Is there time to plan for discharge?
  - If leaving hospital before QIO decision, does patient go home or to facility?
- Only applies to Original Medicare



Outpatient Observation Stay
Medicare Advantage Disadvantage

- With no prospective appeal option, members must follow the plan's appeal process:
  - First step is reconsideration by the plan (30 days)
  - Try expedited reconsideration if situation jeopardizes "health, life, or ability to regain function"
- Best advice:
  - Try to get status changed to admission (26%)
  - Hope plan doesn't change after discharge



Medicare Prescription Payment Plan

Medicare Prescription Payment Plan
The Basics

- "Maximum Monthly Cap on Cost-Sharing Payments Program:"
  - CMS shorthand "Medicare Prescription Payment Plan"
  - For everyone else MPPP or M3P
- Similar to an installment payment plan

Medicare Prescription Payment Plan
The Good Intentions

- Those who reach the $2,000 cap can face a big bill
- MPPP allows enrollees to pay in monthly installments, spread out over the year
- That may help:
  - Manage budgets
  - Provide relief from costs
  - Promote medication compliance

Medicare Prescription Payment Plan
The Basics

- Any Part D enrollee is eligible (stand-alone, Medicare Advantage, retiree plans)
- Variation among plans as to who qualifies
- Enrollees pay nothing at the pharmacy
- Will get monthly bills from drug plan, can pay via electronic transfers, cash, or check
- Enrollee can opt out at any time; then responsible for full payment before next prescription

Medicare Prescription Payment Plan
The Basics

- MPPP applies:
  - Only to drugs listed in a plan's formulary
  - Provided by an in-network pharmacy
- Will not save any money
- Not everyone will benefit

Medicare Prescription Payment Plan
The Numbers

- Over 1.2 million beneficiaries should have received the "Likely to Benefit Notice:"
  - Stand-alone Part D plan – 800,000 (65%)
  - MA-PD plan – 440,000 (35%)
- Only 16% (190,000) who filled prescription in first two months of 2025 were in the MPPP:
  - Stand-alone Part D plan – 70,000 (37%)
  - MA-PD plan – 120,000 (63%)

Medicare Prescription Payment Plan
Challenges for the Enrollee

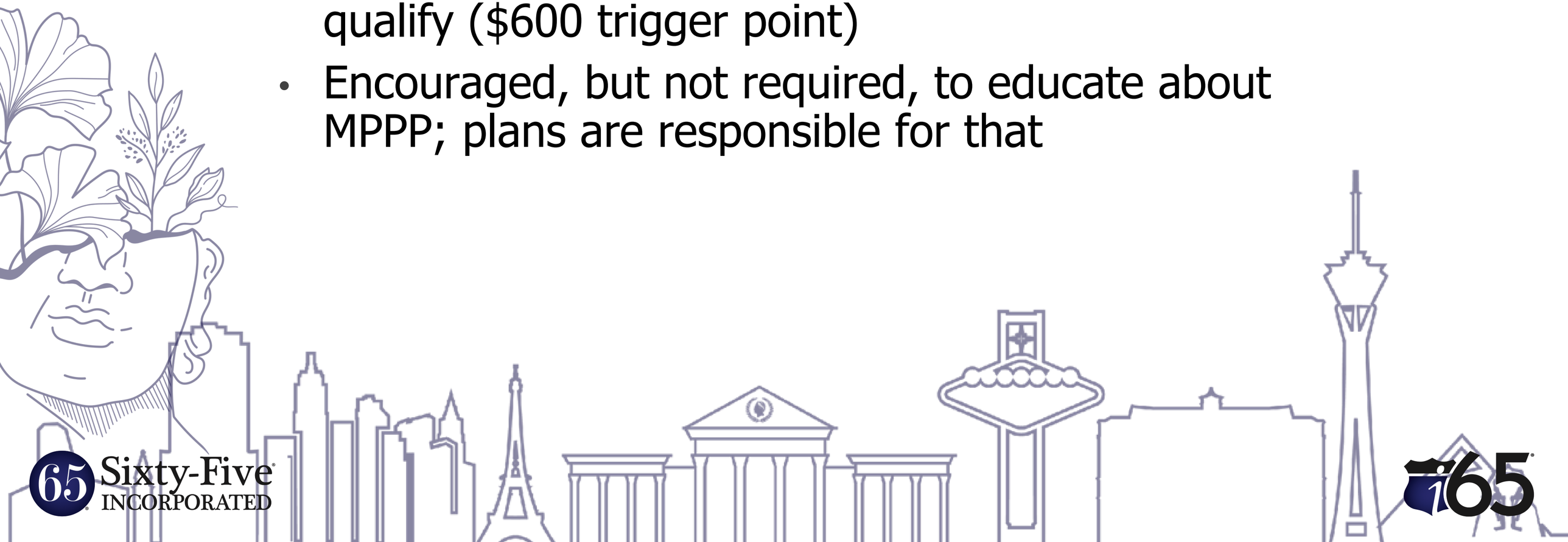
- Understanding the MPPP, how it operates
- Determining whether it will be beneficial (optional)
- Making sense of invoices:
  - Pay nothing at pharmacy, then bills arrive
  - Complex calculations (not simply dividing by 12)
  - Monthly amounts can change
  - Can confuse invoices with Medicare bills

Medicare Prescription Payment Plan
Challenges for the Enrollee

- Knowing when to enroll
- Difficulty enrolling in the MPPP:
  - Enroll through the plan; method depends – fax, email, online form
  - Some plans say to enroll through medicare.gov
  - Cannot opt in at pharmacy counter (2026)
  - Very difficult to find plan-specific information

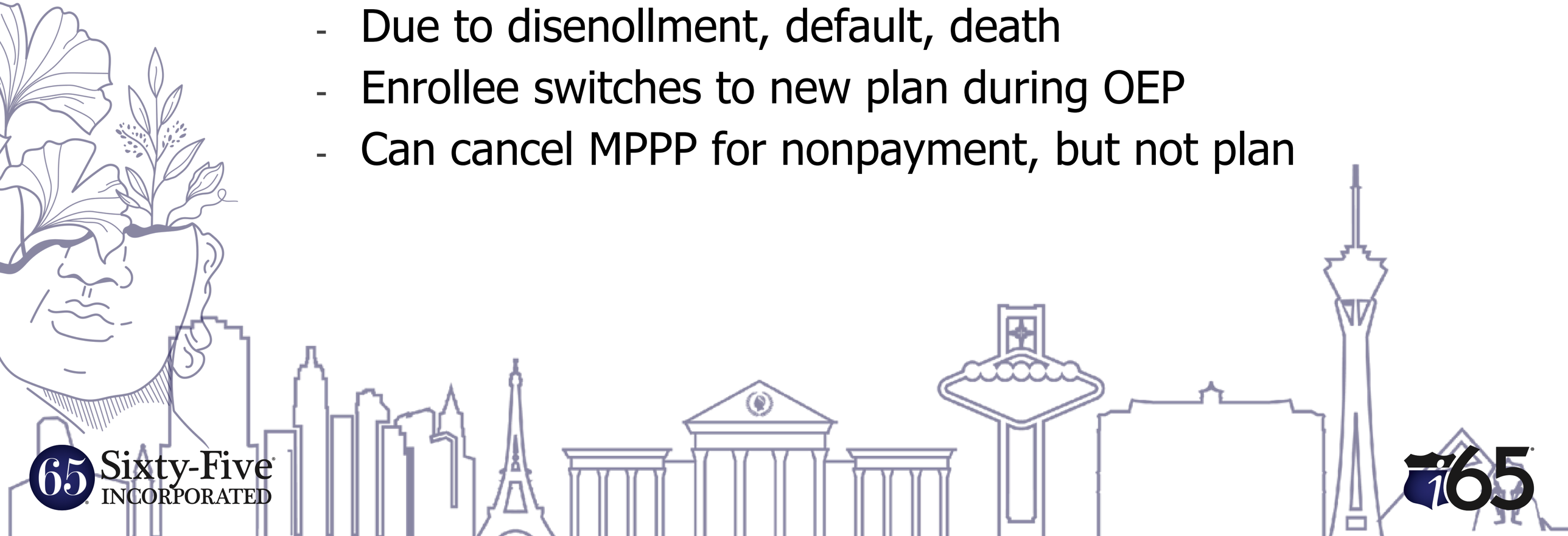
Medicare Prescription Payment Plan
Challenges for the Pharmacy

- Identify customers who have enrolled
- Provide "Likely to Benefit Notice" to those who can qualify ($600 trigger point)
- Encouraged, but not required, to educate about MPPP; plans are responsible for that



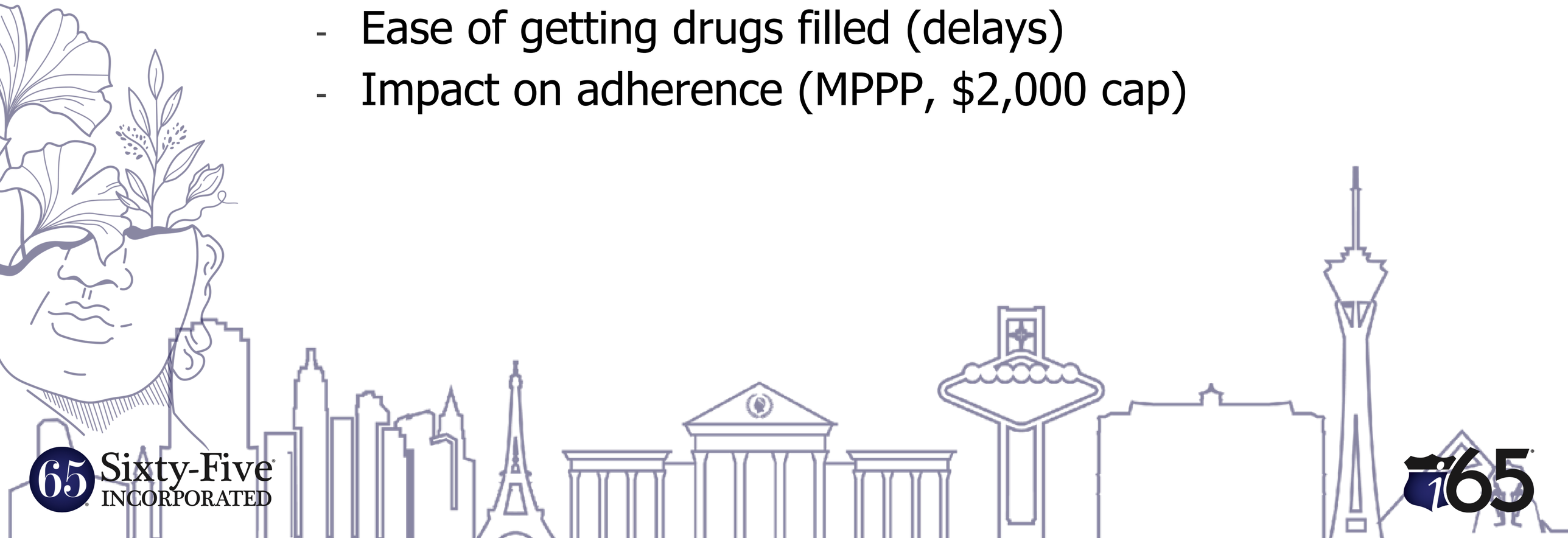
Medicare Prescription Payment Plan
Challenges for the Drug Plan

- Must identify, notify, educate enrollees
- Deal with bad debt ("left holding the bag"):
  - Due to disenollment, default, death
  - Enrollee switches to new plan during OEP
  - Can cancel MPPP for nonpayment, but not plan



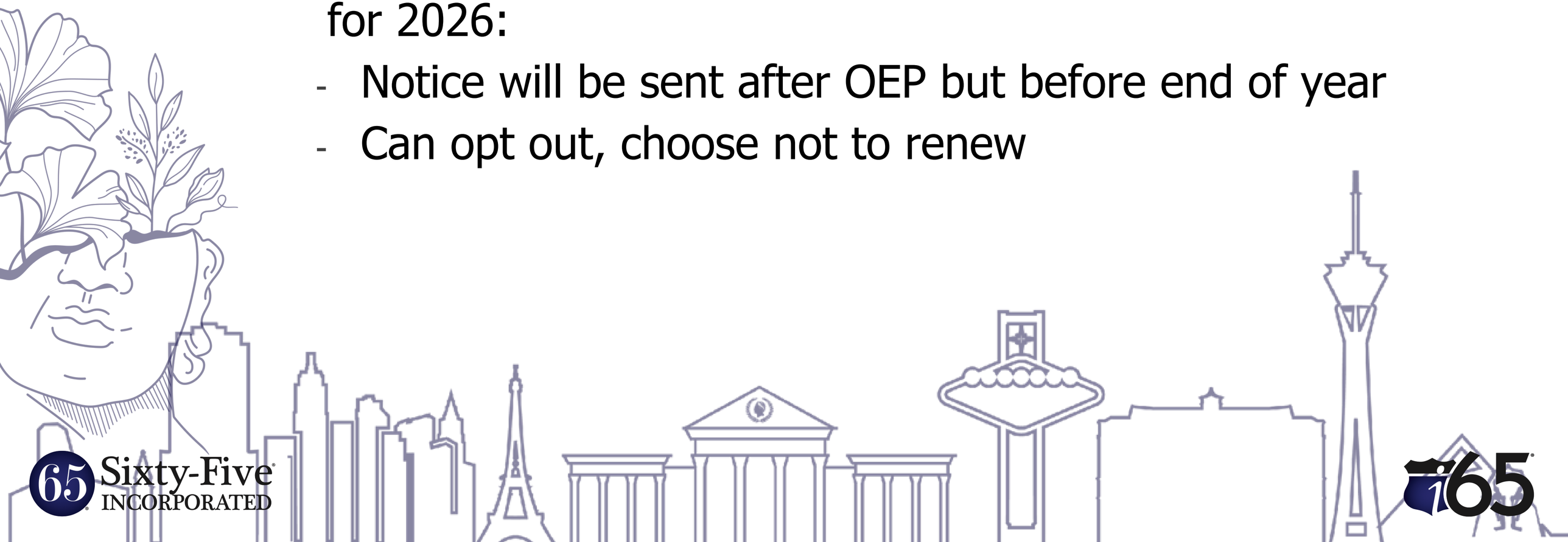
Medicare Prescription Payment Plan
Challenges for the Drug Plan

- Impact on quality ratings:
  - Member experience (complexity, confusion)
  - Ease of getting drugs filled (delays)
  - Impact on adherence (MPPP, $2,000 cap)



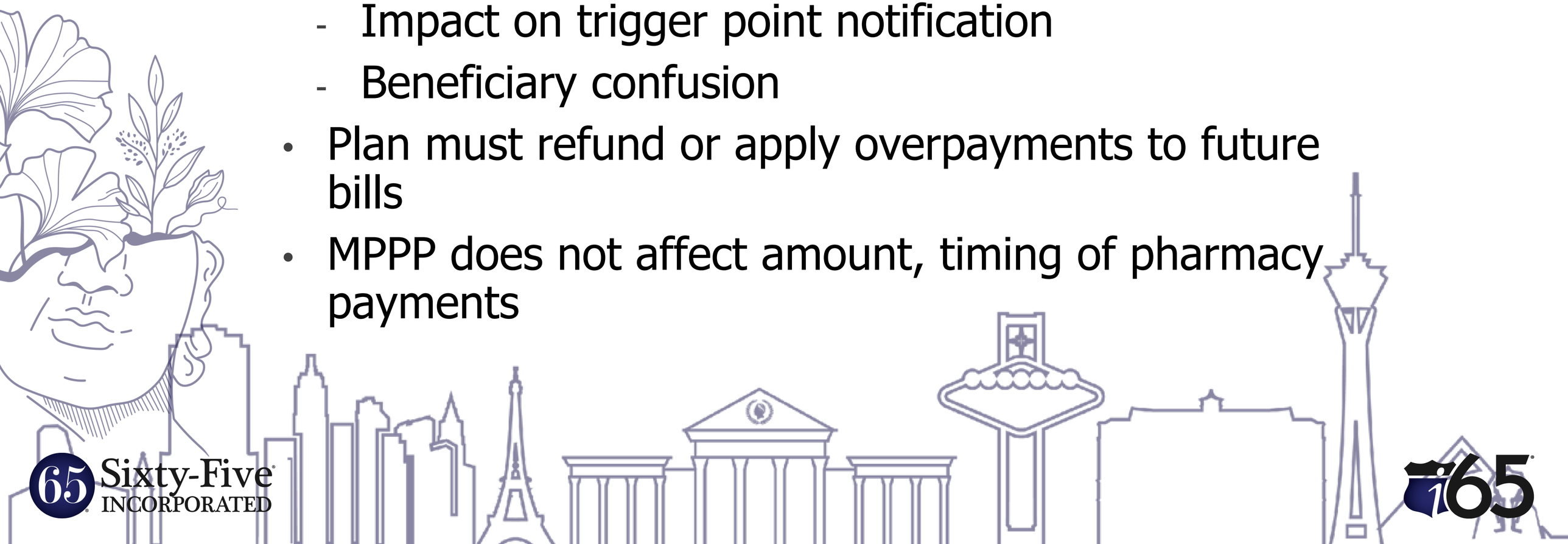
Medicare Prescription Payment Plan
2026: New or Finalized Regulations

- 2026 cap $2,100
- 2025 participants will be renewed automatically for 2026:
  - Notice will be sent after OEP but before end of year
  - Can opt out, choose not to renew



Medicare Prescription Payment Plan
2026: New or Finalized Regulations

- Pharmacies do not have to inform enrollees about the actual cost of a drug at the point of sale:
  - Impact on trigger point notification
  - Beneficiary confusion
- Plan must refund or apply overpayments to future bills
- MPPP does not affect amount, timing of pharmacy payments



MPPP: How You Can Help
Know When Enrollment Is/Isn't Beneficial

- Reaching the $2,000 threshold in first few months:
  - In the MPPP – those who want lower payments spread throughout the year
  - Not in the MPPP – can afford $2,000; pay it, be done

Reach the Cap in January

Month	Your monthly cost for drugs covered by Part D	
	Without this payment option	**With** this payment option
January	$2,000.00	$166.67
February	$0.00	$166.67
March	$0.00	$166.67
April	$0.00	$166.67
May	$0.00	$166.67
June	$0.00	$166.66
July	$0.00	$166.67
August	$0.00	$166.66
September	$0.00	$166.67
October	$0.00	$166.66
November	$0.00	$166.67
December	$0.00	$166.66
TOTAL	**$2,000.00**	**$2,000.00**

MPPP: How You Can Help
Know When Enrollment Is/Isn't Beneficial

- Reaching the $2,000 threshold in first few months:
  - In the MPPP – those who want lower payments spread throughout the year
  - Not in the MPPP – can afford $2,000; pay it, be done
- Reaching the cap later in year:
  - In the MPPP – higher monthly payments
  - Not in the MPPP – can afford $2,000; pay it, be done

2026 threshold $2,100

Reach Cap Mid-Year

Month	Your monthly cost for drugs covered by Part D	
	Without this payment option	**With** this payment option
July	$2,000.00	$333.33
August	$0.00	$333.33
September	$0.00	$333.34
October	$0.00	$333.33
November	$0.00	$333.34
December	$0.00	$333.33
TOTAL	**$2,000.00**	**$2,000.00**

MPPP: How You Can Help
Know When Enrollment Is/Isn't Beneficial

- Those who have low drug costs:
  - In the MPPP – considerable variation with higher costs in later months
  - Not in the MPP – payments can be smoother

2026 threshold $2,100

Low Drug Costs

Month	Your monthly cost for drugs covered by Part D	
	Without this payment option	**With** this payment option
January	$37.15	$37.15
February	$37.15	$3.38
March	$37.15	$7.09
April	$37.15	$11.22
May	$37.15	$15.86
June	$31.16	$20.32
July	$37.15	$26.51
August	$37.15	$33.94
September	$37.15	$43.22
October	$37.15	$55.61
November	$37.15	$74.18
December	$37.15	$111.33
TOTAL	**$439.81**	**$439.81**

MPPP: How You Can Help
Know When Enrollment Is/Isn't Beneficial

- Those who have higher costs but will not reach the cap:
  - In the MPPP – costs can be unpredictable, all over the map, increasing in later months
  - Not in the MPPP – once deductible is met, costs are known and usually smoother

2026 threshold $2,100

Higher Costs, not Reach the Cap

Month	Your monthly cost for drugs covered by Part D	
	Without this payment option	**With** this payment option
January	$185.51	$166.67
February	$185.51	$18.58
March	$185.51	$37.13
April	$72.61	$45.20
May	$63.62	$53.15
June	$63.62	$62.24
July	$63.62	$72.84
August	$63.62	$85.56
September	$63.62	$101.47
October	$63.62	$122.67
November	$63.62	$154.49
December	$63.62	$218.10
TOTAL	**$1,138.10**	**$1,138.10**

Medicare Prescription Payment Plan
Diane's Recommendation: Consider the MPPP

- The $2,000 cap is a reality within first half of year
- $2,000 in one or two payments would be a hardship

Medicare Prescription Payment Plan
Diane's Recommendation: Skip the MPPP

- Will not reach the cap
- Will reach the cap in last months of the year
- The $2,000 is not a problem
- Do not want to change method for drug payment or deal with monthly statements, bills

2026 threshold $2,100

Prior Authorization

Prior Authorization
The Good Intentions

- Evidence-based medical management tools
- Goals:
  - Ensure patient safety and optimal care
  - Promote appropriate and effective use of services
  - Control costs

Medicare Advantage Literature

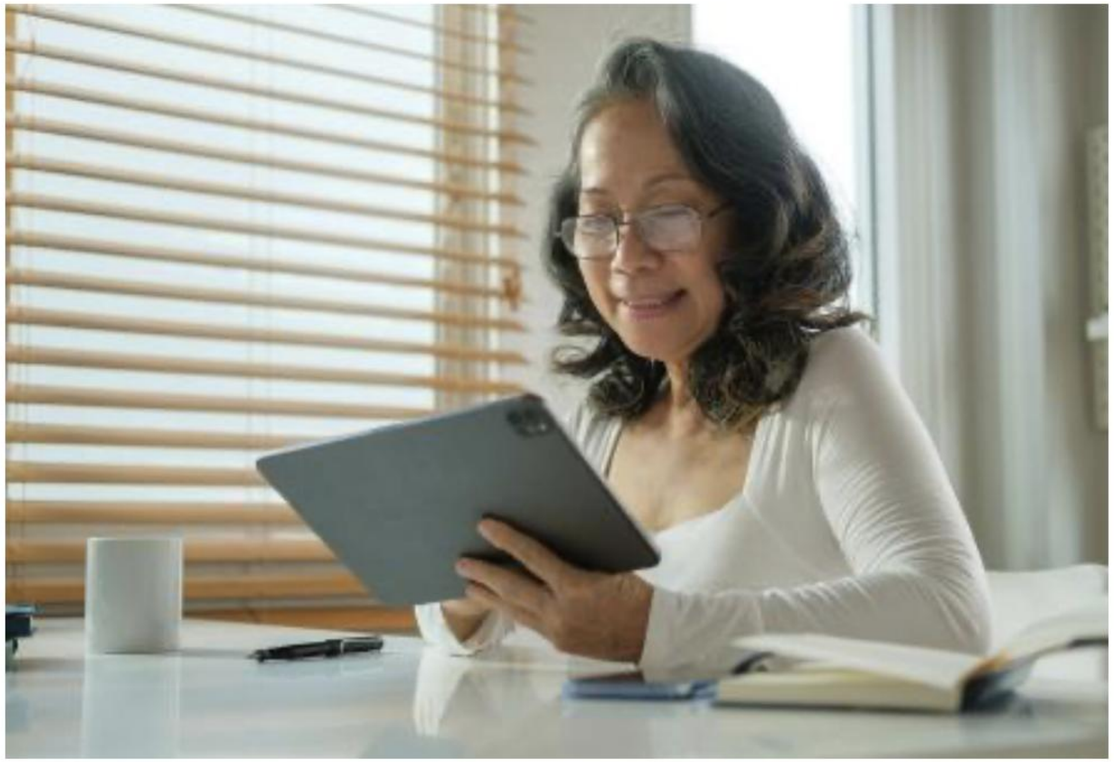
How prior authorization protects you

We take steps to help ensure your treatment is safe, effective and medically right for you. Learn how this review process works and how it helps you.

Medicare Advantage Literature

Prior authorizations help keep patients safe, improve health, and make care more affordable

Medicare Advantage Literature



Some medical procedures, tests and prescriptions need prior authorization, which is sometimes called preapproval or precertification. This helps us make sure that your health care services are appropriate for your personal medical needs.

Here's how the prior authorization process works:

1. Visit your doctor

To get prior authorization, your

Prior Authorization

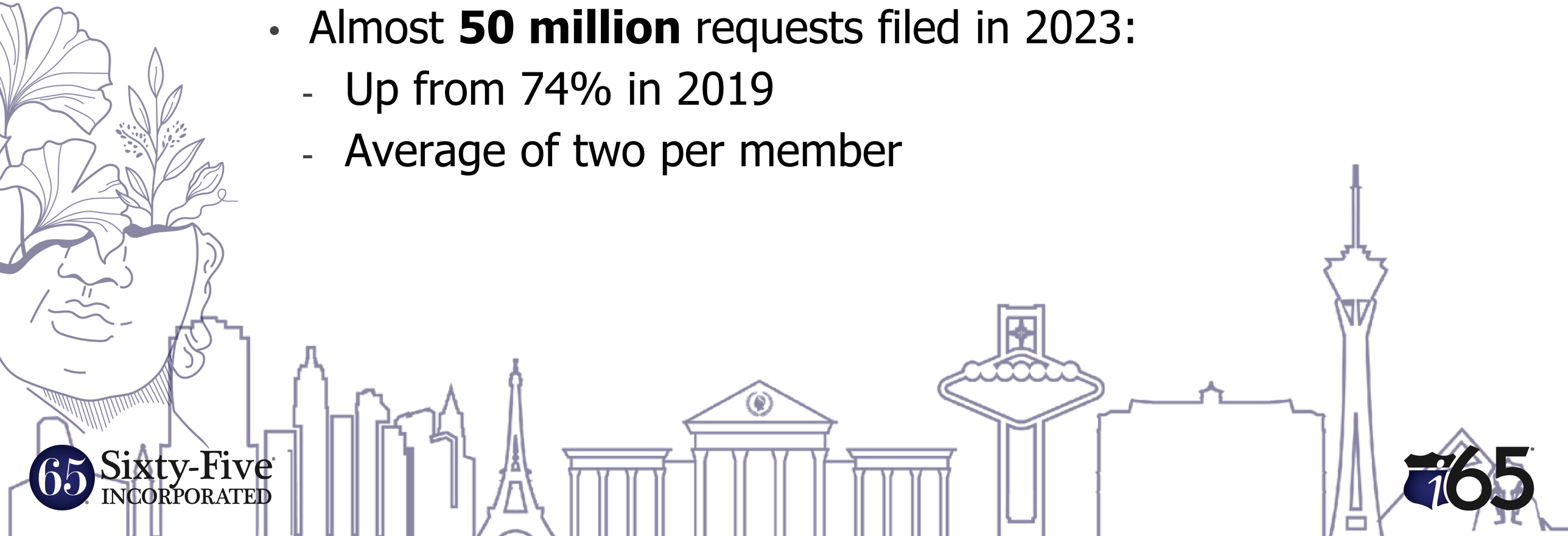
The Medicare Advantage Nightmare

- Requirement for service to be covered
- From *65 Incorporated* perspective, it started becoming a big problem around 2014–2015
- Today:
  - 99% of members in plans with authorization
  - 93% of physicians report delay in necessary care
  - 82% report patients abandon care

Prior Authorization

The Medicare Advantage Nightmare

- RNs spend **467 hours/year**, almost $35,000 (CMS)
- Physicians complete **39 requests per week**
- Almost **50 million** requests filed in 2023:
  - Up from 74% in 2019
  - Average of two per member



Prior Authorization

The Medicare Advantage Nightmare

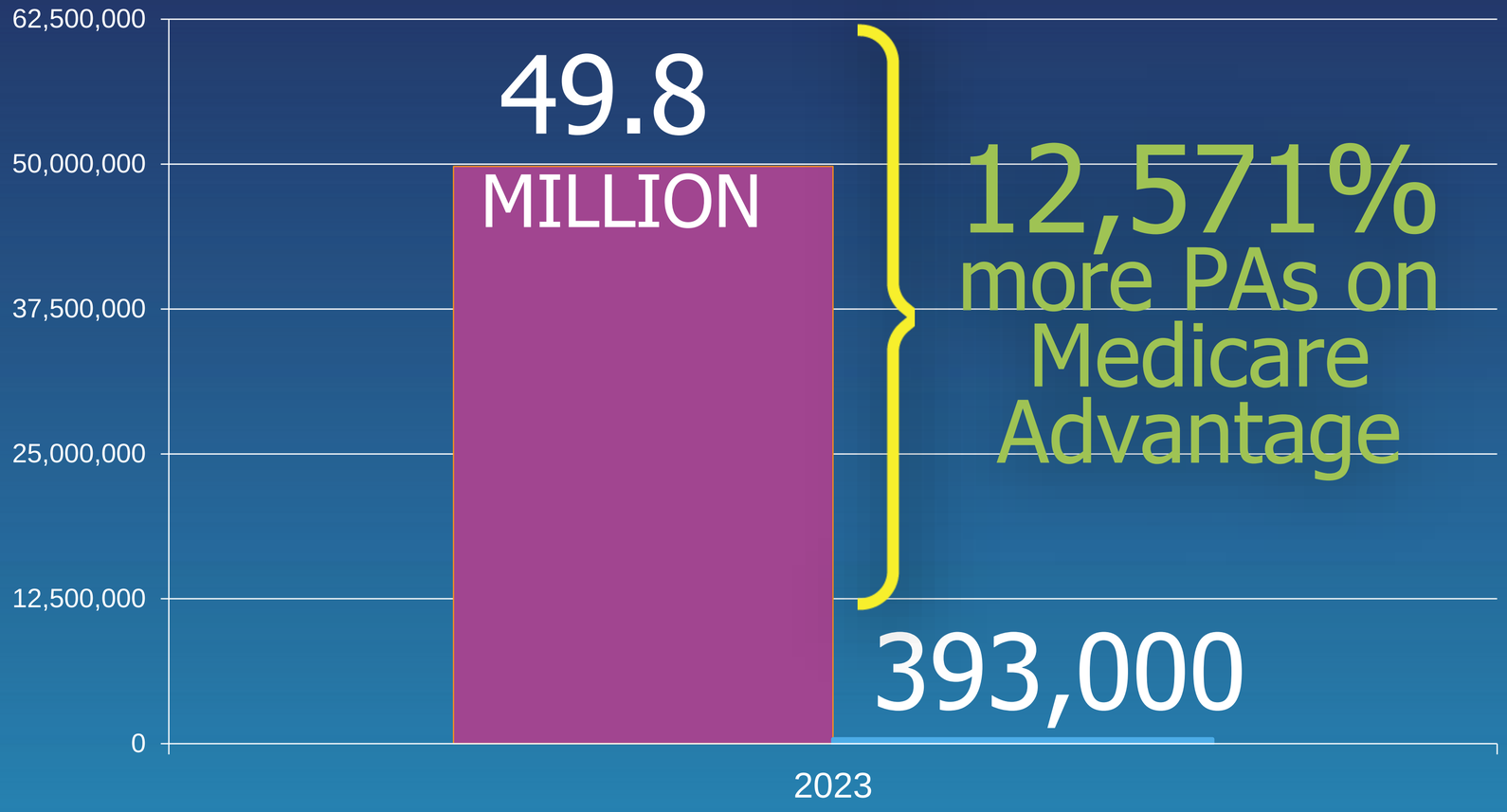
- Over **3.2 million requests were fully or partially denied**:
  - Just 10% of denials were appealed
  - 82% were fully or partially overturned
- If service not authorized but provided, plan member must pay

Prior Authorization

The Medicare Advantage Nightmare

- Plans have been denying approved hospitalizations, which led to subsequent denial of SNF stays
- CMS rule restricts plans ability to reopen/modify previously approved stay for obvious error or fraud only

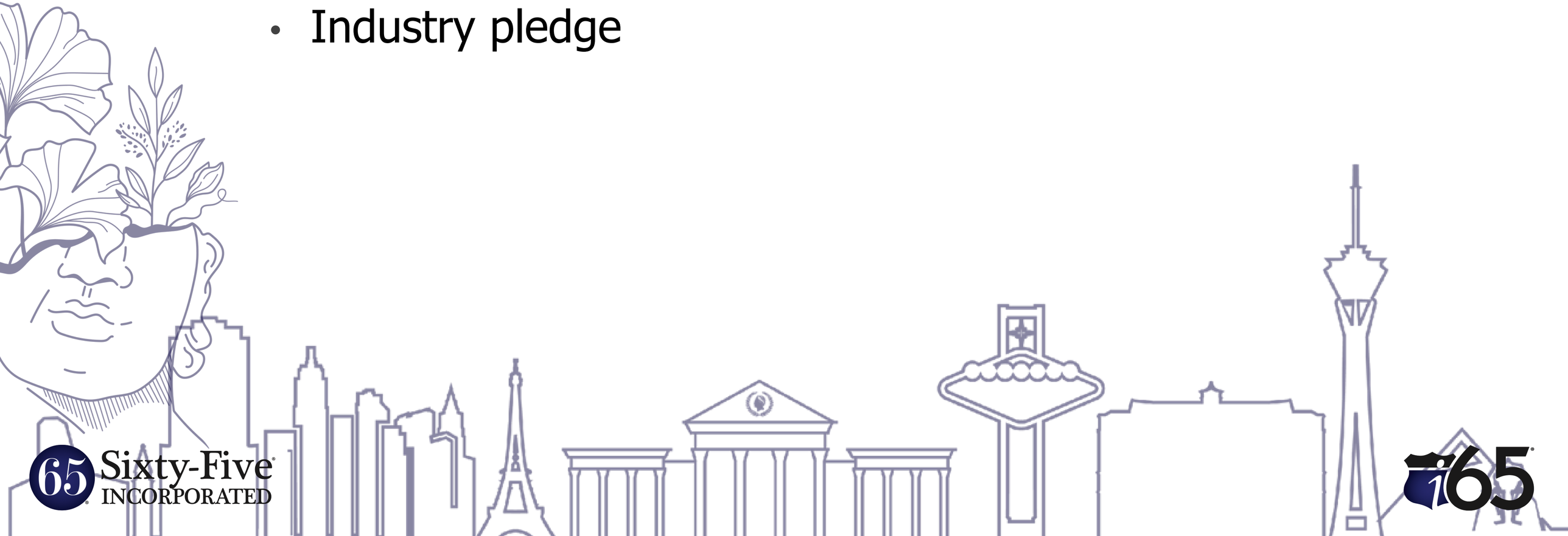
Prior Authorizations By Type of Medicare Coverage



www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

Prior Authorization Reform Measures

- CMS rule
- Plan solutions
- Industry pledge



Prior Authorization

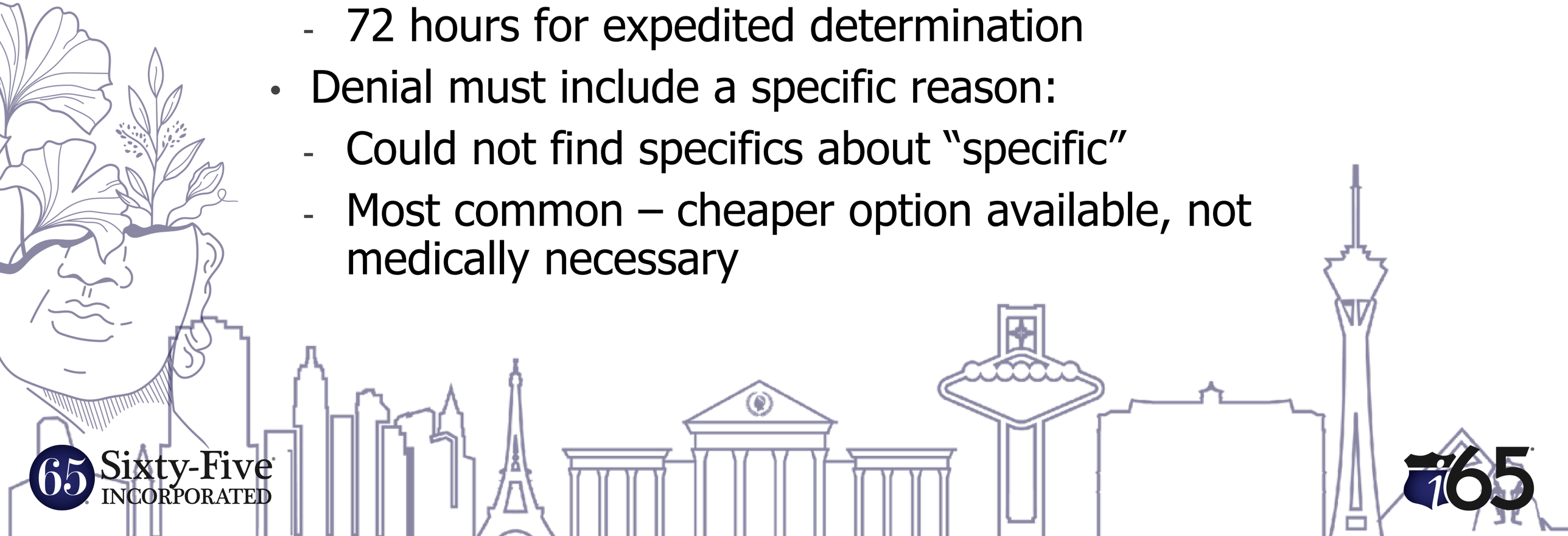
CMS Final Rule for Prior Authorization

- Applies to Medicare Advantage, not commercial insurers or fee-for-service Medicare
- Three new and one updated application programming interfaces (API) by January 2027:
  - Patient, provider access, payer-to-payer, prior authorization
  - Prior authorization rules, requirements
  - Facilitate data sharing

Prior Authorization

CMS Final Rule for Prior Authorization

- A deadline for decisions, effective January 1, 2026:
  - Seven days for standard request
  - 72 hours for expedited determination
- Denial must include a specific reason:
  - Could not find specifics about “specific”
  - Most common – cheaper option available, not medically necessary



CPT/HCPC Code	Description
E1620	BLOOD PUMP FOR HEMODIALYSIS REPLACEMENT
E1625	WATER SOFTENING SYSTEM FOR HEMODIALYSIS

DURABLE MEDICAL EQUIPMENT (CONT.)

CPT/HCPC Code	Description
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY EACH
E1634	PERITONEAL DIALYSIS CLAMPS EACH
E1635	COMPACT TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES FOR HEMODIALYSIS PER 10
E1637	HEMOSTATS EACH
E1639	SCALE EACH
E1699	DIALYSIS EQUIPMENT NOT OTHERWISE SPECIFIED
E1812	DYN KNEE EXT/FLEX DEVC W/ACTV RESISTANCE CONTROL
E2310	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&ONE PWR
E2311	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&TWO/MORE
E2321	PWR WC ACSS HND CNTRL REMOT JOYSTCK NO PRPRTNL
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE
E2617	CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE
K0020	FIXED ADJUSTABLE HEIGHT ARMREST PAIR
K0037	HIGH MOUNT FLIP-UP FOOTREST EACH
K0039	LEG STRAP H STYLE EACH
K0044	FOOTREST UPPER HANGER BRACKET REPL ONLY EACH
K0046	ELEVATING LEGREST LWR EXTENSN TUBE REPL ONLY EA
K0047	ELEVATING LEGREST UPR HANGER BRACKT REPL ONLY EA
K0050	RATCHET ASSEMBLY REPLACEMENT ONLY
K0051	CAM RLS ASSEM FOOTREST/LEGREST REPL ONLY EACH
K0056	SEAT HT<17/=TO/>21 IN LTWT/ULTRALTWT WHLCHAIR
K0065	SPOKE PROTECTORS EACH
K0072	FRONT C ASSEMBLY COMPL SEMIPNEU TIRE REPL ONLY E
K0073	CASTER PIN LOCK EACH
K0098	DRIVE BELT FOR POWER WHEELCHAIR REPLACEMNT ONLY
K0105	IV HANGER EACH
K0609	REPL ELEC W/AUTO EXT DEFIB GARMNT TYPE ONLY EA
K0743	SUCTION PUMP HOME MODEL PORTABLE FOR USE WOUNDS

CPT/HCPC Code	Description
E1620	BLOOD PUMP FOR HEMODIALYSIS REPLACEMENT
E1625	WATER SOFTENING SYSTEM FOR HEMODIALYSIS

DURABLE MEDICAL EQUIPMENT (CONT.)

CPT/HCPC Code	Description
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY EACH

DME codes
3 1/2 *of 14 pages*

Orthotics/prosthetic codes
7 1/2 *of 14 pages*

Radiology ***1 1/2*** *pages*
Breast reconstruction ***1/2*** *page*
Vein procedures ***4*** *codes*
Hysterectomy, spine surgery ***2*** *codes*

K0056	SEAT HT<17/=TO/>21 IN LTWT/ULTRALTWT WHLCHAIR
K0065	SPOKE PROTECTORS EACH
K0072	FRONT C ASSEMBLY COMPL SEMIPNEU TIRE REPL ONLY E
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DURABLE MEDICAL EQUIPMENT (CONT.)

CPT/HCPC Code	Description
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY EACH
E1634	PERITONEAL DIALYSIS CLAMPS EACH
E1635	COMPACT TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES FOR HEMODIALYSIS PER 10
E1637	HEMOSTATS EACH
E1639	SCALE EACH
E1699	DIALYSIS EQUIPMENT NOT OTHERWISE SPECIFIED
E1812	DYN KNEE EXT/FLEX DEVC W/ACTV RESISTANCE CONTROL
E2310	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&ONE PWR
E2311	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&TWO/MORE
E2321	PWR WC ACSS HND CNTRL REMOT JOYSTCK NO PRPRTNL
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Only 16% of physicians reported that these changes reduced the volume of prior authorization requirements

Prior Authorization Humana Solutions **Accelerates Efforts to Eliminate Prior Authorization**

- Reduce administrative burden as quickly as possible
- Eliminate one-third of codes by January 1, 2026
- Provide decision on 95% of complete, electronic requests
- Report its metrics (approved, denied, average time for decision) publicly
- Launch Gold Card that waives requirements for compliant providers

Industry Pledge

HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System

WASHINGTON, DC—JUNE 23, 2025—U.S. Health and Human Services (HHS) Secretary Robert F. Kennedy, Jr. and Centers for Medicare & Medicaid Services (CMS) Administrator Dr. Mehmet Oz today met with industry leaders to discuss their pledge to streamline and improve the prior authorization processes for Medicare Advantage, Medicaid Managed Care, Health Insurance Marketplace® and commercial plans covering nearly eight out of 10 Americans.

In a roundtable discussion hosted by HHS, health insurers pledged six key reforms aimed at cutting red tape, accelerating care decisions, and enhancing transparency for patients and providers. Their commitments reinforce the role of CMS in monitoring outcomes and promoting accountability. Companies represented at the roundtable included Aetna, Inc., AHIP, Blue Cross Blue Shield Association, CareFirst BlueCross BlueShield, Centene Corporation, The Cigna Group, Elevance Health, GuideWell, Highmark Health, Humana, Inc., Kaiser Permanente, and UnitedHealthcare.

Prior Authorization

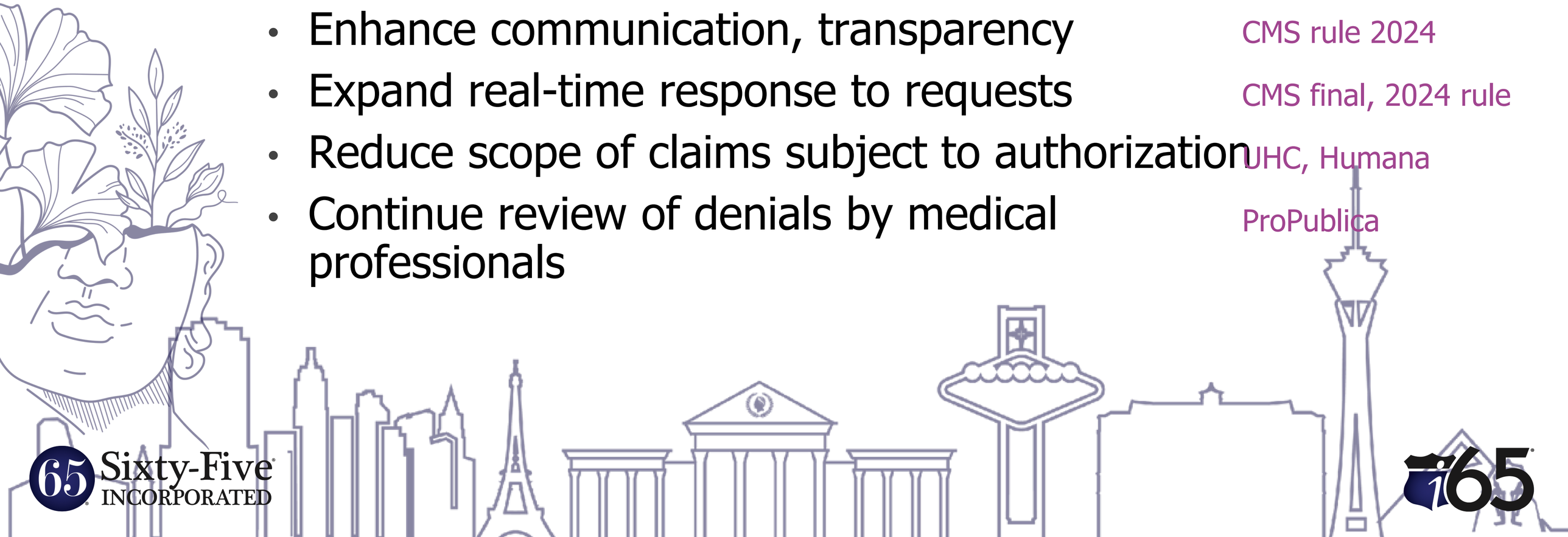
Industry Pledge to Fix Broken System

- Standardize electronic prior authorization
- Honor existing approvals in plan changes
- Enhance communication, transparency
- Expand real-time response to requests
- Reduce scope of claims subject to authorization
- Continue review of denials by medical professionals

Prior Authorization

Industry Pledge to Fix Broken System

• Standardize electronic prior authorization	CMS final rule
• Honor existing approvals in plan changes	CMS rule 2023
• Enhance communication, transparency	CMS rule 2024
• Expand real-time response to requests	CMS final, 2024 rule
• Reduce scope of claims subject to authorization	UHC, Humana
• Continue review of denials by medical professionals	ProPublica



Prior Authorization Deja Vu

Industry Pledge to Fix Broken System 2018

- *Standardize electronic prior authorization*
- *Honor existing approvals in plan changes*
- *Enhance communication, transparency*
- *Expand real-time response to requests*
- *Reduce scope of claims subject to authorization*

Prior Authorization
CMS Rule, Industry Pledges, Plan Solutions

- All about processes:
  - Streamline, standardize, communicate, maybe reduce
  - Get answer quicker, information for appeals
- However, these initiatives do not tackle:
  - Number of denials issued
  - The reason for denials
  - The use of AI, algorithms, human involvement
  - Complicated appeals process

Prior Authorization: How You Can Help
Follow a Process

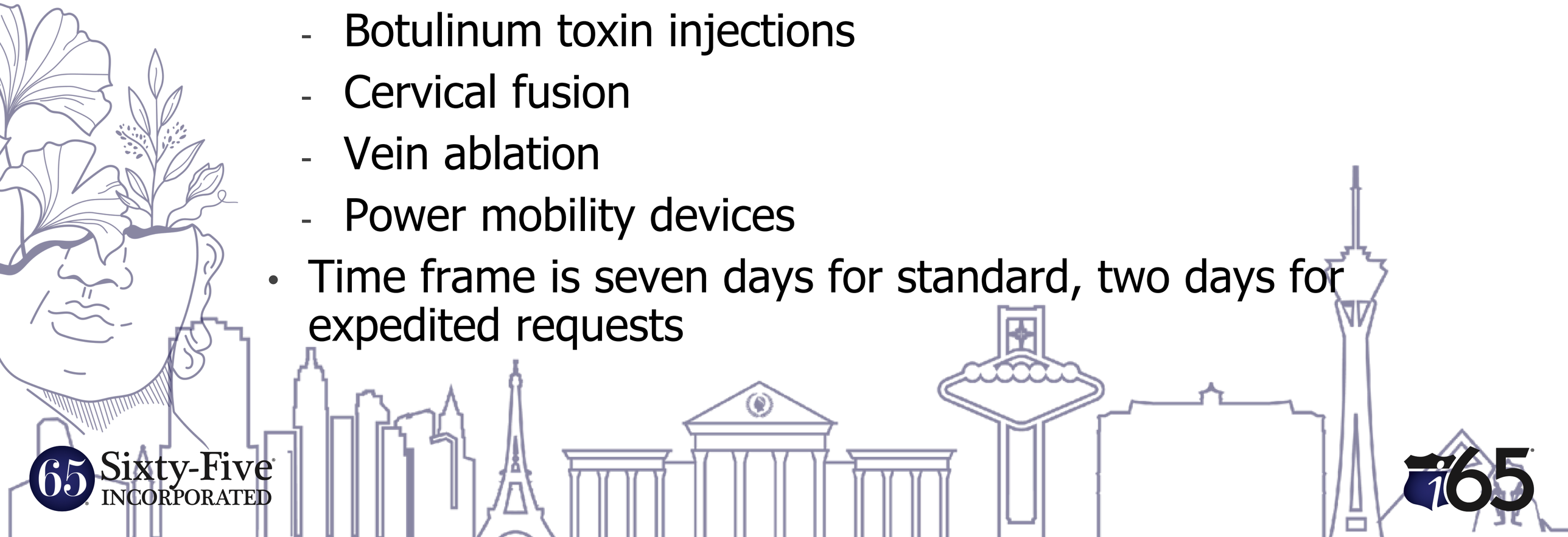
- Know when authorization is required (most important point):
  - Start with the Medicare Plan Finder
  - Then get details from the plan's Evidence of Coverage

Prior Authorization: How You Can Help
Follow a Process

- Know when authorization is required (most important point):
  - Medicare Plan Finder
  - A plan's Evidence of Coverage
- Confirm that someone in the physician's office is in charge and the date due
- Double-check that approval is received before the service is provided

Prior Authorization
Original Medicare

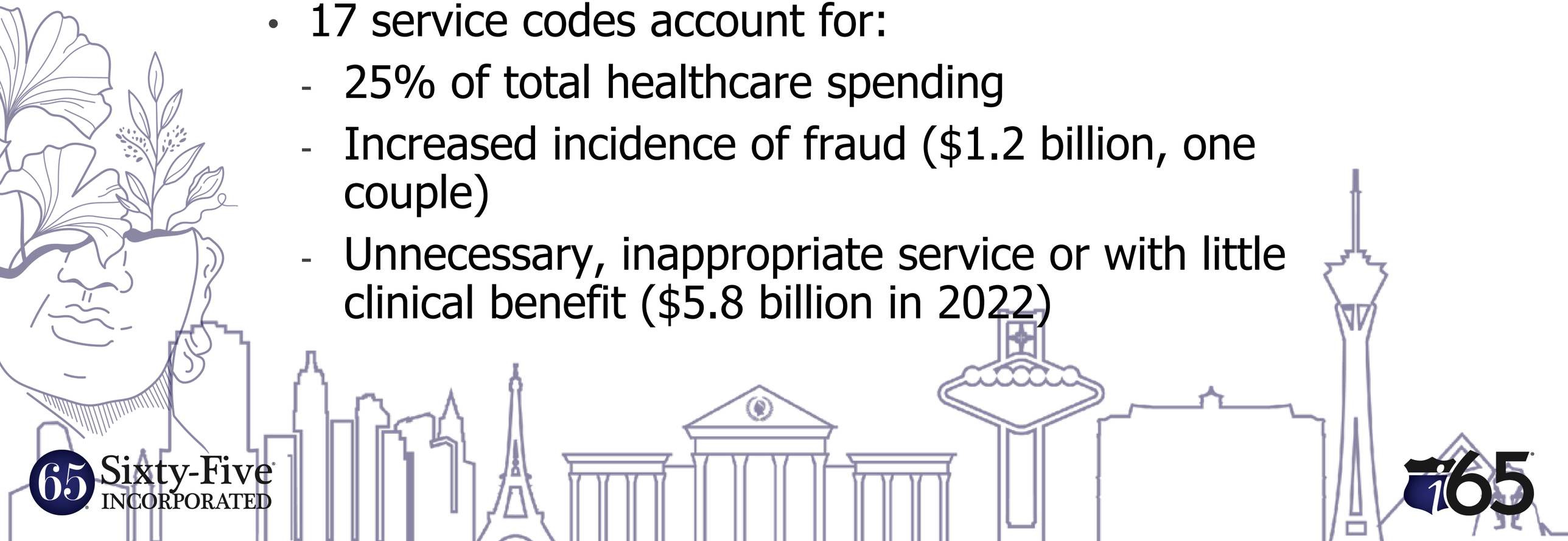
- CMS requires authorization (45 codes) for:
  - Commonly performed cosmetic procedures
  - Botulinum toxin injections
  - Cervical fusion
  - Vein ablation
  - Power mobility devices
- Time frame is seven days for standard, two days for expedited requests



Prior Authorization

WISeR Model for Original Medicare

- Wasteful and Inappropriate Service Reduction model
- 17 service codes account for:
  - 25% of total healthcare spending
  - Increased incidence of fraud ($1.2 billion, one couple)
  - Unnecessary, inappropriate service or with little clinical benefit ($5.8 billion in 2022)



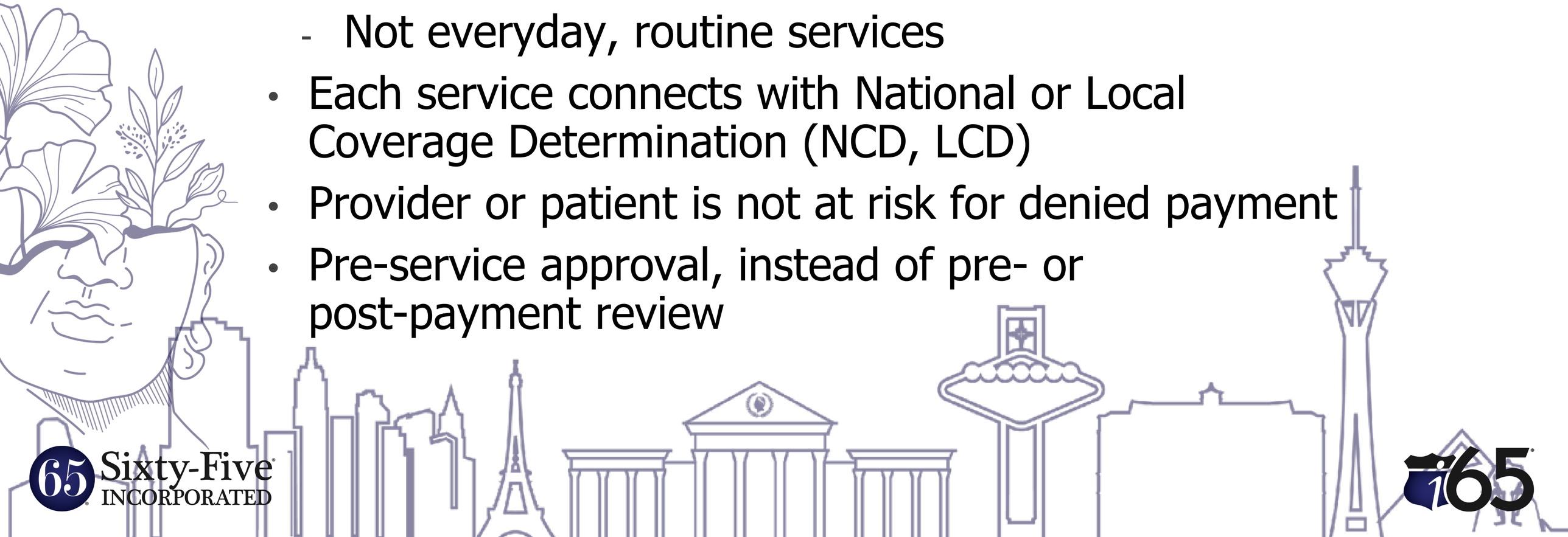
Prior Authorization

WISeR Model for Original Medicare

- Begins January 1, 2026
- Two three-year periods
- Six states (AZ, NJ, OH, OK, TX, WA)
- Provider can choose to submit request; if not, will be subject to pre-payment review by the MAC (Medicare Administrative Contractor)

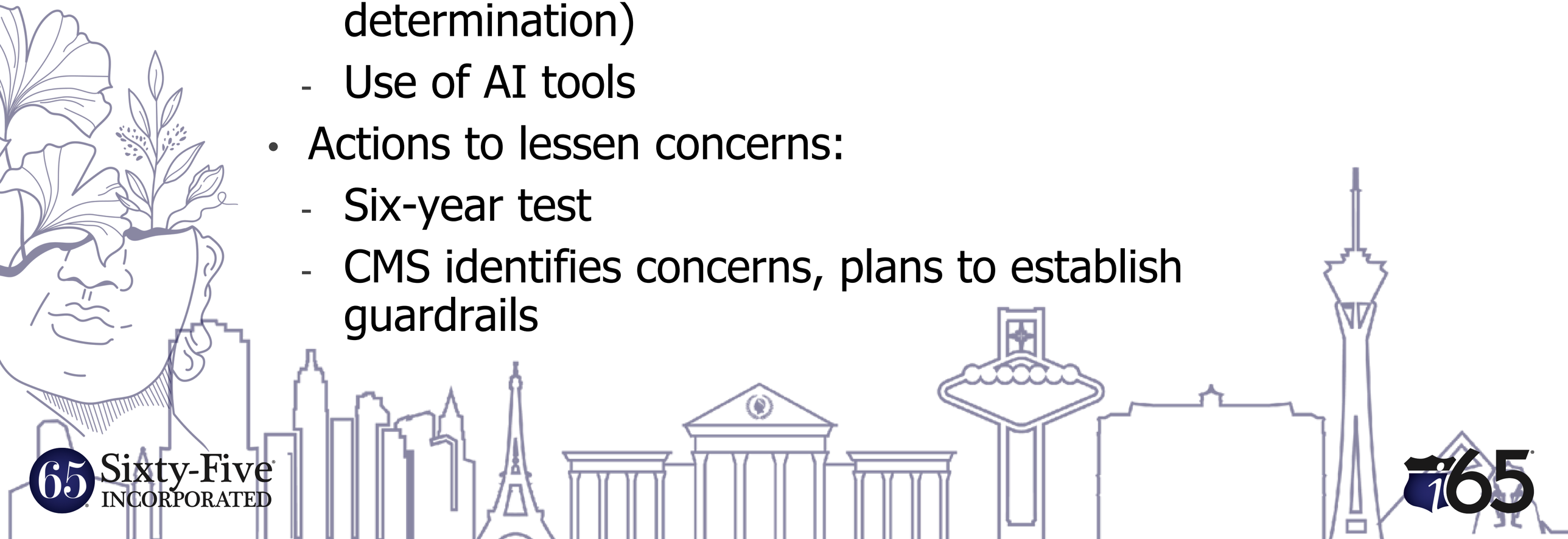
Prior Authorization
WISeR Model vs. Medicare Advantage

- A defined list of services:
  - High-cost, fraud potential, low value
  - Not everyday, routine services
- Each service connects with National or Local Coverage Determination (NCD, LCD)
- Provider or patient is not at risk for denied payment
- Pre-service approval, instead of pre- or post-payment review



Prior Authorization
WISeR Model Concerns

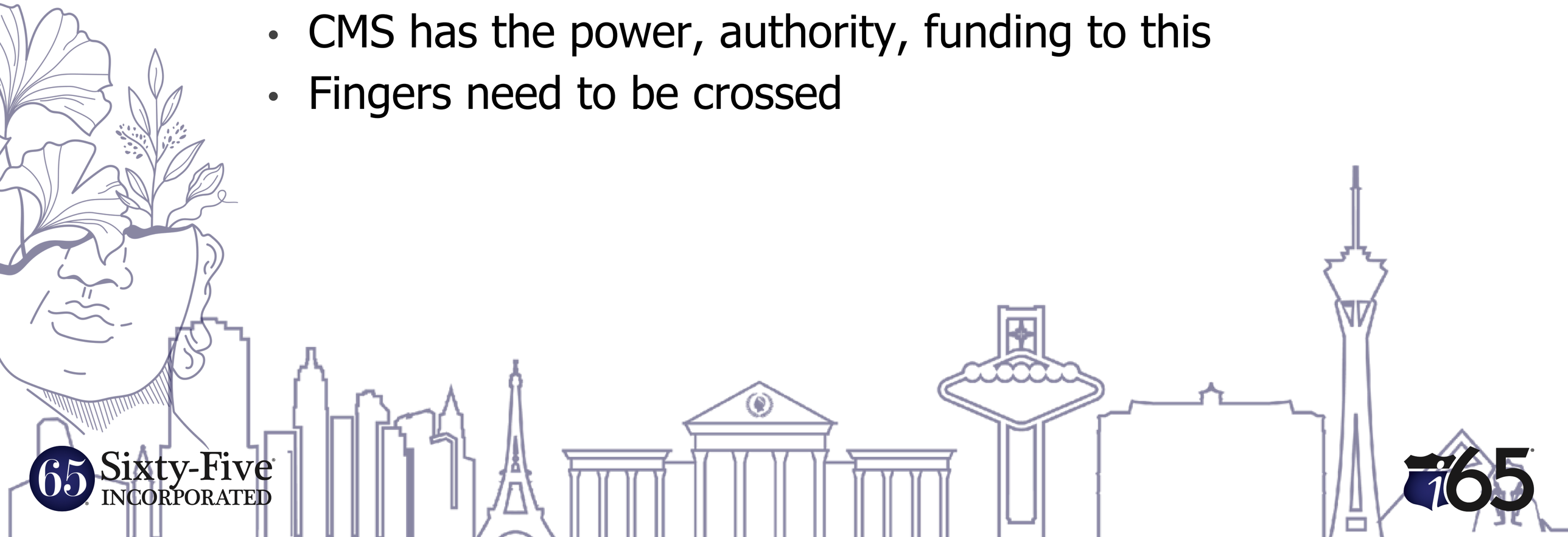
- Two big ones:
  - Payment based on money saved (non-determination)
  - Use of AI tools
- Actions to lessen concerns:
  - Six-year test
  - CMS identifies concerns, plans to establish guardrails



WISeR Model

Parting Comments

- Prior authorization needs to be restrained
- Fraud and wasteful need to stopped
- CMS has the power, authority, funding to this
- Fingers need to be crossed



Prior Authorization Part D Drugs

Prior Authorization Part D Prescription Drugs

The Good Intentions

- Ensure that drugs are:
  - Medically necessary
  - Cost-effective
  - Used appropriately

Prior Authorization

Part D Prescription Drug Plans

- Drug plans have required prior authorization since 2006
- One way to ensure that plans pay only when appropriate
- $2,000 cap means:
  - Drug plans pick up bigger share of cost
  - More problems with getting costly drugs approved

Prior Authorization

Reasons for Part D Prior Authorization

- Lower-cost alternative drug available
- The prescribed drug:
  - Is not for a medically accepted indication
  - Falls under Part A or Part B, not Part D
  - Has certain dosages or forms
  - Has special monitoring requirements
  - Is a controlled substance
  - May interact with other drugs

Prior Authorization: How You Can Help

Part D Prior Authorization

- Be proactive, know drugs subject to authorization

www.medicare.gov/ plan-compare

OTHER DRUG INFORMATION		
	Tier	Prior authorization
Hydrochlorothiazide 25mg tablet	Tier 1	–
Rybelsus 7mg tablet	Tier 3	Yes
Valsartan 160mg tablet	Tier 2	–

Prior Authorization: How You Can Help

Part D Prior Authorization

- Be proactive, know drugs subject to authorization
- The prescriber or drug plan member can submit the request (pharmacists don’t know the situation)
- Do not wait until the last minute:
  - Process can take time
  - 72 hours for standard request, 24 hours expedited

Prior Authorization: How You Can Help

Part D Prior Authorization

- Discuss situation with the physician
- Watch for notification from the plan
- Know that there is an appeals process
- Review other plans during Open Enrollment Period:
  - One plan may apply prior authorization for a certain medication and another doesn't
  - Watch for trade-offs

Now You Can Help

When Medicare's Good Intentions Go Bad