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Welcome to "Washington Update," the weekly e-newsletter on the latest health care happenings in the nation's capital that affect APG's members.

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Proposed Prior Auth Rule Could Bolster Legislative Efforts

As expected, CMS this week released a sweeping proposed rule that would require payers and providers participating in Medicare Advantage, Medicaid and CHIP (both fee-for-service and managed care), and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) to share prior authorization data electronically and within an allotted period of time. The measure—a revised and expanded version of a Trump administration rule originally finalized in late 2020—would impose large changes on insurers, providers, and patients alike. For example:

- Under the proposed rule, payers would be required to develop and maintain a digital pathway that automates the prior authorization process—including

facilitating prior authorization requests and decisions directly from electronic health records or practice management systems.
- Payers would need to include a specific reason for denying a prior authorization request to enhance providers' understanding and make it easier for a new request to be submitted.
- Through the same application program interfaces that payers must now use to communicate other information to patients, they would also have to alert patients about prior authorization decisions and the impact on patients' care.
- With the exception of QHP issuers, payers would have to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. But CMS also seeks comment on shorter turnaround times, such as 48 hours, for expedited requests and five calendar days for standard requests.

APG intends to file comments on the proposed rule, which are due back to CMS by March 13, 2023.

The proposed rule holds uncertain implications for the Improving Seniors Timely Access to Care Act, which would mandate electronic prior authorization in Medicare Advantage only. The legislation passed the House unanimously earlier this year but stalled in the Senate after a Congressional Budget Office analysis determined that the 10-year cost of the legislation would be $16 billion. Congressional aides backing the bill believe that the proposed rule could reduce that estimate by half, and that legislation is still needed to strengthen provisions around required prior authorization timelines for Medicare Advantage plans. APG will continue to follow and report to members on developments.

APG Expresses Support for CMS' Proposed National Provider Directory

CMS recently sought input from stakeholders on creation of a National Directory of Healthcare Providers and Services (NDH). If a proposal is finalized, the agency will create and host an NDH to modernize, streamline, and simplify the now-chaotic processes of maintaining provider directories. Providers could submit their information electronically through a single national portal, which payers could then use to update their own directories.

In its response to the agency, APG enthusiastically supported creation of an NDH and recommended that there be opportunities for providers to review information included in any new national directory. APG also recommended that there be a single "source of truth" for sorting out inconsistencies in posted information. Recognizing that an NDH would be improved over time, APG encouraged CMS to expedite the review and improvement process so that health plans and others now maintaining their separate provider directories could eventually rely solely on the NDH sooner rather than later.

CMS has not yet specified a timeline for creating an NDH but has indicated that the agency is considering a staged approach that would add more data elements and features over time. If providers and payers are required to participate, CMS will have to follow regular notice-and-comment rulemaking process, so roll-out would be at least a year away.

Senators Ready Bid for 2-Year Extension of AAPM Bonus for Year-End

The 5 percent bump in Medicare fee-for-service payments for clinicians participating in advanced alternative payment models (AAPM) would be extended for two more years under bipartisan legislation that's expected to be introduced next week in the Senate.

Draft legislation sponsored by Sen. John Barrasso (R-WY), a physician, and Sen. Sheldon Whitehouse (D-RI), would also allow HHS to set the thresholds for clinicians receiving the 5 percent incentive payments. As is, clinicians must receive half of their Medicare Part B payments through an AAPM to qualify for the bonus, with that threshold scheduled to rise to 75 percent in 2023.

Prospects for the legislation are uncertain amid the end-of-year spending scramble. Without congressional action, 2022 will be the last year that clinicians will earn the bonus.

Medicaid Provisions Could Be Included in Potential Year-End Legislation

APG has joined 17 other stakeholders to advocate for Medicaid coverage provisions as well in any year-end spending legislation. As *Washington Update* has previously reported, APG in particular seeks permanent federal Medicaid funding for Puerto Rico and other U.S. territories. Congress has previously provided short-term funding for Medicaid programs in Puerto Rico and other U.S. territories, but the current funding will expire on December 16, 2022. In addition, APG and other stakeholders ask Congress to implement guardrails for streamlining redeterminations of beneficiaries' Medicaid eligibility once pandemic-era coverage provisions expire.

APG will continue to monitor developments as Congress considers year-end legislation and potential Medicaid provisions that could be included.

APG Answers Frequently Asked Questions on ACO REACH

In January, the Center for Medicare and Medicaid Innovation's Direct Contracting program will officially transition to the revamped ACO REACH model (for Realizing Equity and Access in Community Health). The impending move has created confusion and some misrepresentation of what patients can expect when they join a REACH ACO. To address these questions, APG has created this explainer for providers and patients. We encourage APG members to share it broadly and repost if desired.

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