The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

August 26, 2022

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-4203-NC, Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

On behalf of our 235 member hospitals, health systems, and other health care organizations, The Hospital and Healthsystem Association of Pennsylvania (HAP), is grateful for the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding the Medicare Advantage (MA) program.

HAP appreciates CMS' interest in exploring opportunities to advance health equity, expand patient access to care, drive innovation, support affordability and sustainability, and engage in collaboration with partners. In this context, we are writing to share several serious concerns about the negative effects of MA Organization (MAO) practices and policies, which impede patient access to health care services, create inequities in coverage between Medicare beneficiaries enrolled in MA versus those enrolled in traditional Medicare, and in some cases, even directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services.

We consistently hear from member hospitals that MA plans frequently apply more stringent medical necessity criteria than traditional Medicare, apply excessive prior authorization requirements, use inappropriate utilization management tools, and require onerous and duplicative clinical documentation submissions to substantiate the need for services. These practices result in delays in care and can cause direct patient harm. In addition, they add financial burden and strain onto the health care system, requiring increased staffing and technology costs to comply with plan requirements, while also contributing significantly to health care worker burnout.[1]

These pain points are only getting worse as enrollment in MAOs continues to increase rapidly. During 2021, nearly 27 million people, representing 46 percent of the total Medicare population, were enrolled in an MAO, and enrollment is growing at a rate of nearly 10 percent per year. By 2023, more than half of all Medicare beneficiaries are expected to be enrolled in an MAO.[2,3] With millions of new enrollees each year, it is more important than ever to implement desperately needed oversight provisions to ensure that those enrolled in MAOs are not unfairly subjected to more restrictive rules and requirements than traditional Medicare, which is contrary to the intent of the MA program.

[1] Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. 2022. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf
[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

HAP greatly appreciates CMS' particular interest in MAO prior authorization practices, as they often create a significant impediment to our members' abilities to provide timely and efficient patient care. They also contribute to clinician burnout, waste valuable health care resources, and drive up costs across the health care system.

According to a 2021 American Medical Association (AMA) survey of more than 1,000 physicians, 91 percent of respondents indicated that prior authorization "had a significant or somewhat negative clinical impact, with 34 percent reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care.[4]

In response to a recent member survey conducted by the American Hospital Association (AHA), 95 percent of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. Further data from AHA's most recent member survey shows that MA plans have the highest inpatient prior authorization denial rate across all payors, most of which are later overturned in favor of the provider.[5]

From an association perspective, HAP can confirm that MAO prior authorization policies and practices have consistently been at the top of the list of hospital concerns for many years. Hospitals report that the degradation in patient care due to more downgrades and denials has only increased, and after medically necessary and clinically appropriate care has been provided, the administrative barriers to being reimbursed in a timely manner have multiplied expontentially. In many cases, additional staff resources are needed just to manage the prior authorization process, and this is happening during a health care workforce shortage.

Hospital concerns about delays in care and inappropriate denials were validated by a recent Department of Health and Human Services Office of the Inspector General (HHS-OIG) report entitled "Some MA Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care".[6] The HHS-OIG found that some of America's largest MAOs fail to cover the same services as traditional Medicare, in direct violation of CMS policy. Specifically, CMS guidance states that MAOs may not impose additional clinical criteria that are more restrictive than traditional Medicare's national and local coverage policies.[7] Using a random sample of denials from the one-week period of June 1–7, 2019, the report estimates the rate at which MAOs deny prior authorization and payment requests that met Medicare coverage rules. **The HHS-OIG found that 13 percent of prior authorization denials and 18 percent of payment denials met Medicare coverage rules and should have been granted**.

The HHS-OIG report highlighted several important issues with MAO prior authorization programs: (1) MAOs frequently use medical necessity and coverage criteria that are more restrictive than

[4] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[5] AHA member survey, December 2021—February 2022
[6] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[7] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.

traditional Medicare; (2) Prior authorization processes are extremely inefficient; and (3) Patient care is negatively impacted because of prior authorization delays and denials.

More Restrictive "Internal" Medical Necessity and Coverage Criteria

As previously noted, CMS rules preclude MAOs from utilizing clinical criteria that are more restrictive than traditional Medicare. However, our members' experiences and the findings from the HHS-OIG report clearly show that MAOs are routinely doing exactly that. Additionally, MAOs often classify their medical necessity criteria as proprietary (or "internal," according to the HHS-OIG) and do not share specifics with hospitals, resulting in a "black box" for providers attempting to determine whether a service will be approved. This lack of transparency is a frequent reason that prior authorization and claims are delayed or denied and results in extensive back and forth between providers and plans about what information is needed to satisfy their proprietary criteria. This often delays patient care unnecessarily and burdens our staff with resource-intensive paperwork that could be easily avoided. Further, in most instances, the authorization is ultimately approved, making such administrative work unnecessary, costly, and wasteful. Yet, MAOs still continue to deny a substantial portion of prior authorizations.

Several examples of where MAO and traditional Medicare clinical criteria frequently vary include coverage of sepsis care, inpatient-level care, emergency services, and post-acute care.

- **Sepsis Coverage:** Several MAOs have unilaterally stopped reimbursing providers for the care necessary to treat certain cases of early sepsis occurring in inpatients. Specifically, these plans are choosing to no longer follow the "Sepsis 2" guidelines, which have been adopted by most practicing physicians and serve as the CMS standard for sepsis coverage. Instead, these plans have unilaterally applied a different standard ("Sepsis 3") for **purposes of determining provider reimbursement only.** This standard more specifically focuses on later stages of sepsis and has been validated only in early retrospective studies and only as an outcome/mortality predictor. It is not supported by current clinical best practices, nor is it recognized by current coding or payment methodologies used by CMS.

  In short, plans' adoption of Sepsis 3 does not change the way providers care for patients with sepsis, it simply enables the plan to decline reimbursement for early sepsis interventions. This policy has the potential to undercut efforts to prevent, detect, treat, and improve sepsis care. It also results in inappropriate underpayment to hospitals that are already struggling to recover from a pandemic while continuing to deliver medically necessary care.

- **Inpatient Care Downgrades to Observation Status:** Given the significant hospital resources involved during a substantial stay in a hospital, inpatient care is typically reimbursed at a higher rate than outpatient care and observation status. Additionally, inpatient stays entitle patients to certain benefit categories, such as post-acute care facility services after discharge. To give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established the two-midnight rule. Under that policy, hospital inpatient admission is considered medically appropriate if the

patient is expected to receive hospital care for at least two midnights. Despite this bright-line CMS medical necessity rule, many MAOs have implemented policies that further restrict inpatient care by placing additional obstacles to admission or retroactively downgrading an inpatient stay to observation status, even when the clinical criteria for inpatient care have clearly been met. This sometimes even occurs for an inpatient stay lasting multiple days and far exceeding the criteria set forth by CMS' two-midnight rule for traditional Medicare. These policies frequently lead to uncertainty for providers and patients, whose medically justified inpatient stays are often denied or retrospectively changed to observations, resulting in reduced provider reimbursement, and potentially impacting a patient's eligibility for needed post-acute care services.

- **Emergency Services:** Several large insurers, including MAOs, have been denying or downcoding coverage of emergency services if the health insurer unilaterally determines that the condition did not meet medical necessity criteria for emergency-level care. Importantly, the plan makes this determination *after the care is delivered* upon reviewing the outcome and patient records, and not based on what the clinician knew at the time the patient presented to the emergency department (ED). Although this policy was purportedly designed to discourage inappropriate use of the ED (a goal hospitals and health systems share), it has instead been used as a blunt tool that causes patients to fear accessing medical services in the context of an emergency. These policies can deter patients from seeking critical and urgent care, while also resulting in significant financial losses to providers when payments are clawed back after the fact for care that was legitimately provided.

  These policies completely ignore hospitals' responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to assess and stabilize anyone who presents to the ED. They also ignore the application of the prudent layperson standard, which requires the need for emergency services to be evaluated based on what an average "prudent" person deems an emergency at the time the individual seeks care. It also requires health plans to provide coverage for emergency care based on symptoms presented at the time of the emergency, not based on the final diagnosis. It is often not known whether certain symptoms are the result of an urgent or non-urgent condition without medical examination and testing—and to determine if the situation was an emergency based on only the outcome is wildly unreasonable and unfair to patients who go to a hospital seeking help when they are scared or in pain.

  HAP deeply appreciates CMS addressing this issue in recent regulations related to the No Surprises Act. However, we continue to experience these concerning practices with certain MAOs, including inappropriate downcoding of claims or line-item denials that do not appear to regulators as a full denial, and thus, would appreciate further scrutiny and enforcement to address these issues.

- **Eligibility for Post-acute Care (PAC) Services:** The HHS-OIG report identified PAC as one of three services most frequently denied requests for prior authorizations and payments that, in fact, met Medicare coverage rules and MA plan billing rules. Erroneous denials and delays such as these restrict access to care during both the PAC and prior hospital stages of

care, for services that would otherwise be covered by traditional Medicare. Indeed, delayed and denied MA coverage for downstream PAC services is a frequent burden, even though such MA decisions contradict the professional judgment of the referring physician. We note that the HHS-OIG report actually highlights multiple examples of medically necessary inpatient rehabilitation facility (IRF) care that should have been covered, raising the profile of this issue and the negative effects on Medicare beneficiaries. These delays and denials erode the overall quality of care provided to patients and undermine cross-setting clinical coordination efforts that are critical to high-quality, patient-centered care.

In addition, MA plans with narrow networks of PAC providers present challenges for patient referrals for downstream specialized care that is not provided by our hospitals, such as services covered by traditional Medicare for IRFs and long-term care hospitals. These settings provide care through inter-disciplinary care teams with specialized clinical training and treatment programs that are critical to achieving patients' rehabilitation and recovery goals. Insurance constructs that result in inadequate PAC provider networks are a critical barrier to our patients accessing these specialized services to which they are entitled.

Regarding financial incentives, it also appears that some MA plans may be motivated to keep a patient in our hospitals for longer than is medically prescribed by the treating physician because the plan is reimbursing us at a flat rate. In this case, the plan is either delaying or attempting to avoid discharging the patient to the next site of care, which would require separate reimbursement. The result is that too many patients are being denied timely access to medically necessary PAC care at the expense of MA plan policies, which, in some cases, are specifically designed to restrict coverage and payment to the greatest extent possible in order to boost plan profits.

It has been reported that at least one large national plan overwhelmingly denies post-acute transfers for Pennsylvania patients, despite all medical criteria being met and insurer policies followed. The hospital has even submitted the *exact same information* to another plan and the admission was approved.

In aggregate, these experiences and concerns are a clear indicator that the MA program is not operating as intended and that patients and their providers are being harmed by the abusive practices of certain insurers. **HAP strongly urges CMS to require MAOs to align medical necessity and coverage criteria with traditional Medicare rules so that Medicare patients have equal access to care regardless of coverage type and to reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization.**

Access To Behavioral Health Services

All the challenges noted above about our experience working with MAOs apply to behavioral health services and, in many cases, are more pronounced in the context of mental health and substance use disorder treatment and services. These include delays in prior authorization decisions; payment denials for care that has been pre-authorized; multiple requests for records; inadequate provider

networks; unilateral, mid-year changes in reimbursement policies; and site of service exclusions. These issues appear to be pervasive in MAO coverage for behavioral health, directly resulting in patient harm. Individuals experiencing behavioral health crises are often unable to access necessary care and services, and often spend extended periods of time waiting for placement in inappropriate settings like the ED as medical staff wade through arcane processes to satisfy MAOs.

Intermediary Administrative Service Entities

Many MAOs rely on subcontractors to administer portions of their benefits. For example, MAOs frequently subcontract to vendors to manage prior authorization adjudication for particular services, such as rehabilitation or behavioral health. While federal guidance requires MAOs to ensure that their vendors or benefit managers adhere to all program rules, hospitals and health systems frequently find that MAOs and their vendors are not consistent in their knowledge or application of MAO rules and processes. A common area of disconnect relates to prior authorization. The MAO tells the provider that no prior authorization is required for a particular service; however, the benefit manager or vendor will tell the provider to submit a prior authorization request. When the vendor denies the claim and the provider appeals, the appeal goes to the MAO for processing, which reaffirms that no authorization was required in the first place. Another common occurrence is that the vendor will collect medical records for purposes of adjudicating a prior authorization request. However, when the vendor denies the request and the provider appeals, the MAO (which handles the appeal) requests the provider send the exact same records that have already been provided to the vendor. These disconnects waste patient and clinician time and add costly burden to the health care system.

HAP strongly encourages CMS to extend its direct oversight to MAO vendors and hold MAOs accountable when their vendors delay patient access to care or cause unnecessary costs and burden in the system.

MAO Oversight

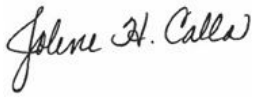
MAO violations of CMS rules including, for example, inappropriate use of proprietary clinical criteria to adjudicate coverage determinations, have negative implications for patients and providers. As a result, we believe greater CMS oversight of MAO conduct is warranted. However, we are concerned that existing data collected on health plan performance may not provide CMS with the comprehensive information it needs to conduct thorough oversight of MAOs. Currently, there are limited reporting mechanisms available to provide CMS with important information about plan-level coverage denials, appeals, grievances, or delays in care resulting from prior authorization and other administrative processes. These are important indicators of beneficiary access and are essential to proper oversight of MAOs. We strongly urge the agency to evaluate its data collection and address gaps.

Additionally, we recommend that CMS establish a provider complaint mechanism that allows providers to flag problematic plan behavior. Through the nature of our care relationships with patients, we have the most frequent interaction with plans, giving us greater insight into circumstances where plans have practices that inappropriately delay or deny patient access to care.

To help ensure that patterns of inappropriate denials and delays are addressed as soon as possible, we need a mechanism to flag problematic MAOs on behalf of our patients. There is currently no streamlined way to do this. **HAP urges CMS to create a mechanism for providers to flag questionable plan processes for regulators. CMS should utilize this information to guide heightened enforcement of problematic plan behavior.**

Thank you for your attention to the comments and concerns we have raised. We strongly support CMS' efforts to improve the MA program and urge the agency to advance rulemaking designed to increase oversight of the program and ensure enforcement of MAO policies which may violate federal rules or circumvent program intent. We believe more sustained oversight and accountability is needed to fully tackle the challenges enumerated by patients and their health care providers and to make meaningful progress towards achieving the CMS Strategic Pillars set forth in the agency's vision for Medicare.

Sincerely,



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