The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

March 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P. O. Box 8013
Baltimore, MD 21244-1850

RE: Request for Information: Prior Authorization for Hospital Transfers to Post-Acute Care Settings during a Public Health Emergency (CMS 4192-P, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program)

Dear Administrator Brooks-LaSure:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), we appreciate the opportunity to comment on prior authorization requirements for patient discharges to post-acute care (PAC) settings and the significant challenges these policies have raised for our members and the patients they serve, especially during the COVID-19 pandemic. **We encourage the Centers for Medicare & Medicaid Services (CMS), working with Congress as necessary, to require plans to waive administrative processes during Public Health Emergencies (PHE).**

HAP represents approximately 240 member institutions, including acute and specialty care, primary care, sub-acute care, long-term care, home health, and hospice providers, and the patients and communities they serve. Our members include small community hospitals and large health systems, in both rural and urban locations, including academic medial centers.

In order to provide the best care for each community during the COVID-19 pandemic, hospitals needed to quickly turn over general acute-care hospital beds and create space for higher-need COVID-19 patients, as well as ensure access to the appropriate level of care for those recovering from the virus. This necessitated urgent modifications to traditional discharge processes and clinical pathways to optimize personnel, physical plant, and other resources. The flexibilities offered by CMS to relax or waive prior authorization requirements for Medicare Advantage (MA) plans were invaluable for general acute care hospitals in implementing these modifications.

However, a substantial limitation of this flexibility is that it encouraged, but did not mandate, that MA plans waive such processes. While many MA plans worked collaboratively with provider partners to waive or relax onerous prior authorization requirements during the PHE, others did not, or only did so during the initial stages. The continued use of prior authorization and other health plan utilization management policies by some plans throughout the pandemic prevented referring hospitals from utilizing desperately needed health system capacity in PAC settings. This has been especially problematic when general acute care beds have been filled to capacity and while hospitals contend with the demands of vaccine distribution and workforce shortages. It also can have unintended consequences for patients who are then forced to stay in acute care settings

unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care. Even today, these challenges persist.

Hospitals shared the following insights:

- Enforcing prior authorization requirements during a public health emergency has a definitive and negative impact on hospitals, patients and PAC facilities
- Even without a PHE, requesting and receiving authorization is an inefficient process. Each insurer is unique and has different policies and procedures. The criteria applied to approve an authorization is inconsistent
- Delays for patients awaiting authorizations can take 72 hours or more; denials are not uncommon, and appealing those denial adds several more days to the process. **We have had patients lose the bed at the PAC facility while they are waiting for authorization.** Extended hospital stays for the administration of authorizations is not in the best interest of patients
- When sicker patients are transported to our hospital, we often know early on that they will need a certain level of rehabilitation post-hospitalization. An interdisciplinary care team makes this recommendation as appropriate and PAC facilities apply their process to confirm that the patient meets the criteria. Submitting a request for authorization for these vulnerable patients takes 48 to 72 hours, best case, and every delay impacts a patient's recovery and puts the patient at risk for becoming medically unstable while awaiting discharge
- As transfer patients wait to move to an appropriate PAC setting, authorization delays simultaneously prevent other patients in need of acute care from being assigned a bed. This causes patients to receive care in a less than ideal location, such as the emergency department (ED) or in a hospital that is trying to transfer the patient to a higher level of care. Ultimately, multiple patients suffer as a result of a delayed authorization request; during a public health emergency this is only exacerbated

We recognize that prior authorization is a tool that, when used appropriately, can help align patients' care with their health plan benefit structure and facilitate compliance with clinical best practices. However, its misuse and application during a PHE has caused a number of specific challenges that have negatively affected patient care and health system capacity during a global health crisis, which we discuss in more detail below. Continued flexibility and adoption of prior authorization waivers by MA plans would materially improve pandemic responses across the country.

Unwarranted Prior Authorization Delays Harm Patient Care: It is clear that keeping patients in the ED or an inpatient bed while waiting for the health plan's decision or response to a prior authorization request is not in the best interest of the patient. These delays often result in missed clinical opportunities for patients to access the more-specialized care typically provided in PAC settings. This is a clear detriment for patients with or recovering from COVID-19 whose condition requires interdisciplinary and targeted PAC care that combines medical care and rehabilitation. This

is particularly important for high-complexity patients and those experiencing cases of "long-COVID-19." Such delays due to prior authorization requirements also can interfere with patients' prescribed PAC plan of care, which is established by the referring hospital's treating physician and clinical team, and is intended to help patients return to their home or community sooner. When patients are delayed from being transferred to more appropriate clinical settings that focus on both medical and rehabilitative needs, their PAC plan of care cannot be implemented as intended, and progress toward their recovery is often negatively affected.

Members report that authorization delays can take several days, or even up to a week, in some cases. Additionally, if the patient needs ambulance transport, this further lengthens the timeframe to move to a PAC setting. In some cases, plans require the hospital to use a participating ambulance provider, and with the current staffing issues, these companies can be hours late for pick up. Any step to expedite the authorization process and improve the patient care experience should be taken.

These concerns are consistent with the findings of a September 2018 report by the Department of Health and Human Services Office of Inspector General (OIG), which warned that high rates of MA health plan payment denials and prior authorization delays could negatively impact patient access to care.[1] Further, a 2021 survey by the American Medical Association (AMA) of more than 1,000 physicians underscores the negative impact on patient care resulting from prior authorization. The survey found that more than **one-third (34%)** of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability, or even death, for a patient in their care. Also, more than nine in 10 physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients abandon treatment due to authorization struggles with health insurers.[2]

General Acute Care Hospitals' PHE Capacity Needs to Be Augmented by PAC: During the pandemic, some general acute care hospital patients could wholly or in part receive clinically appropriate care in another setting, such as a long-term care hospital, inpatient rehabilitation facility or skilled nursing facility. However, prior authorization requirements frequently delayed or prevented discharge in these cases, requiring general acute care hospitals to allocate clinical resources to manage patients who could otherwise be safely discharged. Utilization of PAC settings is a critical component of the health system's necessary response to a PHE, and health plan administrative processes should not supersede the imperative to free up general acute care hospital capacity and facilitate patient transfers to other settings where clinically appropriate.

Further, from a PAC perspective, there are widely held concerns about the behavior of MA plans who approve prior authorization requests for PAC, but later issue retrospective denials for the same services. This has been a long-standing and problematic issue for many PAC providers and the

[1] U.S. Department of Health and Human Services, Office of Inspector General (OIG). "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials." September 25, 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.
[2] American Medical Association, "2021 AMA Prior Authorization (PA) Physician Survey." Accessed at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

resulting hesitancy also contributed to delays in patient transfers from general acute care hospitals to PAC facilities during the PHE.

Health Plans' Adding Administrative Burden to the National PHE Response: Many MA plans use inconsistent administrative protocols and a dizzying array of timelines and requirements for prior authorization requests, reviews, approvals and communication, which are unnecessary at best, but rise to the level of unconscionable during a PHE. Excessive requirements and variation between them adds burden to the system as providers and their staff must ensure they are following the right set of rules and processes for each plan, which may change from one request to the next, and also can vary by plan, product, and vendor. Despite the tremendous time and resources needed to comply with such extensive requirements, prior authorization requests are often returned multiple times to provide additional information and are further delayed by slow health plan responses, which typically do not occur outside traditional business hours. During a time of national emergency where workforce shortages and strained health system capacity have been persistent challenges, there is simply insufficient bandwidth to comply with such cumbersome administrative procedures.

Prior authorization processes also have exacerbated workforce challenges and contributed to physician and other staff burnout during the PHE. Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. These staff often are physicians and nurses who have been diverted from patient care. Part of the challenge stems from health plans' use of peer-to-peer calls to establish prior authorization for a service or treatment without providing access to clinicians with the right type of expertise. Physicians report that their offices spend, on average, two business days each week dealing with prior authorization requests, with 88 percent rating the burden level as high or extremely high.[3]

Several member hospitals shared the following information:

- Staffing is a concern at every level of this process. Many have been working at max capacity —and more—for two years now and it is taking a toll. Spending time on the extensive administrative work required to get these approvals when they could be caring for patients is an ongoing source of frustration for doctors and nurses
- Increased length of stay results in increased cost of care, delayed patient throughput, increased ED wait times, and patient dissatisfaction
- When patients are delayed or denied the appropriate level of care, they are exposed to greater risk of hospital-acquired infections and the like. Patients also risk becoming further deconditioned and losing the PAC bed due to delays
- The hospital continues to run at very high occupancy—this means patient care is delayed because they are boarding in the emergency room until a bed is available

[3] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

- Delays also impact the PAC facility. They evaluate the patient, anticipate certain goals and a certain care plan, and staff accordingly. When there is a delay, that plan must often be altered and can result in negative financial impact for the facility

Lack of Transparency of Clinical Guidelines: Health plans commonly use medical necessity criteria and other clinical guidelines for general acute care hospital and PAC admissions, which differ by plan and deviate from those used by fee-for-service (FFS) Medicare. These modifications often are deemed proprietary and not shared with providers, resulting in a black box methodology for determining whether a service is medically necessary. As a result, it becomes nearly impossible for providers to anticipate what the health plan might request as evidence of medical necessity pursuant to a criteria that they will not share.

As a result of this lack of transparency in clinical guidelines, there is often extensive back and forth between providers and health plans in response to insurer requests for excessive amounts of documentation to substantiate the need for particular services. It is not uncommon for health plans to request information that is not directly relevant to making a determination about whether post-acute care is needed (e.g., when evaluating a prior authorization request for rehabilitation services, requesting information on a medication that would not impact the need for rehabilitation services). Further, with regard to transitions to PAC, many plans apply their medical necessity criteria based on the subjective judgment of clinicians with limited or no knowledge of PAC.

A member hospital noted that many insurers say they use industry standard Milliman and InterQual guidelines as their criteria; however, in practice it is actually those AND something more, and hospitals are not told what the "something more" is until they get a denial.

Overuse of Prior Authorization: Some health plans require prior authorization even for services where there is no evidence of abuse and for which the standards of care are well established. Specifically for PAC services, health plans frequently deny the presence of medical necessity for services that are supported by the literature and that are covered by FFS Medicare. For example, despite clear clinical guidelines directing providers to place certain medically complex stroke patients in inpatient rehabilitation facilities for a combination of medical and intensive rehabilitation services, health plans commonly require prior authorization or even deny this service.

One member noted that the authorization for PAC is approved more than 90 percent of the time, and questioned why it always take at least three (3) days to get an authorization for these services. The hospital also pointed out that the volume of denials continues to increase despite the fact that the services requested are not new and that there has been no finding that the process has been misused.

OIG Found Unwarranted MA Denials: The majority of the prior authorization and coverage denials are for covered, medically necessary services that are rejected for administrative processing reasons as opposed to concerns about the legitimacy or appropriateness of the service. Generally in these cases, clinicians treat patients using their best medical judgment, but too often their expert opinion is overridden by the plan (and often by a clinician without relevant expertise in the particular

specialty or PAC discipline). Ultimately, many of these denials are overturned through time-consuming administrative appeals. The September 2018 OIG report referenced earlier found that among appealed cases, MA plans overturned 75 percent of their own denials between 2014–2016 (approximately 216,000 denials per year) through their own appeals processes.[4] These findings highlight a pattern of health plans inappropriately denying access to services and payment that should have been provided.

Thank you for your attention to these issues. Urgent and continued action is needed to ensure that health plans' administrative processes do not impede patients' ability to receive timely, quality, medically necessary care in clinically appropriate downstream settings. This is more important than ever as we continue into our third year of a global pandemic, fighting new variants and surges, administering additional vaccine doses, addressing workforce shortages, and maintaining critical testing and treatment capacity. **We again urge CMS, working with Congress, to establish the authority to require—not just encourage—health plans to waive these processes during PHEs.**

Please don't hesitate to reach out to me directly with any questions.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Health Care Finance and Insurance

[4] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.