August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically

***Re: Request for Information: Medicare Advantage Program (*CMS-4203-NC)**

Dear Administrator Brooks-LaSure:

On behalf of our 26 acute care hospitals and our four specialty hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to respond to the request for information (RFI) on the Medicare Advantage (MA) Program. We remain concerned about the lack of clear jurisdiction for oversight of MA plans and some MA plans' inappropriate restrictions on beneficiary access to medically necessary care, including those highlighted in a recent report issued by the Department of Health and Human Services' Office of Inspector General (HHS-OIG), and urge Congress to increase its oversight of these plans.

We encourage the Centers for Medicare & Medicaid Services (CMS), working with HHS-OIG and Congress as necessary, to ensure there is sufficient oversight and regulations of these plans.

In addition to our comments below, we support the detailed comments submitted by the American Hospital Association (AHA).

Inappropriate and excessive denials for prior authorization and coverage of medically necessary services is a pervasive problem among certain plans in the MA program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first imaging and therapies, and other direct patient harms. In addition, these practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan requirements. They are also a major burden to the health care workforce and contribute to worker burnout. An advisory issued last month by Surgeon General Vivek Murthy, M.D., notes that burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.[1]

[1]https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf (http://https://www.hhs.gov/sites/default/files/health- worker-wellbeing-advisory.pdf)

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Many of these harms are evidenced by the striking report (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf) issued in April by the HHS-OIG. As demonstrated by the findings, problems with MA plan utilization management and coverage policies have grown so large — and have lasted for so long — that strong, decisive, and immediate enforcement action is needed to protect sick and elderly patients, the providers who care for them, and American taxpayers, who pay MA plans more to administer Medicare benefits to enrollees than they would to the traditional Medicare program.

We support the AHA's request for the Department of Justice to create a "Medicare Advantage Fraud Task Force" to conduct False Claims Act investigations into commercial health insurance companies that are found to routinely deny patients access to services and deny payments to health care providers. (https://www.aha.org/lettercomment/2022-05-19-aha-department-justice-re-false-claims- act-investigations) This would ensure that older Americans receive the care they need under MA and federal dollars are appropriately spent to provide, not deny, necessary services.

Addressing the disparities between traditional Medicare and the MA program also is a critical equity issue. The traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MA plans. The MA program currently has 26.4 million beneficiaries or 42% of the total Medicare population in 2021. Therefore, a little more than half of Medicare beneficiaries are not subject to the types of restrictions on access to care faced by beneficiaries enrolled in the MA program. We believe all Medicare beneficiaries should have equal access to medically necessary care and consumer protections, and that those enrolled in MA plans should not be unfairly subjected to more restrictive rules and requirements, which are unlawful and contrary to the intent of the MA program.

Office of Inspector General Raises Concerns about Beneficiary Access to Care under Medicare Advantage

The MA program is designed to cover the same services as traditional Medicare, and by law, MA plans may not impose additional clinical criteria that are "more restrictive than Original Medicare's national and local coverage policies."[2] However, the recent HHS-OIG report found that some of America's largest MA plans have been violating this basic legal obligation at a staggering rate.

The report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and should have been granted. In a program the size of MA, improper denials at this rate are unacceptable. Yet, as the report explained, because the government pays MA plans a per-beneficiary capitation rate, there is a perverse incentive to deny services to patients or payments to providers in order to boost profits. As a result, many insurers

[2] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16

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have found the MA program to be their most profitable line of business and have sought expansion into MA as part of their growth strategy.[3]

Egregious Health Plan Policies Remain Unchecked

Hospitals and health systems have been raising concerns for many years about MA plan tactics that restrict and delay access to care while adding burden and cost to the health care system. Below is additional information on the types of issues that threaten access to medically appropriate care.

More Restrictive "Internal" Medical Necessity and Coverage Criteria.

CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than traditional Medicare. However, the HHS-OIG report clearly details that MA plans are routinely doing exactly that. Additionally, MA plans often classify their medical necessity criteria as proprietary and do not share its specifics with providers, resulting in a "black box" methodology for determining whether a service will be approved. This leaves providers and patients unable to anticipate what the plan may require as evidence of medical necessity, leading to unnecessary delays and denials and unequal coverage of medically necessary care for MA beneficiaries.

Sepsis Coverage

Several MA plans do not adhere to CMS clinical guidelines for sepsis, instead utilizing standards that are not supported by current clinical best practices, nor recognized by current coding or payment methodologies used by CMS. Such a policy reduces patient access to care and undercuts quality improvement efforts to prevent, detect, treat, and improve sepsis care.

One NH Hospital reports that since January 2021, 93% of sepsis denials by Medicare Advantage plans were based on use of Sepsis 3 criteria. The discrepancies between the MA plan's use of Sepsis 3 criteria and CMS' expectations for use of Sepsis 1 criteria causes inappropriate denials for hospitals and creates administrative burden related to appeals.

Inpatient Care Downgrades to Observation Status

In order to give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established that hospital inpatient admission is considered medically appropriate if the patient meets the criteria of the two-midnight rule, even if the patient's inpatient hospitalization stay is shorter than 48 hours.

A down coding strategy utilized by MA plans is to deny beneficiaries for inpatient status and instead, move patients to observation (outpatient) status. This policy generally eliminates a MA beneficiary's eligibility for post-acute care coverage because MA generally only pays for post-acute care ***after a qualifying inpatient*** hospital stay and do not provide this coverage following an observation hospitalization. Hospitals report that nearly any stay that is less than 48 hours

[3] https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief

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will be automatically downgraded to an observation stay rather than an inpatient stay, even if the patient clearly meets the inpatient criteria at the time of admission.

Eligibility for Post-Acute Care (PAC) & Prior Authorization Processes

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. 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.

Many of MA policies provide barriers to transitions to post-acute care services. Perhaps most concerning, is for patients who have suffered a stroke. Traditional Medicare members can be admitted to an inpatient rehabilitation facility (IRF) without the need for a prior authorization as this is a compliant IRF CMS diagnoses. Evidence based guidelines recommend acute rehab for stroke patients ***as soon as possible*** in order to maximize neuroplasticity of the brain in the recovery practice. However, all MA stroke cases must go through an authorization process.

The administrative process associated with prior authorization of post-acute care by the MA plans typically adds up to four days to hospitalization and even more if the request is initiated on a Friday or weekend. It is particularly concerning that many of the MA plans take full advantage of the CMS rules that allow MA plans 14 days to make a determination on a prior authorization request. This administrative delay preventing a patient from transitioning out of an acute care hospital into a more appropriate level of care means that other patients in need of that acute care bed cannot be served. While delays in patient transitions from acute care to a post-acute care setting have always been a concern, they have been particularly egregious during the COVID-19 pandemic as hospitals have been dealing with surges of COVID-19 patients as well as non-COVID patients adding even more strain on an overburdened health care system. Additionally, each request requires hours of staff time to demonstrate medical necessity to the MA plan. It should be noted that the staff at both the acute care hospitals and staff at post-acute care facilities, who have not even received the patient yet, must dedicate significant resources to obtaining these approvals that are rarely required under traditional Medicare. These delays contribute to a decline in the patient's condition and waste costly resources.

While alignment of medical necessity and coverage criteria is the single biggest challenge related to MA prior authorization policies, the actual process of complying with MA plan processes is in dire need of reform as well. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. For each plan, providers and their staff must ensure they are following the right rules and processes, which vary substantially between plans and by service, and are often unilaterally changed in the middle of a contract year. This heavily burdensome process contributes to patient uncertainty regarding their care plan and can leave them in limbo, facing delays in care while the aforementioned steps are completed. According to a 2021 American Medical Association survey, 93% of physicians reported care delays associated

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with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment.[4]

Emergency Services

Several large insurers have been denying or down coding coverage of emergency services 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. 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.

Specialty Pharmacy Coverage

Large insurers are increasingly requiring health care providers to obtain physician-administered drugs from the insurer's owned or affiliated specialty pharmacy instead of allowing the health care facility to provide the drug on-site from its own inventory. This practice, known as white bagging, raises serious patient safety concerns, creates the potential for significant delays in time-sensitive medical care and adds tremendous burden and cost to the health care system. The white bagging practice will be part of a recently announced investigation by the Federal Trade Commission into the vertical integration of pharmacy benefit managers and large health insurance companies who wholly own mail order specialty pharmacies, which are being used to steer patients for profit.[5]

Greater Accountability Is Needed

The findings of the HHS-OIG report, as well as the broader experience of MA beneficiaries, hospitals, and health systems, clearly indicate that greater oversight of MA plans is needed to ensure appropriate beneficiary access to care. To address these concerns, the NHHA specifically urges Congress to:

- **Establish Controls for MA Plan Usage of Prior Authorization**. The NHHA supports The Improving Seniors' Timely Access to Care Act of 2021 (H.R.3173/S.3018), which would streamline prior authorization requirements under MA plans by making them simpler and uniform, and eliminating the wide variation in prior authorization methods that frustrate both patients and providers.

- **Improve Data and Reporting**. We strongly urge Congress to establish standardized reporting on health plan performance metrics related to coverage denials, appeals, and grievances by plan and to require that these be made publicly available.

[4] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[5] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry

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- **Conduct More Frequent and Targeted Plan Audits**. Pursuant to the HHS-OIG recommendations, we urge additional CMS audits be conducted and targeted to specific service types of MA plans that have a history of inappropriate denials.

- **Establish Provider Complaint Process**. Health care providers, including hospitals and health systems, act on behalf of their patients when working with insurers to obtain approval and coverage for medically necessary care. We encourage Congress to establish a process for health care providers to submit complaints to CMS for suspected violation of federal rules by MA plans.

- **Align Traditional Medicare and Medicare Advantage Medical Necessity Criteria.** All Medicare participants, whether enrolled in an MA plan or traditional Medicare, deserve to have the same access to essential medical services. We urge Congress to create legislative protections that prohibit MA plans from utilizing medical necessity and coverage criteria that is more restrictive than the criteria used in traditional Medicare.

- **Enforce Penalties for Non-Compliance**. Congress should ensure that CMS exercise its authority to enforce penalties for MA plans that fail to comply with federal rules, including the provisions recommended above regarding plan reporting and adherence to medical necessity criteria that are not more restrictive than traditional Medicare. Additional requirements are insufficient without enforcement action and penalties to support compliance.

- **Provide Clarity on the Role of States in MA Oversight.** One of the challenges in regulating MA plans is the split responsibility of insurance oversight between the federal and state governments. In order to ensure that CMS and states exercise their authorities as needed, we encourage Congress to delineate and strengthen the specific oversight and enforcement responsibilities of state and federal authorities.

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 HHS-OIG and Congress, to increase oversight over these plans.** If you have any questions, please feel free to contact me or Brooke Belanger, Vice President, Financial Policy and Compliance at (603) 415-4253 or bbelanger@nhha.org.

Sincerely,

Steve Ahnen
President

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