



Charles N. Kahn III
President and CEO

September 1, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Needed Improvements to Medicare Advantage Organization Practices

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH has serious concerns about ongoing and worsening practices of MA plans that are using prior authorization, inadequate provider networks, extended observation care, retroactive reclassification of patient status (i.e., inpatient versus observation), and pre- and post-payment denial policies that are inappropriately limiting Medicare beneficiary access to needed hospital and health care services and improperly delaying or withholding payment for medically necessary services.

These policies have been especially problematic over the past 15 months as hospitals have focused on responding to the COVID-19 pandemic. We appreciate that the Centers for Medicare & Medicaid Services (CMS) August 20, 2021, memo to MA plans "strongly

encouraged” all plans to “waive or relax prior authorization requirements and utilization management processes to facilitate the movement of patients from general acute-care hospitals to post-acute care and other clinically-appropriate settings, including skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, and home health agencies.” Our member hospitals in areas surging under this fourth wave of COVID-19 are experiencing the strain of bed and staffing shortages, and CMS’ recommendation for MA plans to facilitate more efficient discharge to appropriate post-acute settings will hopefully help them respond to the growing crisis.

But MA plans’ problematic practices related to prior authorization and payment denials are not new. In September 2018, the HHS Office of Inspector General (OIG) reported on MA plan prior authorization policies and appeals. The OIG found high rates of overturned prior authorization and payment denials and identified problems related to denials of care and payment. Among other recommendations, the OIG urged HHS to address inappropriate denials and insufficient denial communications. While CMS agreed with the OIG findings and needed changes, these practices have continued and worsened.

Proliferation of Authorizations, Denials, Downcoding, and Reclassifications

The use of various pre-payment and post-payment “tools” by MA plans is proliferating, with a negative impact on patient access and provider payment for services. While some of these tools are meant to ensure program integrity, these plan tactics often go beyond the legitimate scope of these efforts, and instead, result in inappropriate delay of care or denial of payments.

Exacerbating these practices, our members have experienced MA plans that consistently use reviewers who lack appropriate licensure and board certification, such as nurses and general practitioners, to overturn the more qualified clinical medical judgments of board-certified physicians and specialists. This is inconsistent with 42 C.F.R. § 422.590(h)(2), which requires that “[w]hen the issue is the MA organization’s denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue . . .”

The 2018 OIG report recommended that CMS reduce the incidence of inappropriate denials by: enhancing oversight of MA contracts and taking corrective action; addressing persistent problems regarding inappropriate denials and insufficient denial letters; and providing enrollees with easy-to-understand and easily accessible information about serious MA plan violations.

The FAH urges CMS to exercise its discretion to follow up on the OIG recommendations and more specifically to consider MA engagement with regard to CMS’ Two-Midnight Rule, Medicare Benefit Determination, Prior Authorizations, Appeal Rights, Risk Adjustment Data Submissions, and Network Adequacy.

Two-Midnight Rule

As the FAH has previously shared with CMS, there has been and continues to be a significant trend among MA plans of denying authorizations for inpatient admissions ordered by physicians and reclassifying them as outpatient observation stays instead. MA plans use a variety of standards to determine whether a particular hospital stay meets their criteria for an inpatient admission (sometimes through remote means which often lack transparency), even though determining patient status is a clinical decision that should be made by the medical professional treating the patient. Additionally, our members have had instances where physicians with financial incentives from the MA plan change the admission status before discharge to reduce the payment for care. To address this issue, as we have previously suggested, CMS should require MA plans and MA plan contracted physicians to follow the two-midnight rule in determining patient status. This is the same standard used by CMS for physicians to determine if a particular hospital stay should be covered as an inpatient admission and this standard is equally appropriate for MA beneficiaries.

Medicare Benefit Determination and Payment Rules

Some plans use proprietary non-CMS-endorsed standards to determine coverage for inpatient procedures and inpatient rehabilitation facility (IRF) coverage. Additionally, the Medicare Inpatient-Only (IPO) list (which CMS has recently proposed to in effect “reinstate”), is the single, definitive source of guidance as to which procedures must be performed in an inpatient setting to be reimbursable by Medicare, yet it is not routinely utilized by plans. Similarly, many MA plans do not apply CMS’ fee-for-service IRF coverage guidelines, instead using proprietary standards that direct enrollees to less intensive care settings than they need, denying access to the intensive, comprehensive, IRF-level care to which they are entitled. The use of these proprietary standards creates confusion and administrative challenges for beneficiaries and providers and results in misalignment between the treatment of Medicare beneficiaries under the fee-for-service program and those in an MA plan. The FAH urges CMS to ensure that MA plans are following Medicare benefit determination and payment rules.

In addition, MA plans pay third-party private contractors on a contingency fee basis to engage in aggressive audit practices in which they review claims to validate DRG coding and to perform charge audits. Often the DRG validation audits result in a denial or downgrade of the underlying diagnoses necessary to support a DRG. Further, these contractors are now questioning the accuracy of the physician documentation regarding the patient’s health and associated comorbidities that support the underlying diagnosis without any clinical basis for doing so. In addition, the charge audits result in the removal of covered charges or the bundling of covered charges for separately reimbursable services. The reviews often are conducted by staff with minimal clinical or billing expertise, do not contain an adequate explanation for the denial or downgraded DRG, and often create confusion due to lack of communication between MA plans and their third-party contractors. These issues are exacerbated due to convoluted and nearly insurmountable appeal processes, as discussed further below. CMS acted several years ago to curb these types of unfair practices under the Medicare fee-for-service recovery audit contractor (RAC) program and should exercise similar oversight of these practices under the MA program.

Authorizations

Our members routinely report delays and inconsistencies with notification and authorization processes for both emergency and elective admissions across MA plans. Some of the more common issues with notifications and authorizations include:

- Inconsistency in the ability of MA plans to implement various notification and authorization systems utilized by providers;
- Lack of transparency and clarity regarding the guidelines plans use to evaluate prior authorization requests;
- Varying authorization and documentation rules across payers and their different products;
- Use of reference numbers that are not authorizations for services and care;
- Inability to rely on prior authorization approvals;
- Delays obtaining prior authorization approval, including for post-acute care, resulting in patients spending more time than clinically necessary in an inpatient setting;
- Delays in access to critical post-acute care and rehabilitation services;
- Limiting peer-to-peer reviews to only permit the attending physician (whose schedule is filled with patient care activities that do not align with also supporting the authorization process) to discuss the provider authorization requests with the plan or only providing a limited time period (e.g., a few hours) in which to have that discussion.

When plans deny the authorization requests, providers struggle to understand why (e.g., based on what guidelines) the request was denied. Sometimes this discontinuity can be addressed without a more formal appeal, but in other instances the provider must enter the extended appeals process. Even when providers make it through the authorization process and receive an approval, they are increasingly finding that some plans do not honor that approval at the time of payment. Plan enrollees and the providers who care for them must be able to rely on authorization determinations. In too many instances, hospitals may not even engage with the plan following an arbitrary denial in light of the time and excessive resource commitment required.

Appeal Rights

Given the challenges described above with authorizations, denials, downcoding and reclassifications, providers (and by extension beneficiaries) are further harmed due to their inability to seek a CMS review. Specifically, the appeal rights for in-network providers are covered by provider participation agreements and are not eligible for appeal to CMS. The appeals processes in participation agreements are complex, cumbersome, not standard across plans, often not automated, and require significant administrative resources and staffing for health care providers. We urge CMS to address these concerns and initiate stricter oversight to ensure Medicare beneficiaries have needed medical and hospital services.

Potential Actions to Mitigate Plan Practices

CMS can take a number of specific actions to reduce the burden of prior authorization, interfere less with patient care, save administrative costs, minimize the need for costly appeals, and better target overuse, waste, and abuse. These include:

- Ensure prior authorization decisions are timely and negative determinations indicate a specific, detailed reason for the denial;
- Improve transparency by providing detailed information on prior authorization policies and tracking and reporting rates of approvals and denials;
- Increase standardization of prior authorization policies, operations, and forms through the use of electronic transmission of prior authorization requests;
- Ensure prior authorization programs adhere to evidence-based medical guidelines and include continuity of care for individuals transitioning between coverage policies;
- Eliminate additional prior authorization for medically necessary services performed during a surgical procedure that already received, or did not initially require, prior authorization; and
- Establish “gold carding,” under which payers reduce prior authorization requirements for providers that have demonstrated a consistent pattern of compliance, improving efficiency and resulting in more prompt delivery of health care services.

Risk Adjustment Claim Encounter Submissions

The FAH urges CMS to consider a modification to the Part C Risk Adjustment Program to ensure that risk adjustment payments are made based on data that more accurately reflect the additional expenditures made by MA plans based on members’ health status. In particular, the FAH supports limiting MA encounter data to data derived exclusively from paid claims or, in the case of a provider that accepts capitation, provider encounter data. The risk adjustment program is designed to “account[] for variations in per capita costs based on health status,”^[1] but at present, we understand that MA plans include MA encounter data from denied, pending, and underpaid claims, which therefore do not reflect the costs incurred by the MA plan. Permitting MA plans to benefit from the inclusion of denied, pending, and underpaid claims through the Part C Risk Adjustment Program is particularly problematic when MA plans deny claims at significantly higher rates than commercial insurance carriers and self-funded group health plans. To put it simply, MA plans should not be able to increase their revenue through the Part C Risk Adjustment Program based on data contained in claims that the MA plan has failed to pay. Limiting the MA risk adjustment data in this way would not place an undue burden on MA plans because the current timelines for submission of this data allows adequate time for the prompt payment of claims prior to the initial data submission deadline, and certainly before the final risk adjustment data submission deadline the following year.

^[1] 42 U.S.C. § 1395x-23(a)(3)(A) (emphasis added).

CMS Should Undertake Enforcement Actions for Network Adequacy

While the FAH acknowledges and appreciates that CMS has taken some steps to address inaccurate provider directories, we are disappointed that CMS has not addressed concerns about MA plans' lack of compliance with network adequacy requirements. An MA plan's apparent compliance with network adequacy standards may obscure issues with actual network adequacy and the scope of represented provider options to enrollees within the network, if the MA plan uses downstream organizations to provide administrative and health care services to beneficiaries. Downstream organizations often are affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees' de facto provider network.

Unfortunately, for purposes of demonstrating network adequacy, CMS reviews the network that the plan presents and not at the unidentified sub-network to which many enrollees are relegated. These "networks within a network" often are far narrower than the provider network depicted in the provider directory or the Health Service Delivery (HSD) tables on which CMS based its approval of an MA plan, thus creating a narrower network as the beneficiary moves through the healthcare continuum. Enrollees may have selected a particular MA plan on the basis of its provider network, only to realize later that a downstream organization will discourage enrollees from accessing particular providers. Moreover, the downstream organization's sub-network may not meet the network adequacy standards to which the MA plan is subject.

Additionally, MA patients also experience situations in which a patient stay no longer meets the standards of care for inpatient services, but there is not a medically appropriate post-acute setting available for discharge. This occurs because the MA plan faces no additional financial costs to extend a patient's hospital length-of-stay under the MS-DRG system, but would face additional costs if it transferred the patient to the appropriate post-acute provider of care. Patients have a right under the Medicare program to be treated in an appropriate environment, and this includes a discharge from the inpatient hospital setting when appropriate.

The FAH recommends four actions CMS could undertake to address these concerns. First, CMS should implement audit protocols that identify and review downstream organizations and take enforcement actions, as necessary, for noncompliance with network adequacy standards. Second, CMS should require that MA plans demonstrate meaningful access, including a review of availability of listed post-acute providers that are accepting MA patients. Third, CMS should audit MA plan practices associated with approving timely discharges to an appropriate post-acute care setting. Fourth, CMS should include a standard in the Star Ratings Program to promote the adequacy and stability of an MA plan's network. Specifically, CMS should design a measure to ensure that beneficiaries are aware of the historical problems that any MA plan has had both with the initial adequacy of its networks and with the changes an MA plan has made during the course of a year that affect its networks.

Requiring that MA plans institute these key improvements will promote transparency, efficiency, and timely decision-making, which ultimately will lead to better patient care.

The FAH appreciates the opportunity to provide these insights into hospital challenges with MA plans and we are committed to working with you to ensure America's seniors in MA plans have improved access and better care. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew H. Hunt". The signature is fluid and cursive, with a large initial "A" and a long horizontal stroke at the end.