



Charles N. Kahn III
President and CEO

March 7, 2022

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: Calendar Year (CY) 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P)

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 appreciates the opportunity to comment on CMS's CY 2023 Medicare Advantage (MA) and Part D Proposed Rule (Proposed Rule) and proposals related to dual-eligible beneficiaries, beneficiary cost sharing limits, Medicare-Medicaid Plans, minimum loss ratio requirements, and network adequacy. We also appreciate CMS's Requests for Information (RFIs) about Medicare Advantage Organizations (MAOs) use of prior authorization during the COVID-19 public health emergency (PHE) and building behavioral health capacity within MAO networks. The MA program is an important and growing part of the Medicare program and we urge CMS to consider the recommendations below to improve beneficiary experience and provider engagement with MAOs.

Part II.A.5.b. Challenges Providers Face When Seeking Payment of Cost-Sharing Amounts for Dual-Eligible Beneficiaries (42 C.F.R. § 422.2)

The FAH shares CMS’ goals of encouraging a streamlined experience for dual-eligible beneficiaries and to simplify claims submission and payment for providers who serve these beneficiaries. The FAH believes that the Financial Alignment Initiative (FAI) has provided the best model to date for seamlessly providing benefits to dual-eligible beneficiaries and ensuring that providers are not burdened with additional claims submission burdens and unpaid cost-sharing amounts. Although the FAH strongly favors expansion of the FAI through additional demonstrations and/or congressional action, the FAH supports other measures that will protect dual-eligible beneficiaries enrolled in MA plans and mitigate the inappropriate provider costs imposed through burdensome processes for handling crossover claims and non-payment of cost-sharing amounts.

With respect to crossover claims, the FAH supports the proposal to require fully integrated D-SNPs (FIDE-SNPs) to simply cover a state’s cost-sharing obligations directly and to require states to direct capitated payments to FIDE-SNPs for those amounts. In processing Original Medicare claims for dual-eligible beneficiaries, CMS automatically sends crossover claims to states rather than imposing this additional burden on the provider. Where a dual-eligible beneficiary is enrolled in an MA plan, however, providers are often left to sort out whether cost-sharing amounts are the responsibility of the state Medicaid agency or a Medicaid managed care plan and must submit a separate claim for those amounts. This administratively burdensome process often results in no additional payment at all, such that the provider incurs higher transactional costs but has its payment effectively reduced by non-payment of the cost-sharing amount. Therefore, the FAH not only supports the proposal to require FIDE-SNPs to simply cover a state’s cost-sharing obligations directly and to require states to direct capitated payments to FIDE-SNPs for those amounts, but also encourages CMS to expand this proposal and its benefits to all D-SNPs.

Even if the foregoing proposal is finalized and expanded to all D-SNPs, the resulting streamlined process would still fall short of correcting the financial incongruity that applies when states deny any cost-sharing obligation at all by application of the “lesser-of” rule and the MAO fails to provide payment for the resulting bad debt. As CMS observes in the preamble, many states pay nothing at all for the Medicare cost-sharing obligations of qualified Medicare beneficiaries (QMBs).¹ As a result, “providers serving dually eligible MA enrollees are systematically disadvantaged relative to providers serving non-dually eligible MA enrollees, which . . . may negatively affect access to Medicare providers for dually eligible enrollees.”²

When QMBs are enrolled in Original Medicare, and Medicaid fails to make payment for Medicare cost-sharing amounts, the provider can claim these unpaid amounts as bad debt and

¹ 87 Fed. Reg. at 1862. Under 42 U.S.C. § 1396a(n), state Medicaid programs can limit coverage of Medicare cost-sharing amounts to the extent the combined payment would exceed Medicaid rates.

² 87 Fed. Reg. at 1884.

receive partial payment.³ When a QMB enrolls in an MA plan, however, their provider might not receive any payment for the unpaid cost-sharing obligation because MAOs are not statutorily compelled to cover providers' bad debts, even in part. This is true even though CMS includes payments for bad debts in its capitated payments to MAOs. As a result, providers are often financially penalized for serving dual-eligible beneficiaries enrolled in MA plans (including D-SNPs) because the total payment to the provider is effectively reduced by the cost-sharing amount. Thus, a provider might provide *the exact same service* to two MA enrollees, and receive a greater total payment on behalf of the enrollee that is entitled only to Medicare benefits compared to the enrollee entitled to both Medicare and Medicaid benefits. MACPAC has expressed concerns that this practice can "limit[] beneficiary access to care," observing that "Providers may be less inclined to provide services to dually eligible beneficiaries" where Medicaid payers fail to pay Medicare cost-sharing amounts.⁴

The FAH believes that the FAI provides a model for effectively addressing the underpayment of Medicare claims for dual-eligible beneficiaries. Under this model, providers submit a single claim to the Medicare-Medicaid Plans (MMPs) and MMPs provide a single payment of the full payment amount for the services without any reduction for any cost-sharing amount. We applaud the approach taken in the FAI and urge CMS to hew D-SNP policies and strategies for dual-eligible beneficiaries enrolled in managed care plans to the FAI model as much as possible.

To the extent an approach drawn from the FAI experience cannot be extended to *all* MA plans that serve duals, however, we urge CMS, at a minimum, to allow providers to claim MA bad debt like Original Medicare bad debt on their cost reports and receive appropriate payment. Although such a strategy would not make providers entirely whole, it would help to offset the impact on providers who serve duals and are unable to collect any cost-sharing amounts. Moreover, this approach better safeguards the Medicare Trust Fund by ensuring that bad debt payments are actually used to address Medicare bad debt. At present, MA bad debt payments are included in CMS' capitation payment to MAOs, but CMS does not require the MAO to pass that on to providers in whole or in part, such that these amounts are often not used to address bad debt issues.

Part II.A.12 Attainment of the Maximum Out of Pocket (MOOP) Limit (42 C.F.R. §§ 422.100, 422.101)

As outlined above, the FAH strongly urges CMS to explore policy options that will protect providers from systematic underpayments attributable to unmet cost-sharing obligations through programs that mirror the FAI and/or by carving MA bad debt out of capitation payments to MAOs and permitting providers to claim MA bad debt on their cost reports. The current situation where providers have their MA payments systematically reduced by uncollectable cost-sharing amounts is untenable, and the FAH urges CMS to more fully address this problem.

³ 42 C.F.R. § 413.89.

⁴ MACPAC, June 2020 Report to Congress on Medicaid and CHIP, Chapter 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context, page 13, available at <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-1-Integrating-Care-for-Dually-Eligible-Beneficiaries-Background-and-Context.pdf>

CMS' proposed amendments relating to the maximum out-of-pocket (MOOP) limit would address the most egregious of these cases by ensuring that provider payment reductions based on enrollee cost-sharing amounts cease once the tally of uncollectable cost-sharing obligations reach the MOOP limit. The FAH supports the proposal to refine the specific categories of spending obligations that count towards attainment of the MOOP limit to include cost-sharing obligations that are "accrued" but go unpaid so that the MOOP does not become a boundless loophole for reducing provider payments. As the preamble notes in explaining the purpose of this proposal, "[i]f the out-of-pocket costs that counts towards the MOOP limit are calculated similarly for dually eligible enrollees with Medicare cost-sharing protections, the providers would . . . know that there was a limit on the liability for unpaid cost-sharing that they must assume."⁵

Again, however, although the FAH supports this proposal to establish an end point for provider liability for enrollee cost-sharing obligations, it is unclear why providers should assume any liability at all for unpaid cost-sharing. This practice serves no discernible policy goal and, if MA rules for dually eligible beneficiaries fail to ensure that providers are reimbursed in full for these amounts, CMS should adopt our suggestion set forth above to allow providers to claim this bad debt in their cost reports and exclude these bad debt payments from CMS' payments to MAOs.

Part II.A.14. Converting MMPs to Integrated D-SNPs

The FAH supports CMS' desire to enable smooth transitions if MMPs are converted to D-SNPs and the framework under proposed 42 C.F.R. § 422.107(e). This framework allows states to ensure that the integrated D-SNP products are structured in a way that mirrors key features of MMPs, including requiring D-SNPs to reimburse providers for all types of dual-eligible beneficiary cost-sharing, and allows for greater transparency regarding D-SNP plan performance. In addition, the FAH urges CMS to preserve another key feature of MMPs by requiring fully-integrated or highly-integrated D-SNPs to provide members with one identification card that provides information regarding *both* the D-SNP and the applicable Medicaid managed care plan. The cards should clearly indicate the following:

- a. The beneficiary's dual eligible status,
- b. The dual eligible beneficiary type (*e.g.*, QMB),
- c. The D-SNP type (*e.g.*, FIDE or highly integrated (HIDE)),
- d. The party that should receive and pay provider claims, and
- e. The party that is responsible for paying the beneficiary's cost-sharing obligations.

Making this information available on the enrollee's identification card would reduce administrative burden for states, MAOs, and providers, and further reduce the risk that a dual-eligible beneficiary is improperly billed for his or her cost share.

Part II.B. Special Requirements During a Disaster or Emergency (42 C.F.R. § 422.100(m))

The COVID-19 pandemic, and particularly the recent fourth surge, illustrated the ways in which rapidly-changing conditions in a disaster or emergency can affect patterns of care, and

⁵ 87 Fed. Reg. at 1885.

underscored that providers need flexibility in these circumstances to ensure beneficiaries have effective access to appropriate and timely care, notwithstanding network limitations and gatekeeper requirements that MAOs may apply in the normal course. As such, the FAH strongly urges CMS to ensure that any revisions to the disaster and emergency requirements at 42 C.F.R. § 422.100(m) do not compromise these critical access-to-care protections for MAO enrollees. The FAH is particularly concerned with the proposal that MAOs would be initially responsible for evaluating whether there is a disruption of access to health care because MAOs have financial incentives to avoid compliance with the additional requirements set forth in section 422.100(m)(1). Leaving the initial determination as to whether a disaster or emergency disrupts access to care in a given area to the MAO may also create unfair or inconsistent outcomes as well as provider and beneficiary confusion if two MAOs operating in the same community reach contrary conclusions regarding whether such a disruption exists. Moreover, while MAOs have historically had case managers on-site at major hospitals within their networks, this practice is less common now, such that MAOs are not well positioned to evaluate whether a state of disaster or emergency is disrupting access to care for enrollees in a particular service area. Rather, hospitals and other providers have on-the-ground information regarding the impact of a disaster or emergency on the delivery of care in their communities. This is especially true when circumstances are developing rapidly, as was true at the height of the most recent surge of COVID cases, or when natural disasters affect beneficiaries' ability to travel across service areas.

Instead, we urge CMS to identify circumstances in which a disruption in access to care is conclusively deemed to exist during a disaster or emergency. For example, as a baseline, if a presidential declaration of a disaster or emergency, a secretarial declaration of a public health emergency, or a declaration by the Governor of a State or Protectorate includes or is supported by a presidential, secretarial, or gubernatorial finding that the disaster or emergency disrupts access to health care, such finding should control for purposes of section 422.100(m). Likewise, if the Secretary has enacted a waiver under Section 1135 of the Social Security Act for the purpose of ensuring that "sufficient health care items and services are available to meet the needs" of Medicare and Medicaid beneficiaries, exercise of this waiver authority should also constitute a determination that a disruption of access to health care exists for purposes of section 422.100(m) for the duration of such waiver.

In other disasters and emergencies that are not conclusively deemed to disrupt access to health care based on the circumstances described above, CMS could initially assume that access to care is in fact disrupted by the disaster or emergency. However, providers, MAOs, beneficiaries, governors, and other stakeholders would have an opportunity to provide direct feedback to CMS by reporting on conditions they are observing and whether conditions indicate that the disaster or emergency is disrupting access to care through a streamlined and centralized process. Together, these inputs would help CMS to identify those emergencies and disasters—like the opioid public health emergency (PHE) and state of emergency in Hawaii to combat the Zika virus—that do not in fact disrupt access to care for any subset of enrollees in the geographic region while still ensuring that beneficiaries swiftly and consistently receive the protections under section 422.100(m) during the many disasters and emergencies—like Hurricane Maria in Puerto Rico—that disrupt access to care for some or all enrollees. In the context of a natural disaster that overwhelms an MAO's in-network providers or displaces beneficiaries out of the service area, for example, the decision to recognize such disruptions in access to care is urgent, and it is important for MAOs, beneficiaries, and providers alike to receive a clear, consistent

message regarding these rules within a particular service area in these circumstances. Finally, in situations where the disruptions in access to health care during an emergency or disaster are intermittent, CMS could use this process to identify times when care is not disrupted despite the ongoing emergency or disaster.

The foregoing centralized process would more effectively and efficiently protect MAO enrollee access to care during disasters and emergencies as compared to a process that relies in the first instance on an MAO's determination. In addition, it would ensure uniformity and minimize uncertainty, avoiding the need for beneficiaries and providers to parse through MAOs' inconsistent determinations as to whether a disruption in access to care exists. In the absence of such a process regarding the disruption of access to health care in an emergency or disaster, the FAH supports retaining the regulatory provisions as currently set forth in section 422.100(m) because current law better and more uniformly protects beneficiaries' access to care during emergencies and disasters.

We also urge CMS to require MAOs to expand the special requirements applicable during a disaster or emergency to ensure that MAOs waive prior authorization requirements for hospital and post-acute care. Relaxing prior authorization requirements in these circumstances would help to ensure that patients get medically necessary, appropriate care in a timely manner, even if providers or MAOs are not in a position to make or respond to prior authorization requests timely. Similarly, waiving prior authorization and length of stay requirements for appropriate post-acute care in skilled nursing facilities, inpatient rehabilitation facilities, long-term acute care hospitals, and home with home health would help mitigate any "disruption of access to health care" by freeing up hospital beds more quickly.

Part II.C. Amending MA Network Adequacy Rules to Require a Compliant Provider Network at Application (42 C.F.R. § 422.116)

The FAH supports efforts to improve oversight and effectiveness of network adequacy among MAOs. Such reviews are critical to ensuring that MAOs fulfill their statutory obligation under section 1852(d)(1)(A) of the Social Security Act to make covered benefits "available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits." In particular, the FAH supports reinstating network adequacy reviews for initial applicants and service area expansion applicants by requiring provider network adequacy reviews at the time of such MA applications. As noted in the Proposed Rule, including network reviews in the application process will "help ensure overall bid integrity, result in improved product offerings, and protect beneficiaries."⁶

The FAH, however, urges CMS to consider further refinements to its network adequacy requirements in order to ensure that Medicare beneficiaries enrolled in MA plans have timely access to appropriate care and benefits through robust provider networks. In order to generally support transparency around network adequacy issues, CMS should include a standard in the Star Ratings Program that highlights both the adequacy and the stability of an MA plan's network. Specifically, CMS should design a measure to ensure that beneficiaries are aware of the

⁶ 87 Fed. Reg. at 1893.

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 plan year that affect its networks. In addition, to further ensure CMS' review of an MA plan's network meaningfully evaluates beneficiary access to care, we urge CMS to establish additional requirements focused on MAOs' use of "sub-networks" and the sufficiency of their post-acute provider networks.

The FAH supports the adoption of network adequacy requirements specific to each sub-network used by an MAO in order to ensure that covered benefits remain available and accessible to each enrollee in the service area. MAO "sub-networks," downstream organizations that provide administrative and health care services to beneficiaries, are often affiliated with their own contracted or employed physician or provider groups. MAOs' 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 notwithstanding the MAO's presentation of its full network in the provider directory and the Health Service Delivery (HSD) tables used in network adequacy reviews. This practice creates confusion among MA enrollees who may have reviewed the plan's network information in an effort to ensure in-network access to their preferred physicians, hospitals, and other providers, only to realize later that a downstream organization will discourage them from accessing particular providers. Moreover, the downstream organization's sub-network itself may not satisfy the network adequacy standards established by CMS in accordance with section 1852(d)(1) of the Social Security Act.

The FAH also encourages CMS to take action to ensure that each MAO offers a sufficient number of in-network post-acute beds. At present, the minimum number requirement under 42 C.F.R. § 422.116(e)(2)(iii) can be satisfied with a single in-network skilled nursing facility (SNF). Further, MA plans' networks are often thin on post-acute providers, which creates challenges for hospitals seeking a medically appropriate destination that is willing and able to accept a timely patient transfer. Where MA enrollees do not have adequate access to in-network post-acute care facilities (including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and SNFs), their care may be inappropriately delayed or disrupted. And during a PHE, post-acute network limitations, along with the utilization management practices discussed in the context of the RFI regarding prior authorization for hospital transfers to post-acute care settings during a PHE, can compromise the care of MA beneficiaries with follow-on impacts for the health care system as a whole. The FAH thus urges CMS to scrutinize MA plans' network for inclusion of post-acute care providers by raising the minimum number requirement for post-acute facilities and monitoring enrollee wait times for discharge to these facilities.

The FAH recommends four actions to address the foregoing concerns with respect to sub-networks and post-acute network adequacy. First, CMS should implement audit protocols that identify and review network adequacy at the sub-network level and take enforcement action, as necessary, for noncompliance with network adequacy standards. Second, CMS should require that MA plans demonstrate meaningful enrollee access to post-acute providers, including by requiring a sufficient ratio of in-network IRF and LTCH to enrollees. SNFs, IRFs, and LTCHs are fundamentally distinct providers. SNFs alone do not adequately reflect the full spectrum of available "rehabilitation" that is available/accessible in a MAO's market. Third, CMS should audit MA plan practices associated with effectuating timely discharges to an appropriate post-

acute care setting and consider a corresponding quality measure for timely discharge in star ratings. Fourth, CMS should include a standard in the Star Ratings Program to promote the adequacy and stability of an MA plan’s network, as discussed above.

Part II.G. Proposed Regulatory Changes to Medicare Loss Ratio Reporting Requirements and Release of Part C Medical Loss Ratio Data (§§ 422.2460)

Reinstatement of Detailed Reporting. The FAH supports the proposal to reinstate detailed reporting of compliance with the medical-loss ratio (MLR) standard by MAOs. We appreciate CMS’ “further consideration of the potential impacts on beneficiaries and costs to the government and taxpayers when CMS has limited access to detailed MLR data” and recognition of “the limitations of [its] current approach to MLR compliance oversight.”⁷ The FAH shares CMS’ concern regarding the increase in the average amount of annual remittances reported by MAOs and Part D sponsors and the increase in the number of contracts that failed to meet the MLR requirement in the years after the reporting requirement was relaxed.⁸ We also concur in CMS’ assessment of the logistical challenges posed by an oversight approach that is driven primarily by audits. The reinstatement of detailed reporting requirements will “improve transparency and oversight concerning the use of Trust Fund dollars.”⁹

Correction of Prior MLR Reports or Submissions. With regard to the proposed technical changes to 42 C.F.R. § 422.4260 and the proposed addition of paragraph (e), we support the proposal to expressly allow MAOs to correct prior MLR reports or data submissions. Consistent with the discussion in CMS’ 2013 MLR rulemaking, we appreciate that this proposed avenue for making corrections would not operate to allow an MAO to avoid remittances in the event that the MAO’s revenue from CMS is adjusted downward, for example as a result of a risk-adjustment data validation (RADV) or other audit.¹⁰ Subsequent revenue adjustments are not generally useful in “assessing how a plan chooses to allocate its available revenues,”¹¹ and it would be inappropriate to give revenue adjustments retroactive effect under proposed subsection (e). On the other hand, the same is not true when assessing the claims data used in the numerator of the MLR. The MLR calculation takes into account certain unpaid claims and incurred but not reported claims,¹² and the FAH is concerned that MAOs currently include claims that are ultimately denied in whole or in part. MAOs should not benefit from claims data for claims that are not ultimately paid by the MAO and thus did not provide value to enrollees, and where subsequently denied claims impact the calculation, the MAO should correct its MLR using the mechanism described in paragraph (e) of 42 C.F.R. § 422.2460, as proposed.

Additional Transparency and Oversight Opportunities—Risk Adjustment Data. We share CMS’ view that the widespread availability of data allows members of the public to develop valuable insights into the operation of the MA program. As discussed in the context of MLR reporting requirements, releasing data “promote[s] accountability in the MA and Part D

⁷ 87 Fed. Reg. at 1903.

⁸ 87 Fed. Reg. at 1903-1904.

⁹ 87 Fed. Reg. at 1845.

¹⁰ 87 Fed. Reg. at 1909.

¹¹ 87 Fed. Reg. at 1909.

¹² 42 C.F.R. § 422.2420(b)(2)(iii), (v).

programs... by allowing the public to see whether and how privately-operated MA and Part D plans administer Medicare – and supplemental – benefits in an effective and efficient manner.”¹³

For the same reasons, we urge CMS to require public reporting of the data that MAOs submit for the Part C Risk Adjustment Program. These data determine CMS’ payments to MAOs and have far-reaching implications for Medicare’s program integrity and the public fisc. Public scrutiny of this data is particularly appropriate given recent concerns raised by the Office of the Inspector General (OIG) in a series of reports. Specifically, the reports show that some MAOs use chart reviews and health risk assessments (HRAs) to add diagnoses to their risk adjustment data submissions that do not appear elsewhere in a beneficiary’s encounter data, thus inflating these risk-adjusted payments from CMS.¹⁴ Wider access to risk adjustment data would promote accountability and discourage problematic practices like those highlighted in the OIG’s reports.

The FAH also 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 actual expenditures made by MAOs 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.”¹⁵ At present, we understand that MAOs include MA encounter data from unpaid, denied and underpaid claims. Such claims do not reflect costs incurred by the MAO for health care services rendered by providers to beneficiaries but actually reflect uncompensated care costs incurred by providers. This is particularly true because we understand MAOs deny claims at significantly higher rates than commercial insurance carriers and self-funded group health plans. Limiting the MA risk adjustment data in this way would not place an undue burden on MAOs because the current timelines for submission of these data allow 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.

RFIs Regarding Prior Authorization and Behavioral Health Specialties Within MA Networks

The FAH appreciates CMS’ RFIs regarding how MA plans responded to the PHE by limiting prior authorization and how MA plans can build more appropriate behavioral health services in their networks and we urge CMS to consider our recommendations discussed below and in the attached letter.

¹³ 87 Fed. Reg. 1906.

¹⁴ OIG Report, “Some Medicare Advantage Companies Leveraged Chart Review and Health Risk Assessments To Disproportionately Drive Payments,” September 2021, OEI-03-17-00474; OIG Report, “Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns,” December 2019, OEI-03-17-00470; OIG Report, “Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns,” September 2020, OEI-03-17-00471.

¹⁵ 42 U.S.C. § 1395x-23(a)(3)(A) (emphasis added).

In addition, the FAH continues to be concerned more broadly about ongoing and worsening activities of MA plans that are using prior authorization; inadequate medical, hospital, and behavioral health provider networks; extended observation care; retroactive reclassification of patient status (i.e., inpatient versus observation); and pre- and post-payment denial policies to inappropriately limit Medicare beneficiary access to needed hospital, post-acute, and behavioral health care services and improperly delay or withhold payment for medically necessary care. While not new, these MAO tactics have been especially problematic over the past 15 months as hospitals have focused on responding to the COVID-19 PHE.

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 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. While CMS agreed with the OIG findings and needed changes, these practices have continued and worsened. The FAH urges CMS to exercise its discretion to follow up on the OIG recommendations.

Specific to MAO prior authorization policies, our members routinely report delays and inconsistencies with notification and authorization processes for both emergency and elective admissions, as well as for discharge to post-acute care services. 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;
- Use of clinical and physician reviewers who do not have clinical experience or training in the areas that require prior authorization (for example, expertise in physical rehabilitation for requests for inpatient rehabilitation care);
- 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 – even with CMS’ guidance to plans to limit prior authorization during the COVID-19 PHE;
- Limiting peer-to-peer reviews with unnecessary barriers, e.g., permit only the attending physician to discuss the provider authorization request with the MA plan, despite the attending physician’s lack of availability due to other patient care responsibilities; this practice is particularly problematic as MA plans often provide a limited time period, such as a few hours) to have the peer-to-peer discussion.

When plans deny prior authorization requests, providers often struggle to understand the rationale for the denial (e.g., based on what guidelines). 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 believe they have successfully made it through the authorization process and receive an approval, increasingly 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, as a practical matter, hospitals may not be able to continually engage with the MA plan following an arbitrary denial in light of the time and excessive resource commitment required.

On September 1, 2021, the FAH sent a letter to CMS outlining many of our concerns and recommendations for addressing the OIG's concerns, prior authorization, and other abusive plan behaviors that can harm patient access to care. A copy of the letter is attached and we urge CMS to use the input from the letter and the RFIs to develop proposals that can address these MA challenges and improve beneficiary access to quality care, consistent with section 10.16 of Chapter 4 of the Medicare Managed Care Manual.

Part III.A. RFI Regarding Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a PHE

The FAH welcomes the opportunity to share information specifically regarding prior authorization requirements for hospital transfers to post-acute settings and appreciates CMS' attention to the unique challenges hospitals face in the context of COVID-19 or another PHE. We were pleased that CMS' August 20, 2021, memorandum "strongly encouraged" MAOs 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."¹⁶ The relaxation of prior authorization requirements for patient transfer by MAOs can be an important strategy for addressing acute-care capacity limitations for all patients and ensuring that MAO enrollees' post-acute care is not unnecessarily delayed due to utilization management barriers.

When a patient is ready for transfer from an acute-care setting to a post-acute environment, the most appropriate course is the prompt and safe transfer of the patient so that s/he may begin to receive post-acute care (e.g., rehabilitation) in the most suitable environment. This process, however, may be slowed by MAO network constraints that limit the options of in-network post-acute providers available to accept transfers of enrollees from acute-care hospitals as well as utilization review activities, from prior authorization requirements that delay transfers to concurrent and retrospective reviews that create payment risk for post-acute providers accepting transfers.

¹⁶ Memo re: "COVID-19 Flexibilities Reminder," CMS, August 20, 2021, available at <https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpms-hpms-memos-archive/hpms-memos-wk-3-august-16-20>.

Utilization review activities, in addition to being inherently burdensome for providers, may be particularly problematic in the context of post-acute care because MAO reviewers often lack the post-acute training and qualifications to properly assess the medical necessity of inpatient rehabilitation and other post-acute care. As a result, post-acute providers are burdened with inappropriate denials and appeals that delay patient access to needed rehabilitation services in the most medically appropriate setting. With respect to retrospective reviews and denials, many MAOs undertake these reviews even where the MAO has *already authorized* the care.

These practices are burdensome for providers and create inappropriate payment risk in cases where the plan has already decided to authorize the care as medically necessary and appropriate, and the FAH continues its long-standing advocacy for rules that ensure the prior authorization of care by an MAO is given binding effect, except in the rare case of fraud. In a PHE, the risks of retrospective claim reviews along with network constraints and utilization reviews have an even more acute impact, delaying post-acute care for individual enrollees while also magnifying capacity issues for acute-care hospitals. Moreover, most MAOs have little incentive to target inefficiencies and delays in post-acute transfers during or outside of a PHE because they largely pay hospitals on a per-case basis such that additional acute care days increase care costs for the hospital while reducing MAO costs in the form of per-diem post-acute facility payments.

Over the course of the COVID-19 PHE, FAH members reported that many MAOs responded to the August 2021 memorandum and earlier guidance with announcements that they would temporarily waive or relax their prior authorization requirements and utilization management processes. Although MAOs' use of this flexibility did make a meaningful difference at some times and for some providers, various factors limited their effectiveness in streamlining hospital transfers to post-acute care settings for multiple reasons. For instance:

- ***Inconsistent Waivers.*** Because the waiver or relaxation of prior authorization and utilization management processes were voluntary and 42 C.F.R. § 422.100(m)(1) does not mandate such waiver or relaxation during a PHE, MAO decisions were highly varied. Moreover, some MAOs waived prior authorization requirements for transfers to some types of post-acute care providers, but not others, making the waiver wholly inapplicable to certain types of post-acute transfers and creating confusion among providers.
- ***Information Dissemination.*** Some MAOs failed to communicate the existence of these waivers to all impacted providers, which significantly limited the effectiveness of the waiver.
- ***Failure to Defer to Hospitals on Capacity Issues.*** Some MAOs limited their waiver or relaxation of prior authorization and utilization management processes to situations where a hospital had an urgent or emergent capacity issue, but failed to defer to the hospital's determination as to the presence of these conditions. As a result, hospitals and post-acute providers at times believed that an MAO's prior authorization requirements were waived based on current conditions in the acute care hospital, only to learn that the MAO disagreed and would deny payment for failure to obtain prior authorization.

- ***Continuation of Other Utilization Review Activities.*** Some MAOs that waived prior authorization requirements for post-acute care nonetheless undertook concurrent or post-utilization reviews of these services. As noted above, these processes result in inappropriate denials and appeals, particularly due to limited MAO reviewer experience with respect to post-acute care. As a result, post-acute care providers have been denied payment for medically necessary services throughout the PHE, even though those services were provided in reliance on the existence of a waiver of prior authorization requirements. Moreover, the risk of retrospective reviews and denials can itself slow transfers to post-acute facilities from acute care hospitals as post-acute providers have long dealt with payment denials after receiving admission approvals.
- ***Failures to Address the Consequences of Delayed Patient Transfers.*** During the COVID-19 PHE, hospitals have seen delays in patient transfers – even with prior authorization waivers. The relaxation of utilization review activities during the PHE should include that plans not review additional acute-care days provided to patients whose transfers to post-acute facilities are delayed for pandemic-related reasons – either delayed response to prior authorization requests or for other PHE reasons such as testing requirements. In many cases, MAOs continue to review patients’ acute care length of stay and deny payment for additional days. For example, many post-acute providers required multiple negative COVID-19 tests before accepting transfer of a patient from the acute care hospital, resulting in additional acute care days pending test results. In other cases, MA plans were even more delayed in responding to authorization requests (presumably due to work from home challenges of review staff). These delays are no fault of the acute care hospital, and it is inappropriate for MAOs and other payers to shift the financial burden of caring for patients impacted by these delays to acute-care hospitals. (And even more egregiously, in some cases the delay led to the denial of the entire inpatient hospital stay.) MAOs should be working with in-network and out-of-network acute and post-acute facilities to streamline transfers while covering the hospital costs that result from delays in transfer.

In short, while we appreciate CMS’ efforts to encourage MAOs to exercise flexibility during the PHE by waiving or relaxing prior authorization requirements and utilization management processes, more concrete measures should be taken to consistently address the impact of MAO utilization review activities and to facilitate the efficient and prompt transfer of patients from acute-care hospitals to appropriate post-acute facilities. Specifically, CMS should amend 42 C.F.R. § 422.100(m)(1) to *require* waiver of prior authorization and other utilization review activities during PHEs that disrupt access to care so that such waivers are applied consistently by MAOs. As discussed above with respect to Part II.B. of the Proposed Rule, the determination of whether a PHE disrupts access to care should not be made by the MAO; rather, certain emergencies should be deemed to disrupt access to care, and others should be presumed to have such a disruptive effect absent a CMS determination to the contrary. In addition, MAOs should be prohibited from mitigating the impact of the waiver of prior authorization requirements by employing concurrent and post-utilization review activities so that hospitals and post-acute providers can be reasonably assured that they will receive appropriate payment for services provided in good faith to MAO enrollees during a public health emergency.

The FAH also urges CMS to take steps to ensure that MAOs' utilization management processes are transparent, timely and reliable, and that they are not used to deny payments to which providers are entitled, whether during a PHE or otherwise. If an MAO provides prior authorization for a service, or waives the requirement altogether, a provider that has provided those services in reliance on that authorization or waiver should not be denied payment. Therefore, the FAH urges CMS to clarify that, absent fraud, a provider should be guaranteed payment for services that are authorized by an MAO.

When prior authorization is used by an MAO, CMS should require the use of appropriate clinical and medical personnel who are experienced with the care or procedure in question. For example, when a level-of-care determination is being made for a patient's transfer to a post-acute care setting, it should be carried out by qualified clinical and medical personnel who are trained and experienced in the level of care involved – an OBGYN physician with no experience in medical rehabilitation should not determine whether a patient can be admitted to an IRF.

Moreover, MA plans should be required to use coverage criteria that are consistent with those established under the fee-for-service program; proprietary coverage guidelines should be prohibited. Finally, CMS should require shorter, more clinically appropriate decision response time requirements for patients who need to be transferred to a post-acute care setting and collect relevant data on MAOs' performance as part of a plan to enforce such timelines.

We have attached a set of case examples highlighting the inappropriate use of prior authorization during the pandemic (and even in times of normal operation) to help provide context on the harmful effects of prior authorization policies on patients and hospitals.

Part III.B. RFI Regarding Building Behavioral Health Specialties Within MA Networks

The FAH appreciates CMS's attention to issues relating to MAO enrollee access to behavioral health care providers and services. The COVID-19 PHE has produced a secondary behavioral health care emergency for many Medicare beneficiaries and others, drawing attention to long-standing network deficiencies and other issues that impede enrollee access to timely and sufficient behavioral health care services. Nonetheless, the behavioral health sector remains widely misunderstood, even by the MAOs that are charged with providing their members with access to these services. We welcome the opportunity to provide CMS with information on the challenges that behavioral health care providers face with MA plans and the follow-on impacts these issues have on enrollee access to care.

Inadequate Network Adequacy for Behavioral Health Services: The FAH is concerned that network adequacy standards do not adequately address enrollee behavioral health care needs and that MAO practices limit the range of behavioral health care providers that are willing to enter or continue network agreements, creating an artificial and MAO-induced shortage of in-network behavioral health care providers. With respect to network adequacy, the standards at 42 C.F.R. § 422.116 do not adequately address behavioral health care network adequacy. These standards impose time and distance standards for inpatient psychiatric facility (IPF) services, but do not establish a minimum ratio of inpatient psychiatric beds to enrollees or establish access standards for other behavioral health care services like partial hospitalization

programs or opioid treatment providers. On the professional side, a smaller fraction of psychiatrists participate in local MA plans' networks than any other specialty: in 2015, MA plans included, on average, just 23% of psychiatrists in a county.¹⁷ Ultimately, many MA enrollees go out-of-network for psychiatric and behavioral health care. For example, in 2014, nearly 30% of all psychotherapy services received by MA enrollees were obtained from out-of-network providers.¹⁸ CMS' standards do not address network adequacy for other behavioral health professionals at all, even though behavioral health is offered along a continuum of care, and successful patient outcomes depend heavily on the full range of behavioral health care services, including partial hospitalization program services, outpatient treatment programs, and other community-based providers. Our members are concerned that MA plans often maintain an inadequate network of community-based behavioral health care providers.

MAOs are statutorily required to ensure that covered benefits—including behavioral health care benefits—are “available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits.”¹⁹ But, in the absence of effective oversight of access to behavioral health care services, MAOs often fail to meet this statutory obligation with respect to behavioral health care, leaving MAO enrollees without prompt access to needed care. And even when MAO enrollees have access to IPF services, deficiencies in the MAO's network of community-based providers that are available to provide services to a patient upon discharge from an IPF create delays and risks for patients in need of post-discharge care and impose unnecessary burdens and costs on IPFs. As discussed above in the context of transfers to post-acute care settings, it is critical for patients to receive the appropriate level of care at the time it is medically necessary, and the same is true in the behavioral health context. The FAH therefore strongly urges CMS to propose amendments to its network adequacy rules and processes to ensure that MAO enrollees actually receive the behavioral health benefits to which they are entitled from appropriate and accessible facilities and clinicians.

MA Utilization Practices Often Disincentivize Network Participation: With respect to concerns that the supply of behavioral health providers willing to contract with MAOs is inadequate, the FAH understands that these supply issues are substantially driven by payer activities and abuses that disproportionately impact behavioral health providers and we believe that strengthened behavioral health network adequacy requirements and oversight would help ensure that MAOs are appropriately incentivized to address payment, utilization review, peer-to-peer review, and other issues that impede contracting for behavioral health services. For example, members report that MAO utilization review activities (including prior authorization, concurrent review, or retrospective review) are often conducted by individuals or contractors who lack specific training or credentials in behavioral health care specialties. Likewise, MAO

¹⁷ Kaiser Family Foundation, “Medicare Advantage: How Robust Are Plans' Physician Networks?” October 5, 2017. Available at <https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/>.

¹⁸ Daria Pelech and Tamara Hayford, “[Medicare Advantage and Commercial Prices for Mental Health Services](#),” *Health Affairs*, February 2019. Available at <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05226>.

¹⁹ Social Security Act § 1852(d)(1)(A), 42 U.S.C. § 1395w-22(d)(1)(A).

medical directors and other reviewers often are not behavioral health care providers, diminishing the effectiveness of MAO peer-to-peer review processes. This is wholly inappropriate, results in improper denials and burdensome appeals, and reflects a failure to recognize the ways in which behavioral health care is different from other health care services in meaningful ways. The FAH therefore urges CMS to exercise MAO oversight to ensure that MAOs' utilization review guidelines are based on "reasonable medical evidence or a consensus of health care professionals in the particular field"—in this case, behavioral health professionals—and "consider the needs of the enrolled population."²⁰

Inadequate Payment for Behavioral Health Services: In the absence of robust and effective oversight of the adequacy of MAOs' behavioral health care provider networks, MAOs systematically undervalue behavioral health care services, depressing payment terms for behavioral health care providers and creating network gaps which limits behavioral health providers available to beneficiaries. The inadequacy of MAO rates is compounded by the failure of many MAOs to pass through bad debt payments to behavioral health providers, and the FAH urges CMS to appropriately address the non-payment of MAO enrollee cost-sharing, by removing bad debt payments from MAO capitation payments and instead permitting providers to claim MA bad debt on their cost reports in the same manner they use to obtain payment for bad debt under Original Medicare. The payment risks for behavioral health providers furnishing services to MAO enrollees are also driven by MAO practices that result in excessive denials and underpayments. When MAOs fail to follow Medicare coverage guidance, misinterpret level of care and/or medical necessity criteria, and fail to provide accurate or timely claims payments, in-network behavioral health providers are forced to take on the burden of claims appeals or accept inadequate payment. Moreover, where MAO network gaps and/or utilization review activities delay discharge from an IPF to a community behavioral health provider, the IPF incurs the costs of additional days of inpatient care and the risk that the MAO will deny payment for these additional inpatient days on the basis of medical necessity—even when the additional inpatient days are attributable to the MAO's own conduct. This is an incongruous result that harms patient care and financially penalizes providers without cost to the MAO, and we urge CMS to require MAOs to pay IPFs for care provided when there is a delay in the availability of community-based care.²¹

Inappropriate Access to Opioid Addiction and Substance Abuse Treatment: FAH members have reported significant and inappropriate denials of behavioral health and substance use disorder treatment services to MA enrollees suffering opioid addiction and other substance use disorder. Despite CMS's recognition of the opioid crisis as a PHE since October 26, 2017 and Medicare coverage for opioid treatment programs, FAH members report that some MAOs routinely deny *all* behavioral health services related to opioid use disorders. This represents a crude cost-containment measure that leads to delays in necessary care and is particularly

²⁰ 42 C.F.R. § 422.202(b).

²¹ We also note that our request to CMS regarding bad debt from non-payment of cost-sharing by dual-eligible beneficiaries has particular resonance in the behavioral health context. Because IPFs serve a large number of dual-eligible patients, the application of the "lesser-of rule," discussed above in response to part II.A.5.b of the Proposed Rule, has a disproportionate financial effect on these providers.

disconcerting in the context of an ongoing PHE. We urge CMS to increase oversight with respect to MAOs' provisions of benefits to enrollees suffering from opioid dependency and other substance use disorders, both when these enrollees seek opioid treatment and when they seek other behavioral health care services.

The FAH appreciates the opportunity to provide comments on the Proposed Rule and 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 M. LaSure". The signature is fluid and cursive, with a prominent flourish at the end.

Attachments:

Attachment A: September 1, 2021 FAH letter to Administrator Brooks-LaSure

Attachment B: Case Examples of Prior Authorization Challenges During the PHE



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.

Attachment B:

Case Examples of Prior Authorization Challenges During the PHE

Federation of American Hospitals

March 2022

Example: Delayed Auth from MAO for patient transfer to Post-Acute Care Facility

Case Scenario: 60-year-old patient presented to the ED for Cardiac Arrest. EMS arrived shortly thereafter and reported finding the patient apneic and asystolic. He was brought to the ED while receiving chest compressions and bag ventilations. Patient was in the hospital for 18 days and discharged in October 2021.

Issue Details: Patient was ready to be discharged by the 15th day to a post acute care facility and case management had already made arrangements to have the patient transferred. However, the transfer was delayed for 3 days due to pending authorization from MAO. Note from SW states “they will not get auth until Monday”.

Prior authorization requirements continued after CMS guidance and lack of response required patient to stay in the hospital unnecessarily.

Discharge – October 2021

Example: Delayed Auth from MAO for patient transfer to Post-Acute Care Facility

Background: Inconsistencies in the provision for relaxing Prior Authorization requirements for patient transfer by MAOs

Case Scenario: 42-year-old patient presented to the ED for bilateral plantar ulcers, with the chief complaints of worsening severe radiating pain in the left foot (to the knee) associated with swelling, drainage and malodor. MRI showed plantar myositis and suspected osteomyelitis of the right third toe and plantar cellulitis and midfoot osteomyelitis of the left foot. Patient was in the hospital for 10 days and discharged in October 2021.

Issue Details: Patient was ready to be discharged on the 7th day to a post acute care facility and CM had already made arrangements to have the patient transferred. However, the transfer was delayed for 3 days due to pending authorization from MAO. Prior authorization requirements were required despite challenging COVID environment.

Discharge – October 2021

Example: Denial for Transfer and Delay in Placement

Case Scenario: 60-year-old homeless Medicare patient was brought to the ED with 2-day history of left arm swelling and pain. Upper extremity ultrasound showed extensive DVT. X-ray showed cardiomegaly with bilateral pleural effusion. Patient was in the hospital for 23 days and discharged in January 2022.

Issue Details: Auth was approved for the first 6 hospital stay days and denied for the remaining days. Initially MAO agreed to place the patient to SNF, however failed to provide the required referral, until the 14th day. MAO subsequently denied to transfer the patient to SNF. Case management (CM) continued to attempt to obtain the auth for transfer via fax and voicemail, thereby extending the IP care to be given to the patient for 14 additional days. On 20th day, CM notes stated the MAO plan was closed over the weekend. Patient left against medical advice (AMA) on 23rd day.

Ultimately, MAO partially approved the IP stay for a 6-day covered stay and denied the remaining hospital days, along with denying SNF placement. Case managers and social workers continued to try to obtain the authorization for transfer, but delay led patient to ultimately leave hospital AMA.

Discharge: January 2022

Example: Denial for Placement in SNF

Case Scenario: 71-year-old patient with a history of stroke, wheelchair bound and admitted to the hospital for weakness, headache and dizziness. Patient also had severe protein calorie malnutrition on admission.

Issue details: Hospital tried to place the patient to a SNF from day 2 of admission. Physician had clearly documented that the patient need for post-acute care. However, MAO gave no response on the request for 6 days, despite multiple follow-up attempts. On 7th day, MAO denied the authorization to transfer to post-acute care facility. Hospital performed Peer-to-peer review twice with the payor, and health plan continued to deny auth. Case management (CM) continued to attempt to obtain the auth via phone, thereby extending the IP care to be given to the patient for 11 additional days.

Patient stayed in the hospital setting longer than needed, taking acute care bed longer than necessary.

Discharge – November 2021