



Charles N. Kahn III
President and CEO

May 19, 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

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.

We are writing to express our strong support for the Centers for Medicare & Medicaid Services (“CMS”) taking steps to protect beneficiaries and address program abuses by Medicare Advantage organizations (“MAOs”). We appreciate CMS’ concurrence with the recommendations made by the Office of the Inspector General (“OIG”) in its recent report, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (hereinafter, “OIG Report”).¹ MAOs systemically apply problematic operating policies, procedures and protocols in addition to the problematic MAO practices identified in the OIG Report. We therefore urge CMS to exercise its broad oversight authority over MAOs to ensure beneficiaries maintain adequate access to their entitled benefits in the medically appropriate healthcare service setting.

¹ Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General (“OIG”), OEI-09-18-00260, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>

As part of CMS' efforts to provide guidance to MAOs regarding the appropriate use of MAO clinical criteria for medical necessity reviews, the FAH urges CMS to clarify that MAOs, their downstream risk providers and their contracted hospitalists must provide their beneficiaries with inpatient coverage and providers with inpatient reimbursement: (1) when appropriate under Medicare's Two-Midnight Rule, and (2) when beneficiaries undergo procedures on the inpatient-only (IPO) list. These two Medicare fee-for-service clinical standards should be applied consistently to all Medicare Advantage (MA) beneficiaries since the MA program and the Medicare fee-for-service program serve the same demographic population and each of these beneficiaries are entitled to the same benefits as required by 42 C.F.R. § 422.100. In addition, the FAH urges CMS to address MAO practices that particularly burden beneficiary access to specific types of care or facility types (especially inpatient rehabilitation facilities ("IRFs") and long term care hospitals ("LTCHs")) because, as the OIG notes, MAOs may have an incentive to deny such care over cost concerns) by: (1) issuing new guidance to ensure MAOs do not disproportionately burden beneficiary access to particular provider types or care through the use of more restrictive clinical criteria or requests for unnecessary documentation, and (2) undertaking targeted audits focusing on IRF and other specific service types that have a history of inappropriate denials. Finally, the FAH urges CMS to examine and address MAO abuses more broadly to promote MA beneficiary access to timely and appropriate care.

I. Inappropriate MAO Utilization Controls Limit and Delay Beneficiary Access to Care

The OIG Report identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA beneficiaries. Specifically:

- *Improper prior authorization denials.* The OIG found that thirteen percent (13%) of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that eighteen percent (18%) of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, and deploy inappropriate pre- and post-payment denial policies, and even denying claims for previously approved services. These activities are often carried out by way of MAOs'

downstream at-risk physicians and contracted hospitalists. All of these activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.²

Many of these harmful practices arise from MAOs' adoption of inappropriate clinical criteria, and the FAH urges CMS to protect beneficiaries by ensuring MAOs adhere to critical Medicare coverage rules. For example, instead of consistently and transparently applying CMS' Two-Midnight Rule, many MAOs use a variety of standards (including unique standards they develop and promulgate on their own) to determine whether a particular hospital stay meets their criteria for an inpatient admission. MAOs deny authorizations for inpatient admissions ordered by physicians and reclassify them as outpatient observation stays with troubling frequency, often using non-transparent, remote means of assessing medical necessity and overriding the treating medical professional's clinical decision. In addition, our members report that MAOs create financial incentives for contracted physicians to change the admission status before discharge and reduce the MAO's payment obligation to hospitals for services and care. Furthermore, members have reported MAO denials of inpatient coverage for procedures included on the Medicare IPO list, which is the single definitive source of guidance as to which procedures must be performed, for patient safety reasons, in an inpatient setting to be covered by Medicare. These practices are not appropriate utilization review activities; instead, they dilute the benefits provided to MA beneficiaries and undermine the benchmarking process used to fund MA coverage and ensure actuarial equivalence. ***The FAH, therefore, continues to recommend that CMS require MAOs and their contracted physicians—including their employed group physicians, downstream at-risk physicians and their hospitalists—follow the Two-Midnight Rule in determining patient status and the medical necessity of an inpatient admission and provide inpatient coverage and payment for each procedure on Medicare's IPO list.*** The consistent application of these requirements across the Medicare program would promote transparency in and fiscal oversight of the MA program.

MAO clinical criteria and review practices may particularly burden beneficiary access to specific types of care, and the FAH supports the OIG's recommendation that CMS undertake targeted audits of particular service types that have a history of inappropriate denials. For example, some MAO plans use proprietary, non-CMS-endorsed standards to determine coverage for IRF services. These standards may direct beneficiaries to less intensive care settings, delaying or denying MA beneficiary access to the intensive, comprehensive, IRF-level care indicated by their condition and reducing access to their entitled benefits. The use of these proprietary standards creates confusion and administrative challenges for beneficiaries and providers and results in an inappropriate misalignment between the treatment of Medicare beneficiaries under the fee-for-service program and those in an MA plan. The OIG's report identified a number of cases in which the MAO improperly denied a request for prior authorization of IRF services. ***The FAH therefore urges CMS to (1) issue new guidance to ensure MAOs do not use more restrictive clinical criteria or request unnecessary documentation, and (2) undertake targeted audits focusing on IRF and other specific service types that have a history of inappropriate denials.***

² For further detail, see Federation of American Hospitals, "Re: Needed Improvements to Medicare Advantage Organization Practices," September 1, 2021 (the "September 1 Letter"), attached hereto.

In order to protect MA beneficiaries, the FAH urges CMS to exercise its broad MAO oversight authority and ensure beneficiary access to their entitled benefits by addressing MAO authorization and payment denials of care that meets Medicare coverage rules. As the OIG observed:

Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Further, beneficiaries enrolled in Medicare Advantage may not be aware that there may be greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.³

The FAH appreciates CMS' concurrence with the OIG's recommendations, including the recommendations to issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews and to update CMS' audit protocols to address the issues identified by the OIG.

II. CMS Should Take Steps to Address Broader MAO Abuses and Protect Beneficiaries

In addition to addressing the OIG findings concerning MAOs' inappropriate prior authorization denials, denials for lack of documentation, and payment denials, the FAH urges CMS to exercise its broad oversight authority to curtail a number of other MAO abuses. By way of example, the FAH previously identified in its September 1 Letter the following MAO activities that inappropriately burden providers and may adversely impact beneficiaries:

- **Network Adequacy:** MA beneficiary access to services and care is often more limited than it would appear in an MAO's Health Service Delivery ("HSD") submission or provider directory that a beneficiary reviewed and relied upon during their open enrollment decision making process to choose an MAO. MAOs often use downstream organizations which direct care to a far narrower provider network, rendering network access to certain providers illusory. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups and their sub-capitation arrangements create a financial incentive to direct care to a particular provider or group, creating a *de facto* provider network at the downstream organization level that is far more limited than the MAO's advertised network. The FAH continues to recommend CMS take action to foster MAO network transparency to protect MA beneficiary's access to care by implementing audit protocols to identify and review the adequacy of downstream organizations' provider networks and taking appropriate network enforcement actions for noncompliance with network adequacy standards. In addition, the FAH urges CMS to incorporate network adequacy in the Star Ratings Program.

³ OIG Letter at 20 (emphasis added).

- Access to Post-Acute Care:** MA beneficiaries routinely experience inappropriate delays in discharge from the inpatient hospital setting due to MAOs': (1) lack of an adequate post-acute network, (2) lack of post-acute providers in MAOs' networks willing to accept beneficiary discharges, and (3) MAOs' utilization review activities, which include prior authorization to the post-acute setting. When a patient is ready for transfer from an acute-care setting to a post-acute environment (including LTCHs, IRFs, and skilled nursing facilities ("SNFs")), the most appropriate course is the prompt and safe transfer of the beneficiary so s/he may begin to receive post-acute care (e.g., rehabilitation) in the most suitable environment. MAOs, however, often are financially incentivized to prolong beneficiaries' hospital stays (often paid at a case rate such as the MS-DRG system) rather than incurring the additional cost of post-acute provider stays, and may delay discharges based on the lack of available or willing post-acute providers or utilization review activities. In addition, MAO's post-acute networks often do not include an adequate number of post-acute facilities to ensure that the appropriate facility is available and post-acute care is not delayed or disrupted. The FAH recommends CMS require MAOs to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in MA beneficiary inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities. In addition, CMS should audit MAO practices associated with approving timely discharges to an appropriate post-acute setting. In contrast to FAH member experiences with MAOs, FAH members generally do not routinely experience these post-acute care issues in the Medicare fee-for-service beneficiary population.
- Risk Adjustment Claim Encounter Submissions:** The FAH understands MAOs currently include MA encounter data from denied (in part or in full), pended, and underpaid claims in their risk adjustment data submissions to CMS, resulting in increased risk adjustment payments that do not reflect the costs incurred by the MAO. This behavior is inconsistent with the purposes of the Part C Risk Adjustment Program and inflates Medicare spending without any corresponding beneficiary benefit. The FAH urges CMS to limit MA encounter data for the Risk Adjustment Program to data derived from fully paid claims or, in the case of a provider that accepts capitation, provider encounter data.
- Use of Third-Party Contractors to Perform Audits:** MAOs often hire private contractors on a contingency fee basis to conduct a variety of audits on a pre-payment or post-payment claims basis. These audit types include: (1) charge audits, where the contractors inappropriately remove Medicare covered charges from claims; (2) MS-DRG audits, where the contractors use proprietary software to downgrade the underlying diagnoses necessary to support a DRG by inappropriately removing or rebundling billed ICD-10 codes; and (3) medical record audits, where the contractors question the accuracy of physician documentation regarding the beneficiary's health and associated comorbidities that support the underlying diagnosis and medical necessity. These audits are undertaken without any clinical basis and regularly fail to include an adequate explanation for the contractor's conclusions. Through this process, remote third-party contractors overrule the professional opinion of the treating professionals, despite often lacking the relevant clinical training or expertise. MAOs' delegation to these contractors

frequently creates confusion due to poor communication between MAOs and their contractors. These issues are exacerbated due to convoluted appeal processes, as discussed below. While the FAH acknowledges that MAOs are obligated to conduct reasonable audits, we are concerned that contingency fee audits conducted by MAOs' contractors are improperly motivated by financial incentives, fueling a "bounty hunter" mentality, and inappropriately burdening providers caring for MA beneficiaries. 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.

- **Appeal Rights:** MA providers' appeal rights are typically governed by their agreements with MAOs. The MAOs' appeals processes are complex, cumbersome, not standard across plans, often not automated, and require significant administrative resources and staffing for health care providers.
- **Improving Transparency and Quality Incentives for MA Stars Ratings Program:** In addition to our recommendations on policy improvements to protect patients in MA, we urge CMS to consider further refinements to its MAO oversight by developing new quality metrics for MAO operations that could be included in the Star Ratings Program. New quality measures should be developed to rate and report on patient access problems related to appeals and denial overturn rates for prior authorization, appeals and overturn rates for payment denials, network adequacy, and service delays. The FAH is currently developing a new MA quality measure concept on Level 1 Appeals to highlight overturn rates for health plans. This measure would supplement the current measure evaluating Level 2 Appeals. We believe such measures would promote competition on these critical access-oriented dimensions of MA plan quality, rewarding and incentivizing better MAO behavior and providing Medicare beneficiaries with critical information on the potential for excessive plan denials for service. We hope to share more on this work with you and your staff soon.

CMS has the statutory authority to address these and other abusive MAO practices as part of its broad oversight authority over MAOs. And, as explained further in the next section, such oversight would not implicate the non-interference clause contained in section 1854(a)(6)(B)(iii) of the Social Security Act or compromise its goals.

III. The Non-Interference Clause Should Be Construed Narrowly

The Social Security Act provides CMS wide latitude to address MAO behavior, and the non-interference prohibitions expressly enumerated in the statute would *not* preclude CMS from taking action regarding MAOs' inappropriate use of clinical criteria to deny or alter care delivery settings, improper actions limiting provider networks, or other abusive measures that inappropriately limit beneficiary access to care and burden providers.

The non-interference clause contains two discrete, narrowly-drawn prohibitions. First, CMS cannot mandate an MAO contract with a specific provider. Second, CMS cannot mandate that an MAO implement a particular price structure within a provider contract. The text of the non-interference clause reads as follows:

In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not [1] require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or [2] require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.⁴

Beyond these two express prohibitions, CMS retains its broad regulatory authority – and responsibility – to ensure beneficiaries receive the Medicare benefits to which they are entitled.

The plain text of the non-interference clause has not been expanded by regulation or judicial precedent. To date, we have only identified limited CMS discussion of section 1854(a)(6)(B)(iii) in the context of mandated payment model adjustments for MAOs, which would plainly violate the statute's directive that CMS not “require a particular price structure for payment under” a provider agreement.⁵ Along similar lines, CMS recently concluded that a commenter's suggestion that CMS require “payment by the MA organization of certain amounts to a contracted provider” is “within the scope of” actions precluded by the non-interference clause.⁶

The larger context of the MA statutory scheme and legislative history confirm the non-interference clause is a narrowly tailored, targeted provision designed to foster competition rather than to place MAO conduct beyond CMS' regulatory reach. Ever since the Medicare and Medicaid programs were enacted in 1965, CMS has been charged with providing a broad swath of Americans with access to essential quality and affordable health care. The MA program incorporates private, CMS-contracted plans in the Medicare program with the objective of expanding beneficiary choice while leveraging plan competition to improve quality and reduce program costs. The MA non-interference clause and the Part D non-interference clause, are designed to preserve that competition by preventing CMS from setting MA rates or mandating contracting with any particular provider.⁷ The legislative history reflects a particular desire to preserve price-based competition among MA plans by prohibiting CMS from setting rates.⁸

⁴ Social Security Act § 1854(a)(6)(B)(iii).

⁵ See CMS, “Report to Congress: Alternative Payment Models & Medicare Advantage” (July 16, 2019), <https://www.cms.gov/medicare/medicare-advantage/plan-payment/downloads/report-to-congress-apms-and-medicare-advantage.pdf>; See also Centers for Medicare & Medicaid Services (CMS), “Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs” (May 1, 2013), <https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/PaymentReductions.pdf>

⁶ Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards, 87 Fed. Reg. 22,290, 22,380 (April 14, 2022).

⁷ In 2003, section 1854(a)(6)(B)(iii) was amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, § 222, 117 Stat 2066, to extend its requirements to Medicare Prescription Drug Plans, and a corresponding provision was included in the Part D statute at 1860D-11(i).

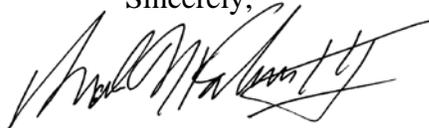
⁸ See 149 Cong. Rec. S15670-03, S15691, describing legislators' goals in incorporating the non-interference clause with respect to Part D plans: “They said: We believe in competition. . . . Let the private sector negotiate their incentives for the insurers to get lower costs out of the pharmaceuticals. . . . Let that mechanism work. Don't have the head of CMS, the Medicare Director in Washington, DC, dictate prices for everybody. *Let us*

Expanded CMS oversight over the abusive MAO practices described in our September 1 Letter and above would not implicate the non-interference clause or compromise its goals. Indeed, the law is clear that Medicare beneficiaries who enroll in MA plans are entitled to the same benefits, at a minimum, that they would receive if they were enrolled in original Medicare.⁹ To that end, CMS retains the authority to ensure MAOs satisfy minimum benefit requirements. By implementing the recommendations we have offered, CMS would ensure MAOs comply with their basic statutory obligation to provide beneficiaries access to timely, adequate, and appropriate care. Such a regulatory response would *promote* meaningful competition between MAOs on the dimensions of quality, value and care delivery while also protecting beneficiaries and providers.

* * *

The FAH appreciates the opportunity to offer these insights. 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,



CC: The Hon. Christi A. Grimm, Inspector General, Department of Health and Human Services
Jonathan Blum, Principal Deputy Administrator and COO, CMS
Dr. Meena Seshamani, MD, PhD, Deputy Administrator and Director, Center for Medicare

Attachment

not set those prices in the Senate. Let us let the marketplace work to squeeze cost and get efficiency out of the system” (emphasis added).

See also 149 Cong. Rec. S15670-03, S15761, “The competition in this bill achieves significant ‘bang for the buck’ because it relies on drug plans to negotiate discounts. CBO says the private insurance model has a cost management factor of 25 percent—the effect of price discounts, rebates, utilization controls, and other tools that a PDP might use to control spending. By relying on the bargaining power of drug plans, this bill will drive down the costs of prescription drugs.”

See also Congressional Budget Office, Letter to the Honorable William H. Frist, MD (January 23, 2004), <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4986/fristletter.pdf>, “CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree.”

⁹ *See* S.S.A. §1852(1)(A), “[E]ach Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original [M]edicare fee-for-service program option”.



Attachment

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 "H".