Federation of American Hospitals®

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January 5, 2023

Via electronic submission at *http://www.regulations.gov*

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-4205-P, Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications: Proposed Rule (Vol. 88, No. 219), November 15, 2023.

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 submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule on Contract Year (CY) 2025 Policy and Technical Changes to the Medicare Advantage (MA) program, Medicare Part D program, Medicare Cost Plan Program, and PACE program, as well as Health Information Technology Standards and Implementation Specifications published in the Federal Register (88 Fed. Reg. 78,476) on November 15, 2023. The FAH supports CMS' proposals geared towards increasing oversight of Medicare Advantage Organizations (MAOs), and urges CMS to consider the recommendations below to continue to improve both the beneficiary experience and provider engagement within the MA program.

Amendments to Part C and Part D Reporting Requirements
(Part IV.D, 42 CFR §§ 422.516 and 423.514)

The FAH commends CMS' commitment to collect more detailed information from MAOs and Part D plan sponsors through amendments to Part C and Part D reporting requirements. Data collection and analysis is essential for CMS to robustly oversee and enforce MA requirements and thereby ensure that MA enrollees receive full coverage for Medicare-covered items and services. As the OIG recommended in its April 2022 report, CMS should "update its audit protocols to look for issues identified in this report."[1] As we have written previously, the FAH urges CMS to adopt this recommendation, which requires, as a first step, CMS to gain sufficient visibility into MAO practices by collecting more granular, real-time data from MAOs. The FAH thus strongly supports CMS' clarifications to sections 422.516 and 423.514, affirming CMS' already-existing authority to collect this additional and more granular data.

The FAH recognizes that, as described within the Proposed Rule, CMS is not proposing to change specific current data collection efforts through the rulemaking, but that instead the changes proposed are to allow CMS, in the future, to add new burdens to plans in collection efforts. ***The FAH strongly supports the promulgation and implementation of increased reporting requirements to promote accountability and transparency for MAOs and to enable CMS to engage in oversight and enforcement activity.*** To that end, the FAH echoes its past comments highlighting operational areas of concern that warrant more granular reporting and urges CMS to expand MAO reporting and oversight. Specifically, the FAH urges CMS to collect more robust data on:

- ***Equitable access to care for MAO enrollees.*** § 422.112(a)(8) requires MAOs to ensure that services are provided in a culturally competent manner to promote equitable access to all enrollees. The FAH notes that many of the structural features that distinguish MA from traditional Medicare, including the use of narrow networks and various utilization controls, oftentimes pose more significant barriers to access to care for the vulnerable populations identified in § 422.112(a)(8). We therefore urge CMS to engage in targeted oversight and data collection to ensure that these populations do not face disproportionately long wait times or frequent denials of care. Direct collection of data from MAOs' health equity analyses (discussed in greater detail below) could support this effort.

- ***MAO denials of prior authorization for particular service types that have a history of inappropriate denials.*** In an April 2022 report, the OIG raised concerns that MAO clinical criteria and review practices may particularly burden beneficiary access to specific types of care, such as inpatient rehabilitation facilities or advanced diagnostic imaging services.[2] The FAH supports the OIG's recommendation that CMS use its

[1] OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022), *at* https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf, at p. 21.

[2] *Id.* at pp. 14-16.

authority to expand MAO reporting obligations in order to undertake targeted audits of particular service types that have a history of inappropriate denials.

The FAH and its members strongly support CMS' initiatives to affirm its reporting authority as implemented and hope CMS will exercise this authority to collect more granular and timely data in order to carry out effective oversight of MAO plans.

Annual Health Equity Analysis of Utilization Management Policies and Procedures (Part IV.D, 42 CFR § 422.137)

We share CMS' concern that MAOs' utilization management practices can create barriers to accessing care, which may disproportionately impact individuals who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. 88 Fed. Reg. at 78,540. Indeed, many of the structural features that distinguish MA from Traditional Medicare, including the use of narrow networks and various utilization controls, oftentimes pose more significant barriers to beneficiaries in these populations. The FAH therefore applauds CMS' proposal to incorporate health equity-related requirements into 42 CFR § 422.137, which addresses MA utilization management activities. In particular, the FAH strongly supports the proposal to require each MAO's utilization management committee to conduct an annual health equity analysis of the use of prior authorization and its effect on individuals experiencing the social risk factors related to income or disability, but urges CMS to expand the analysis to reach additional utilization management activities and to require further disaggregation of the data so that utilization management issues for particular items and services can be evaluated. The FAH also supports the proposal to require MAO utilization management committees to include at least one member with health equity expertise.

While both proposals encourage MAOs to analyze their own utilization management practices through a health equity lens, we urge CMS to play a more active role in ensuring that MAOs are thoughtfully incorporating these considerations into their decision-making processes and are not engaged in utilization management activities that, in practice, exacerbate inequities, compromising timely and appropriate access to covered items and services for beneficiaries with social risk factors. To that end, the FAH urges CMS to require disaggregation of data for each category of items and services so that service-specific adverse impacts are not obscured by aggregation and to facilitate further regulatory oversight by requiring direct reporting of health equity assessments (including the metrics identified in proposed § 422.137(d)(7)) to CMS.

With respect to disaggregation, the FAH strongly supports the proposal to require the health equity analysis be undertaken at the plan level and agrees that "this level of analysis is important to discern the actual impact of the use of utilization management on enrollees that may be particularly subject to health disparities."[3] The FAH also appreciates CMS' specific request for comment on "any specific items or services, or groups of items or services, subject to prior authorization that CMS should consider also disaggregating in the analysis."[4] Granular data collection and reporting is critical to efforts to identify disparities in access to covered benefits

[3] 88 Fed. Reg. at 78,542.
[4] *Id.*

that may not be obvious when data is "rolled up" and not reported by specific plan or by item and service. ***The FAH, therefore, urges CMS to require the MAO health equity analysis include reporting on prior authorization and other utilization management metrics for each category of items and services (e.g., inpatient hospital services, inpatient rehabilitation facility services, inpatient psychiatric services, and so forth) rather than aggregated across all items and services and fully supports the proposal to require this analysis to be undertaken at the plan level.***

As discussed in further detail within the FAH's comments[5] on the *Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule* (CMS-00578-P) submitted on March 13, 2023, requiring item- and service-level reporting is necessary for CMS and the public to understand whether an MAO's prior authorization practices are disproportionately affecting enrollees with specific needs; particularly, individuals who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Disaggregation is necessary to achieve meaningful review of health equity analysis reports, as review of only aggregated prior authorization metrics across items and services would result in high-volume prior authorization requests obscuring data around other critical items and services and diminishing the value of the data for beneficiaries. For instance, reporting the specified metrics for behavioral health services may reveal that enrollees with one or more social risk factors may face a higher rate of denials or successful appeals or unreasonably long authorization delays for behavioral health services compared to enrollees generally, but these disparities may not be visible at all if behavioral health services are aggregated with the full range of covered items and services. As made clear by the OIG's April 2022 report, inappropriate prior authorization denials can disproportionately impact particular service lines such as advanced imaging services, post-acute care in skilled nursing facilities and inpatient rehabilitation facilities, and injections because the MAO is financially incentivized to lower costs by denying higher cost services in favor of lower cost options.[6] The evaluation of prior authorization data for these services for enrollees with and without social risk factors may disclose disparities that are not apparent on an aggregate basis. But, disaggregation should not be confined only to services where prior authorization denials are a known problem—rather, the disaggregation should allow for analysis of each service category so that the process is capable of shedding light on health equity issues for specific service categories and the MAO's utilization management committee can take appropriate action. The FAH, therefore, strongly recommends that disaggregation be required for each category of covered items and services, including but not limited to inpatient hospital services, inpatient rehabilitation facility services, inpatient psychiatric facility services, post-hospital extended care services, partial hospitalization and intensive outpatient services, and advanced diagnostic imaging services.

Moreover, an MAO's health equity analysis should look beyond prior authorization and evaluate *all* its utilization management activities, particularly concurrent review, through a health equity lens. At a minimum, the "prior authorization" data reviewed in the health equity analysis

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[5] https://www.fah.org/wp-content/uploads/2023/03/Improving-Interoperability-and-Prior-Authorization-31323-FINAL.pdf

[6] OIG, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022), *at* https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

should include concurrent review data. Concurrent review is particularly common in the context of inpatient acute and post-acute stays, where MA organizations often authorize care through a concurrent review process because the review necessarily takes place when a patient is already receiving care from the provider. (This is often true when the MA organization requires authorization of post-stabilization services and/or when authorization is provided for defined periods with further authorizations over the course of the enrollee's stay.) It would be inappropriate for an MA organization to call its review activity "concurrent review" in order to escape reporting obligations arising from proposed section 422.137(d)(6).

In terms of transparency around the health equity analyses, the FAH supports the proposal to require each MAO to post the health equity analysis on the MAO's website at a location easily accessible to the general public. To allow CMS to engage in meaningful oversight of MAOs and to promote MAO accountability for health equity analyses, however, the FAH strongly urges CMS to also require each MAO to submit its health equity analyses directly to CMS. The FAH is concerned that public reporting alone does not adequately facilitate regulatory enforcement of the prior authorization requirements in situations where non-compliance disproportionately impacts enrollees with social risk factors. In addition, and as discussed in further detail within the FAH's comments[7] on the *Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule*, direct submission of the data to CMS would incentivize impacted payers to validate and verify prior authorization performance data before submission so that the data would be more likely to provide enrollees with reliable and actionable information. ***The FAH urges CMS to exercise its authority under proposed 42 CFR §§ 422.516 and 423.514 to require submission of granular prior authorization data supporting health equity analyses directly to CMS.***

In addition, we urge CMS to include the FAH's Level 1 Denials Upheld Rate quality measure into the Stars Rating Program for its potential to improve patient care quality, provider experiences, and insurer accountability. Currently, there is inadequate accountability for insurers when they delay or deny access to treatment that a doctor and patient agree is most appropriate. We firmly believe that the FAH-developed quality measure represents an opportunity to change the current dynamic and reduce the frequency of delayed or denied care for MA beneficiaries.

A large volume of overturned denials at Level 1 of the appeals process suggests that beneficiaries are not getting the care they need in a timely manner. Wrongful delays or rejections of needed care can result in treatment abandonment, harm patient outcomes, and increase unnecessary provider burden. Since many beneficiaries do not contest their insurer's coverage decisions, it is critical that MAOs are held accountable for making appropriate decisions, as early as possible.

While the existing Medicare Part C Star Ratings measure, *Reviewing Appeals Decisions*, assesses Level 2 appeals reviewed by an external independent reviewer, it alone, is not enough. The Level 1 Denials Upheld Rate measure, which evaluates appeals reviewed internally by insurers (Level 1), increases accountability for appropriate decision-making earlier in the appeals

[7] https://www.fah.org/wp-content/uploads/2023/03/Improving-Interoperability-and-Prior-Authorization-31323-FINAL.pdf

process thereby reducing the time and resource burden of external reviewers and ensuring that patients get the necessary care in a timely and appropriate manner.

Recent efforts by Congress to require MA plans to submit their numbers of prior authorization requests, approval rates, denial rates, and appeal approval rates to the Secretary for public reporting further underscore the need for more granular data reporting and greater transparency around the appeals process.

Expanding Network Adequacy Requirements for Behavioral Health (Part III.A, 42 CFR § 422.116(b)(2))

We applaud CMS' recognition that behavioral health is offered along a continuum of care, and successful patient outcomes depend heavily on the full range of behavioral health care services that includes outpatient programs in addition to partial hospitalization program services and inpatient facilities. Our members are concerned that MA plans often maintain an inadequate network of community-based behavioral health care providers. ***The FAH therefore supports the proposal for CMS to evaluate MAO network adequacy along the dimension of behavioral health by adding a combined behavioral health specialty type, "Outpatient Behavioral Health," at section 422.116(b)(2).*** Measuring the adequacy of MA plans' provider networks with a specific focus on behavioral health not only promotes the goal of expanding *all* enrollees' access to covered services, but also dovetails with CMS' vital goal of promoting health equity for MA enrollees.

In implementing this new behavioral health specialty type, the FAH urges CMS to carry out oversight activities and regular reviews to ensure that MAOs satisfy the new network adequacy standards for Outpatient Behavioral Health. Such reviews are critical to ensuring that MAOs fulfill their statutory obligation 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." The FAH encourages CMS to engage in review actions, such as audit protocols and implementation of enhanced reporting requirements, to ensure that covered Outpatient Behavioral Health benefits are available and accessible to each enrollee in the service area.

Enhance Enrollees' Right to Appeal an MA Plan's Decision to Terminate Coverage for Non-Hospital Provider Services (Part V.B, 42 CFR § 422.626)

We support CMS' proposal to align the process for all Medicare beneficiaries to receive independent review of the decision to terminate services from a home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF) or skilled nursing facility (SNF), even in the event of an untimely appeal or the circumstance where the enrollee has stopped receiving these services from the provider before the termination date. Our members frequently assist patients in navigating the appeals processes required by MAOs and are therefore familiar with how frustrating and cumbersome these appeals can be. The FAH therefore supports CMS' proposal to align MA enrollees' appeal rights with those of traditional Medicare beneficiaries in these circumstances, and we encourage CMS to engage in education efforts to help beneficiaries better understand their appeal rights.

Improvements for Special Needs Plans
(Part VIII, 42 CFR §§ 422.100, 422.503, 422.504, 422.514, 422.530, and 423.38)

Aligned Enrollment. The FAH supports CMS' efforts to improve experiences for dually eligible individuals, including by encouraging their enrollment in D-SNPs and promoting aligned enrollment. We thus support CMS' proposals to encourage aligned enrollment by making changes to certain special enrollment periods; requiring a D-SNP that also offers Medicaid managed care plans (MCCPs) in the same service area to limit enrollment of beneficiaries in the service area to those who are also enrolled in the MCCP; and addressing "choice overload" by limiting the number of D-SNPs the same entity can offer in a single service area.

D-SNP Look-Alikes. We also continue to share CMS' concerns regarding the proliferation of D-SNP look-alikes, which undermine CMS' efforts to improve coordination of care for dually-eligible beneficiaries. We therefore support CMS' proposal to address the proliferation of these plans by reducing the enrollment thresholds for non-renewal of contracts with look-alikes.

Out-of-Network Cost Sharing Limits. We applaud CMS' proposal to cap out-of-network cost-sharing for D-SNP PPOs, which can be significantly higher than those imposed in the traditional Medicare context. While beneficiaries or states are sometimes burdened with these high costs, in most circumstances, providers will simply not receive any payment of these cost-sharing amounts, because many states apply a "lesser-of" rule by which they do not owe Medicare cost-sharing amounts for a qualified Medicare beneficiary (QMB) if the provider would earn a combined payment in excess of the Medicaid rate.[8] As a result, out-of-network providers often receive payment amounts that fall far below what they would earn in the traditional Medicare context, even though they are serving patients eligible for *both* Medicare and Medicaid. We share CMS' concern that a benefit design that underpays providers in this manner "may compromise access to services for these enrollees."[9]

A benefits structure that imposes high out-of-network cost-sharing burdens also undermines central features of the MA program, including the statutory requirement that the plan provide payment for services obtained out-of-network such that "the sum of such payment and any cost sharing provided for under the plan, is equal to at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts)."[10] As noted in the preamble to the Proposed Rule:

> When a D–SNP PPO imposes cost sharing greater than Traditional Medicare and that cost sharing is unpaid by the State and uncollectable from the beneficiary, the MA organization has, in effect, failed to fulfill the spirit of its side of this statutory scheme

[8] 42 U.S.C. 1396a(n).
[9] 88 Fed. Reg., at 78,584.
[10] 42 U.S.C. § 1395w–22(a)(2)(A).

and the providers are in effect forced to accept less than they would receive under original Medicare if they agree to treat the D–SNP PPO enrollee.[11]

The FAH thus strongly supports CMS' proposal to cap cost-sharing at the same limits applicable in the traditional Medicare context for a number of services, and urges CMS to expand this proposal to all services, not only certain services provided on an out-of-network basis. We agree that it would be "overly complex and likely unworkable" to apply cost-sharing limits only in circumstances where the provider would ultimately receive a payment less than it would receive under traditional Medicare.[12] Simply applying the cap to all out-of-network services covered by the D-SNP, however, would be a straightforward and fair solution.

While the FAH greatly appreciates CMS' attention to the challenges of imposing appropriate cost-sharing amounts on dually-eligible enrollees receiving out-of-network services covered by a D-SNP PPO, we note that this problem is widespread *whenever* a provider serves a QMB. When a QMB seeks services, even within his or her MA plan's network, the provider often does not receive any cost-sharing at all and is ultimately underpaid relative to traditional Medicare and its rate negotiated with the MAO because of states' application of the "lesser-of" rule described above. As CMS has observed in the past, this creates the incongruous situation where "providers serving dually eligible MA enrollees are systemically disadvantaged relative to providers serving non-dually eligible MA enrollees, which . . . may negatively affect access to Medicare providers for dually eligible enrollees."[13] ***We urge CMS to address this situation in service of its overarching goal of advancing health equity.*** To that end, we recommend CMS allow providers to claim MA bad debt on their cost reports and receive appropriate payment in the same manner they do for Medicare bad debt. Although this would not make providers entirely whole, it would help to offset the inequitable impact on providers who serve dually eligible enrollees and are unable to collect cost-sharing amounts.

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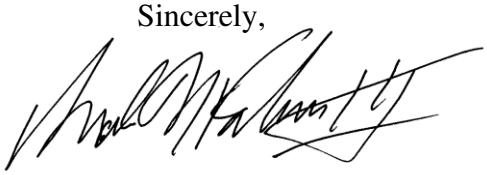
The FAH appreciates the opportunity to submit these comments on these important issues to patients and providers. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,



[11] 88 Fed. Reg., at 78,585.
[12] 88 Fed. Reg. at 78,586.
[13] 87 Fed. Reg. 1842, 1884 (January 12, 2022).