American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

August 31, 2022

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

Re: CMS-4203-NC, Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding the Medicare Advantage (MA) program.

The AHA appreciates CMS's interest in exploring opportunities to advance health equity, expand patient access to care, drive innovation, support affordability and sustainability, and engage in collaboration with partners to improve the MA program. In this context, we are writing to share several serious concerns about the negative effects of Medicare Advantage Organization (MAO) practices and policies, which impede patient access to health care services, create inequities in coverage between Medicare beneficiaries enrolled in MA versus those enrolled in Traditional Medicare, and in some cases, even directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services.

As enumerated below, such practices include abuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by Traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year, among others. These practices add billions of wasted dollars to the health care

system, are a major driver of health care worker burnout,[1] and worst of all, harm the health of Medicare beneficiaries.

These pain points are only getting worse as enrollment in MAOs continues to increase rapidly. In 2021, nearly 27 million people, representing 46% of the total Medicare population, were enrolled in a MAO, and enrollment is growing at a rate of nearly 10% per year. By 2023, more than half of all Medicare beneficiaries will be enrolled in an MAO.[2,3] With millions of new enrollees each year, it is more important than ever to implement desperately needed oversight provisions to ensure that those enrolled in MAOs are not unfairly subjected to more restrictive rules and requirements than Traditional Medicare, which are contrary to the intent of the MA program. However, as the MA program continues to grow, 78% of hospitals and health systems responding to a recent AHA survey reported that their experience with commercial insurers and MAOs is getting worse. Less than 1% said it was getting better.[4]

These challenges also are contributing to the unprecedented financial strain that hospitals and health systems are currently facing. Specifically, the types of inappropriate delays and unnecessary denials reported by hospitals and health systems are costly and burdensome for providers to resolve, resulting in millions of dollars of delayed payment or non-payment for services rendered and compromising the financial stability of hospitals across the country. Even prior to the pandemic, approximately one third of hospitals were operating on a negative margin and another third were just breaking even. Meanwhile, the cost of caring for patients has increased by nearly 20% on a per patient basis since pre-pandemic levels due to unprecedented surges in labor and supply costs, as well as inflation, further driving up hospital expenses.[5] As a result, operating margins for hospitals in 2022 have been generally negative to date.

Insurer practices that deny and delay payment for services appropriately rendered to patients exacerbate these financial challenges and destabilize providers of critical health care services. For example, in our most recent survey, 50% of hospitals and health systems reported having more than $100 million in accounts receivable for health insurance claims that are older than six months. This amounts to $6.4 billion in delayed or potentially unpaid claims that are six months old or more among the 772 reporting hospitals, leaving providers with untenable financial liability. In MA specifically, one-third of hospitals reported having $50 million or more in accounts receivable that are six months or older, suggesting that MA plans make up a significant portion of the problem.

---

[1] Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. 2022. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf
[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/
[4] The AHA fielded this member survey between December 2021 and February 2022. The results reflect responses from 772 hospitals in 47 states.
[5] https://www.aha.org/costsofcaring

At the same time, many of these insurers are reaping record-breaking financial profits, realizing much of this financial windfall by delaying and denying coverage of health care services for Medicare beneficiaries which they are contracted to cover. The government pays MAOs a per-beneficiary capitation rate, thus incentivizing them to minimize, to the extent possible, coverage of services to patients or payments to providers in order to boost their own profits — and there is mounting evidence that this is precisely what certain MAOs have been doing — again and again.[6] In doing so, many insurers have found the MA program to be their most profitable line of business and have sought expansion into MA as part of their growth strategy.[7,8] This is a critical red flag that greater oversight and accountability is needed.

In the following sections, we enumerate several issues and concerns regarding certain MAO practices and policies that restrict or delay access to care. We also address considerations for health equity, behavioral health access and post-acute care services in the MA program, as well as implications for continued growth in MA enrollment and the potential effects on cost and access. We conclude by summarizing specific recommendations that we believe are necessary to hold MAOs accountable for complying with the law, protecting beneficiaries from harm and ensuring the sustainability of the Medicare program.

However, our input is not all dire, and we point out where certain MAOs are taking steps to improve access to care and health outcomes while also creating efficiencies. We particularly see innovations occurring within MAOs that are part of integrated health systems. While the short comment period precludes us from fully exploring the unique value that these integrated MAOs provide, we look forward to other opportunities to highlight these positive developments with the agency.

Section A: Advance Health Equity

Serious inequities exist in health care access, cost and quality for patients based on their race, ethnicity, gender and gender identity, age, sexual orientation or other demographic and social factors. The AHA shares CMS's strong commitment to advancing health equity, and our members are working hard to identify and address health disparities to close existing gaps in health outcomes across patient populations. We appreciate the agency's attention to health equity in the context of the MA program. This is especially important given that MAOs are now enrolling higher proportions of historically underrepresented and structurally marginalized enrollees compared to Traditional Medicare, and the greatest MA enrollment increases in recent years have been among Black, Asian and Hispanic populations.[9]

---

[6] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf

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

[8] https://www.forbes.com/sites/brucejapsen/2021/10/01/parade-of-health-insurers-expand-medicare-advantage-into-hundreds-of-new-counties/?sh=591ab1106b69

[9] Meyers, David, et al. Growth in Medicare Advantage Greatest Among Black and Hispanic Enrollees. Health Affairs. June 2021. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00118?url_ver=Z39.88-

Given that MAOs enroll a disproportionate share of historically medically underserved populations, addressing disparities between Traditional Medicare and the MA program is also a critical equity issue. One of the most important issues to address is the difference in utilization management techniques and coverage rules between the Traditional Medicare program and the MA program. These can include MAOs' disproportionate use of site of service policies, narrow or tiered network structures, and prior authorization, as well as higher rates of denials resulting from a more restrictive coverage rules. For example, the Traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MAOs. As noted above, the MA program has nearly 27 million beneficiaries, representing 46% of the total Medicare population. Therefore, a little more than half of Medicare beneficiaries are not subject to the types of access restrictions faced by beneficiaries enrolled in the MA program. Such practices represent a structural inequity among Medicare beneficiaries and have the potential to increase disparities between beneficiary groups. We believe **all Medicare beneficiaries should have equal access to medically necessary care and consumer protections,** and that **those enrolled in MA plans should not be unfairly subjected to more restrictive rules and requirements**, which are unlawful and contrary to the intent of the MA program.

Given this dynamic and the rapid growth in MA enrollment, particularly among traditionally marginalized communities, it is imperative that we evaluate how MAOs contribute to or help address health inequities. Below we address several issues and considerations relevant to health equity, including health insurance literacy, the MA Star Ratings program, disenrollment trends and data standardization.

BENEFICIARY HEALTH INSURANCE LITERACY

Once a Medicare beneficiary opts to enroll in the MA program, they face an unprecedented assortment of MAOs to choose from. A total of 3,834 MAOs are available nationwide, and the average beneficiary has 39 MAO options in their service area. These plans can vary significantly in terms of cost sharing, covered services, provider networks and quality ratings.[10] They also vary significantly from Traditional Medicare in ways that may not be easily understood to a beneficiary when evaluating their Medicare enrollment options. For example, as noted above, MAOs routinely use prior authorization and utilization management techniques that are not widely used in Traditional Medicare and may present barriers to care. This may not be apparent to enrollees when making coverage decisions even though it is a critical difference between MA plans and Traditional Medicare and is germane to making an informed enrollment selection.

[10] Freed, Meredith, et al. "Medicare Advantage 2022 Spotlight: First Look." Kaiser Family Foundation. 2021. https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-

Health insurance literacy, defined as a person's ability to seek, obtain and understand health coverage, is essential for individuals to make educated decisions about their health care. Research has shown that low health insurance literacy is correlated with lower socioeconomic status.[11] Moreover, Medicare beneficiaries with poor health insurance literacy are more likely to choose plans with lower-premiums and suboptimal coverage.[12] Beneficiaries with low health insurance literacy are less likely to understand disparate plan features and may be particularly disadvantaged when shopping in an MA marketplace with such a high number and wide range of options. MAO plan choices are often littered with narrow networks, inaccurate provider directories and ever-shifting plan-contracted providers, making it even more difficult for the average person to evaluate and understand their insurance coverage options. While evaluating MAO benefits is challenging for all beneficiaries, evaluating these choices is even more difficult for beneficiaries with low health insurance literacy, which can contribute to disparities in a beneficiary's access to and use of insurance coverage. This difficultly analyzing plan choices is further compounded for those diverse patient populations with limited English-language proficiency.[13]

Health insurance literacy and cultural humility are essential means of reducing racial and ethnic disparities in health care. Therefore, it is imperative that MAOs foster inclusiveness with the diverse communities they serve and engage enrollees and potential enrollees of diverse backgrounds in culturally competent ways to increase patient engagement and education. As administrators of a public benefit, MAOs have a core responsibility to provide culturally and linguistically appropriate services to their enrollees. These activities are key to advancing health equity, improving patient safety and quality of care, and eliminating health disparities. **Therefore, we urge CMS to prioritize the development of policies and programs that ensure MAOs are providing enrollees with the necessary tools for health insurance literacy while considering the increasing diversity of the Medicare population. Further, CMS should undertake efforts to ensure that MAOs provide culturally competent resources to beneficiaries with diverse values, beliefs and behaviors to meet patients' social, cultural and linguistic needs.**

MA STAR RATINGS

Data indicate that Black, Asian, and Hispanic beneficiaries in MAOs tend to be enrolled in lower-rated plans. Evidence suggests that this could be a result of higher-rated plans failing to enter markets with a significant population of historically marginalized populations, as well as plans struggling to perform well in the MA Star Ratings program

[11] Tipirneni, R., et al. "Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost." *JAMA Network Open*. 2018. https://doi.org/10.1001/jamanetworkopen.2018.4796
[12] Park, Sungchul, et al. "Association of Health Insurance Literacy with Enrollment in Traditional Medicare, Medicare Advantage, and Plan Characteristics Within Medicare Advantage." *JAMA Network Open.* 2022. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788633
[13] Cultural Competence in Health Care: Is it Important for People with Chronic Conditions? Georgetown University Health Policy Institute. https://hpi.georgetown.edu/cultural/

if they serve a higher proportion of individuals from underserved communities.[14] It is imperative that we understand why this disproportionate enrollment in lower-rated plans exists to address the potential resulting inequities.

Payment bonuses for four- and five-star rated plans through the MA Star Ratings program amount to over $6 billion in additional payments to MAOs annually, which creates a significant financial incentive for MAOs to earn high ratings. However, five-star rated plans are only modestly associated with quality of health care experience for disadvantaged enrollees. In fact, as plan Star Ratings increase, so too do the disparities among beneficiaries of various racial, ethnic and socioeconomic groups.[15] Therefore, plans can earn high ratings and the corresponding financial bonuses despite their enrollees experiencing disparate or worse health outcomes compared to other groups. Accordingly, we are deeply concerned that MAOs not only lack incentives to address health care disparities but also may be incentivized to avoid enrolling structurally marginalized populations altogether.

Moreover, the current payment bonuses for MAOs tend to overpay plans for healthier enrollees and underpay for complex enrollees. It is well-established that communities dealing with sustained hardship and with low-income residents may have higher rates of certain chronic conditions, such as diabetes, asthma and hypertension, that can make their care more clinically complex.[16] Overall, these communities bear a disproportionate share of the nation's morbidity and mortality. However, MAO quality performance programs do not adequately account for social risk factors, which can lead to lower Star Ratings and systemic underpayments for plans serving a large proportion of enrollees from communities facing structural inequities. MAO performance scores generally decrease as the proportion of enrollees with complex health and social needs increases. Because performance is linked to payment bonuses, decreases in performance scores worsen finances for those plans serving the most vulnerable. This creates financial motivations for plans to target and enroll healthier, more homogeneous populations.

Hospitals and health systems are longstanding supporters of transparency and are committed to continuing to work with CMS to advance the goal we share — providing the public with accurate, meaningful information about quality. Therefore, while we first encourage CMS to take steps to ensure traditionally marginalized communities have access to higher rated plans, we also urge the agency to ensure that plans serving

---

[14] Park, Sungchul, et al. "Racial and Ethnic Disparities in Access to and Enrollment in High-Quality Medicare Advantage Plans." *Health Services Research*. March 2022. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13977

[15] Meyers, David, et al. "Association of Medicare Advantage Star Ratings with Racial, Ethnic, and Socioeconomic Disparities in Quality of Care." *JAMA Health Forum*. 2021. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781100

[16] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. National Academies Press. 2017. The Root Causes of Health Inequity. https://www.ncbi.nlm.nih.gov/books/NBK425845/

higher rates of individuals from these communities are fairly assessed in the Star Ratings program.

DISENROLLMENT

As we discuss throughout our comments, the AHA is deeply concerned about MAO policies that restrict or delay patient access to care. These policies include excessive use of prior authorization, inappropriate and overly restrictive medical necessity criteria, and narrow networks, among others. We fear these policies are applied disproportionately in lower-rated MAOs that, as described above, tend to serve more structurally marginalized populations. Subsequently, when beneficiaries are faced with restrictive MAO policies that impact their ability to access needed care, they often switch plans.[17]

The AHA finds it troubling that MAO disenrollment figures are significantly higher for historically underrepresented beneficiaries compared to white beneficiaries. Moreover, as will be further outlined in our subsequent comments on prior authorization, patients with MA coverage in their final year of life are more than twice as likely to switch to Traditional Medicare compared to those not in their final year of life. This extensive disenrollment suggests that MAOs do not sufficiently support high-need beneficiaries who often require greater health care interventions in their final year of life. Further, it may also be evidence of how excessive and inappropriate use of utilization management tools create real-time barriers to care for patients, who as a result choose to leave the plan when faced with a serious health condition or illness because they cannot get the care recommended by their medical team. This voluntary disenrollment from MAOs often is attributed to negative plan experiences, which could also be caused by lack of MAO cultural competency or other insurer-erected barriers to accessing care.[18]

If Medicare beneficiaries opt for an MAO over Traditional Medicare, one way to help them select the right MAO is to increase the weighting of plan experience data in the MA Star Ratings program, specifically including data on disenrollment. Currently, disenrollment accounts for only one of the 35 to 45 measures included in the Star Ratings system. Given disenrollment's low weight in the Star Ratings calculations, it is not clear that MAOs have adequate incentive to retain structurally marginalized and high-need enrollees, which may contribute to adverse selection for plan enrollment and beneficiary disenrollment. **Therefore, the AHA believes that CMS should consider weighing disenrollment more heavily, as this may incentivize plans to better target and coordinate care for structurally marginalized communities who are at greater risk of experiencing barriers that may result in disenrollment. The AHA also encourages CMS to investigate the root causes of disenrollment for these**

[17] Martino, Steven, et al. "Rates of Disenrollment from Medicare Advantage Plans are Higher for Racial/Ethnic Minority Beneficiaries." *Medical Care*. 2021 https://pubmed.ncbi.nlm.nih.gov/34054025/
[18] Martino, Steven, et al. "Rates of Disenrollment from Medicare Advantage Plans are Higher for Racial/Ethnic Minority Beneficiaries." *Medical Care*. 2021 https://pubmed.ncbi.nlm.nih.gov/34054025/

populations, which may be an indicator of MA beneficiary frustration with barriers to accessing care. This may be instructive to inform further policy and programmatic changes that are needed to reduce access barriers, improve member experience and promote greater equity for enrollees.

NEED FOR DATA STANDARDIZATION

Data are foundational for efforts to address disparities and health equity. Data help to quantify the extent of health disparities impacting our communities across race, ethnicity, sexual orientation, gender identity and socioeconomic status. Our collective ability to address health disparities hinges on the availability and quality of the underlying demographic and social need data. Data must be leveraged to identify care disparities, direct efforts and resources accordingly, measure progress toward achieving health equity, and establish accountability practices. However, lack of data standardization, including uniform definitions of key terms, hinders data collection and analysis. Advancing health equity calls for more robust data and industry standardization.

We recognize that there are opportunities to improve the consistency and accuracy of demographic and social risk data available to hospitals, CMS and insurers. Before data can be useful, it must first be standardized. Currently, data about patient's race, ethnicity and socioeconomic status are lacking, and the availability of data varies across Medicare and MAOs. Misaligned terminology, inadequate demographic and social need data categories, and missing information contribute to inaccuracies. Even Medicare's enrollment data on race and ethnicity are inconsistent with federal data collection standards, and these inconsistencies inhibit the work of identifying and improving health disparities within the Medicare population. **Therefore, we believe it is vital for CMS to foster consistency and standardization in its approaches to collecting, analyzing and using demographic and social risk data.** This includes a consistent approach across CMS itself, and across other federal agencies and programs. Given the breadth of health equity issues, and the wide range of stakeholders affected by it, CMS can help ensure that all stakeholders use consistent definitions and standards. Furthermore, such standards should be thoroughly field tested before broader implementation.

Additionally, **we encourage CMS to explore the extent to which there are any demographic data elements collected at the time of Medicare and MA enrollment that could be used more widely across programs**. **The AHA believes that CMS must prioritize the use of existing data to which CMS itself may already have access before considering new data reporting requirements.** For example, to the extent CMS and MAOs are collecting demographic and social risk data during the time of enrollment, the agency should explore ways of improving its accuracy, and determine whether the data could be linked to quality measure data for hospitals and other health care providers. These steps could help provide additional data for CMS's efforts to identify disparities in performance and outcomes, while reducing the need for additional data collection by hospitals and other providers.

Section B: Expand Access, Coverage and Care

The AHA commends CMS for collecting information regarding the adequacy of MA coverage and beneficiary access to medically necessary treatment and services. The AHA believes that MAOs frequently misapply benefits and utilize inappropriate utilization management processes in ways that significantly impede patient access to necessary care. As detailed below, we urge CMS to carefully review MAO policies regarding prior authorization and medical necessity criteria, access to behavioral health services and post-acute care, and network adequacy (as detailed in both this section and other aspects of our response). Additionally, we appreciate the opportunity to provide information regarding the role of telehealth in MA plans, intermediate administrative services entities, deceptive MAO marketing practices and the need for increased MAO oversight.

PRIOR AUTHORIZATION AND MEDICAL NECESSITY DETERMINATIONS

The AHA appreciates CMS's interest in MAO prior authorization practices, as they often create a significant impediment to our members' ability to provide efficient, timely and therefore high-quality, patient care. Reforming prior authorization processes so that they work better for patients and providers is one of our highest priorities.

As you know, prior authorization is a process whereby a provider, on behalf of a patient, requests approval from the patient's insurer before delivering a treatment or service. Although initially designed to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, many MAOs apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and drive-up costs for the health care system.

According to a 2021 American Medical Association survey of more than 1,000 physicians, 91% of respondents indicated that prior authorization "had a significant or somewhat negative clinical impact, with 34% reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care."[19] In response to a recent AHA member survey, 95% of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. And the resource intensive staff time spent managing health policies adds tremendous cost and burden to the health care system. For example, **one 20-hospital system spends $17.5 million annually just complying with health plan prior authorization requirements. And a single 355-bed psychiatric facility needs 24 full-time staff to deal with authorizations**.

[19] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Our most recent AHA survey data shows that health plans serving public programs are more likely to deny inpatient prior authorization requests, and specifically that **MA plans have the highest inpatient prior authorization denial rate across all payers**, followed by Medicaid managed care and then commercial products. These rates vary despite physicians following the same clinical guidelines and regardless of a patient's type of coverage, suggesting that the denials are linked to financial, not clinical, considerations. Further, these survey data reflect that **MA plans are aggressively and systematically denying nearly 20% of all inpatient prior authorization claims** off the bat, most of which are later overturned.

The federal government also has acknowledged the risk of delays in care caused by prior authorization requirements, which is why it urged health plans to ease such requirements during the COVID-19 public health emergency (PHE). Specifically, CMS guidance encouraged individual and small group health plan issuers to "utilize flexibilities related to utilization management processes, as permitted by state law, to ensure that staff at hospitals, clinics, and pharmacies can focus on care delivery and ensure that patients do not experience care delays."[20]

Such concerns about delays in care and inappropriate denials were validated by a recent Department of Health and Human Services Office of the Inspector General (HHS-OIG) report entitled, "Some MA Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care."[21] The HHS-OIG found that some of America's largest MAOs fail to cover the same services as Traditional Medicare, in direct violation of CMS policy. Specifically, CMS guidance states that MAOs may not impose additional clinical criteria that are "more restrictive than [Traditional] Medicare's national and local coverage policies."[22] Using a random sample of denials from the one-week period of June 1−7, 2019, the report estimates the rate at which MAOs deny prior authorization and payment requests that met Medicare coverage rules. **The HHS-OIG found that 13% of prior authorization denials and 18% of payment denials met Medicare coverage rules and should have been granted**.

The HHS-OIG report highlighted several important issues with MAO prior authorization programs: (1) MAOs frequently use medical necessity and coverage criteria that are more restrictive than Traditional Medicare; (2) Prior authorization processes are extremely inefficient; and (3) Patient care is negatively impacted because of prior authorization delays and denials.

More Restrictive "Internal" Medical Necessity and Coverage Criteria

As previously noted, CMS rules preclude MAOs from utilizing clinical criteria that are more restrictive than Traditional Medicare. However, our members' experience and the

[20] https://www.cms.gov/newsroom/press-releases/cms-news-alert-april-23-2020
[21] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[22] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.

HHS-OIG report clearly show that MAOs are routinely doing exactly that. Additionally, MAOs often classify their medical necessity criteria as proprietary (or "internal," according to the HHS-OIG) and do not share specifics with providers, resulting in a "black box" for providers attempting to determine whether a service will be approved. This lack of transparency is a frequent reason that prior authorization and claims are delayed or denied; without adequate information, providers are more likely to submit requests that do not meet all the payers' standards simply because they do not have the appropriate information on the insurer's internal criteria. Leaving providers in the dark about what documentation they must provide results in extensive back and forth between providers and plans, which only serves to delay care and unnecessarily burden staff with resource-intensive paperwork. Further, in most instances, the authorization is ultimately approved, making such administrative work unnecessary, costly and wasteful. For example, **our most recent member survey shows that 69% of all inpatient prior authorization denials are ultimately overturned in favor of the provider.** Yet, MAOs still continue to deny a substantial portion of prior authorizations.

Several examples of where MAO and Traditional Medicare clinical criteria frequently vary include coverage of sepsis care, inpatient-level care, emergency services and post-acute care (which we address in detail in a separate section).

- **Sepsis Coverage.** Several MAOs have unilaterally stopped reimbursing providers for the care necessary to treat certain cases of early sepsis occurring in inpatients. Specifically, these plans are choosing to no longer follow the Sepsis 2 guidelines, which have been adopted by most practicing physicians and serve as the CMS standard for sepsis coverage. Instead, these plans have unilaterally applied a different standard (Sepsis 3) for purposes of determining provider reimbursement only. This standard more specifically focuses on later stages of sepsis and has been validated only in early retrospective studies and only as an outcome/mortality predictor. It is not supported by current clinical best practices, nor is it recognized by current coding or payment methodologies used by CMS. In short, plans' adoption of Sepsis 3 does not change the way providers care for patients with sepsis, it simply enables the plan to decline reimbursement for early sepsis interventions.

  This policy has the potential to undercut efforts to prevent, detect, treat and improve sepsis care. It also results in inappropriate underpayment to providers who continue to deliver the medically necessary care. One independent hospital noted that these sepsis-related plan policy changes result in a per-case reduction in reimbursement ranging from $500 to $6,000 depending upon the factors involved. This represents a loss of more than $100,000 annually for this single hospital, attributed solely to inappropriate health plan sepsis coding changes. In short, the benefit of these policies accrues only to the plan, and the motivation is purely financial, not clinical. The adoption of these changes in policy during the COVID-19 pandemic has been a particular affront to patients and their providers amid a national health emergency for which sepsis is a common corollary

condition to COVID-19. Further, these policy restrictions have often been adopted in the middle of contract years, outside of standard contract negotiations and without consultation of network providers.

- **Inpatient Care Downgrades to Observation Status.** Inpatient care is typically reimbursed at a higher rate than outpatient care and observation status given the more intense resources required to care for patients needing that level of care. Additionally, inpatient stays entitle patients to certain benefit categories, such as post-acute care facility services after discharge. To give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established the two-midnight rule. Under that policy, hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Despite this bright-line CMS medical necessity rule, many MAOs have implemented policies that further restrict inpatient care by placing additional obstacles to admission, including, as reported to the AHA by member hospitals, directly pressuring providers to classify patients as "under observation" prior to the submission of claims, even when the clinical criteria for inpatient care have clearly been met. This has the effect of both reducing provider reimbursement and reducing the plan's reported rate of denials if they can convince the provider to submit a lower-level claim without issuing a formal denial.

  These policies frequently lead to uncertainty for providers and patients, whose medically justified inpatient stays are often denied or retrospectively changed to observations, including situations in which the clinical necessity far exceeds clinical guidelines. For example, one health system AHA member reported an 80-year-old patient suffering from pneumonia, dehydration, malnutrition and other comorbidities was admitted to the hospital as an inpatient, receiving care for eight days. Despite exceeding both the CMS two-midnight rule (by multiple days) and MCG criteria, the patient's MAO downgraded her stay to observation. Such classifications misrepresent the care received by the patient, impede a patient's ability to receive coverage for certain benefits and care plans, and require lengthy appeals processes that increase the cost of care delivery. They also can change a patient's cost-sharing amount, potentially exposing them to higher cost-sharing depending on the patient's benefit structure, or even prevent the patient from being eligible for post-acute care services if their hospital stay is not coded as inpatient care.

- **Emergency Services.** Several large insurers, including MAOs, have been denying or downcoding coverage of emergency services if the health insurer unilaterally determines that the condition did not meet medical necessity criteria for emergency-level care. Importantly, the plan makes this determination after the care is delivered upon reviewing the outcome and patient records, and not based on what the clinician knew at the time the patient presented to the emergency department (ED). Although this policy was purportedly designed to discourage

inappropriate use of the ED (a goal hospitals and health systems share), it has instead been used as a blunt tool that causes patients to fear accessing medical services in the context of an emergency. These policies can deter patients from seeking critical and urgent care, while also resulting in significant financial losses to providers when payments are clawed back after the fact for care that was legitimately provided.

These policies completely ignore hospitals' responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to assess and stabilize anyone who presents to the ED. They also ignore the application of the prudent layperson standard, which requires the need for emergency services to be evaluated based on what an average prudent person deems an emergency at the time the individual seeks care. It also requires health plans to provide coverage for emergency care based on symptoms presented at the time of the emergency, not based on the final diagnosis. It is often not known whether certain symptoms are the result of an urgent or non-urgent condition without medical examination and testing — and to determine if the situation was an emergency based on only the final outcome is unreasonable and unfair to patients who go to a hospital seeking help when they are scared or in pain.

The AHA deeply appreciates CMS addressing this issue in recent regulations related to the No Surprises Act. However, we continue to hear that some plans are effectively disregarding these regulations, including through inappropriate downcoding of claims or line-item denials that do not appear to regulators as a full denial.

In one example of inappropriate downcoding, an AHA member hospital shared the experience of a 15-year-old patient who presented to the emergency department with an attempted overdose.[23] It was determined that the overdose was intentional, and she was diagnosed with suicidal ideations, major depressive disorder, mood disorder and personal history of self-harm. The hospital billed CPT code 99285, which is for a level 5 emergency department visit to address "problem(s) [that] are of high severity and pose an immediate significant threat to life or physiologic function."[24] A psychiatric case involving an intentional attempted overdose reasonably meets this definition. However, the health plan downcoded this case to a lower-level visit despite the diagnosis codes on the claim clearly supporting the billing of a level 5 emergency visit. In fact, the insurer's policy manual lists "suicidal or homicidal patient" as a clinical example of when CPT code 99285 would be appropriately used. Nonetheless, commercial insurers, including MAOs, continue to routinely downcode provider claims like

[23] This example, provided by a member hospital, occurred with a commercial insurer that has a large footprint in the MA market. While this specific example is from a commercial insurance product, the issue of emergency department downcoding is broadly applicable in MA products, where MAOs commonly apply the same set of problematic policies and utilization management tools that are used in the commercial insurance market.
[24] MAO Policy Manual, CPT 99285/HCPCS G0384 High Complexity

this, forcing providers to continually have to fight to have claims appropriately coded and covered by the plan.

These examples are a clear indicator that guidance to MAOs must be clarified and supplemented with greater directives, something recommended by the HHS-OIG. In this context, **we strongly urge CMS to require MAOs to align medical necessity and coverage criteria with Traditional Medicare rules so that Medicare patients have equal access to care regardless of coverage type and to reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization.**

Prior Authorization in the Final Year of Life

As patients near the end of their life, the need for care frequently increases. Although MAOs are prohibited from limiting coverage based on a patient's health status, the use of prior authorization may force beneficiaries to rethink their coverage, especially with the patient burdens and delays in care discussed in the previous section. In fact, a 2021 Government Accountability Office (GAO) report discovered that patients with MA coverage in their final year of life are more than twice as likely to switch to Traditional Medicare compared to those not in their final year of life. The report highlights that "beneficiaries in the last year of life generally have high levels of service utilization, and certain MAO practices, such as prior authorization, may present administrative burdens to accessing care."[25] Such a statistically significant increase in disenrollment is likely a sign that MAO policies are preventing adequate access to care for patients.

Additionally, such widespread disenrollment makes plan quality measurement, such as mortality rate of MA plans, less reliable and potentially misleading, since the mortality rate will be artificially deflated if patients are disenrolling in droves during their final year of life. With patient care costing more in the final year of life and plans being measured based on mortality metrics, appropriate monitoring of disenrollment is essential to ensure that plans are not misusing prior authorization or other utilization management tools to incentivize patients with deteriorating health status to disenroll. **We urge CMS to conduct greater oversight of MA beneficiary disenrollment in the final year of life to protect patient care access for enrollees with complex or costly health needs.**

Prior Authorization Submission/Response Process: Electronic Transactions

While alignment of medical necessity and coverage criteria is the single biggest challenge related to MAO prior authorization policies, the actual process of submitting a prior authorization request and receiving a response is in dire need of reform.

[25] https://www.gao.gov/assets/gao-21-482.pdf

This heavily burdensome process, which is detailed in a recently published AHA report, requires providers to complete a number of steps, many of which must be repeated after inappropriate denials — or if the MAO claims they lost or did not receive files that were sent.[26] These steps will vary not just by each unique insurer but often within different products offered by the same insurer. Therefore, providers find themselves often navigating dozens, if not hundreds, of different policies, as well as needing to switch between technologies based on the insurers' preferred approach. This could mean logging into a proprietary insurer portal or submitting requests via fax. Moreover, the process can change with each request.

Such processes drain clinicians by pulling them away from patient care to do paperwork and spar with insurance administrators, while also increasing the risk that patients will abandon treatment recommendations due to delays and hassles. According to an advisory issued by Surgeon General Vivek Murthy, M.D., burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.[27] According to a 2021 American Medical Association survey, 93% of physicians reported care delays associated with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment.

Much of the burden associated with prior authorization could be reduced by the adoption of standardized electronic prior authorization transaction(s). Such an approach has the potential to save patients, providers and health plans significant time and resources and can speed up the care delivery process. **We urge CMS to establish a standard electronic transaction for providers to submit and receive responses for prior authorizations and supporting documentation.**

ACCESS TO BEHAVIORAL HEALTH SERVICES

CMS has requested input on several facets related to MA beneficiary access to behavioral health services, including mental health and substance use disorder services, and any steps CMS should take to ensure enrollees have access to the covered behavioral health services they need.

Access issues for behavioral health services are pronounced regardless of payer, but AHA research and reports from members uncovered specific instances of administrative barriers and inadequate networks in MAOs. All the challenges noted above that hospitals and health systems face working with MAOs apply to behavioral health services and, in many cases, are more pronounced. These include delays in prior authorization decisions; payment denials for care that has been pre-authorized; multiple requests for records; inadequate provider networks; unilateral, mid-year changes in reimbursement policies; and site of service exclusions. These issues appear to be

[26] https://www.aha.org/system/files/media/file/2022/07/Commercial-Health-Plans-Policies-Compromise-Patient-Safety-White-Paper.pdf
[27] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

pervasive in MAO coverage for behavioral health, directly resulting in patient harm. Individuals experiencing behavioral health crises are often unable to access necessary care and services, and spend extended periods waiting for placement in inappropriate settings like the ED as medical staff wade through arcane and nonsensical processes to satisfy MAOs. Regulators have largely deferred to the dispute resolution mechanisms in provider/health plan contracts, as federal law places restrictions on the government's ability to intervene in "contractual disputes," leaving health plan abuses largely unchecked.

Our members are plagued by plans that routinely deny coverage for behavioral health services as a standard practice, frequently citing "ineligibility" as the reason for such denials. Our members report that the eligibility for behavioral health services — like admission to an inpatient psychiatric facility — differs by the type of software used by various plans, and that adding comorbidities after admission might result in an inappropriate denial at discharge. Plans also change eligibility rules with little notice, and often require copious amounts of information that is not medically relevant for the service being requested, but without which the claim will be denied.

The lack of alignment between the application of MAO coverage rules and established clinical guidelines, as well as Traditional Medicare coverage rules, is a particularly problematic issue for behavioral health services. For example, despite establishing medical necessity for a 28-day detoxification program, plans often deny coverage beyond 7-days.

Another barrier that limits behavioral health access is the narrow network construct. MAOs are increasingly building narrow networks. According to a 2019 Health Affairs study, "some policymakers have raised concerns that networks may have become excessively restrictive over time, potentially interfering with patients' access to providers."[28] While the exact breadth of MA networks varies by locality, MAOs use narrow networks more often for psychiatric care than any other specialty. The Kaiser Family Foundation found that, on average, **MAOs included less than one-quarter of psychiatrists in a county, and more than a third included less than 10% of psychiatrists in their county**.[29] This study also found that one in three MA enrollees were in plans with narrow networks, defined as plans which include less than 30% of physicians in the county, compounding issues related to adequate access within the plan's network. This means that a Traditional Medicare enrollee receiving care for serious mental health issues likely would need to find a new provider if they were to enroll in an MAO. In general, MAO networks are unlikely to include the necessary services for beneficiaries with complex behavioral health needs. According to a 2019

[28] Feyman Y., Figueroa J., Polsky D., Adelberg M., and Austin Frakt, "Primary Care Physician Networks in MA." *Health Affairs*, Vol. 38, No. 4, April 2019. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05501
[29] "MA: How Robust Are Plans' Physician Networks?" Kaiser Family Foundation, October 2017. https://files.kff.org/attachment/Report-Medicare-Advantage-How-Robust-Are-Plans-Physician-Networks

study by the Congressional Budget Office (CBO), patients went out of network in their MAO more frequently for mental health services than for comparison services.[30]

Part of the reason these networks are lacking is due to the challenges to establish contracts between specialized behavioral health providers and MAOs; contracting is limited by the prices MAOs pay for in-network mental health services, which are significantly lower than what Traditional Medicare pays for identical services. As found in the CBO study, **MAOs paid an average of 13% to 14% less for in-network mental health services than Traditional Medicare**, despite paying up to 12% more than Medicare when the same services were provided by other specialties.

And yet, patients tend to pay more out-of-pocket for mental health services than for other medical services under MA. This difference is driven by higher in-network cost sharing for mental health services. As found in the same CBO study, MA patients paid an average of $9 more for mental health services than for comparison services delivered by in-network providers. These network and insurance benefit design challenges are likely to discourage savvy beneficiaries from enrolling in an MAO; however, those not as versed in the complex task of evaluating insurance coverage might just be surprised when they attempt to access care.

We recognize that nationwide shortages in workforce, especially in behavioral health, as well as deficiencies in the availability of data and analytic capabilities, make it a serious challenge to ensure that a MAO network sufficiently meets the needs of its enrollees. Many of our recommendations below align with principles for designing network adequacy standards for behavioral health that are outlined in the November 2021 report from the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) Office of Behavioral Health, Disability and Aging Policy.[31] We acknowledge that these principles are based on ideals; however, we believe that MAOs can achieve these ideals with their considerable resources, access to data and insight into their beneficiaries' utilization patterns.

Time and Distance Standards

Plans are often held to generic standards in terms of what types of providers must be accessible within certain driving distances from a beneficiary's location and certain lengths of time before an appointment is available. These standards are often applied to broad categories of "licensed, accredited, or certified professionals," but the category of "behavioral health professionals" includes a wide range of subspecialists with varying areas of expertise. While we understand the rationale for using the term "behavioral health" in regulation to encompass both mental health and substance use disorders, **the AHA recommends that for the purposes of defining network adequacy, mental**

[30] Pelech D. and Tamara Hayford, "Datawatch: MA and Commercial Prices for Mental Health Services," *Health Affairs,* Vol. 38, No. 2, February 2019. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05226
[31] https://aspe.hhs.gov/reports/network-adequacy-behavioral-health

health and substance use disorders should be differentiated and explicitly listed to ensure appropriate in-network access to providers in each of these uniquely specialized behavioral health concentrations. For example, a network that includes a hospital offering an outpatient eating disorder clinic would not be adequate for an enrollee seeking medication-assisted therapy for opioid use disorder. Similarly, contracting with certified professionals does not ensure that those providers are certified in subspecialties needed across the enrollee population or community.

MAOs can use data on enrollee characteristics — such as quantitative information from claims describing utilization and diagnostic patterns as well as qualitative information like that found on hospital community health needs assessments — to determine, generally, how, when, where and with whom enrollees seek care. With these capabilities, **it is reasonable to expect MAOs to be able to meet more specific time and distance standards**. Alternatively, a simpler approach would be to hold MAOs to time and distance standards to ensure access to basic categories of services including adult psychiatric care, substance use disorder treatment including medication-assisted therapy, and crisis stabilization services. By covering these behavioral health disciplines at a minimum, beneficiaries would at least be able to access care for critical needs in the short-term and perhaps have more time to seek appropriate subspecialty out-of-market or out-of-network care where needed.

Network Adequacy Monitoring Strategies

Furthermore, **we recommend proactive network adequacy monitoring strategies in addition to retroactive compliance reviews**. We commend CMS for the provisions included in the calendar year (CY) 2023 MA Final Rule which require MA plans to demonstrate compliance with network adequacy standards when the MAO is expanding service areas or entering a new market. However, **we encourage the agency to go further by establishing standard network review protocols to be implemented by all CMS regional offices, including secret shopper exercises to confirm if providers listed in an MAO directory are indeed actively enrolled, in-network and have appointment availability.** For behavioral health, such network review protocols should include comparisons of MAO networks against a comprehensive list of services, as well as an **analysis of claims and utilization history by service to assess provider capacity**. Reviewing claims data is an important opportunity to measure realized access to care and support further analysis of provider capacity and population health needs in relation to defining an adequate network. Simply having a designated type of facility in-network is not sufficient to ensure patient access if there are not routinely adequate numbers of beds and appointments available for the volume of patients requiring these services.

We understand that developing a robust, highly specialized network of providers is a daunting task considering the severe shortages of behavioral health providers across the country; however, these shortages and gaps in coverage will persist without further action, harming patients in the process. A proposed network adequacy review protocol

should not only identify those MAOs who fail to offer adequate access to necessary care, but also identify general gaps in access to inform future network design and policy. By monitoring trends in utilization, HHS and agencies under its authority can inform broader policy efforts to improve mental and behavioral health access beyond alterations to network adequacy standards.

ACCESS TO POST-ACUTE CARE SERVICES

Post-acute care (PAC) services can be some of the most challenging services for patients to access because of inappropriately restrictive health plan policies. Indeed, our general acute-care hospital members report that one of their greatest sources of frustration in dealing with MAOs is the inability to get approval to move patients to the most appropriate PAC site of care. Their concerns were echoed in the recent HHS-OIG report, which identified PAC as one of three services most frequently denied requests for prior authorizations and payments even when the setting or course of treatment met Medicare coverage rules and MAO billing rules for the patient's condition. Specifically, the HHS-OIG report included multiple examples of medically necessary inpatient rehabilitation facility (IRF) care that should have been covered and specifically warned about the potential for negative effects on Medicare beneficiaries. These include:

- **Patient Case D270: Denial of a Discharge to an IRF.** A 67-year-old was diagnosed with acute right-sided ischemic stroke and seen at the ED with new onset slurred speech. The MAO denied the prior authorization request stating that the beneficiary's condition did not meet Medicare coverage rules for admission to an IRF. However, the HHS-OIG physician panel determined that admission to an IRF was medically necessary and in line with the Medicare Benefit Policy Manual. The beneficiary had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore, should have been under the frequent supervision of a rehabilitation physician. At the time of the HHS-OIG report publication, this decision had not been reversed.

- **Patient Case D278: Denial of a Discharge to an IRF.** A 68-year-old had chronic obstructive pulmonary disease, congestive heart failure and peripheral vascular disease. The beneficiary was admitted to the hospital with a femur fracture and underwent a screw placement surgery. After the surgery, the beneficiary developed anemia and pneumonia. The MAO denied the request stating that the beneficiary's condition did not meet all medical necessity criteria for admission to an IRF under Medicare guidelines. The MAO recommended instead that the beneficiary could be discharged to a skilled nursing facility (SNF), home health or home with outpatient therapy. The HHS-OIG physician panel determined that the recommendations for outpatient therapy were not sufficient and that admission to an IRF was necessary and consistent with the Medicare Benefit Policy Manual. The beneficiary had ongoing medical conditions that could generate more medical complications if not closely assessed by a

physician daily. The beneficiary also had the ability and need to participate in physical therapy and occupational therapy for three hours at least five days per week, needed help with walking and at least two people to help with balance and recovery from the screw placement in the beneficiary's hip. At the time of the HHS-OIG report publication, this decision had not been reversed.

- **Patient Case D343: Denial of a Discharge to an IRF.** An 89-year-old had a history of Parkinson's disease, dementia and prostate cancer who had been treated in the ED. The MAO denied the request stating that the beneficiary did not have a medical problem that required care in an IRF. However, the HHS-OIG reviewers determined that the requested inpatient rehabilitation stay met requirements in the Medicare Benefit Policy Manual and was medically necessary because it would allow the beneficiary to regain the ability to perform the activities of daily living that the beneficiary was able to do prior to the hospital admission. This denial was overturned upon appeal.

These types of inappropriate delays and denials for PAC services often directly harm patients, erode the overall quality of care provided and result in missed clinical opportunities for specialized therapy necessary to optimize patient recovery and function. They also undermine cross-setting clinical coordination efforts that are critical to high-quality, patient-centered care.

For example, one AHA member shared the experience of a 54-year-old patient with multiple recent hospital admissions who presented to an acute care hospital with infected pressure ulcers, urinary tract infection, acute kidney injury and pneumonia. After primary acute care interventions, the general acute care hospital referred the patient to a long-term acute care hospital (LTACH) to execute a post-acute plan of care including wound care, pain and nutrition management, physical and occupational therapy, monitoring of labs including renal function and daily medical management. The MAO denied the LTACH placement three times in a single month, indicating each time that the patient did not meet medical necessity criteria for an LTACH stay and recommended a lower level of care. After three denials without a successful appeal, the MAO forced the patient to be discharged to a SNF, against the recommendation of the patient's physician and care team. The patient got significantly worse during this time and was readmitted to the general acute care hospital within a month. After subsequent treatment, a fourth attempt to receive MAO authorization to transfer the patient to an LTACH for appropriate PAC services required a peer-to-peer review before being ultimately approved, more than two months after it was first requested. This represents a two-month delay in medically necessary care for an acutely ill patient whose opportunity for a full and speedy recovery was compromised as a result of inappropriate plan denials. These types of cases are well-documented and occurring with alarming frequency as abusive MAO practices appear to remain largely unchecked, despite the harm occurring to beneficiaries.

Beyond individual case examples, these practices are further evident in the observed differences in the use of certain PAC services among patients enrolled in MA versus Traditional Medicare. An analysis conducted by the National Association of Long Term Hospitals found that in 2015, MA beneficiaries were approximately half as likely as Traditional Medicare beneficiaries to receive services at an LTACH (44%) or an IRF (53%), and 9% less likely to use SNFs relative to their Traditional Medicare counterparts. [32] We believe these observed differences are largely the result of prohibitive authorization practices and the application of more restrictive medical necessity criteria by MAOs, which inappropriately limit patient access to covered PAC services.

This is further supported by an AHA analysis of Medicare claims data between 2019 and 2020, which shows that MA beneficiaries who are discharged to PAC settings are generally sicker (measured by mean case-mix index), and experience longer stays in the referring hospital (measured by mean length of stay) compared to Traditional Medicare beneficiaries who are discharged to PAC settings. For example, MA beneficiaries who are discharged from a general acute care hospital to an LTACH experienced 30% higher case-mix index (CMI) and a 35% longer length of stay (LOS) in the referring hospital compared to Traditional Medicare beneficiaries discharged to an LTACH in the first three quarters of 2019.[33] This strongly suggests that MA plans are limiting access to PAC settings to only the sickest and most acute patients, which limits access to other patients who would benefit from clinically appropriate, covered PAC services.

These variations could be the result of extensive prior authorization requirements in MA that do not exist in Traditional Medicare, the use of more restrictive admissions criteria by MAOs, or other differences in how MAOs are applying Medicare coverage criteria and rules in ways that limit access. At a minimum, this concerning variation warrants closer study to determine whether there is a correlation between higher CMI and longer LOS among MA enrollees and restrictive PAC admissions criteria — and whether this results in unequal access to PAC services between the two subgroups of Medicare beneficiaries. Greater transparency into MAO medical necessity and admissions criteria is necessary to conduct such an inquiry.

The PAC delays and denials described above appear to be the result of several problematic plan practices including the following.

Excessive and Inappropriate Use of Prior Authorization

[32] National Association of Long Term Hospitals (NALTH), “Medicare Advantage Limits Use of Long-Term Care Hospitals; Users Have Significantly Higher Severity than in Traditional Medicare,” Feb. 10, 2021.
[33] The AHA analysis used the fiscal year 2019 and 2020 Medicare Provider Analysis and Review (MedPAR) files and specifically looked at discharges in the first three quarters of calendar years (CY) 2019 (pre-PHE) and 2020 (PHE). Since the last quarter of CY 2020 is not in the MedPAR file, we used comparable quarters/time periods.

The burden associated with inappropriate use of prior authorization is well documented and discussed in other sections of these comments. However, it is notable that inappropriate use of prior authorization has a particularly pronounced effect on PAC patients and providers where health plan authorization is needed to transfer a patient to another setting or facility and inability to do so can result in significant delay and harm to a patient's rehabilitation. With this in mind, it is troubling that PAC facilities experience some of the highest denial rates. For example, one AHA member reports that nearly half of all LTACH requests for prior authorization to date in 2022 have been denied by their largest MAO. Notably, this rate of denial is growing, with the member reporting an increase of nearly 13% in LTACH denials from this MAO in the last few years (from 30.7% in 2018 to 43.4% in 2022). This reflects a pattern of aggressive authorization denials that is common among MA plans, especially for PAC services, which unfairly delays and limits access to care for thousands of patients.

Even when prior authorizations are ultimately approved, the turnaround time can be so long that the process causes harmful delays in patient care. This challenge is particularly pronounced in post-acute care transitions where patients are sometimes held in general acute care hospital beds for multiple days after a referral to a post-acute care facility while waiting for MAO approval. In fact, one PAC provider reports that **11% of their MA referrals take 10 days or longer to resolve**.

Inadequate PAC Expertise of Health Plan Reviewers

Oftentimes, health plans use medical reviewers with backgrounds in general medicine but with no specialty or post-acute care knowledge. Too frequently, the medial judgement of the treating physician who examined the patient is overridden by the plan's clinical staff, which is often a registered nurse or other clinician with little or no PAC clinical expertise. This can result in inappropriate denials, while also exacerbating insurer requests for excessive amounts of documentation because the requestor is unfamiliar with the details of a particular service, condition or specialty area. For the same reason, it is not uncommon for health plans to request unnecessary information that is not directly relevant to deciding about whether post-acute care is needed (e.g., when evaluating a prior authorization request for rehabilitation services, requesting information on a medication that would not impact the need for rehabilitation services, etc.).

Inadequate Networks of PAC Providers

Inadequate networks of PAC providers present challenges for patients referred for downstream specialized care that is not provided by the referring hospital, such as services covered by Traditional Medicare for IRFs and LTACHs. These settings provide care through interdisciplinary care teams with specialized clinical training and treatment programs that are critical to achieving patients' rehabilitation and recovery goals. Insurance constructs that result in inadequate PAC provider networks are a critical barrier to patients accessing these specialized services to which they are entitled. For

example, we commonly hear from PAC providers that MAOs will refuse to contract with IRFs in a given market. In one such case, an MAO reported that they do not believe they need IRFs in the network. In others, MAOs have reported that they believe MA enrollees' rehabilitation needs are being met by non-IRF (i.e., SNF) providers in the plan's network. One of these circumstances has resulted in there being zero IRFs in a majority of the counties in a state with high MA penetration.

This is a clear indication that more rigorous network adequacy standards are needed for post-acute care providers to ensure that there are a sufficient number and type of each post-acute care facility in MAO networks to meet specialized patient needs. The size and bed capacity of such facilities should also be considered in developing stronger network adequacy requirements for post-acute care facilities, as even in cases where there are a specified number of PAC facilities available in a certain geographic area, there may not be available beds, which can further restrict patient access.

Inequity between MA and Traditional Medicare Policies

As described above, there are alarming inequities in the application of certain policies in the MA program compared to Traditional Medicare, most notably with respect to MAOs' use of more restrictive medical necessity criteria. As we have noted, this is particularly pronounced in post-acute care where more restrictive criteria are routinely applied to post-acute care admissions, resulting in inappropriate denials for medically necessary services that would have been covered under Traditional Medicare. Beyond medical necessity criteria, there are also other concerning areas where MAO policies or practices diverge from Traditional Medicare in ways that are unexpected. For example, our members report that under Traditional Medicare, home health care services are routinely approved and initiated within 48 hours of discharge from a general acute care hospital where indicated. However, in their experience with MAOs, our members report that it can routinely take four to five days for home health services to begin. This is an unreasonable amount of time to leave patients and their families without the support they need, and it further reflects the concerning inequities in the availability of covered services between MA and Traditional Medicare enrollees.

Excessive Retroactive Denials

There are widely held concerns about the behavior of MAOs who approve prior authorization requests for PAC services, but later issue retrospective denials for the same services. This has been a long-standing and problematic issue for many PAC providers and results in hesitancy on the part of PAC providers to accept patients for whom coverage of their care will frequently be denied. Such hesitancy further contributes to delays in patient transfers from general acute-care hospitals to PAC facilities. This fear was palpable among PAC providers during the COVID-19 pandemic when certain MA plans offered temporary waivers of prior authorization at CMS's urging but the plan had a history of retroactively denying payment for services after approving or waiving prior authorization.

MAO Financial Incentives

It also appears that some MAOs may be motivated by financial reasons to keep a patient in the referring hospital for longer than is medically prescribed by the treating physician. In this case, the plan has already paid the hospital a flat rate for care and is either delaying or attempting to avoid discharging the patient to the next site of care, which would require a separate, additional reimbursement. Indeed, the AHA claims data analysis described above reflects that LOS in the referring hospital is typically longer for MA beneficiaries than Traditional Medicare beneficiaries being discharged to a PAC setting. Specifically, in the first three quarters of 2019, the LOS in the referring hospital was 35% longer for MA beneficiaries being discharged to an LTACH compared to Traditional Medicare beneficiaries; 27% longer for MA beneficiaries being discharged to an IRF; and 14% longer for MA beneficiaries being discharged to a SNF. This also suggests that the more costly or intensive the recommended PAC setting is, the longer the MAO forces the patient to wait in the acute care hospital to be transferred, perhaps in hopes of delaying or deterring the need for additional payment in another setting of care. Such behavior is an egregious violation of federal rules and public trust. In such cases where financial incentives are taking precedence over patient care needs, we urge CMS to take swift action to hold plans accountable with strong enforcement action and appropriate penalties, including civil monetary penalties.

ROLE OF TELEHEALTH

As the experience of the past two-plus years of the COVID-19 pandemic has demonstrated, telehealth services can be a crucial access point for many patients and can extend the reach of providers to fill gaps in care, enhance patient and clinician safety, and support continuity of care. However, the reliance on virtual care during this time has also exposed the depths of the “digital divide.” Significant proportions of the population are unable to access care via telehealth modalities due to a lack of equipment, broadband internet or technology knowhow.

The MA approach to incorporating telehealth into the assessment of network adequacy offers issuers a credit towards meeting time and distance standards. Plans that contract with certain types of telehealth providers must only prove that 80% — as opposed to 90% — of enrollees reside within the required time and distance standards. This method is only appropriate if those certain types of telehealth providers are accessible to the enrollees who need them. By automatically applying this 10% credit, CMS runs the risk of allowing issuers to dilute their market with virtual providers who may not actually have capacity to take on patients while simultaneously reducing their in-person footprint. **We recommend that capacity standards are applied to telehealth providers in a similar way to in-person providers — that is, to consider a provider to be part of the network, that provider must be accepting new patients and offer specified services within a certain number of days.**

INTERMEDIARY ADMINISTRATIVE SERVICE ENTITIES

Many MAOs rely on subcontractors to administer portions of their benefits. For example, MAOs frequently subcontract to vendors to manage prior authorization adjudication for particular services, such as rehabilitation or behavioral health. While Federal guidance requires MAOs to ensure that their vendors or benefit managers adhere to all program rules, hospitals and health systems frequently find that MAOs and their vendors are not consistent in their knowledge or application of MAO rules and processes.

A common area of disconnect relates to prior authorization. The MAO tells the provider that no prior authorization is required for a particular service; however, the benefit manager or vendor will tell the provider to submit a prior authorization request. When the vendor denies the claim and the provider appeals, the appeal goes to the MAO for processing, which reaffirms that no authorization was required in the first place. Another common occurrence is that the vendor will collect medical records for purposes of adjudicating a prior authorization request. However, when the vendor denies the request and the provider appeals, the MAO which handles the appeal requests the provider send the exact same records that have already been provided to the vendor. These disconnects waste patient and clinician time and add costly burden to the health care system.

As further evidence of these concerning trends, one of the nation's largest MAOs began using a new intermediary vendor last year to manage certain post-acute care administrative processes for their MA members in a number of states. A member PAC provider compared data on referrals and admissions before and after the introduction of the intermediary vendor. The analysis reflects that their system experienced a 28% (542) decrease in the number of patients approved for IRF admission in the 333 day days following the introduction of the vendor, despite an increase in referrals during this time. The PAC provider's IRF admission rate with that MAO dropped from 44% of referrals admitted previously to 26% within a year from when the intermediary service vendor started managing the process. These trends reflect a drastic shift in the rate of approval for IRF care, which is unlikely to be a coincidence, but rather a broader strategy to use third party vendors to impose tighter controls on the admission process and restrict utilization. In fact, the vendor has issued tip sheets for PAC placement which directly reference medical necessity criteria which are not part of Medicare's coverage rules, giving further credence to concerns that MAOs are applying more restrictive criteria in ways that are resulting in decreased admissions, as shown here. We are concerned that this is a much broader trend and an area where greater transparency and oversight is needed.

We encourage CMS to extend its direct oversight to MAO vendors and hold MAOs accountable when their vendors delay or restrict patient access to care, or add unnecessary costs and burden in the system.

MAO MARKETING PRACTICES

The MA program was established to give seniors' choice in the health insurance coverage they receive. As discussed in the health care literacy section above, for beneficiaries to make a meaningful selection, they must be able to understand what they are choosing, including their potential financial obligations, the scope of the provider network, potential care restrictions and supplemental offerings. MAO marketing practices must be carefully monitored to ensure accuracy and clarity to protect informed patient choice. We were pleased to see that CMS values this same concept, as shown in the health plan oversight provisions included in the CY 2023 MA Final Rule, which included important restrictions aimed at controlling improper marketing to MA beneficiaries. To further the important steps taken in this rule, **the AHA recommends that CMS require greater transparency regarding prior authorization and other utilization management restrictions, accessible network information and plan-level information on inappropriate coverage denials and delays in care**.

A health plan's provider network is arguably the most important information for a prospective enrollee, as patients need to understand which health care providers they can use to access necessary care and services. As a result, any MA marketing should be required to provide the prospective enrollee with access to information about which providers are part of the plan network. Particularly with MA, where prospective enrollees may be switching from an employment-based commercial insurance network with a completely different provider network (even if with the same parent insurance organization), it is essential that plans are upfront about which providers participate in their network. Such information should include clear information concerning any site of service restrictions or other plan policies that may prevent patients from accessing a particular service from a network physician or facility. This will help prevent patients from being misled into believing that their plan will cover specific services from their regular or preferred care team, only to find out after enrolling that their new plan will not cover their treatment as expected.

Furthermore, as previously discussed, prior authorizations can prevent patients from accessing necessary care in a timely fashion. In addition to the inappropriate denials revealed by the HHS-OIG report, prior authorization also requires provider submission of clinical criteria and lengthy plan consideration periods, which can delay a patient's access to necessary services or drugs. To help patients select a plan that is right for them, potential beneficiaries should be able to access all the drugs and services for which an MAO requires prior authorization. In the case of specialty pharmacy coverage, patients should also be provided information about medications which require step therapy or white bagging, site of service exclusions for medication administration, or medications placed in a tiered or preferred formulary structure which may impact patient cost-sharing. Particularly for patients with chronic or recurring conditions, knowledge of whether a necessary therapy will be subject to prior authorization or other insurance benefit design barriers can be an important criterion in a patient's selection process.

Finally, **we urge CMS to collect, audit and make public data on MAO denials, appeals, grievances and delays.** This data is needed to conduct appropriate oversight

of MAOs and should be the backbone of future enforcement efforts, as we discuss in more detail below. This information should also be available to beneficiaries in an easily accessible manner and alongside other MAO marketing materials presented to seniors during the enrollment process to ensure people have an opportunity to make an informed decision about their coverage options.

MAO OVERSIGHT

Hospital and health systems' experience with MAOs suggests that some MAOs are failing to adhere to CMS policies, something that the previously cited HHS-OIG report also validated. These violations, for example, inappropriate use of proprietary clinical criteria to adjudicate coverage determinations, have negative implications for patients and providers. As a result, we believe greater CMS oversight of MAO conduct is warranted. However, our examination of CMS' data collection on health plan performance suggests that the agency may not have the information it needs to conduct thorough oversight of MAOs. Currently, there are limited reporting mechanisms available to provide CMS with important information about plan-level coverage denials, appeals, grievances or delays in care resulting from prior authorization and other administrative processes. These are important indicators of beneficiary access and are essential to proper oversight of MAOs. We strongly urge the agency to evaluate its data collection and address gaps.

Additionally, we recommend that CMS establish a provider complaint mechanism that allows providers to flag problematic plan behavior. Through the nature of their care relationships with patients, clinicians often have the most frequent interaction with plans, giving them unique insight into when plans have practices that inappropriately delay or deny patient access to care. To help ensure that patterns of inappropriate denials and delays are addressed as soon as possible, providers need a mechanism to flag problematic MAO activity. There is currently no streamlined way to do this. **We encourage CMS to create a mechanism for providers to raise issues to regulators. CMS should utilize this information to guide heightened enforcement of problematic MAO actions.**

Enhanced Data Collection and Reporting

Administrative data maintained by MAOs is one area that CMS, other regulators, researchers and the public can review to better understand and improve the experience of beneficiaries enrolled in MA, as well as support their plan selection process. Below we provide an assessment of opportunities to improve collection and use of data on MAO performance in areas of importance to beneficiaries and their providers, including prior authorization requests, coverage determinations, appeals and grievances and member complaints.

Prior Authorizations and Coverage Denials. Currently, MAOs are required to report fully favorable, partially favorable, and adverse organization decisions at the contract

level, inclusive of both prior authorization requests (“predeterminations”) and claims payments. MAO coverage denials (i.e., organization determinations that are partially favorable or adverse including prior authorization determinations) include the total number of organization determinations and the disposition, as well as whether the determination pertained to a claim submitted or a prior authorization request. This approach does not enable reviewers to analyze subtypes of prior authorization determinations, such as the type of item or service requested (e.g., behavioral health, inpatient services, Part B drug, etc.).

Each MAO sponsor must conduct a yearly independent audit of their data to determine their reliability, validity, completeness and comparability in accordance with specifications developed by CMS. To ensure the independence of the data validation, organizations must not use their own staff to conduct the data validation. Instead, sponsors are responsible for acquiring external data validation resources. CMS specifies the standards for selecting a data validation contractor, data validation standards and interview protocol questions. CMS makes a pass/not pass determination at the contract level for all data validation reviews after the annual deadline for submission of findings and provides the aggregate results to sponsors in the summer or fall of the same calendar year. The pass/not pass determination is appealable. CMS also evaluates a sponsor's data validation results prior to using plan reported data in performance measures (if applicable), and inclusion in reporting requirements public use files. A sponsor must score at least 95% for a specific reporting section and be compliant with data validation standards/sub-standards for relevant data elements for CMS to consider the reported data valid for public use.

It appears to us that CMS uses MAO determination data in a relatively limited manner. First, the determination data are not used in Star Ratings. Further, there is no documentation to suggest that this specific data drives oversight decisions like identifying which MAOs to audit. However, as a general matter, compliance with reporting is a contractual obligation of all MAOs, so CMS could issue compliance notices and take enforcement actions in response to reporting requirement failures. CMS may issue a particular non-compliance notice called a Corrective Action Required (CAR). MAOs respond to CARs through corrective action plans, and CMS may require the MAO to hire an independent validator to certify the deficient practice is corrected. Therefore, CMS may issue warning notices or CARs to non-compliant MAOs who are not reporting determination data in good faith. Should the non-compliance persist, CMS could impose intermediate sanctions (e.g., suspension of marketing and enrollment activities), civil monetary penalties (CMP) or terminate the contract. However, we are not aware of an instance in which non-compliance has resulted in an intermediate sanction.

The AHA recommends CMS take the following steps to improve the quality and use of MAO data on prior authorizations and coverage determinations.

- **Frequency.** Instead of requiring MAOs to hold each quarterly report until the end of the year and submit in February of the following year, CMS could require more frequent reporting to the end of the month following the applicable quarter. This would allow CMS to access the data and monitor performance close to real-time during the year. CMS previously required quarterly submissions, at least as recently as 2011, according to a 2014 OIG report.[34]

- **Transparency.** CMS could publish a list of MAOs that must respond to a CAR notice from CMS as they once did in 2012. If CMS believes the data is reliable, it could also produce a list of outlier contracts.

- **Disaggregation.** It is not clear if CMS has good visibility into prior authorization request dispositions by item or service category without asking MAOs to separately report this from other types of requests. CMS could address this by adopting the definitions/questions used in the National Association of Insurance Commissioners (NAIC) Market Conduct Annual Statement (MCAS) regarding prior authorizations.

- **Consequences.** Because data integrity is so foundational to meaningful oversight processes that could flow from it, CMS could tie failure to validate data to more concrete consequences than simply removing the data from the public use file. One example would be to use failure to pass data validation to target more frequent plan auditing or adopt more serious consequences for non-compliance (failure to submit complete data or validate data) like suppressing the insurer on Plan Finder, or more consequently, imposing enrollment freezes or issuing CMPs. CMS has, in the past, issued CMPs for other administrative processes, such as failing to produce fully accurate member materials; the agency might take a similar approach here.

- **Audits.** CMS could flag high rates of MAO determinations denials, partially or fully unfavorable, to identify MAOs for program audits to understand if the plan is correctly applying plan terms or medical necessity criteria. The HHS-OIG made a similar recommendation in 2014 for CMS to identify whether outlier data values reflect inaccurate reporting or atypical performance and to use reporting requirements data as part of its reviews of MA organizations' performance.[35]

- **MA Star Ratings Program.** CMS could treat high rates of organization determination denials, partially or fully unfavorable, as a display measure to increase transparency. Over time, CMS could assess data reliability to determine whether the display measure could be reasonably integrated as a star measure with Star Ratings consequences.

---

[34] CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited, March 2014, available at: https://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf
[35] Ibid.

Appeals. Appeals data are reported to CMS differently than prior authorizations, coverage denials and grievances data. Appeals data are reported to CMS through its independent review entity (IRE), MAXIMUS, a CMS contractor responsible for adjudicating external reviews requested by the enrollee after an unfavorable appeal decision is made by the plan. First level appeals are considered and processed within the MAO.

Data reported to the IRE that are relevant for two Star Ratings as described below include: (1) total number of Part C appeals cases processed by the IRE; (2) number of Part C appeals which were overturned; (3) number of Part C appeals which were upheld; (4) number of Part C appeals which were partially overturned; (5) number of Part C appeals which were dismissed; (6) number of Part C appeals which were withdrawn; (7) number of Part C appeals which the IRE considered to be late; and (8) percent of Part C appeals which were processed in a timely manner.

Regarding data validation, first, prior to submission, the MAO must validate the data to ensure that the appeal is submitted by an individual who is eligible to appeal. The IRE appeals process does not begin until the third party (e.g., authorized representative) is validated. Second, MAXIMUS will review the case file from the first level appeal that the plan adjudicated internally. When it reviews the file, it may correct deficiencies. For example, MAXIMUS may correct the date that the appeal began which is important for the Star Ratings measures associated with appeals.

CMS uses appeals data the plan reports to the IRE to generate two Star Ratings:

- Plan Makes Timely Decisions about Appeals: Percent of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.
- Reviewing Appeals Decisions: This rating shows how often an independent reviewer thought the health plan's decision to deny an appeal was fair. This includes appeals made by plan members and out-of-network providers.

Each of these Star Ratings measures are weighted 1.5. By contrast, some Star Ratings measures are double or triple-weighted, while CAHPS scores are quadruple-weighted. Any non-compliance CMS identifies through the IRE's oversight processes could give rise to a CAR notice.

The AHA recommends CMS take the following steps to improve the quality and use of MAO data on appeals.

- **Transparency.** CMS could publish a list of MAOs that must respond to a CAR notice from CMS.
- **Auditing.** CMS could use extremely low rates of appeals, high rates of untimely appeals or inappropriate appeals decisions (as determined by the IRE's review of

the case file to assess whether the appeal decision was fair) to identify MAOs to audit. The OIG made a similar recommendation in 2014 for CMS to identify whether outlier data values reflect inaccurate reporting or atypical performance and to use reporting requirements data as part of its reviews of MAO performance.[36] The OIG also suggested in a 2018 report that extremely low numbers of appeals or high numbers of overturned denials upon appeal raise a concern that beneficiaries and providers may not be getting services and payment that MAOs must provide.[37]

- **MA Star Ratings Program.** CMS could increase the weight of the two appeals Star Ratings to double or even triple weighted. This would emphasize the importance of enrollee experience.

Grievances. CMS collects data on MAO grievances, defined as "any complaint or dispute, other than an organization determination, or appeal about any aspect of the operations, activities, or behavior of a Part C organization, regardless of whether remedial action is requested."[38,39] Like coverage denials, grievance data is reported to CMS at the contract level. MAOs are required to report metrics on the total number of grievances, number of expedited grievances and number of dismissed grievances. The data validation process is like the organization determination data validation process described above.

CMS uses grievances data in a somewhat limited manner. First, grievance data are not used in Star Ratings. Rather, the reported grievance rate is a display measure. In contrast to the Star Ratings available on the Medicare Plan Finder tool on www.medicare.gov, information about sponsors' performance on these display measures are displayed without any assignment of Star Ratings. Instead, the display measures are posted on the CMS website in a zip file. The measures are posted approximately in December of each year, which means the most recent year of data would not be used by beneficiaries during the annual election period. In theory, the data could influence an enrollee's decision to switch MAOs after Jan. 1 during the open enrollment period from Jan. 1 to March 31, but we are not aware of any evidence suggesting grievances data informs plan switching as opposed to an enrollee's individual experience, like issues with provider access or continuation of coverage of items or services like prescription drugs. Like determination data, an MAO's failure to

[36] CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited, March 2014, available at: https://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf
[37] Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, September 2018, available at: https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp
[38] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-M
[39] As further background, an MAO must establish meaningful grievance procedures. The medical exigency standard requires MAOs to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the organization needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a MAO to process an enrollee's request for an expedited organization determination or reconsideration requires a response from the MAO within 24 hours.

pass data validation of grievance reporting requirements will result in removal from the public use files.

As best we can tell, grievance data do not drive oversight decisions like identifying which MAOs to audit. However, as a general matter and as described above, compliance with reporting is a contractual obligation of all MAOs with the potential for CMS enforcement actions.

The AHA recommends CMS take the following steps to improve the quality and use of MAO data on grievances.

- **Frequency**. Instead of requiring sponsors to hold each quarterly report to the end of the year and submit in February, CMS could require more frequent reporting to the end of the month following the applicable quarter as described above.[40]

- **Transparency.** CMS could publish a list of MAOs that must respond to a CAR notice from CMS.

- **Consequences.** CMS could tie failure to validate data to more concrete consequences than simply removing the data from the public use file. One example would be to use failure to pass data validation to target more frequent plan auditing or emphasizing more serious consequences for noncompliance (failure to submit complete data or validate data) like suppressing a plan on Plan Finder, or more consequently, imposing enrollment freezes or issuing CMPs.

- **Audits.** CMS could tie high grievances rates to identify MAOs for program audits to understand if the plan has areas of deficient operations, as described above.[41]

- **MA Star Ratings Program.** CMS could convert high rates of grievances from a display measure to a star measure that figures into a MA plan's Star Rating.

Member/Provider Complaints. Member and provider complaints are similar in form to grievances but are generally addressed through a process run through CMS's complaint tracking module (CTM). MAOs do not report their CTM records to CMS as their grievance logs. Complaints received directly by the MAO do not need to be collected in the CTM and can be handled as grievances. Therefore, plan grievance and CTM numbers may vary significantly by plan.

In practice, CMS or the plan receives complaints directly from beneficiaries. CMS intakes complaints received via the Medicare call center in real-time or a CMS Regional Office. Other types of complaints received by CMS are uploaded daily through a data

[40] CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited, March 2014, available at: https://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf
[41] Ibid.

upload. Plans must manage their complaints using the CTM. Plans are then required to respond within a certain timeframe depending on the issue level.

MAOs report complaints resolution information to CMS. Overall, MAO notes should show that the MAO has researched the complaint, taken appropriate steps towards resolution, addressed all beneficiary issues and informed the beneficiary of the resolution.

Regarding data validation, CMS does not appear to perform data integrity checks in advance of sending the complaint to the MAO for resolution nor perform any action to validate the MAO's resolution notes.

CMS pulls complaints data after the end of a measurement timeframe to generate a quantitative snapshot of the CTM data for a given MAO, which informs a Star Ratings measure: complaints about the health plan. CMS calculates complaint rates per 1,000 enrollees adjusted to a 30-day basis. From 2020 to 2021, CMS increased the weight of the complaints measure to 2. Any non-compliance CMS identifies regarding the CTM could give rise to a CAR notice.

The AHA recommends CMS take the following steps to improve the quality and use of MAO data on member and provider complaints.

- **Transparency.** CMS could publish a list of MAOs that must respond to a CAR notice from CMS.
- **Auditing.** CMS could use CTM data to identify opportunities for more targeted auditing of MAOs or other appropriate oversight activity.
- **MA Star Ratings.** CMS could increase the weight to the Star Ratings measure from 2 to 2.5 or 3 to emphasize the importance of member experience measures.
- **Categorization.** CMS does not ensure the integrity of CTM categorization and, as a result, is not in position to identify MAOs with deficient operations in key areas (e.g., provider access). CMS could clarify correct categorization requirements and audit to ensure accuracy. Over time, this would make CTM data a more useful oversight tool.

Section C: Drive Innovation toward Person-centered Care

CMS posed several questions related to how the MA program may help advance adoption of value-based models to support person-centered care. Hospitals and health systems are committed to improving patient access to care, enhancing care coordination and the patient experience, improving health outcomes, and supporting patient affordability and sustainability of the overall health care system. Hospitals and health systems participate in an array of value-based purchasing (VBP) models, and a number have assumed full financial risk through insurance offerings. As of our latest

survey data, approximately 50% of general medical/surgical hospitals participated in some form of performance-based programs within their payer contracts, including shared savings, bundled payments, direct contracting, accountable care organizations and medical homes.[42] In addition, approximately 100 are licensed to take full risk as a health plan (including approximately 70 that serve as MAOs).

The AHA works to support our members to evaluate and participate in these models. For example, in the past year, two board-level AHA task forces explored different elements of risk adoption to support providers in their consideration of such models. These included primary care capitation and variations on full and partial risk models in partnership with provider-led health plans.

Despite widespread interest in participating in VBP models, hospitals and health systems face many challenges to doing so. We hear frequently that many commercial insurers, including MAOs, have not been willing to enter meaningful VBP arrangements. When plans do offer VBP arrangements, they tend to be designed without input from providers and therefore are either not workable or serve solely to financially benefit the plan. For example, plans may be unwilling to share the real-time data that providers would need to manage populations in a risk-based reimbursement environment and yet demand as part of their proposed arrangements expansive access to provider medical records with unclear objectives.

Another challenge is managing competing payer interests. Successful value-based arrangements require alignment across patients, plans and providers. This means that both the plan and the provider must agree to the objectives and parameters of the relationship, ensure clarity regarding responsibilities for care management, set performance metrics and targets and agree to common technology and information sharing. These are highly complex arrangements that require willing and committed partners with dedicated staff and near constant communication. It is challenging for providers who routinely contract with many different plans to participate in even just a few payer-specific models at once.

One model where we have seen innovation is within plans — including MAOs — that are part of integrated delivery systems where the provider and plan functions can more readily coordinate to improve patient access to care and care coordination. For example, one provider-led health plan recently eliminated a substantial number of prior authorizations for patients cared for in their system after hearing complaints from both patients and providers about the resulting delays in care, including for services that were nearly always approved. In addition, they realized that prior authorization processes were often at odds with their care coordination and efficiency objectives. They shared an example where an ordering physician could have facilitated the patient getting the necessary test during the same appointment. However, the patient had to wait for plan approval, which meant the patient had to return for another appointment on

[42] AHA 2020 Annual Survey

a different day. This provider-led plan was able to address this patient and clinician friction point by aligning the necessary data systems and modifying the health plan benefit design. They also worked closely with their clinicians to ensure awareness of the new processes and objectives.

Given the short timeframe to submit comments, we are unable to provide comprehensive recommendations on how to further advance VBP adoption within the MA program. However, we welcome further conversation with CMS about how provider-led health plans can provide unique value to beneficiaries and the program.

Section D: Support Affordability and Sustainability

IMPLICATIONS OF MA ENROLLMENT GROWTH

This rapid growth in MA enrollment has significant implications for health care spending, patient access to care, provider utilization and revenue expectations, provider administrative costs, program oversight, and setting of rates — both within the remaining Traditional fee-for-service Medicare program and for MAOs. **We strongly encourage CMS to thoroughly evaluate the implications of this transition for enrollees, taxpayers and the overall health care system.**

From a taxpayer perspective, we do not believe that spending 104% as compared to the Traditional Medicare program is financially sustainable, and we question whether beneficiaries and taxpayers are getting sufficient value for this higher rate of spending. While we do not question the significance of certain MA program features, such as capped beneficiary cost-sharing and access to supplemental benefits, we are deeply concerned that enrollees and policymakers may be unaware of the trade-offs they are making for access to those benefits — specifically, reduced choice among providers and restricted access to covered services. Indeed, the government is essentially paying more for less care, which has direct implications for beneficiaries. For example, we point to the research in Section B, which found that beneficiaries with substantial medical needs are more likely to disenroll from an MAO in their last year of life when their care needs are the highest and return to the Traditional Medicare program. This points to frustrations with the barriers they face in accessing the care they need, as well as to the HHS-OIG's findings regarding inappropriate denials by MAOs. Accordingly, **we urge CMS to carefully review capitated MAO reimbursement structures to ensure that the Medicare Trust Fund is being spent judiciously and that MAOs are not being overpaid to cover contracted services, especially when there is evidence that MAOs are refusing to pay for appropriate use of such services. We also recommend that CMS examine opportunities to eliminate perverse incentives that may encourage MAOs to deny medically necessary care to increase plan profits**.

Separately, we also encourage CMS to evaluate the implications of high MA enrollment on the ability of the agency to effectively set MAO benchmarks. We are aware, for example, that Puerto Rico, which has nearly 80% of all Medicare beneficiaries enrolled

in MA (and 94% of beneficiaries with both Medicare Parts A and B), may be experiencing the implications of not having adequate and comparable enrollment in the Traditional Medicare program, which is needed to effectively set MA benchmarks.[43] Inadequate payment to MAOs trickles down to inadequate funding for providers, jeopardizing their ability to continue offering services in their communities.

At the same time, increased enrollment growth in MA reduces the remaining volume of claims processed through the Traditional Medicare program, potentially upending the methodologies used to set payments. For example, high MA enrollment can affect how relative weights for MS-DRGs are determined since discharges for MA beneficiaries are excluded in weight setting analysis, and weights consequently are applied to the standardized amount to determine the payment rate per MS-DRG. MA enrollment also plays a role in Traditional Medicare payment rates in the context of Medicare Disproportionate Share Hospital (DSH) payments. As more and more beneficiaries are enrolled in MA, the number of inpatient prospective payment system discharges estimated by CMS to determine DSH goes down and therefore lowers DSH payments. **We urge CMS to conduct a thorough review of Traditional Medicare payment methodologies that could be impacted by high MA enrollment and to work with stakeholders to determine whether changes in policy are needed to mitigate potential negative consequences.**

Finally, we believe more analysis must be done to understand other financial impacts on the health care system of growing MA enrollment. As noted above, MA beneficiaries tend to have different utilization patterns to enrollees in the Traditional Medicare program. Indeed, MAOs' business model is predicated on reducing medical spending. All stakeholders must understand what growth in MA enrollment means for health services utilization and, consequently, provider reimbursement. This is particularly true as a substantial portion of provider costs are fixed and a reduction in utilization does not necessarily equate to a commensurate reduction in expenses. At the same time, caring for MA beneficiaries often increases providers' administrative costs, as we discuss more below. **We encourage CMS to evaluate the overall impact of continued growth in MA on health system resources and make the results public. Doing so will enable policymakers and other stakeholders to make informed policy decisions.**

MAO PRACTICES THAT CONTRIBUTE TO HEALTH SYSTEM COSTS

Some commercial health insurers, including MAOs, have implemented policies that add billions of dollars in unnecessary administrative costs to the health care system. As discussed above and detailed extensively in a recent AHA report, insurers' use of policies that deny or delay medically necessary care, such as inappropriate prior authorization or overly restrictive medical necessity policies, have become extraordinarily burdensome on hospitals, health systems and patients. These complex

[43] Goldman, M. "PUERTO RICO: The 'canary in the coal mine' for Medicare Advantage growth," *Modern Healthcare*, Ju. 16, 2022; Accessed at: https://digital.modernhealthcare.com/2022/07/16/puerto-rico-the-canary-in-the-coal-mine-for-medicare-advantage-growth/content.html

payment and reporting requirements have led to massive administrative costs for providers. For example, in 2019, one large hospital system reported spending $10 million per month on administrative costs associated with commercial health plan prior authorization policies.[44] CMS could take many steps to reduce administrative waste in the MA program, including requiring plans to comply with standard, electronic processes for prior authorization, as well as adhering to the same clinical criteria as the Traditional Medicare program, which would dramatically reduce the amount of staff time spent on administrative tasks such as appeals of inappropriate prior authorization denials.

RISK ADJUSTMENT

Risk adjustment is a critical component of any risk-based reimbursement model. While MAOs must have adequate resources to care for their enrollees, it is imperative that the additional resources support patient access to care. Various stakeholders, including MedPAC, have raised concerns about several aspects of the MA risk adjustment program. However, we are limiting our comments to one specific issue: potential gaming by MAOs when they submit diagnoses and service codes to CMS for risk adjustment purposes that they stripped from the claim in the context of provider reimbursement.

MAOs routinely remove diagnoses and service codes from provider claims. Specifically, providers submit claims that may include multiple diagnoses and services for a patient, consistent with the patient's condition and supported by evidence in the medical record. However, MAOs routinely remove certain service codes or diagnoses from the bill, which frequently results in lower reimbursement to the provider. These are considered line-item denials or downcoding. For example, several large commercial insurers began declining to cover care for certain sepsis diagnoses, stating that the plan does not cover sepsis care until the condition has been exacerbated to a more advanced state. While we separately point out in another part of these comments the absurdity of failing to cover early sepsis interventions, we raise this here as a potential example of how the risk adjustment program may need to be reformed.

Specifically, we interpret CMS guidance as allowing plans to deny coverage for a particular diagnosis/service while simultaneously sending those codes to CMS for risk adjustment purposes. CMS guidance states: "CMS expects that MAOs and other entities will submit EDRs [encounter data records] for each service or item covered by the plan and provided to an enrollee, regardless of the payment status of the claim (for example, accepted, pending, or denied for payment by MAO). Because an EDR is a record of a service or item covered by the plan and provided to an enrollee while enrolled in that plan, the MAO's final adjudication status of a claim from a provider is not

[44] https://www.aha.org/system/files/media/file/2022/07/Commercial-Health-Plans-Policies-Compromise-Patient-Safety-White-Paper.pdf

relevant to the MAO's submission of an EDR report to CMS."[45]

Allowing MAOs to financially benefit from enhanced payment based on codes that they stripped from a provider's claim amounts to double dipping. The MAO receives revenue to cover the care through both its benchmark payment and the risk adjustment program but then reduces its expenses by denying payment to the provider for the service. While hospitals and health systems do not have access to the necessary data to validate the extent to which this occurs, **we strongly urge CMS to prohibit plans from submitting for risk adjustment purposes codes for which the payer fails to reimburse the provider for the beneficiary's care.**

MEDICAL LOSS RATIO

The MLR measures the amount of premium dollars that go toward health care services and quality improvement activities and caps the amount that insurers can spend on administrative activities or profits. MAOs are required to spend at least 85% of premium dollars on care and quality improvement. **The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to patients' access to care and to hold health plans accountable for how premium dollars are spent, and we urge CMS to impose increased scrutiny on plan expenditures to ensure that patient premiums are being utilized appropriately.**

We are greatly concerned about the ways in which vertical integration within some of the largest insurers can enable plans to channel excessive health care dollars to their affiliated health care and data services providers at patients' expense. To be clear: we do not view all plan payments to affiliated entities as problematic, such as when an integrated system's health plan pays affiliated clinicians an appropriate rate for patient care. What is problematic, however, is when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that inappropriately increase health system costs, as well as when plans use their benefit design to steer patients to their affiliated providers without properly educating them about these network rules in advance.

For example, the three largest pharmacy benefit managers — CVS Caremark, Express Scripts and OptumRx — are all owned by large, national insurers that offer MA coverage throughout the country. Pharmaceutical purchasing from PBMs is a prominent expense for an MAO, and the dollars spent on such procurement are classified as qualified care expenses for MLR calculations. The vertical integration of PBMs and MAOs could enable plans to manipulate their PBM expenses by paying larger sums to their affiliated PBMs in order to meet MLR expense requirements, allowing plans to skirt regulations while still keeping premium dollars for their parent company's bottom line. To further enhance revenue for the PBM, the plans can implement coverage restrictions

[45] CMS May 2018 Encounter Data Submission and Processing Guide, https://www.csscoperations.com/internet/cssc4.nsf/files/ED_Submission_Processing_Guide.pdf/$File/ED_Submission_Processing_Guide.pdf.

on where their enrollees access certain drug therapies. Indeed, PBMs have been a primary enabler of site-of-service restrictions on physician-administered specialty drugs, which are often announced to beneficiaries mid-year. In other words, the plan sells the coverage under one set of network rules about where the beneficiary may access services but then changes those rules mid-coverage year.

Additionally, we are concerned about the categorization of funds spent on programs designed to limit coverage as "quality improvement" expenses. We understand that health plans may be able to count some or all their utilization management functions in the numerator of the MLR under the category of "quality improvement." As detailed above, we are deeply concerned that many MAO prior authorization and other utilization management programs can impede patient access to timely, necessary care. Although contrary to the intent of the legislation, we believe that many insurers may be intentionally disguising their cost-control mechanisms as "quality improvement" initiatives as a way of preventing the issuance of rebates to consumers.

For example, "Leveraging Utilization Management to Reduce Medical Loss Ratio Rebates," is a blog post from Medecision, a care management company owned by a large commercial insurer/MAO. In the blog, the company touts that if plans include an outcome or safety component in their utilization management programs, "then the money spent on UM will count toward a plan's 80–85%. Patient care is improved and health plans hit their numbers, thus reducing the amount of rebates. Talk about a win-win."[46] We believe that actively engaging in processes designed to shield expenses from potential patient rebates flies in the face of the goals of MLR standard. **We urge CMS to review how insurers are categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities.**

Section E: Engage Partners/Stakeholders

We strongly support efforts to engage stakeholders in ongoing planning, review and refinement of the MA program. Obtaining the beneficiary perspective is particularly crucial. Health care providers, including hospitals and health systems, often act on behalf of their patients when working with insurers to obtain approval and coverage for medically necessary care. As a result, providers are in a strong position to help identify faulty or outdated program rules or bad actors. Unfortunately, as previously noted, there currently is no streamlined or direct way for providers to report concerns to CMS. When issues are raised, they are frequently labeled as "contractual disputes" and therefore not subject to agency intervention. However, what may appear to be a contractual dispute is often evidence of widespread, persistent behavior on the part of plans in ways that directly impact patient access to care. However, without a way for providers to report issues, CMS has no ability to establish a fact pattern needed to engage in enforcement activity. **As previously expressed, we encourage CMS to establish a process for**

[46] https://blog.medecision.com/leveraging-utilization-management-to-reduce-medical-loss-ratio-rebates/

health care providers to submit complaints to CMS for suspected violation of federal rules.

Summary of Recommendations

Advance Health Equity

- The AHA urges CMS to prioritize the development of policies and programs that ensure MAOs are providing enrollees with the necessary tools for health insurance literacy while considering the increasing diversity of the Medicare population. Further, CMS should undertake efforts to ensure that MAOs provide culturally competent resources to beneficiaries with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients' social, cultural and linguistic needs.
- The AHA recommends that CMS consider weighing disenrollment more heavily in the MA Star Ratings program, as this may incentivize plans to better target and coordinate care for structurally marginalized communities who are at greater risk of experiencing barriers that may result in disenrollment. The AHA also encourages CMS to investigate the root causes of disenrollment for these populations, which may be an indicator of MA beneficiary frustration with barriers to accessing care.
- The AHA urges CMS to foster consistency and standardization in its approaches to collecting, analyzing and using demographic and social risk data.
- The AHA encourages CMS to explore the extent to which there are any demographic data elements collected at the time of Medicare and MA enrollment that could be used more widely across programs. The AHA believes that CMS must prioritize the use of extant data to which CMS itself may already have access before considering new data reporting requirements.

Expand Access: Coverage and Care

- The AHA strongly urges CMS to require MAOs to align medical necessity and coverage criteria with Traditional Medicare rules so that Medicare patients have equal access to care regardless of coverage type and to reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization. This is especially critical for the coverage of PAC and behavioral health services, sepsis criteria, emergency services and inpatient admissions in general.
- The AHA urges CMS to conduct greater oversight of MA beneficiary disenrollment in the final year of life to protect patient care access for enrollees with complex or costly health needs.
- The AHA urges CMS to establish a standard electronic transaction for providers to submit and receive responses for prior authorizations and supporting documentation.

- The AHA recommends that for the purposes of defining network adequacy, mental health and substance use disorders should be differentiated and explicitly listed in regulation to ensure appropriate in-network access to providers in each of these uniquely specialized behavioral health concentrations.
- The AHA recommends CMS develop and adopt proactive network adequacy monitoring strategies in addition to retroactive compliance reviews. Specific suggestions include establishing standard network review protocols to be implemented by all CMS Regional Offices, including secret shopper exercises to confirm if providers listed in an MAO directory are indeed actively enrolled, in-network and have appointment availability. Further, we believe that MAOs should be held to more specific time and distance standards.
- The AHA urges CMS to address the root causes of pervasive, inappropriate denials of PAC services, which unfairly limit access to medically necessary PAC services for millions of MA beneficiaries. Specific suggestions include prohibiting MAOs from utilizing more restrictive admissions criteria than Traditional Medicare; requiring PAC-specific specialty expertise among plan reviewers; developing more rigorous network adequacy standards for PAC facilities including requirements that consider the number, size and specific types of facilities; and increased scrutiny and accountability for MAOs which systematically seek to delay transfers to PAC facilities for their own financial benefit.
- The AHA recommends that capacity standards are applied to telehealth providers in a similar way to in-person providers — that is, to consider a provider to be part of the network, that provider must be accepting new patients and offer specified services within a certain number of days.
- The AHA encourages CMS to extend its direct oversight to MAO vendors and hold MAOs accountable when their vendors delay patient access to care or cause unnecessary costs and burden in the system.
- The AHA recommends that CMS require greater transparency regarding prior authorization and other utilization management restrictions, accessible network information and plan-level information on inappropriate coverage denials and delays in care.
- The AHA urges CMS to collect, audit and make public data on MAO denials, appeals, grievances and delays.
- The AHA encourages CMS to create a mechanism for providers to raise issues to regulators. CMS should utilize this information to guide heightened enforcement of problematic MAO actions.
- The AHA recommends CMS take a series of steps to improve the quality and use of MAO data related to the following areas. These steps include proposed changes to the frequency of reporting, increased transparency, penalties for non-compliance, more targeted auditing and suggestions for how these data could be incorporated into Star Ratings.
    - Prior authorizations and coverage determinations (enumerated on p. 28)
    - Appeals (enumerated on p. 30)
    - Grievances (enumerated on p. 31)

- Member and provider complaints (enumerated on p. 32)

Support Affordability and Sustainability

- The AHA urges CMS to carefully review capitated MAO reimbursement structures to ensure that the Medicare Trust Fund is being spent judiciously and that MAOs are not being overpaid to cover contracted services. We also recommend that CMS examine opportunities to eliminate perverse incentives that may encourage MAOs to deny medically necessary care to increase plan profits.
- The AHA urges CMS to conduct a thorough review of Traditional Medicare payment methodologies that could be impacted by high MA enrollment and to work with stakeholders to determine whether changes in policy are needed to mitigate potential negative consequences.
- The AHA encourages CMS to evaluate the overall impact of continued growth in MA on enrollees, taxpayers and the overall health care system and make the results public. Doing so will enable policymakers and other stakeholders to make informed policy decisions to address the effects of the transition to a system where most Medicare beneficiaries are served by MAOs.
- The AHA encourages CMS to take several steps to reduce administrative waste in the MA program, including requiring plans to comply with standard, electronic processes for prior authorization, as well as adhering to the same clinical criteria as the Traditional Medicare program, which would dramatically reduce the amount of staff time spent on administrative tasks.
- The AHA strongly urges CMS to prohibit plans from submitting for risk adjustment purposes codes for which the payer fails to reimburse providers for the beneficiary's care.
- The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to patients' access to care and to hold health plans accountable for how premium dollars are spent and urges CMS to impose significant scrutiny on plan expenditures to ensure that patient premiums are being utilized appropriately.
- The AHA urges CMS to review how insurers are categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities.

Engage Partners/Stakeholders

- The AHA encourages CMS to continue to seek and amplify the beneficiary perspective in its oversight of the MA program, and specifically to establish a process for patients and/or health care providers to submit complaints to CMS for suspected violation of federal rules.

Conclusion

Thank you for your attention to the comments and concerns we have raised. We strongly support CMS's efforts to improve the MA program and urge the agency to advance rulemaking designed to increase oversight of the program and ensure enforcement of MAO actions which may violate federal rules or circumvent program intent. We believe more sustained oversight and accountability is needed to fully tackle the challenges enumerated by patients and their health care providers and to make meaningful progress towards achieving the CMS Strategic Pillars set forth in the agency's vision for Medicare. We applaud CMS' efforts to advance health equity in the Medicare program and stand ready to support your efforts, as well as those of our hospital and health system members in their continued efforts to address health disparities and promote equitable care delivery in their communities.

The AHA is pleased to be a resource on these issues and would welcome the opportunity to provide any additional information that would be helpful to the agency in its policy development or possible rulemaking processes. Please feel free to contact me if you have any questions, or have a member of your team contact Michelle Kielty Millerick, AHA's senior associate director of health insurance coverage policy, at mmillerick@aha.org or Terrence Cunningham, AHA's director of administrative simplification policy, at tcunningham@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development