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November 11, 2024

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

Re: CMS-10913 Medicare Part C Utilization Management Annual Data Submission and Audit Protocol Data Request

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) proposed Medicare Part C Utilization Management Annual Data Submission and Audit Protocol.

The AHA appreciates CMS' interest in improving Medicare Advantage (MA) data collection and audit capabilities to increase transparency and oversight of the program as it continues to grow. We applaud the agency's recent rulemaking designed to improve consumer and beneficiary protections for MA enrollees and believe efforts to increase data collection, reporting, targeted auditing and transparency in the program will further advance these important aims. Indeed, as enrollment in the MA program has for the first time reached more than half of all people enrolled in Medicare, it is more important than ever to establish and implement stronger data-driven auditing and oversight capabilities.

The AHA has written extensively to CMS and other federal agencies in recent years, articulating serious concerns about the negative effects of certain Medicare Advantage Organization (MAO) practices and policies.[1] These include:

- Abuse of utilization management programs.
- Inappropriate denial of medically necessary services that would be covered by Traditional Medicare.
- Use of overly restrictive proprietary medical necessity criteria that are not transparent to patients or providers.
- Requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access and unilateral restrictions in health plan coverage applied in the middle of a plan year, among others.

These practices unequivocally 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, directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services. They also add billions of wasted dollars to the health care system and are a major driver of burnout among health care workers.[2]

Over the past few years, CMS has taken important steps to advance and finalize critical rulemaking to address some of these issues, increasing oversight of MAOs and seeking to better align coverage offered by MAOs with Traditional Medicare. We applaud the important beneficiary protections included in the CY 2024 MA final rule, which went into effect in January, and subsequent frequently asked questions (FAQ) guidance issued in February 2024; however, more robust enforcement and transparency is needed to ensure compliance with these important coverage protections.

Hospitals and health systems across the country continue to report noncompliance with the new rules, including failure to adhere to the two-midnight benchmark, application of more restrictive criteria than Traditional Medicare and medical necessity denials for services that received prior authorization, among others. More troubling, health care providers have limited mechanisms to seek resolution of these violations and are routinely referred to the plan to address them through contractual dispute resolution mechanisms — even when the issue at hand is a violation of federal law or regulation.

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[1] AHA Comments to CMS in Response to MA RFI (May 2024); AHA Comments to CMS in Response to MA RFI (August 2022); AHA Comments to HHS OIG re: Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care; AHA Urges CMS to Rigorously Enforce New Policies to Safeguard MA Coverage; AHA Urges CMS to Swiftly Correct Medicare Advantage Plan Policies that Appear to Violate CY 2024 Rule

[2] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

With these challenges in mind, it is more important than ever that CMS conduct proactive, rigorous and data-driven audits to assess MAO compliance with federal rules and regulations and target enforcement actions to address problematic plan practices that impede patient access to care. **Accordingly, the AHA strongly supports CMS' intention to collect information from MAOs to assess plan compliance with updates to the MA utilization management (UM) program requirements codified in the CY 2024 MA final rule (§ 422.101 and 422.137), which clarified coverage criteria for basic benefits and the annual review of plan UM tools**. CMS' proposal to utilize the data submitted by MAOs through this process to assess the number and types of services that have associated internal coverage criteria, to assess trends related to the development and utilization of internal coverage criteria, and to inform selection of MAOs and specific items and services to undergo audit annually will increase needed program oversight in a meaningful way.

Most importantly, increased scrutiny and enforcement of existing MA regulations will help protect Medicare beneficiaries from inappropriate delays and denials of Medicare-covered services. Timely and accurate information on MA plan performance and compliance with existing CMS regulations are critical to ensuring that patients 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 and run afoul of federal rules.

In the following sections, we provide a set of principles for data collection and reporting that guide our recommendations, as well as detailed comments on the scope and mechanisms for required reporting and opportunities to increase public transparency. We also provide specific recommendations to strengthen requirements and reporting related to MAOs' use of internal coverage criteria, compliance with the two-midnight benchmark and access to post-acute care, where hospitals and health systems report the greatest challenges and concerns with MA practices that diverge from Medicare rules and requirements. Finally, we identify several other priority areas that warrant increased oversight for consideration in data collection and audit protocols, including MAO requests for additional documentation, peer-to-peer requests, member appeals and business practices of third-party vendors.

PRINCIPLES FOR DATA COLLECTION AND REPORTING

In evaluating new data collection and reporting requirements for the MA program, we recommend CMS consider the following principles:

- **Administrative Simplification:** New data collection and reporting requirements should be designed to minimize the administrative burden on the health care delivery system and stakeholders. This includes only collecting the minimum amount of data needed to meet program and agency objectives and conduct appropriate oversight.

- **Data Utility:** Required data elements should have a specific, clear and legitimate purpose related to conducting meaningful program oversight or improvements.
- **Accuracy and Validation:** CMS should engage in meaningful auditing of MAO submissions to assess the accuracy and completeness of plan-reported data.
- **Public Transparency:** Data collection and reporting on the MA program should be made publicly available to increase transparency for patients, providers, beneficiary advocates and other stakeholders, and CMS should lend appropriate consideration to preventing disclosure of proprietary information where possible.
- **Enrollee Access to Information:** Data collection and reporting efforts should provide current or prospective Medicare enrollees with useful information about the performance of MAOs to assist beneficiaries in making informed choices about their Medicare coverage options. This may include information about the rates of prior authorization and denials, as well as CMS' determinations about plan compliance with federal rules, in addition to other reporting that is already factored into plans' star-rating measures for this purpose.
- **Enable Comparisons between Traditional Medicare and MA:** Required data collection elements should ensure MA plan performance can be compared to Traditional Medicare, where appropriate, given the ultimate objective to ensure beneficiary parity in coverage and access between programs.
- **Applicability to Integrated Delivery Systems:** In designing data collection requirements, CMS should consider the unique ways that integrated delivery systems collect and maintain data. The data collected and maintained by integrated delivery systems and other integrated payer-provider organizations may be structured differently from traditional health insurance carriers and thus may require additional information to ensure correct interpretation. For example, integrated health systems may structure prior authorization processes differently from traditional insurers or may have more complete clinical data from providers due to having access to the electronic medical record, which may present nuances in how data from integrated health systems are reported or the extent to which they can be compared to other plans. Any new reporting requirements should accommodate such structural differences for integrated health plans.

SCOPE OF REPORTING, AUDITING AND PUBLIC TRANSPARENCY

Data Collection and Reporting on Plan Performance. While we recognize the intended data collection and audit requirements are specific to UM protocols, we encourage CMS to consider broader applications of data collection and reporting on plan performance that would provide CMS with information about plan-level coverage denials, appeals and grievances, and delays in care resulting from plan administrative processes. These are important indicators of beneficiary access and are necessary for meaningful oversight of MAOs. For example, plans with excessively high service and payment denial rates or unreasonably high beneficiary grievance rates, compared to

other plans, may be indicative of inappropriate behavior that warrants further inquiry or audit. The Department of Health and Human Services Office of Inspector General (HHS OIG) made a 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 MAOs' performance.[3] We believe this could be a useful approach to conducting data-driven enforcement activity and recommend that CMS consider approaches to use the data collected to identify outliers in performance that inform audit and enforcement activity.

Routine Auditing. We applaud CMS' proposal to conduct targeted auditing related to compliance with the internal coverage criteria consistent with this protocol on an annual basis. We recommend that audits pursuant to this plan be focused on MAOs that are outliers in reported plan performance data or have a history of suspected or actual CMS rule violations on their record. With these factors in mind, we recommend that CMS regularly audit a sample of MA plan denials, using a similar methodology as the 2022 HHS OIG report, to review MA plan determinations for the appropriate application of Medicare coverage rules and criteria. As discussed below, we also encourage these audits to focus on service lines with a history of inappropriate denials such as inpatient hospital admissions and post-acute care. Finally, it is important that CMS be the ultimate arbiter of determining plan compliance with the federal regulations through such audits and that MAOs are not permitted to demonstrate compliance with self-reported data that is not independently validated by CMS or another independent entity.

Enforcement Action. The efficacy of these proposed data collection and auditing protocols in ensuring compliance with federal rules will depend on how CMS utilizes the reported information. The data submissions CMS collects must be used in combination with other existing MA data reporting requirements to guide the agency's oversight and enforcement activities. For example, in addition to the actions described in the proposed protocol, CMS also could incorporate organization determination data or data collected regarding compliance with UM protocols into MAO star ratings or publish a public list of MAOs subject to Corrective Action Required (CAR) plans based on the audit findings.

In addition, penalties are a necessary part of enforcement to incentivize compliance with CMS rules. CMS' acknowledgment in the 2024 MA final rule that many of the included provisions are restatements of existing CMS policy shows that rules alone are insufficient to achieve compliance and that enforcement is critical to ensuring meaningful change. Based on the findings of the data CMS collects through this process, we urge CMS to exercise its authority, where appropriate, in issuing warning letters and CARs to noncompliant MAOs. Additionally, if such noncompliance persists, we recommend that CMS impose intermediate sanctions (e.g., suspension of marketing and enrollment activities) and civil monetary penalties — or terminate the contract in

[3] https://oig.hhs.gov/oei/reports/oei-03-11-00720.pdf

cases where a plan does not make good faith efforts to comply. Each of these elements will be critical in ensuring the important changes CMS has codified in recent rulemaking become standard operating procedures for MAOs and have the intended effects on beneficiary protection and access to care.

We also want to acknowledge that in our advocacy for greater enforcement activity, we recognize not all MAOs are the same; many have active partnerships with providers in service of their shared patients/members and consistently act in good faith to follow the rules. To this end, we believe that enforcement actions should be targeted at MAOs that have a history of suspected or actual violations or whose performance metrics related to appeals, grievances, denials, UM tools or use of internal coverage criteria could be indicative of a broader problem warranting investigation. Every effort should be made in carrying out enforcement activities to ensure that undue burden is not placed upon MAOs that consistently act in good faith and adhere to CMS rules.

Public Transparency. The information collected by CMS through the proposed data collection, reporting and audit protocols will provide critical feedback about plan performance and compliance with important federal rules designed to protect Medicare beneficiaries. This information should be aggregated and made publicly available for enrollees, prospective enrollees, patients, providers, and the general public to increase transparency and accountability in the MA program. In addition to the publication of the data collected through this protocol, we also encourage the agency to publish a redacted database of CMS' Complaints Tracking Module (CTM), including the nature and frequency of complaints, as well as their resolution. This would increase public transparency into common complaints against MAOs and how they are being addressed while increasing oversight and transparency in the areas CMS is targeting for additional reporting and auditing.

PRIORITY AREAS FOR DATA COLLECTION AND REPORTING

The AHA broadly supports CMS' intended areas for data collection, reporting and auditing. There are three specific areas that we believe warrant the greatest attention and scrutiny with respect to auditing plan compliance: MAO use of internal coverage criteria; hospital inpatient admissions and compliance with the two-midnight benchmark; and post-acute care access. These areas are persistent challenges for patients and providers with respect to securing coverage and payment for Medicare-covered services consistent with CMS regulations and should be prioritized in data collection, reporting and auditing efforts.

MAO Use of Internal Coverage Criteria

The AHA strongly supports recent CMS efforts to create parity between MA and Traditional Medicare in processes and criteria used to make medical necessity determinations. In the calendar year (CY) 2024 final rule, CMS codified that MA

organizations must make medical necessity determinations in accordance with all Traditional Medicare coverage requirements, including rules established in statute, regulation, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

Further, the CY 2024 rule establishes that MAOs may only utilize internal criteria when Medicare coverage criteria are not fully established under Traditional Medicare. In such instances, MA organizations may utilize internal coverage criteria if it (a) is publicly available, (b) is based on current evidence in widely used treatment guidelines or clinical literature, and (c) indicates how the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

Despite the final rule and subsequent clarifying guidance from CMS, MAO use of proprietary medical necessity criteria that are more restrictive than Traditional Medicare and not transparent to patients or providers is a pervasive problem in the MA program. Our members report that many MAOs consistently fail to meet some or all of the requirements for using internal coverage criteria codified at § 422.101(b)(6). This includes instances of the criteria not being easily or publicly accessible, utilizing sources that are neither widely used guidelines nor peer-reviewed literature, and altogether ignoring the requirement to demonstrate that the additional criteria used provide an identifiable clinical benefit that outweighs potential patient harm from delayed or decreased access to services. Indeed, the persistent use of proprietary or internal coverage criteria continues to result in inappropriate denials and reduced access to Medicare-covered services — the very problem the CY 2024 final rule sought to address.

With this in mind, we are grateful for CMS' focus on increasing oversight and compliance with these important provisions and believe CMS' intended data collection and auditing mechanisms have strong potential to improve plan adherence and thus MA beneficiary access to care. While we remain hopeful that heightened scrutiny will result in changes in MAO behavior, we also believe that even stronger and more specific reporting and audit requirements may be needed given the long and well-documented history of some MAOs' failure to cover and pay for services that meet Medicare coverage and billing rules.

We recommend that CMS scrutinize the data on internal coverage criteria collected in the proposed process to ensure consistency with regulatory obligations and to conduct appropriate MAO audits needed to ensure compliance. Specifically, **data collection and audit protocols should require MAOs to demonstrate how they are meeting the requirements of § 422.101(b)(6) for each specific clinical condition for which the MA plan adopts an internal coverage criterion.** Clinical benefit must be clearly demonstrable from the clinical literature meeting the evidentiary standard for that specific clinical condition and/or patient population. In addition, such audits should include a review of large third-party medical necessity compendiums to ensure that plan

guidelines are sufficiently based on acceptable evidence that meets CMS' evidentiary standard.

Finally, while internal coverage criteria typically refer to clinical criteria for coverage, **we urge CMS to clarify that for the purposes of this data collection protocol, reporting on internal coverage criteria also applies to MAO internal criteria for *payment policies*.** MAOs routinely argue that reimbursement policies are payment issues and therefore they have sole discretion to determine how contracted providers are paid for these services. This is a common issue in payment for sepsis care where insurers reduce payment to providers for Medicare-covered sepsis treatment through a payment classification policy.

However, contrary to this notion, CMS has clarified that MAOs provide coverage for services by paying for them. For example, CMS states in the CY 2024 MA final rule that MAOs "provide coverage by furnishing, arranging for, or *making payment for* [emphasis added] Part A and Part B items and services … [therefore] it is irrelevant whether Traditional Medicare considers the criteria part of a coverage rule or a payment rule." With this in mind, **we urge CMS to examine internal criteria for payment policies with the same level of scrutiny being applied to clinical coverage criteria to ensure criteria are transparent and not more restrictive than Medicare.** Indeed, we believe that MAOs that continue to adopt *payment or coverage criteria* that differ from Traditional Medicare for the purpose of denying payment or coverage for Medicare-covered services are in direct violation of § 422.101(a) and (b). Therefore, internal criteria for payment policies being used to deny payment for care should not be exempt from CMS oversight and scrutiny and should be included in the proposed data collection and audit protocol.

Classification of Coverage Criteria as "Not Fully Established." The CY 2024 MA final rule establishes that coverage criteria are considered "not fully established" when "additional, unspecified criteria are needed to interpret or supplement general provisions to determine medical necessity consistently." In such limited circumstances, MAOs are permitted to use additional coverage criteria. While this definition is intended to limit MAO's ability to use internal or proprietary criteria that is more restrictive than Medicare, we routinely hear reports from our members of MAOs continuing to implement coverage criteria beyond the limited set of circumstances allowed by this definition. In fact, it remains commonplace for MAOs to cite third-party clinical criteria guidelines as a justification for denial of an MA-covered item or service with no further explanation or justification as to why or how the MAO concluded that Medicare criteria are not fully established or how the criteria comply with the specifications at § 422.101(b)(6). Indeed, the continued and widespread use of internal coverage criteria by certain MAOs is the root cause of many of the concerns we raise in subsequent sections of this letter regarding denials for inpatient hospital stays and post-acute care, which result in denial of services that otherwise meet Medicare criteria.

Accordingly, we strongly support CMS' proposal to collect additional information from MAOs regarding plans' interpretation of when Medicare criteria is not fully developed and how they justify that additional criteria are needed to interpret or supplement Medicare rules. It is also important to understand the specific procedures MAOs have adopted in cases where they are using additional clinical criteria beyond Medicare to enable appropriate oversight. In this regard, **we believe the specifications for reporting on coverage criteria included in the Medicare Part C UM annual data request protocol and the document specifications for the standardized formatting of internal criteria for MA are a tremendously important step forward in increasing oversight and compliance of these important provisions**.

However, we believe more guardrails are needed with respect to self-reported MAO data to ensure that plans do not continue to routinely use their own criteria that are more restrictive than Medicare. The proposed data collection format largely gives MAOs the discretion to dictate what the applicable Medicare rules are for a given service or item and to self-report whether there is permissible flexibility for the MAO to apply additional coverage criteria. While MAOs' self-reporting on their use of internal coverage criteria can be an important tool to aid oversight, CMS, or an independent entity or contractor acting on the agency's behalf, should be the ultimate arbiter of whether Medicare criteria are fully established — not MAOs. Allowing plans to adopt their own various and likely divergent interpretations of when Medicare criteria is not fully established also creates confusion, fuels disagreement between providers and payers on criteria that should be standardized and can further contribute to inequities in coverage for MA enrollees that may vary by plan or geography. With this in mind, **we urge CMS to provide more specific guidance on the limited set of circumstances when Medicare criteria are not fully developed and for the agency to serve as the ultimate arbiter of MAO compliance with Medicare rules.**

Recommendations

- Identify and publish, either proactively or through a review of information collected in this process, guidelines that CMS uses to determine whether criteria are fully established, citing specific examples of situations when additional criteria are permissible and when it is prohibited.
- Collect plan-level information on the total number and percentage of medical necessity determinations that are made using internal coverage criteria. This information is necessary to evaluate whether certain MAOs continue to apply internal coverage criteria broadly as a blanket practice or whether they are only doing so in the limited set of circumstances where permissible.
- Include MAO internal criteria for payment policies in the data collection and audit protocol in addition to internal clinical coverage criteria.

- Require MAOs to report plain language explanations of the denial rationale in cases where adverse medical necessity determinations are made using internal coverage criteria.

Hospital Inpatient Admissions and Compliance with the Two-midnight Benchmark

The CY 2024 final rule requires plans to adhere to the two-midnight benchmark, referring to the inpatient admission criteria for Traditional Medicare in 42 CFR § 412.3, which is used by Medicare to determine whether inpatient hospital care is medically necessary. While requiring MAOs to adhere to the two-midnight benchmark was an important step forward in achieving coverage parity between MA and Traditional Medicare, securing MAO approval for inpatient hospital admissions remains another area of persistent struggle for patients and their providers. Our members continue to report widespread frustrations with the denial of inpatient hospital care that extended over two midnights (and frequently over multiple days), without sufficient explanation as to why the admitting clinician's expectation that care would span two midnights was incorrect or unreasonable. Many hospitals and health systems report little to no change in the volume of initial inpatient denials, even if a greater number of them are being overturned later in the appeals process.

In addition, we continue to receive reports from members about cases where MAOs are downgrading multi-day hospital stays to observation status, including some cases that extend over a week in the hospital, with practices that continue to be more restrictive than Medicare and are inconsistent with the two-midnight benchmark. For example, an AHA member shared an MAO denial letter for an inpatient hospital stay for a patient who was in the hospital receiving inpatient-level of care for **eight days**. The denial letter concludes, "although this member was in the hospital two midnights, the member did not meet acute inpatient criteria and/or did not fail observation level of treatment." The denial letter fails to explain why or how the physician's admission evaluation was incorrect and is devoid of any analysis of how the two-midnight rule was considered, if at all, in making the determination. While there may be factors other than the actual length of stay that can be considered when making a level of care determination, we do not believe CMS intended to create a loophole allowing plans to deny inpatient-level payment for a patient who required an eight-day hospital stay and otherwise substantively ignores the two-midnight rule. This continues to be an area where there are wide gaps in parity and alignment between coverage of inpatient care under MA and Traditional Medicare, and greater scrutiny is needed.

While CMS' proposed data collection and reporting requirements would broadly capture procedures MAOs use to evaluate the medical necessity for inpatient hospital admissions, **we strongly recommend that CMS create supplementary requirements specifically intended to assess compliance with the two-midnight benchmark given the importance of this provision and the history of non-compliance.**

In addition, while CMS proposes to collect both the name of the Medicare item or service and the Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes associated with various services, we recommend that CMS track and analyze internal coverage criteria for hospital care at the Medicare service level. CPT codes and HCPCS codes alone may not provide a comprehensive view of MAO actions to downgrade or deny hospital-level care. For example, CPT codes do not distinguish between inpatient and outpatient services, meaning CPT codes alone would not provide adequate insight into MAO determinations related to the appropriateness of inpatient care and compliance with the two-midnight benchmark.

Recommendations

- Collect data on requests for inpatient hospital authorizations rather than data by CPT or HCPCS code to ensure denied or downgraded requests for inpatient hospital admissions are appropriately captured.
- Collect data on MA plan level of care determinations that downgrade care from inpatient to observation status, including the rationale.
- Audit plan processes for conducting level-of-care reviews to ensure that any refusal to provide or pay for services, in whole or in part — including downgrades of inpatient care to observation status — is an organization determination by the plan subject to requirements under § 422.566(b)(3).
- Collect and monitor additional data on length of stay for observation cases between MA and Traditional Medicare and denials of inpatient cases exceeding two days at the plan level.
- Conduct targeted audits of plans with outlier values for observation length of stay or long-stay inpatient denials.
- Conduct targeted audits to assess whether MAOs are reviewing *only* permissible factors when making a medical necessity determination for inpatient hospital care (i.e., that the admitting physician's decision that care would extend beyond two midnights was reasonable and appropriately documented in the medical record) — and not applying additional criteria where prohibited by CMS rules.

Post-acute Care

After a stay in an acute-care hospital, many Medicare beneficiaries require institutional post-acute care, which is a basic benefit under the Medicare program and provided by inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), skilled-nursing facilities (SNFs) and home health agencies (HHAs). These services are critical to the recovery of beneficiaries and allow them to receive different levels of skilled medical care and rehabilitation. Without an appropriate and safe post-acute discharge destination, beneficiaries often otherwise need to remain in the acute-care hospital, which strains system resources and adds unnecessary costs. In other words, post-acute

care is a critical component of the continuum of care as it keeps hospital lengths of stay to the minimum necessary to treat a patient's condition, lowers risks for unnecessary readmissions, maximizes functional and medical outcomes for beneficiaries, and frees up much-needed inpatient capacity. Despite the importance of appropriate access to post-acute services in the continuum of care, post-acute services are frequently restricted by MAOs through prior authorization and application of inappropriate internal coverage criteria that can delay and deny access to services.

As described in AHA's recent letter to the HHS OIG regarding their examination of MAO use of prior authorization for post-acute care, hospitals and health systems continue to report persistent challenges with MAO practices that inappropriately deny MA beneficiaries access to covered post-acute care services. These challenges remain unresolved despite CMS rulemaking and clarifying guidance specifically addressing MAO obligations to provide access to post-acute care services consistent with Medicare coverage requirements. These findings and experiences have been further corroborated by a 2022 report from the HHS OIG on MAO use of prior authorization, which found disproportionately high rates of inappropriate denials for post-acute care, and a more recent report from the U.S. Senate Permanent Subcommittee on Investigations, which found that post-acute care is subject to excessive rates of prior authorization review and denials that have increased in recent years.[4,5]

Given the well-documented history of inappropriate denials, it is vital that CMS make post-acute care a priority in its audits and oversight of UM practices of MAOs. As explained further below, this should include ensuring that post-acute care services are included on lists of targeted services, that data can allow utilization comparison between Traditional Medicare and MAO beneficiaries, and that CMS' audit protocols can properly capture the unique nature of hospital discharges to post-acute care.

Inclusion of post-acute care services in data collection and audit requirements. For the reasons described above, we believe the data collection and audit protocol should include specific submission requirements related to post-acute care services. In particular, CMS should collect the following information for authorization requests for *each type* of post-acute care admission (HHA, SNF, IRF and LTCH):

- Total number of requests and the approval and denial rate of those requests.
- Number of appeals of denied requests at each appeal level, and the outcomes of those appeals.
- The ultimate discharge disposition of requests that were denied.
- Detailed information about the rationale for denied requests.

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[4] https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/
[5] https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000873.asp

- The acute care hospital length of stay for patients both approved and denied for post-acute care admissions.
- Emergency department utilization and readmissions rates for patients approved and denied for post-acute care admissions.
- Overall utilization rates of post-acute care for MAO beneficiaries.

It is important that data collected through this protocol allow for meaningful comparison of post-acute service utilization between MAO and Traditional Medicare beneficiaries at both the plan and service level. Post-acute care utilization diverges significantly between the two programs, which can be an early warning system for identifying potential improper use of UM policies by MAOs. Further, collecting comparative data on post-acute care utilization can provide insight where data on authorizations might be misleading. For example, due to the restrictive practices of certain MAOs, hospitals may be less inclined to request authorizations for certain post-acute care services due to the high likelihood of denial. This, in effect, creates an invisible problem whereby the improper behavior of MAOs is not reflected in the authorization data and is hidden from CMS' view. Accordingly, collecting data on utilization that can be compared to Traditional Medicare utilization will allow for some degree of proxy insight into whether MAOs have deterred requests for post-acute care admissions due to inappropriate denial patterns or policies.

AHA also recommends that CMS solicit data to compare the utilization of upstream services between Traditional Medicare and MAO beneficiaries, such as the use of short-term acute care hospitals and related length-of-stay metrics. One concerning trend we have observed is that MAO beneficiaries in need of post-acute care have longer lengths of stay in the acute care hospital than their Traditional Medicare counterparts. This is due to the prior authorization processes employed by MAOs, which can extend stays several days or even weeks, along with subsequent appeals and difficulty finding appropriate placement when requests are denied. Collecting data on lengths of stay in acute care hospitals for beneficiaries needing post-acute services will provide CMS insight into the impact of the UM practices of MAOs on the continuum of care, including unnecessary burdens and costs on hospitals.

Further, CMS also should collect data on emergency department utilization and readmissions for MAO beneficiaries who seek post-acute care in a way that can be compared to Traditional Medicare. As previously explained, MAOs often deny appropriate post-acute requests, which can lead to suboptimal placement following discharge from an acute care hospital. Providers have observed this can result in MAO beneficiaries suffering complications that lead to emergency department visits or hospital readmissions. Frustratingly, the MAOs often then will not pay the hospital for a second visit under their readmissions policy, further straining acute care hospitals. As such, CMS should collect data on emergency department and readmission utilization for post-acute beneficiaries, both those that were approved and denied, in a way that allows comparison between MAO and traditional Medicare beneficiaries.

As explained previously, post-acute care admissions are vital to beneficiaries but also may be more difficult to capture in the same way other services may be examined through data collection. Therefore, CMS should establish a protocol for conducting targeted audits of authorization decisions of all post-acute admissions, specifically including LTCH, IRF, SNF and HHA admissions. These audits should:

- Look comprehensively at admission determinations for post-acute care services, including a close examination of the criteria used to evaluate requests and consistency with Traditional Medicare rules.
- Examine the qualifications of the MAO reviewers issuing adverse determinations and whether they have training and experience in post-acute care services as required.
- Evaluate whether denial rationales apply the relevant Medicare criteria to the specific circumstances of the patient and are not overly general, such that the provider and patient cannot determine why the care was denied.
- Ensure post-acute care cases are being treated consistently within the same plan and across different MAOs.
- Examine disenrollment data to identify the prevalence of cases where beneficiaries sought to change Medicare plans or coverage options after being denied post-acute care services.

Data-collection methodology for capturing post-acute care services. While we recognize the proposed data collection focuses on UM tools, a modified approach may be needed to ensure that CMS' audit protocols can properly capture the unique nature of hospital discharges to post-acute care, including denied prior authorization requests for post-acute care admissions. The proposed approach relies on CPT or HCPCS codes to classify services for review. As CMS knows, payment for institutional post-acute services would be designated by a Diagnosis-Related Group or "DRGs" (LTCHs), Case Mix Groups or "CMGs" (IRFs and HH), and Health Insurance Prospective Payment System or "HIPPS" (SNFs). Therefore, if CMS were to request information regarding these services, it would not be captured by requesting CPT or HCPCS codes as those are not used for payment for these types of admissions. Even if CMS were to use DRGs, CMGs or HIPPS, we believe this still would not be sufficient to capture the problem of denied requests for post-acute care admissions. This is because the DRG, CMGs and HIPPS are not generated until after the patient is admitted and evaluated by the post-acute care providers. Therefore, in the instance of a denied request for post-acute admissions, there would be no DRG, CMG or HIPPS to provide, and CMS would be entirely missing the cases of denied admissions.

For this reason, AHA recommends that CMS not rely on service codes for data and audits on UM but instead use service type or a similar classification. For example, CMS should request data generally on requests for LTCH, IRF, SNF and HH authorizations, rather than specifying a specific CMG, DRG or similar grouping classification. This

would ensure that CMS does not fail to capture denied requests for admissions that never generate a service code.

ADDITIONAL ISSUES WARRANTING GREATER SCRUTINY AND INCLUSION IN CMS DATA COLLECTION OR AUDITING PROTOCOLS

While CMS intends to collect data from MAOs needed to assess compliance with UM program requirements in § 422.101 and 422.137, there are several related areas that we encourage CMS to consider for further reporting and audit requirements where we believe additional scrutiny is warranted. These relate to MAO processes that may block member appeals for denied services, MAO requests for additional documentation from providers that may unnecessarily delay service authorization or claim adjudication, the timing and process for securing peer-to-peer consultations, and oversight of third-party MAO vendors.

Member appeals. As described in our May 2024 RFI letter, AHA members have reported concerns with how certain MAOs handle member appeals in a manner that appears designed to shield denials from independent review entity (IRE) review and CMS oversight. For example, members have shared examples with us of several large, national MAOs unilaterally deeming member appeals invalid or converting medical necessity appeals filed on behalf of patients into provider disputes, thereby circumventing plan obligations to report these appeals to CMS and blocking IRE access to essential data on plan appeals that impact the calculation of plan star ratings. We would be pleased to share redacted examples with CMS upon request.

Additionally, certain MAOs are consistently failing to issue the required Notice of Dismissal to parties requesting reconsideration, despite clear CMS rules requiring them to do so. Instead, a plan that unilaterally determines an appeal is invalid or converts a member appeal to a provider dispute evades public reporting requirements, making member appeals invisible to CMS and its contractors. This impedes oversight and transparency efforts related to coverage and access to Medicare benefits in the MA program.

Specifically, we have received reports from members that certain MAOs are denying member appeal rights if inpatient services have been completed and the member has no financial liability for the denial, citing that the denial is not subject to appeal. This commonly occurs for inpatient status denials where an MA plan refuses to authorize an inpatient admission where treatment cannot be delayed. CMS has clarified in recent rulemaking that the enrollee may request a standard or expedited plan reconsideration of organizational determinations for inpatient status denials (4204-F), but we continue to hear that these appeal rights are not being honored. In some cases, it appears that plans wait until the inpatient services have been completed and set the patient liability to $0, citing service completion and lack of member financial liability as the rationale for invalidating a member's reconsideration request. We also understand that CMS' IRE for

Part C reconsiderations does not accept member reconsideration requests if the service has been completed and the member cost-sharing for the denial is set to $0, which further ensures that these types of member appeals are shielded from visibility and oversight.

As a result, there is no recourse for a member to appeal an inpatient denial, and neither CMS nor its contractors have any visibility in these types of denials. And, certain MAOs appear to be exploiting this loophole to avoid payment for services where in-network coverage and payment are explicitly required by law (SSA 1852(d)(1)(E) and 422.113(b)). In effect, these plan practices collectively deprive MA enrollees of exercising the regulatory protections available to them under federal rules.

Furthermore, these plan practices also ensure that certain member appeals do not count against the plan for the purpose of its star-rating calculation, which considers appeal measures. If the member appeals are invalidated by the plan and not reported to CMS' IRE, it is as if they do not exist for the purpose of calculating the star-rating appeals measures. This inappropriately skews MA plan star ratings on appeals measures, which we believe leads to most of the largest national plans receiving star ratings of 97-100%, despite potential inaccuracies or omissions in the data being used to calculate these measures. It also serves to further enrich MAOs that are shirking their responsibility to pay for the basic benefit of inpatient care, circumventing appeal rights for that care and then being financially rewarded for their performance on appeals measures that do not reflect the full scope of reconsideration requests.

Given the importance of ensuring beneficiaries have appropriate opportunity to exercise their appeal rights when coverage for Medicare benefits is denied, we urge CMS to include member appeal processes in the proposed data collection and auditing protocols to evaluate compliance with existing federal rules. Specifically, we urge CMS to:

- Increase oversight and monitoring of plan compliance with the reporting of appeal measures to the CMS IRE for Part C reconsiderations to ensure accurate reporting, transparency into appeal procedures and findings, and calculation of star ratings.
- Require MAOs to report on the number of member appeals that the plan determined were not valid due to the service being completed or the patient liability being set to $0.
- Require MAOs to report on their standard operating procedures related to the handling of member appeals, including the handling of appeals for inpatient hospital admissions where the services have been completed.

MAO requests for additional information. To determine medical necessity for prior authorization requests and claims, plans must receive all necessary clinical information in advance of adjudication. Frequently, if a plan receives a prior authorization request or

claim that does not have sufficient information, then the plan will send the provider a request for additional information (RFAI). Although this process seems relatively straightforward, our members report that plans often engage in repeated RFAIs that significantly prolong prior authorization and claim determinations. This is of particular concern in the MA program where there are no federally-mandated prompt payment standards. Excessive or unnecessary RFAIs can result in delayed care, treatment abandonment, and prolonged claims adjudication processes that delay determinations on patient financial responsibility and payment for care rendered to patients.

As a result of concerns that certain plans are misusing RFAI processes to delay authorizations or claims processing, we recommend that CMS include data collection and reporting requirements related to MAO RFAIs in the proposed protocol. Specifically, we recommend CMS:

- Collect the following information:
  - The percentage of claims that require an RFAI.
  - The percentage of prior authorizations that require an RFAI.
  - The average number of RFAIs required for claims.
  - The average number of RFAIs required for prior authorizations.
  - The average length of time from the date a prior authorization request is received to the date at which it is adjudicated (including any time it took for the plan to complete information collection processes).
- Analyze plan RFAI processes to ensure that plans are not interfering with prior authorization and claims adjudication by inappropriately using RFAIs.
- Audit plan RFAI information to ensure that plans are only collecting information needed for the adjudication of medical necessity, as is required under the CY 2024 MA rule.

Peer-to-peer reviews. The CY 2024 rule requires clinicians rendering adverse medical necessity determinations to have sufficient training and experience in the particular field of medicine related to the denied item or service. This provision is an important improvement to MAO processes, which previously were not subject to any rules or requirements about the qualification of the MAO clinician overruling the recommendation of the patient's treating physician to deny recommended care. While a peer-to-peer consultation can provide a productive opportunity for the requesting clinician to discuss the rationale for their proposed treatment recommendation with a representative from the patient's MAO, our members continue to report that many MAO representatives conducting peer-to-peer consultations fail to have the requisite training necessary to engage in an informed medical discussion about the patient's condition or the proposed treatment plan. In other cases, MAO clinicians conducting peer-to-peer reports who do not have the requisite authority to overturn or alter a decision about a denial they are discussing, rendering the process useless. In many circumstances, it can take days to schedule a peer-to-peer with an MAO, and the MAO may unilaterally select the time or provide an unreasonably short window for the treating clinician to

respond without regard to his or her availability. All these practices serve to diminish the utility of the peer-to-peer process, often with the effect of further delaying authorization and patient care. In such instances, the peer-to-peer review process fails to be a meaningful consultation about medical necessity between clinical professionals and becomes merely another barrier to timely access to care.

Peer-to-peer consultations have become an integral part of MAO UM processes and an important vehicle for carrying out — or sometimes delaying — medical necessity determinations that affect patient care. Accordingly, these processes should not be excluded from CMS' examination of MAO UM processes. While MAOs are not required to offer peer-to-peer consultations, **we recommend that CMS include peer-to-peer consultations within the scope of new data collection and auditing requirements to collect additional information on MAOs' use of these processes and examine any resulting implications on beneficiary access to care**. Specifically, we recommend that CMS:

- Clarify that clinicians involved in any peer-to-peer processes have the appropriate medical training and experience in the applicable field of medicine consistent with requirements in the CY 2024 final rule related to prior authorization.
- Collect information from plans on:
    - The percentage of prior authorizations for which a peer-to-peer consultation was utilized.
    - The frequency with which initial plan determinations are changed as a result of the peer-to-peer consultation.
    - The MAO process for scheduling peer-to-peer consultations with providers, including the MAO's standard operations when peer-to-peer requests are made during evenings, holidays or weekends.
    - The average time from a provider request for a peer-to-peer consultation to the consult occurrence.

Oversight of third-party vendors. Many MAOs rely on subcontractors to administer portions of their benefits, conduct UM processes, or conduct other types of coverage and payment audits. For example, MAOs frequently subcontract to vendors to manage prior authorization adjudication for services such as rehabilitation or behavioral health. While federal guidance requires MAOs to ensure that their vendors or benefits 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 that 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 burdens to the health care system.

With these challenges in mind, **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 burdens to the system. Specifically, CMS should consider conducting audits on MAO third-party vendors directly and/or require reporting of vendor practices and outcomes related to MA organization determinations to be added to the proposed data collection protocol.** Further, CMS may wish to collect data to examine whether certain outcomes, such as denial or overturn rates, vary by whether the MAO itself conducted the determination or a third-party vendor was responsible for the review.

We thank you for the opportunity to comment on these important topics. Please contact me if you have any questions, or feel free to have a member of your team contact Michelle Kielty Millerick, AHA's director for health insurance and coverage policy, at mmillerick@aha.org.

Sincerely,

/s/

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Public Policy Analysis and Development