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 the Arizona Hospital and Healthcare Association and our more than 75 hospital and health system members, thank you for 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.

AzHHA very much appreciates CMS’s interest in exploring opportunities to strengthen the Medicare Advantage program through advancements in health equity, expansion in patient access to care, innovation, improvements in affordability and sustainability, and engagement and collaboration with partners. In this context, AzHHA would like to share concerns about the negative impact of several MA plan practices and policies that impede patient access to healthcare services, result in inequities in coverage between Medicare beneficiaries enrolled in MA compared to those enrolled in Traditional fee-for-service Medicare, and in some cases, directly harm Medicare beneficiaries through unnecessary delays in care or denial of covered services.

Specifically, MA plans frequently:

- Apply more stringent medical necessity criteria than Traditional Medicare,
- Apply excessive prior authorization requirements,
- Use inappropriate utilization management tools, and
- Require onerous and duplicative clinical documentation submissions to substantiate the need for services.

These practices often delay care unnecessarily and can result in direct patient harm. In addition, they increase financial strain on the healthcare system, requiring increased staffing and technology costs to comply with plan requirements, while also contributing significantly to
healthcare worker burnout. In fact, one AzHHA member recently informed us that due to the burden of MA plan practices, they now employ more staff “to get paid appropriately” than they employ in their traditional billing department.

These pain points have gotten increasingly worse as enrollment in MA plans has expanded. MA plan penetration in Arizona currently exceeds 50 percent.¹ With millions of new enrollees added nationally each year, it is vital that CMS increase oversight of the MA program to ensure that those enrolled in MA plans are not unfairly subjected to more restrictive rules and requirements than Traditional Medicare, which are contrary to the intent of the MA program.

PRIOR AUTHORIZATION & MEDICAL NECESSITY DETERMINATIONS

Ninety-three percent of respondents to a 2021 American Medical Association survey indicated that prior authorization delayed access to necessary care and 34 percent reported 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.”²

In response to a recent member survey conducted by the American Hospital Association (AHA), 95 percent 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. Further data from AHA’s most recent member survey shows that MA plans have the highest inpatient prior authorization denial rate across all payers, most of which are later overturned in favor of the provider.³ Conversations with AzHHA members underscore these points. Some concerns raised by our members include:

- “The majority of MA plans routinely deny authorization, and this must be appealed by the beneficiary, who may not be familiar with appeal rights.”
- “MA plans across the board do not get back to hospitals timely on authorizations (24-72 hours). If it is a Friday, the hospital won’t hear from the plan until Tuesday and the patient may be discharged by then.”
- “Case managers learn to not refer to inpatient rehabilitation facilities because of the high bar to get an MA plan patient authorized. Traditional Medicare patients have a greater advantage in getting into a higher level of care than MA plan patients.”
- Plans with narrow networks are particularly problematic. A case manager with a large health system reports post-acute care narrow networks can tag on four to five days for a discharge to a skilled nursing facility (SNF) or inpatient rehabilitation facility (IRF). Sometimes the only available contracted facility is located 30 miles or more from the patient’s home, so the patient declines services to which they should be entitled.

³ AHA member survey, December 2021 – February 2022
Over the duration of the COVID 19 public health emergency AzHHA routinely had to “negotiate” with MA plans to waive prior authorization (PA) for admission to post-acute care facilities in order to decompress medical surge at acute care hospitals. This was an arduous process and gave us insight into the administrative hurdles our members face with MA plans—especially those with a national profile who are not traditionally connected to the state. And while we felt it was vitally important for MA plans to waive PA for post-acute care services during peaks in medical surge, we were cognizant of the fact that some facilities would not accept patients without authorization due to fear of payment denial. This was borne out after last winter’s COVID 19 wave when several IRFs were denied payment.

Our 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. The HHS-OIG found that some of nation’s largest MA Organizations (MAOs) fail to cover the same services as Traditional Medicare, in direct violation of CMS policy. CMS guidance states that MAOs may not impose additional clinical criteria that are more restrictive than Traditional Medicare’s national and local coverage policies. Using a random sample of denials from a one-week period from June 1st to 7th, 2019, the report estimates the rate at which PA and payment requests that met Medicare coverage rules were denied. The report found that 13 percent of prior authorization denials and 18 percent of payment denials met Medicare coverage rules and should have been granted.

The HHS-OIG report highlighted several important issues with MAO PA programs:

- MAOs frequently use medical necessity and coverage criteria that are more restrictive than Traditional Medicare;
- Prior authorization processes are extremely inefficient; and
- Patient care is negatively impacted because of prior authorization delays and denials.

While CMS rules preclude MAOs from utilizing clinical criteria that are more restrictive than Traditional Medicare, our members’ experience and the findings from the HHS-OIG report show that MAOs routinely do this. Additionally, MAOs often classify their medical necessity criteria as proprietary (or “internal,” according to the HHS-OIG) and do not share specifics with providers. This results in a “black box” for providers, who are simply trying to determine whether a service will be approved.

This lack of transparency is a frequent reason why PA and claims are delayed or denied and results in extensive “back and forth” between providers and plans regarding what information is needed to satisfy their proprietary criteria. (These inefficiencies are exacerbated when a MA plan utilizes a third-party vendor to review PA requests.) Such administrative hurdles often unnecessarily delay patient care and burden providers with resource-intensive paperwork that

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5 CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.
could be easily avoided. Further, in most instances, the authorization is ultimately approved, making such administrative work unnecessary, costly and wasteful.

Some specific concerns our members cite include:

- While Traditional Medicare requires a patient to need at least two of three therapies (occupational, physical or speech therapy) for admission to an IRF, some MA plans require all three therapies.
- In discussing an amputation patient with an MA plan, the plan’s UR nurse told an AzHHA member that the plan “typically doesn’t authorize amputees for IRF admission.” The IRF admissions officer asked the plan’s UR nurse if the plan went by Medicare guidelines, because a recent amputation is a qualifier for Medicare. She said the plan goes by Medicare and “other criteria,” which was not specified.
- Criteria for admission to long-term acute care hospital services also varies by MA plan and does not routinely align with Traditional Medicare. According to our members, some MA plans allow "stable critical drips," others require the patient to be off all critical drips, which include cardiac and sedation drips.
- Our members also report that increased use of third parties by MA plans for prior authorization has exponentially increased administrative burden and delay in care and service denials for Medicare beneficiaries.⁶

AzHHA members have also pointed out several coverage policies that have been rolled out nationally and locally by MA plans where the clinical criteria vary from Traditional Medicare. These include coverage of sepsis care, inpatient-level care, emergency services and post-acute care.

**Sepsis Coverage**

AzHHA members report that several MA plans have unilaterally stopped reimbursing them for the care required to treat certain cases of early sepsis 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

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⁶ While federal guidance requires MAOs to ensure their vendors or benefit managers adhere to all program rules, our members tell us that MAOs and their vendors are inconsistent in their knowledge or application of MAO rules and processes. For example, 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.
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 hospitals as they continue to deliver medically necessary care.

**Inpatient Care & Observation Status**

Given the significant hospital resources involved during a substantial stay in a hospital, inpatient care is typically reimbursed at a higher rate than outpatient care and observation status. 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 this policy, hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights.

Despite this clearly delineated CMS medical necessity rule, our members tell us that many MA plans have established policies placing additional obstacles to admission or retroactively downgrading an inpatient stay to observation status, even when the clinical criteria for inpatient care have clearly been met. Conversely, members tell us some plans have begun denying payment for hospitalization after **exactly 48 hours** of a patient being in ‘observation status’ if the patient is not converted to ‘inpatient status’ during this time. Moreover, due to the lack of transparency around the MA plan’s medical necessity criteria—which often shift from week to week, providers are left in the dark regarding which guidelines to follow.

**Emergency Services**

Several large national insurers, including MAOs, have adopted policies to deny or down-code coverage of emergency services if the health insurer 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 the information available to the clinician at the time the patient presented to the emergency department (ED). Although these policies were purportedly designed to discourage inappropriate use of the ED (a goal AzHHA members share), they have instead been used as a tool for deterring 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 provided in good faith.
These policies completely ignore both hospitals’ responsibilities under the Emergency Medical Treatment and Labor Act and the application of the prudent layperson standard. We are grateful that Arizona has adopted the prudent layperson standard in statute, under which health plans must provide coverage for emergency care (screening and stabilization) based on symptoms presented at the time of the emergency, not based on the final diagnosis. However, this requirement does not extend to plans not regulated by the state. As such, we deeply appreciate CMS addressing this issue in recent regulations related to the No Surprises Act. However, our members continue to experience concerns concerning practices with certain MAOs, including inappropriate down-coding of claims or line-item denials that do not appear to regulators as a full denial, and thus, would appreciate further scrutiny and enforcement to address these issues.

**Eligibility for Post-Acute Care Services**

The HHS-OIG report identified PAC as one of three services most frequently denied requests for prior authorizations and payments that met Medicare coverage rules and MA plan billing rules. Erroneous denials and delays such as these restrict access to care during both the PAC and prior hospital stages of care, for services that would otherwise be covered by Traditional Medicare. Indeed, delayed and denied MA coverage for PAC services is a frequent burden, even though such MA decisions contradict the professional judgment of the referring physician. The HHS-OIG report highlights multiple examples of medically necessary IRF care that should have been covered, raising the profile of this issue and the negative effects on Medicare beneficiaries. Some examples have also been cited by AzHHA members and described previously in this letter.

In addition, (and as also cited in this letter) MA plans with narrow networks of PAC providers present challenges for patient referrals for downstream specialized care, such as services covered by Traditional Medicare for IRFs and long-term acute care hospitals. These settings provide care through inter-disciplinary 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 Medicare beneficiaries’ access to these specialized services to which they are entitled.

MA plans may also be motivated to keep a patient in a short-term acute care hospital for longer than is medically prescribed by the treating physician because the plan is reimbursing the hospital a flat case rate. In this instance, the MA plan is either delaying or attempting to avoid discharging the patient to the next site of care, which would require separate reimbursement. The result is too many patients are being denied timely access to medically necessary PAC.

In summary, these experiences and concerns are a clear indicator that the MA program is not operating as intended and that patients and their providers are being harmed by the abusive practices of certain insurers. **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.**
MAO OVERSIGHT

MAO violations of CMS rules including, 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, including more direct oversight of third-party MAO vendors.

However, we are concerned that existing data collected on health plan performance may not provide CMS with the comprehensive 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. Providers are uniquely positioned have greater insight into circumstances where 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, a mechanism is needed to flag problematic MAOs on behalf of patients. There is currently no streamlined way to do this. **As such, AzHHA encourage CMS to create a mechanism for providers to flag questionable plan processes for regulators. CMS should utilize this information to guide heightened enforcement of problematic plan behavior.**

Thank you for the opportunity to provide feedback on the MA program. We strongly support CMS’s efforts to strengthen program and urge the agency to advance a rulemaking to increase oversight of the program and ensure enforcement of MAO policies that may violate federal rules or circumvent program intent. We believe more sustained oversight and accountability is needed to make meaningful progress towards achieving the CMS Strategic Pillars set forth in the agency’s vision for Medicare.

Sincerely,

Debbie Johnston
Executive Vice President
Arizona Hospital and Healthcare Association