FLORIDA HOSPITAL ASSOCIATION
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HOSPITALS & HEALTH SYSTEMS

August 31, 2022

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

Re: Request for Information: Aspects of the Medicare Advantage Program (CMS 4203-NC, Medicare Program

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to provide insights and information on ways to strengthen the Medicare Advantage program.

Florida has one of the nation's largest percentage of Medicare eligible patients enrolled in Medicare Advantage plans. 2.3 million beneficiaries, or 56% of the total Medicare population are enrolled in, one of the 583 different plans offered by 27 MA plan providers in the state. Participation in MA plans varies in parts of the state, with the more metropolitan areas have a higher enrollment rate than the rural areas. In Miami-Dade, 78% of the Medicare population is covered by a Medicare Advantage plan with most of the metropolitan areas above 60% Medicare Advantage penetration. With an average premium cost is $8.54, according to an analysis by the Kaiser Family Foundation, these plans are very attractive to seniors with limited income.

Keeping track of the disparate requirements among the different products and plans adds substantial complexities to ensure adherence to plan rules to obtain necessary care for the Medicare member. Though Medicare rules and reimbursement are very transparent, each Medicare Advantage plan has its own set of rules and policies which do not always follow Medicare.

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Understanding the nuances of 583 plans and staying current on policy changes, requirements for authorizations, and credentialling and payment, requires hospitals to dedicate significant staff resources. Full time staff are dedicated to monitor and study individual plan requirements to ensure all the processes are followed exactly or risk denials or payment reductions. Florida hospitals have noted they have more than doubled their staff just to monitor health plan policies, obtain prior authorization and to challenge payment denials from the managed care plans.

Through this Request for Information (RFI), the Centers for Medicare & Medicaid Services (CMS) is seeking feedback on ways to strengthen Medicare Advantage (MA) in ways that align with the Vision for Medicare and the CMS Strategic Pillars and create more opportunities for stakeholders to engage with CMS. FHA is pleased CMS issued this RFI, given the growing frustration our members have with the MA plans and program.

Prior authorization and Utilization Management

CMS requests information on how MA plans use utilization management techniques, such as prior authorization; the approaches MA plans use to exempt certain clinicians or items or services from prior authorization requirements; and steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care.

This is an area of significant opportunity for CMS to make changes benefitting both the beneficiary and the provider community. CMS guidance states that MA plans may not impose additional or more restrictive clinical criteria than traditional Medicare. However, a Department of Health and Human Services Office of the Inspector General (HHS-OIG) report, *"Some MA Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care"* found some of the largest MA plans fail to cover the same services as traditional Medicare. This report identified several important issues with the MA plan prior authorization programs including (1) the use of 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 due to prior authorization delays and denials.

From the beneficiary perspective, understanding what and why some items or services requires prior authorization, how long it takes to obtain those and reasons for denial creates anxiety, confusion, and dissatisfaction. Furthermore, given the differences of prior authorization processes between traditional Medicare and each individual MA plan contributes to beneficiary confusion.

For MA provider hospitals, the challenges include difficulties in determining whether an item or service requires prior authorization since this varies by plan, lack of standardization and variation of prior authorization requirements and processes among the MA plans and the time and resources required to track prior authorization requirements by plan. Timelines to obtain the prior authorization also vary and plans frequently require additional prior authorization criteria, ssuch as peer-to-peer review with a health plan medical director. Furthermore, despite all the upfront efforts, having obtained the prior authorization does not guarantee payment for those services, with MA plans denying payment after the care is delivered.

Hospitals were acutely impacted by varied authorization policies during the COVID-19 pandemic surges. While CMS "strongly encouraged" plans to waive authorization requirements for discharge to post-acute care, some MA plans were more flexible than others. Additionally, some plans waived prior authorization for skilled nursing care but would not waive prior authorization for discharges to rehabilitation hospitals or long-term acute care hospitals. Hospitals had to create detailed lists to track plan specific waivers, which varied by types of services waived, procedures and expiration dates.

The problem is compounded, our members report, when MA plans cherry-pick Medicare coverage criteria when it benefits them and alternative guidelines to determine medical necessity, such as InterQual or Milliman, when that is more favorable to the health plan. Navigating these differences and criteria requires clinician involvement, additional documentation and resources, resulting in care delays. Even when hospitals follow prior authorization procedures prior to the provision of care, MA plans have denied payment or retroactively state that the care did not meet medical necessity. These types of denials, typically overturned after hospitals appeal them, result in payment delays, additional administrative costs and staff burnout.

Creating a standardized list of services and procedures requiring prior authorization for MA plans would reduce the administrative burden on hospitals and other providers and

reduce confusion for the Medicare beneficiary. It would allow for more consistency in the program and likely result in patients receiving more timely access to medically necessary services.

MA plans also restrict access to care through their approval process, often only approving the delivery of care associated with limited and specific CPT codes. If the approved procedure is performed, but the provider must adapt their care plan necessitating "unapproved" care, the subsequent payment is typically denied for lack of authorization, despite the provider deeming it medically necessary. CMS should require MA plans adopt the approach used by the Veteran's Administration, which authorizes care by "Standard Episodes of Care" and gives a wide range of codes (OV, labs, radiology, surgeries, etc) that will be covered during a procedure so the provider can treat the patient as needed and then only go back to the VA to authorize only certain services.

We believe the recommendations listed below would improve access to care and provider experience.

1. CMS should adopt a standard list of services and procedures that do not require prior authorization and update the list at least semi-annually based on the review of data on the types of requests for prior authorization and the resulting approval and denial rates. All MA plans would be required to waive prior authorization requirements for the CMS list of services.
2. If the service requires medical review, there should be a standard process and timeframes to minimize potential delays and undue administrative burden. This should include processes to schedule peer to peer reviews that do not make approval prohibitively difficult.
3. MA plans should be prohibited from denying payment retrospectively when the service or procedure was authorized.
4. CMS should prohibit plans from denying payment for care deemed medically necessary during an authorized procedure due to lack of prior authorization.
5. Statistics about prior authorizations should be tracked and publicly reported. These would include but not be limited to:
    a. Average time for prior authorization
        i. Urgent
        ii. Non-urgent

   b. Percentage of PA requests approved
   c. Percentage of PA requests denied
   d. Percentage of PA requests appealed
   e. Percentage of PA appeals overturned.
6. MA plans should be required to adopt a program to exempt providers consistently meeting prior authorization requirements.
7. CMS should require that MA plans or their third-party vendors use electronic "portals"tracking and monitoring a subset of services such as transportation, behavioral health, DME, home care, etc.
8. CMS should adopt standard authorization waivers during state and federal public health emergencies to remove any barriers for discharging, admitting, and providing timely services to patients

Utilization Management Approaches

As noted above, MA plans frequently apply more stringent medical necessity criteria than Traditional Medicare and require onerous and duplicative clinical documentation submissions to substantiate the need for services. These practices result in delays in care and can cause direct patient harm. Our members have identified two areas that illustrate how their criteria differ from traditional Medicare – coverage for sepsis and inpatient level of care.

- **Sepsis Coverage.** Florida hospitals are reporting an increasing number of MA plans unilaterally denying reimbursement for sepsis patients if they do not meet the new Sepsis 3 criteria. Sepsis 3 requires development of organ dysfunction for diagnosis of sepsis, which is associated with significantly higher mortality and morbidity. Limiting reimbursement and coverage to the Sepsis 3 definition misses the goal of early diagnosis of sepsis to prevent death or severe morbidity. MA plans are performing clinical validation retrospectively, determining whether the patient truly possessed the conditions documented in the medical record, and denying payment for those cases that did not progress to complete organ failure, despite the providers providing timely, evidenced-based care for the patient. MA 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 results in inappropriate underpayment to providers who continue to deliver the medically necessary care. Additionally, since the denial is retrospective, those codes signifying severe sepsis are likely included in the original claim from which health plan risk adjustments are determined.

Hospitals have prioritized sepsis care, focusing on early detection and intervention to prevent bad outcomes. Sepsis mortality is tracked closely by hospitals and CMS, as part of the Inpatient Quality Reporting Program, requires reporting on adherence to the sepsis bundle, which is based on the Sepsis 2 definition. Plans refusing to pay for care that does not meet the more stringent Sepsis 3 criteria is a clear example of the inconsistency between MA plan policies and CMS policy.

- **Inpatient Care Downgrades to 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 that policy, hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Despite CMS's policy on observation stays, many MA plans have implemented policies that further restrict inpatient care by placing additional obstacles to admission, including, directly pressuring providers to classify patients as "under observation" prior to the submission of claims or change it after a prepayment review, even when the clinical criteria for inpatient care was clearly met. This has the dual benefit of reducing provider reimbursement and reducing the plan's reported rate of denials if the provider submits 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. FHA member hospitals have reported cases where the patient is in observation status for 5-7 days and met MCG criteria but the MA plan refuses to approve inpatient care. 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.

Use of Third Party Contractors

MA plans frequently contract with third parties to conduct clinical validation reviews, prior authorizations for post-acute care, and coordination of services such as transportation, home health, durable medical equipment and other services. While federal guidelines require MA plans to ensure their vendors adhere to all program rules, hospitals report they do not follow CMS rules and the MA plans have assigned their responsibilities to these vendors without necessary oversight to ensure compliance. The result is third-party contractors incentivized to provide barriers to care without fear of penalty from CMS.

While hospitals do not have contracts with these vendors, those subcontractors are contracted by MA plans to make final determinations regarding denial of services or ex-post down coding to another level of care. The MA plan, of which the hospital has contracted, essentially takes a hands-off approach to managing care under the plan. For example, hospitals have shared cases where the MA plan tells the provider that no prior authorization is required for a particular service; however, third-party 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 MA plan 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 MA plan (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.

We encourage CMS to extend its direct oversight to third-party vendors and hold MA plans accountable when their vendors delay patient access to care or cause unnecessary costs and burden in the system.

Behavioral Health Services

Access to behavioral health services is critical to providing the best care and chances for recovery for a Medicare Advantage member. Research has shown that patients with behavioral health concerns have a higher likelihood of readmission than those without. Behavioral health care is critical for the health and well-being of Medicare patients. CMS notes that the MA plans report experiencing difficulties in building an adequate network of behavioral health providers. In this RFI, CMS is requesting information and insight on the challenges in contracting with and accessing behavioral health providers for Medicare Advantage members.

In general, the lack of behavioral health providers available in a MA plan's network places an extra burden on hospitals as they try to find placement for patients and support patient mental health needs. Medicare Advantage members with behavioral health needs are even more challenging to place in post-acute care primarily due to the lack of providers available to provide mental health services in the post-acute care setting.

Among the challenges include a shortage of behavioral health providers, low reimbursement rates, and barriers to accessing care such as limits on the number of visits and copayment amounts. Many of the MA plans sub-contract with third-party provider networks, which are not evaluated or monitored by state and federal regulatory agencies. These third-party networks place barriers to accessing care along with placing limitations on the care provided. Frustrations with dealing with these groups impact the willingness to contract, the use of these services, and challenges in obtaining approvals to obtain care.

Florida hospitals report significant challenges in accessing and referring MA plan members to behavioral health providers. Many times, the rate the behavioral health

provider receives from the MA plans is so low that it is not financially feasible to treat these members. Additionally, the documentation requirements, authorization barriers, and denied or reduced payments make it administratively difficult and frustrating for behavioral health providers, resulting in a lack of willingness to contract. Negotiating a contract is also challenging because typically the provision of behavioral health services has been offloaded to a third-party vendor, who is focused more on the price point than the delivery of care.

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, for the purposes of defining network adequacy, mental 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.

MA plans can use data on enrollee characteristics—such as quantitative information from claims describing utilization and diagnostic patterns as well as qualitative information similar to 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 MA plans to be able to meet more specific time and distance standards**. Alternatively, a simpler approach would be to hold MA plans 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 care out-of-market or out-of-network where needed.

Finally, maintaining behavioral health networks in rural areas is even more problematic given the shortage of providers and the ability to attract and retain providers in a rural community. A 2019 CDC report noted that rural markets include a higher percentage of individuals receiving medications for behavioral health conditions but a significantly lower proportion of individuals engaged in counseling or psychotherapy. Because of this, the number of clinicians interested in working in rural areas is substantially lower because the market for their services is so much thinner.

Recommendations

1. MA plans should cover behavioral health telemedicine to increase access to care so those with greater needs are directed to in-person visits.
2. When appropriate permit a downward substitution of specialties: Medicaid allows for MA-level therapists who are not yet licensed to bill under the supervision of a licensed therapist; Medicaid and commercial insurances allow LMHCs and LMFTs to bill – Medicare is restricted to LCSWs and licensed PhDs, PsyDs, MDs, Dos, and APRNs. APRNs must accept differential (lower) rates than MDs, despite providing the same services. A broader group of potential providers would result in an easier time populating networks.
3. For the purposes of defining network adequacy, mental 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.
4. Ensure MA plans account for beneficiary time and distance to care when establishing network adequacy
5. Promote behavioral health care in rural areas by requiring a differential fee structure to financially incentivize behavioral health providers to work in rural areas.

Network Adequacy

Strengthening access to care for the Medicare beneficiaries is an important focus in improving the Medicare Advantage program. Timely access to primary care is important to ensure that Medicare beneficiaries can access care to manage their acute and chronic conditions, hopefully avoiding unnecessary admissions and readmissions.

CMS requests information on updating network adequacy requirements to further support access to primary care, behavioral health services, and a wide range of specialty services.

Ensuring plans have the appropriate number of providers is key to serving the Medicare Advantage beneficiary. While CMS has some standards, we believe there is opportunity for a more comprehensive methodology to monitor and track network adequacy.

Many of the MA plans contract with the same providers. On an individual plan basis, it appears they meet the network adequacy requirements. However, when it is evaluated holistically, the networks might not be adequate because of the overlap of providers in the different plans. For post-acute care, this issue is particularly challenging since many post-acute providers (home health, skilled nursing, long-term acute care, behavioral health) limit the number of MA patients they will accept due to the low reimbursement, denials, or administrative burden. Having an adequate network for services covered under the MA program is key to members getting timely access to care and services.

CMS should exercise proactive network adequacy monitoring strategies in addition to retroactive compliance reviews. We commend CMS for the provisions included in the CY23 MA Final Rule which require MA plans to demonstrate compliance with network adequacy standards when the MA plan 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 MA plan directory are indeed actively enrolled, in-network, and have appointment availability. For behavioral health, such network review protocols should include comparisons of MA plan networks against a comprehensive list of services, as well as an analysis of claims and utilization history by service to assess provider capacity. 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.

Recommendations:

1. Adopt more comprehensive reporting to determine network adequacy including information on the range of services provided by providers and

appropriateness to the population covered by the plan. This would include third party vendors who have been contracted to provide certain services.
2. Monitor overlap of network providers in multiple plans to ensure providers have capacity (this includes SNF and other post-acute care providers
3. Address issues with lack of home health providers and monitor service timeframes and no-show rates
4. Develop time standards for home health, DME, and monitor compliance with those along with transportation vendor performance. Develop an audit process to ensure the accuracy of the data reported.
5. Exercise proactive network adequacy monitoring strategies in addition to retroactive compliance reviews

Additional Steps to Ensure MA Program is Serving the Community

CMS needs to provide more oversight of the Medicare Advantage Program and increase its authority to address problems identified by providers. There is no formal complaint process or resolution through CMS to address hospital struggles with MA plan issues. Historically, when these issues are reported, the response from CMS has been hands-off, delegating a resolution to the plan and provider, identifying the problem as a contractual issue beyond their scope of enforcement. Additionally, state insurance regulators indicate they have no oversight of the program other than whether they are meeting the state statutory requirements for solvency. This leaves few avenues, other than legal action, to resolve issues with MA plans.

We believe greater CMS oversight of MA plan conduct is warranted. 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 MA plans. 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 MA plans. We strongly urge the agency to evaluate its data collection and address gaps.

In addition to the data collection recommended regarding prior authorization, CMS should also collect the following data, which should be reviewed and analyzed by the agency and publicly reported:

- Number of claims denied
- Value of the claims denied
- Reasons for denial
- Appeal rates
- Appeal overturn rates
- # of enrollee complaints
- Complaint Rate per 10,000 member
- # of provider complaints
- # of provider complaints resolved

Additionally, we recommend that CMS establish a provider complaint mechanism that allows providers to flag problematic plan behavior. Through the nature of our care relationships with patients, we have the most frequent interaction with plans, giving us 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, we need a mechanism to flag problematic MA plans on behalf of our patients. There is currently no streamlined way to do this. We 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.

FHA appreciates the opportunity to be a resource on these issues and would welcome the opportunity to continue to provide information to CMS in future MA rulemaking processes. Please feel free to contact Michael Williams at michaelw@fha.org if we can provide any additional information.

Sincerely,

Mary C. Mayhew

President and CEO

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