New Hampshire Hospital Association

February 10, 2023

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

Submitted electronically

Re: CMS 4201-P, Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Program

Dear Administrator Brooks-LaSure:

On behalf of our 26 acute care hospitals and our five specialty hospitals, the New Hampshire Hospital Association (NHHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for policy and technical changes to the Medicare Advantage (MA) program in contract year 2024. Ensuring patients have readily accessible forms of care is of the utmost importance. The NHHA shares CMS' goals to improve patient access to care in various settings, as well as establishing resource management procedures to ensure that the disbursement of health care services are not mismanaged or potentially wasted.

The proposed rule includes important protections for MA beneficiaries and clarifications for Medicare Advantage Organizations (MAOs) that will improve how coverage works for enrollees, promote more timely access to care, strengthen access to behavioral health providers, help patients understand their Medicare coverage options, and reduce the administrative burden of health plan requirements on health care providers. We strongly support the proposed changes intended to strengthen consumer protections and oversight of MAOs, which are critical and urgently needed, and we encourage the agency to expeditiously finalize these important program updates. We also offer our concerns about the proposed changes to the legal standard for identifying overpayments and recommend that CMS either withdraw this section of the proposed rule or restore the portions of prior CMS rulemaking on overpayments which afforded providers with the necessary time to investigate and accurately identify overpayments.

Our member hospitals frequently encounter challenges in working with MAOs and securing timely authorization and payment for care they provide to their patients resulting in unnecessary delays and increased administrative burdens. These challenges often include misuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by Traditional Medicare, requirements for unreasonable levels of

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documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year, among others.

Our key comments and recommendations are included below and focus on prior authorization and medical necessity criteria; behavioral health access; post-acute care; oversight and enforcement; and our concerns regarding the proposed changes to the legal standard for identifying overpayments.

Prior Authorization and Medical Necessity Criteria

The MA program was intended to provide beneficiaries with coverage of an equivalent set of services to Traditional Medicare with a level of access that is no less favorable. However, that aim is not consistently achieved. In fact, an April 2022 Department of Health and Human Services Office of the Inspector General (HHS-OIG) report found that 13% of MA prior authorization denials and 18% of MA payment denials that were reviewed met Medicare coverage rules and should have been granted.[1] **As a result, we strongly support CMS' proposal to limit MAOs from adopting more restrictive rules than Traditional Medicare, seeking to ensure MAOs provide access to an equivalent set of covered services as intended.**

Specifically, CMS proposes that MAOs can only create internal medical necessity criteria "when there is no applicable coverage criteria in Medicare statute, regulation, NCD [national coverage determination], or LCD [local coverage determination]," and that such criteria must be "based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers." Eliminating MAOs flexibility to apply differential and opaque criteria when determining medical necessity — which today are often inconsistent with Medicare coverage rules — would be significantly beneficial for patients. Despite existing CMS rules precluding MAOs from using clinical criteria that are more restrictive than Traditional Medicare, our hospitals routinely experience MAOs doing exactly that. Currently, MAOs often classify their medical necessity criteria as proprietary and do not share specifics with hospitals, resulting in a "black box" when staff attempt to determine whether a service will be approved. This lack of transparency is a frequent reason that prior authorization and claim reimbursements are delayed or denied.

Hospital inpatient admission is one area in which plans often administer proprietary medical necessity criteria that is inconsistent with Medicare coverage rules. Inconsistent and more restrictive plan criteria for inpatient admissions frequently leads to uncertainty for providers and patients — whose medically justified inpatient stays are often denied or retrospectively downgraded to observation stays, even in situations where the clinical necessity for the admission far exceeds plan requirements.

The strategy utilized by MAOs to deny beneficiaries for inpatient status and instead, move patients to observation (outpatient) status has significant impact to MA beneficiaries. This policy generally eliminates a MA beneficiary's eligibility for post-acute care coverage because MAOs generally only pay for post-acute care ***after a qualifying inpatient*** hospital stay and do not provide this coverage following an observation hospitalization. Hospitals report that nearly

[1] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

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any stay that is less than 48 hours will be automatically downgraded to an observation stay rather than an inpatient stay, even when the patient clearly meets the inpatient criteria at the time of admission.

Inappropriate denials of necessary inpatient coverage would be prohibited under CMS' proposal, which explicitly reiterates that coverage of inpatient admissions, skilled nursing facility (SNF) care, home health services and inpatient rehabilitation facilities (IRF) are basic Medicare benefits for which MAOs may not utilize proprietary medical necessity criteria. We urge CMS to finalize these important provisions codifying that MAOs must provide access to care for basic benefits in a way that is consistent with, and no more restrictive than, Traditional Medicare coverage rules.

Further Clarity to Support Understanding and Compliance

In the face of compelling evidence that certain MAOs have historically circumvented federal rules in applying overly restrictive medical necessity criteria, we recommend that CMS adopt more specific language regarding the Traditional Medicare rules that MAOs are required to follow. For example, we interpret that the reiteration of inpatient admissions as a basic benefit and the requirement that MAOs cover basic benefits in a fashion that is no more restrictive than Traditional Medicare means that MAOs must follow the Two-Midnight rule and adhere to the Inpatient Only List. This would effectively prevent MAOs from downgrading inpatient hospital stays that exceed two midnights to observation status — a practice that effectively applies a more restrictive set of criteria to an inpatient admission. We urge CMS to explicitly state that MAOs must follow the Two-Midnight rule, for example, as opposed to leaving this open to interpretation. Additionally, to enhance clarity and adherence, we encourage CMS to offer greater specificity and delineate the specific rules that MAOs must follow pursuant to Traditional Medicare coverage rules where possible.

Relevant Medical Expertise to Review Medical Necessity Determinations

NHHA commends CMS's proposed update to § 422.566(d), which seeks to ensure appropriate personnel make medical necessity determinations for MA beneficiaries. MA patients should be able to rely on the expert judgment of their medical care team as opposed to a health plan clinician who has never treated or even met the patient — and may not have the same training or specialty expertise as the treating physician. To ensure that denials are made based on relevant and applicable medical expertise, reviewing clinicians must have appropriate training in the field of medicine for the service being requested.

One area in which this is particularly important is peer-to-peer discussions. Our member hospital physicians frequently participate in MAO-required peer-to-peer discussions as part of the health plan appeals process where the clinicians can explain the merits of their recommended treatment approach and advocate for its coverage. Specialists often report that they encounter MAO medical professionals who do not have applicable expertise in the requested service discipline yet are responsible for conducting medical necessity reviews in that service area. This practice alone effectively eliminates the value of a peer-to-peer discussion.

However, an even more egregious practice is the extraordinarily limited time frames that MAOs allow for participation in the peer-to-peer process. One of our member hospitals recently reported that they had trouble getting in touch with an MAO after a denial. After a significant

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delay, **the MAO responded with a request for a peer-to-peer review and indicated the provider needed to secure a physician to conduct the peer-to-peer *within the next 10 minutes* or the case would be denied**. Such practices circumvent the intent of peer-to-peer conversations for clinicians to discuss the merits of a patient case as well as the pros and cons of a recommended approach and allow MAOs to deny patient care for administrative reasons unrelated to patient need or clinical merit.

We appreciate CMS's recognition of this issue in proposing updates to the qualifications of the reviewing clinician and urge CMS to specify that these rules apply to peer-to-peer discussions in addition to prior authorization reviews. Further, we support requiring the proposed utilization management committee (UM committee) to use the expertise of a clinician with experience in a particular service area when reviewing and updating UM policies for that service or item. These policies will all help ensure MA plans are not limiting patients' access to care, decrease the time it takes to discharge a patient to the most appropriate setting, and help reduce the administrative burden of hospitals and providers when caring for MA beneficiaries. Finally, we recommend CMS clarify that this provision applies to expedited reviews in addition to standard requests for prior authorization.

Site of Care Protections

NHHA commends CMS for the inclusion of provisions designed to protect patients from unnecessary site of care restrictions. Specifically, CMS states multiple times in the preamble that when care could plausibly be provided "in more than one way or in more than one type of setting," an MAO may not impose its choice of site of care and deny the request on those grounds if there is no basis for such restriction in Traditional Medicare. **Protecting patients from inappropriate site of service restrictions is imperative**, **as such changes can impede patient access and delay care**, especially when adopted mid-plan year or applied to critically ill or complex patient populations. To ensure that the regulations in effect create such protection, we encourage CMS to establish more explicitly a clearly stated site of service limitation in the regulatory text (as opposed to the preamble) that directly prohibits MAOs from adopting policies which restrict the site(s) where a covered service can be delivered when there is no basis for that restriction in Traditional Medicare.

Continuity of Care

We recommend that CMS finalize its proposed patient protections for continuity of care. As proposed, CMS would require prior authorizations to be valid for the entirety of a prescribed treatment and require plans to honor existing prior authorizations for no less than 90 days of patient enrollment. This would preclude the need for additional prior authorizations for each episode of care in a series of prescribed treatments, such as a regimen of chemotherapy, which can delay or interrupt ongoing treatments unnecessarily. Regulations eliminating plan use of repetitive mid-treatment prior authorizations would benefit many, particularly vulnerable patients. We commend CMS for codifying these important patient protections to support continuity of care, and stress the importance of finalizing these proposals.

Improving Access to Behavioral Health Services

NHHA applauds CMS for its proposals to expand access to behavioral health services and strengthen MAO provider networks. Inadequate behavioral health provider networks have been a consistent problem for many years, impeding access to critical services. We specifically

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support CMS's proposal to add clinical psychologists, licensed clinical social workers and prescribers of medication for opioid use disorder as specialty provider types for which there are specific minimum network standards, in addition to the current requirements to demonstrate adequate inclusion of psychiatry providers and inpatient psychiatric facilities. Behavioral health care services involve a wide continuum of providers, facilities, and settings, all of which must be incorporated into insurance coverage to sufficiently meet specialized patient and community needs. In addition, by expanding the types of behavioral health specialty providers required to be in-network beyond physician-level psychiatrists and inpatient psychiatric facilities, MAOs will have a wider array of qualified provider types to contract with in meeting requirements — and enrollees will have access to a broader selection of appropriately trained specialists.

Improving Access to Post-Acute Care Services

NHHA commends CMS for the significant steps it has taken in this proposed rule to address concerns regarding MA beneficiary access to medically necessary post-acute care (PAC) services. Institutional PAC providers, including inpatient rehabilitation hospitals and units (IRFs), skilled nursing facilities (SNFs) and home health agencies (HHAs) play a vital role for recovering MA beneficiaries. These providers work to restore function and allow beneficiaries to return to their lives after a serious illness or injury, usually after an acute care hospitalization. However, MA beneficiaries are frequently denied access to these covered services or suffer long delays in receiving authorization for transfer to an appropriate PAC facility. This harms patients who are robbed of specialized rehabilitation care to optimize their chances of recovery, exacerbates capacity issues at general acute care hospitals and saddles health care workers with time consuming administrative appeals processes to get patients what they need.

Many of the MAOs prior authorization policies and procedures provide barriers to transitions to post-acute care services. Perhaps most concerning, is for patients who have suffered a stroke. Traditional Medicare members can be admitted to an inpatient rehabilitation facility (IRF) without the need for a prior authorization as this is a compliant IRF CMS diagnoses. Evidence based guidelines recommend acute rehab for stroke patients ***as soon as possible*** in order to maximize neuroplasticity of the brain in the recovery practice. However, all MA stroke cases must go through an authorization process.

The administrative process associated with prior authorization of post-acute care by the MAOs **typically adds up to four days to hospitalization and even more if the request is initiated on a Friday or weekend.** It is particularly concerning that many of the MAOs take full advantage of the CMS rules that allow MAOs 14 days to make a determination on a prior authorization request. We appreciate that a separate proposed rule currently open for public comment seeks to reduce the timeframe for prior authorization approval to 24 hours for expedited determinations and seven (7) business days for standard requests. This reduction in timing is a step in the right direction; however, the proposed reduced timeframes are still too long. Time is of the essence for most patients in need of post-acute care. This administrative delay preventing a patient from transitioning out of an acute care hospital into a more appropriate level of care negatively impacts that specific MA beneficiary and also means that other patients in need of that acute care bed cannot be served. While delays in patient transitions from acute care to a post-acute care setting have always been a concern, they have been particularly egregious since the onset of the

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COVID-19 pandemic as hospitals have been dealing with unprecedented occupancy rates.[2] These unnecessary delays negatively impact patients and add unnecessary strain on an overburdened healthcare system.

Additionally, each prior authorization request requires hours of staff time to demonstrate medical necessity to the MAO. It should be noted that the staff at both the acute care hospitals and staff at post-acute care facilities, who have not even received the patient yet, must dedicate significant resources to obtaining these approvals that are rarely required under traditional Medicare. These delays contribute to a decline in the patient's condition and waste costly resources. Accordingly, CMS' proposed modifications and additions will help ensure MAOs utilize proper criteria when evaluating requests for PAC services, that MAOs use prior authorization in an appropriate manner, and that the need for repeated prior authorization requests do not disrupt patient care and unduly burden providers. These updates are especially critical for PAC services, which the HHS-OIG report highlighted as one of the top service categories experiencing inappropriate denials for covered services. In addition, to shore up the protections proposed in this rule and to ensure the availability of appropriate PAC services in MAO networks, we recommend that CMS add a requirement that IRFs and HHAs be explicitly added to network adequacy requirements.

Enforcement and Oversight

Throughout this proposed rule, CMS has thoughtfully addressed a wide range of stakeholder concerns about MAO policies and practices which may delay or restrict access to care. As described above, we believe these policies will go a long way to protect MA beneficiaries, increase access to care, and implement important guardrails needed to ensure the MA program functions as intended. However, CMS notes in several sections of the proposed rule that the provisions are restatements or codification of existing CMS policies or practices, which underscores the importance of the work ahead in the implementation phase to hold plans accountable and ensure compliance. We also recognize that many of these policies govern operational processes related to authorization, claims processing and payment, which are difficult to meaningfully oversee without rigorous oversight to include plan-level data collection and reporting, regular auditing, pathways for stakeholders to report suspected violations and penalties for non-compliance. Each of these elements will be critical in ensuring these important changes become standard operating procedures for MAOs and have the intended effects on beneficiary protection and access to care.

Changes to the Standard for Identifying Overpayments

CMS' proposal to change the legal standard for identifying an overpayment (from the current standard of "reasonable diligence" to the False Claims Act definition of "knowingly") would result in an unrealistic strict 60-day timeline to return overpayments once they have been identified. This new proposed timeline will be nearly impossible to meet, subjecting organizations to unnecessary False Claims Act liability, even when they are acting in good faith to comply.

Although it is unclear exactly why CMS believes it is necessary to change its approach, the proposed rule incorrectly suggests that it is legally required to do so. The text and history of the

[2] NH_Hospitals_Face_Difficult_2023_FINAL.pdf (nhha.org)

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relevant statutory provision (42 U.S.C. § 1320a-7k(d)(2)(A)) indicate that CMS must afford overpayment recipients with sufficient time to conduct audits and investigations to identify the size, scope, and nature of overpayments, so long as that overpayment recipient demonstrates good faith while working to identify the exact amount it must return to the Secretary. There was good reason for Congress to adopt this approach. A 60-day timeframe for returning overpayments, without an appropriate period to investigate and quantify the overpayment, is entirely unrealistic. Once a provider identifies a potential overpayment, compliance and revenue cycle teams conduct an extensive and rigorous audit investigation to collect facts, identify the source of the discrepancy, mitigate any continuing circumstances if the issue is ongoing, and determine exactly how much money must be returned. This requires identifying every claim that may have been overpaid by claim number, dates of service, and amount billed and paid. It also may involve complex statistical sampling followed by quality checks, as well as consultations with the Medicare Administrative Contractor. Given the six-year lookback period, moreover, in many instances claims data is already archived or stored on legacy systems and must be "restored" such that it can be queried for the unique claims at hand. In some cases, identifying refunds involves applying different legal standards to different years of claims because Medicare rules change over time, further complicating the analysis and identification.

Previous CMS rulemaking on this topic, including the 2016 Final Rule on Reporting and Returning Overpayments, appropriately recognized these practical realities and clarified that up to six months is permitted to conduct a necessary investigation and appropriately quantify an overpayment. HHS should not deviate from this current practice and impose an unrealistically strict 60-day deadline on hospitals and health systems to return overpayments. Instead, once a provider knows of the existence of an overpayment, HHS should allow a reasonable timeframe for them to identify exactly how much they must repay **before any 60-day clock is triggered**. No judicial decision —and certainly no statute — requires any change in CMS's existing approach. **To that end, HHS should withdraw this portion of the proposed rule and/or restore the portions of the 2016 Final Rule that afford providers with the necessary time to investigate and accurately identify overpayments**.

We thank you for the opportunity to comment on these important topics. We particularly appreciate CMS's thoughtful proposals to improve how the Medicare program works for patients and their providers and appreciate your consideration of our recommendations. We urge CMS to expeditiously finalize the health plan oversight and consumer protections included in the proposed rule and to adopt our recommended modifications to the proposed policy on overpayments. If you have any questions, please feel free to contact me or Brooke Belanger, Vice President, Financial Policy and Compliance at (603) 415-4253 or bbelanger@nhha.org.

Sincerely,

Steve Ahnen
President

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