Federation of American Hospitals®

Charles N. Kahn III
President & CEO

March 6, 2020

Electronically Submitted on www.regulations.gov

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies [CMS-2020-0003]

Dear Director Kouzoukas:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Many of our members contract with Medicare Advantage Organizations (MAOs) to provide services to Medicare Part C beneficiaries. We believe that it is important for the Centers for Medicare & Medicaid Services (CMS) to consider the views of direct providers of patient care to these beneficiaries in order to structure the Part C program to best serve beneficiary interests.

The FAH is pleased to provide CMS with our views in response to the above-referenced *Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies*, published on February 5, 2020 (Advance Notice).

Attachment V. Updates for Part C and Part D Star Ratings – Potential New Measure Concepts (pg. 73)

Prior Authorizations (Part C)

The FAH appreciates CMS' desire to improve prior authorization processes – particularly in MA – and is pleased to see that CMS has started work on a prior authorization-related measure that could be used as part of the Star Ratings. As CMS correctly notes, "Prior authorization is a critical aspect of plan performance since it affects how quickly plan enrollees can get needed care and services."[1]

Our members routinely report delays and inconsistencies with prior authorization processes across MA plans that negatively impact patients' access to timely medically necessary services, as well as payments to providers for those services. Some of the more common issues with prior authorization include: lack of transparency and clarity regarding the guidelines plans use to evaluate prior authorization requests; delays in plans approving requests; varying authorization and documentation rules across payers and across plans within the same payer; lack of ability to rely on prior authorization approvals; and onerous and confusing appeals processes.

For example, different payers – and sometimes different plans within the same payer – use varying proprietary guidelines to evaluate prior authorization requests. These guidelines frequently vary from the well-established guidelines and tools used by providers (e.g., the guidelines used by hospitals to determine appropriate inpatient admissions), leading to conflict between a health care provider's assessment of a patient's need for services and the assessment from the patient's insurance company. When plans deny the prior authorization request, providers struggle to understand why (e.g., based on what guidelines) the request was denied and/or how to correct any real or perceived errors in the request. Sometimes this discontinuity can be addressed without a more formal appeal, but in other instances the patient and/or provider must enter the appeals process. Delays in the adjudication of these appeals results in unnecessary delays in patients receiving needed medical services, with the attendant adverse consequences.

In addition to delays resulting from denials and resultant appeals, MA plans are increasingly taking longer to review and adjudicate the initial request. Plans can take multiple days to approve prior authorization for post-acute care, resulting in patients spending more time than necessary in an inpatient setting, delaying access to critical post-acute care rehabilitation services, and risking patients ultimately being readmitted to the hospital from their home or a less-appropriate post-acute care setting. These delays result in a misalignment in access to timely services for Medicare fee-for-service beneficiaries versus MA plan enrollees.

Providers are also contending with varying authorization and documentation rules across payers and across plans within the same payer. The lack of a single standard across MA plans for prior authorization and documentation rules further contributes to administrative burden and costs for providers and delayed services for beneficiaries. For example, some plans only permit the attending physician to discuss the patient's prior authorization request with the plan and will

[1]CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, February 5, 2020, page 73.

only provide a limited time period (e.g., a few hours) in which to have that discussion. This is simply unrealistic for a busy attending physician (whose patient care duties often can prevent the physician from receiving the message to discuss the prior authorization within the designated window of time) and leads to clinician and patient frustration.

Even when enrollees and providers make it through the onerous prior authorization process and receive an approval, they are increasingly finding that plans do not honor that approval at the time of payment. Plan enrollees and the providers who care for them must be able to rely on prior authorization determinations. For example, if a plan provides prior authorization for an inpatient admission or a procedure, the plan should be bound by that pre-service determination for payment purposes.

The concerns from our members and their patients are highlighted in a September 2018 Department of Health & Human Services (HHS) Office of Inspector General (OIG) report on MA service and payment denials. The OIG report noted the very low rates of appeals from beneficiaries and providers and the high rates at which MA plans overturn their own denials at various levels of the appeals process.[2] The report stated, "MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits."[3]

The low rate of appeals – which the OIG found to be 1 percent[4] – in response to prior authorization denials and other MA practices is concerning and signifies an appeals process [that] can be confusing and overwhelming, particularly for critically ill beneficiaries,"[5] and that requires significant administrative resources and staffing for health care providers. The initial denial is often reversed or overturned on appeal, but not without significant effort on the part of the health care provider. This cycle of requests, denials, back-and-forth, and appeals delays patient access to needed services and is unnecessarily burdensome for enrollees and burdensome and costly for providers.

In addition to developing a prior authorization-related measure for the Star Ratings, the FAH also urges CMS to swiftly implement the recommendations from the OIG report, including: enhancing oversight of MA contracts and taking correcting action; addressing persistent problems regarding inappropriate denials and insufficient denial letters; and providing enrollees with easy-to-understand and easily accessible information about serious MA plan violations.

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[2] HHS OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*, Sept. 2018, available at: https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp. The report notes that "Medicare Advantage Organizations (MAOs) overturned 75 percent of their own denials during 2014-2016" and that "(t)he high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers rarely used the appeals process." The report further states that during the two-year period 2014-2016, "beneficiaries and providers appealed only 1 percent of denials to the first level of appeals."
[3] *Id.* at pg. 17.
[4] *Id.* at pg. 7.
[5] *Id.* at pg. 10.

The FAH appreciates the opportunity to comment on the Advance Notice. We look forward to continued partnership with CMS as we strive for a continuously improving health care system. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,