Federation of American Hospitals®
Charles N. Kahn III
President and CEO

March 1, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3442-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies [CMS-2024-0006]**

Dear Administrator Brooks-LaSure,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 tax-paying community 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 areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include 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.

The FAH appreciates the opportunity to provide the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) with feedback on the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies published in the Federal Register on January 31, 2024. The FAH supports CMS' proposals geared towards increasing oversight of Medicare Advantage Organizations (MAOs) and urges CMS to consider the recommendation below to continue to improve both the beneficiary experience and provider engagement within the MA program.

**FAH urges CMS to include the newly developed quality measure, Level 1 Upheld Denial Rate, in the Part C and D Star Ratings Program for its potential to improve patient care quality, provider experiences, and insurer accountability.**

At present, there is insufficient responsibility imposed on insurers when they postpone or refuse access to treatment agreed upon by a doctor and patient as the most appropriate. We strongly advocate that the quality measure developed by the FAH offers a chance to alter the current scenario and decrease the occurrence of delayed or denied care for MA beneficiaries.

High numbers of overturned denials at Level 1 of the appeals process likely indicate that beneficiaries are not receiving necessary care promptly. Two Office of the Inspector General (OIG) reports (2018 and 2022) found widespread and persistent issues with inappropriate denials among MAOs, necessitating additional oversight. As many beneficiaries do not appeal care decisions, MAOs must be held accountable for making appropriate decisions at the initial determination stage (before Level 1 appeals). Delays or denials of necessary care due to incorrect denials lead to treatment abandonment, negatively impact patient outcomes, and increase unnecessary provider burden.

To address these concerns, in 2023, the FAH developed and tested a measure to assess the frequency with which an MAO review found their original determination decision to deny coverage to patients to be reasonable. The measure, entitled "Level 1 Upheld Denial Rate," was added to the CMS measures under consideration (MUC); (MUC2023-212) list in 2023. Recently in January 2024, the measure received overwhelming support and a recommendation from the Clinician Pre-Rulemaking Measure Review (PRMR) committee to adopt the measure into the Medicare Star Ratings Program[1].

While the existing Medicare Part C Star Ratings measure, Reviewing Appeals Decisions, assesses Level 2 appeals reviewed by an external independent reviewer, it alone is not enough. The Level 1 Denials Upheld Rate measure, which scrutinizes appeals of denials of initial determinations internally conducted by insurers, enhances accountability for sound decision-making at an earlier stage in the appeals process. This will reduce the burden on external reviewers in terms of time and resources, ensuring that patients receive necessary care promptly and appropriately. FAH urges CMS to add the Level 1 Upheld Denials Rate measure to Part C and D Star Ratings, to take plan accountability one step beyond public reporting by tying performance to financial incentives.

**FAH encourages CMS to increase data collection around prior authorizations, denials, and information related to health equity**

The "Level 1 Upheld Denial Rate" quality measure is currently calculated using the Part C and D Data Validation Public Use File using the following variables: Total number of Part C reconsiderations made in the contract year (numerator); and total number of adverse Part C reconsiderations made in the contract year (denominator). As currently specified, the data is not able to differentiate the reason for the denial, the setting in which the denial occurred, or any patient characteristics related to who is getting denied.

[1] Partnership for Quality Measurement Powered by Battelle. (2024). Pre-Rulemaking Measure Review Measures Under Consideration 2023 Recommendations Report. https://p4qm.org/articles/now-available-2023-prmr-recommendations-report

One enhancement to the measure would be to know the reason for denial, the setting in which care is being denied, and the service that is being denied. Having this granularity, such as if the denial was for lack of prior authorization, would provide greater transparency into reasons for denials and allow CMS to make actionable recommendations on how to improve processes, quality of care, and beneficiary experience.

Recent efforts by Congress to require Medicare Advantage plans to submit their numbers of prior authorization requests, approval rates, denial rates, and appeal approval rates to the Secretary for public reporting further underscores the need for transparency and accountability around the appeals process. This initiative could be leveraged to increase the data transparency of the Level 1 Appeals Measure in order to increase efficiency and reduce burden. This type of increased transparency will help address CMS' concerns around greater beneficiary protections.

The second enhancement is around demographics for who is getting denied. We know many beneficiaries do not appeal care decisions, and those who do so, are less comfortable navigating the healthcare system and may be unfairly exploited in the process. Being able to stratify the Level 1 Appeals quality measure by different stratifications, such as race/ethnicity, age, and dual-eligibility, would help illuminate potential disparities in care being provided.

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We appreciate the opportunity to comment on the Advance Notice. We look forward to continued partnership with HHS on this issue. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,