March 7, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

SUBJECT: CMS-4192-P, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (Vol 87, No 8), January 12, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule updating policies for the contract year 2023 Medicare Advantage (MA) and Medicare Prescription Drug Benefit programs. CHA's comments are limited to the agency's proposals related to improving experiences for dual eligible individuals and a request for information (RFI) on the impact of MA plan prior authorization polices on hospital transfers to post-acute care (PAC) settings during a public health emergency (PHE).

Improving Experiences for Dually Eligible Individuals

California is home to 1.4 million individuals dually eligible for both Medicaid (Medi-Cal) and Medicare[1]. Improving care for this vulnerable population is an important goal of the state's ongoing reforms to the Medi-Cal program under the California Advancing and Improving Medi-Cal (CalAIM) initiative. A key component of CalAIM is a transition to a statewide aligned Managed Long-Term Services and Supports and Dual Eligible Special Needs Plan (D-SNP) structure, which will expand the availability of aligned D-SNPs for voluntary enrollment for dual eligible beneficiaries. California hospitals have a long history of working to better coordinate care for their dually eligible patients, including participation under CMS' financial alignment initiative, which was established in several counties and enrolled these beneficiaries into Cal MediConnect plans for management of their Medicare and Medicaid benefits. CHA's member experiences with these earlier efforts inform our comments on several of CMS' proposals.

[1] https://atiadvisory.com/wp-content/uploads/2022/02/Profile-of-the-California-Medicare-Population.pdf

499 So. Capitol Street SW, Suite 410, Washington, DC 20003 ▪ Office: (202) 488-3740 ▪ FAX: (202) 488-4418

1215 K Street, Suite 700, Sacramento, CA 95814 ▪ Office: (916) 443-7401 ▪ www.calhospital.org

Enrollee Participation in Plan Governance
CHA supports CMS' proposal to require MA organizations that offer one or more D-SNP to establish an enrollee advisory committee that includes a reasonably representative sample of the enrolled population. While we do not believe CMS needs to impose more prescriptive requirements for committee membership than are proposed, we urge CMS to ensure MA organizations develop processes that facilitate input from vulnerable enrollee groups who may not be able to fully participate in an established committee. For example, residents of long-term care facilities and/or individuals with behavioral health needs will have unique needs related to access and coordination between the D-SNP and their Medi-Cal managed care plan but may find it challenging to participate on a committee. We urge CMS to require plans to demonstrate how they ensure that feedback from vulnerable populations is collected and incorporated into the work of the committee.

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment
CHA strongly supports CMS' proposal to require all D-SNPs to include one or more standardized questions on housing stability, food security, and access to transportation as part of their health risk assessments beginning with the 2024 contract year. It is increasingly understood that social risk factors contribute to health care disparities; however, a lack of standardized data has impaired the ability of policymakers to fully understand the links between these factors and health inequities. As hospitals work to address health care disparities, we are encouraged to see CMS require plans to collect data that will inform future policymaking and provide plans with a better picture of the unmet needs of their enrollees.

CMS notes in the proposed rule that it will specify the standardized questions in future sub-regulatory guidance. However, the agency shares examples of the types of questions that it is considering. They include those developed for the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) screening tool and certain standardized patient assessment data elements (SPADEs) required for PAC settings by the IMPACT Act. CHA urges CMS to adopt questions — such as those included in the AHC HRSN screening tool — that can be utilized widely across plans and providers to maximize opportunities to compare data across settings and services.

However, we caution the agency against utilizing questions from the PAC patient resident assessment instruments. The patient assessment instruments used in each of the PAC settings — long-term care hospital-Continuity Assessment Record and Evaluation (LTCH-CARE), inpatient rehabilitation facility-Patient Assessment Instrument (IRF-PAI), Minimum Data Set (MDS), and Outcome and Assessment Information Set (OASIS) — are based on a "medical" model under which they are designed to determine medical care needs and associated resource use in the context of the care setting. In contrast, an assessment of social care needs must be completed using a "social" model and address the interaction of the individual beneficiary's medical and functional status and their living and social situation. The functional status assessments in PAC assessment instruments will identify the individual's mobility, including their typical ability to get in and out of a bed or chair, to ambulate functional distances, or to climb stairs. However, this information is insufficient to address ongoing social or medical needs, such as whether the individual has a home with stairs or a capable caregiver.

Scope of Services
As previously mentioned, California is in the process of reforming its Medicaid program under CalAIM, which will encourage dually eligible beneficiaries to enroll in a D-SNP plan aligned with their Medi-Cal managed care plan. While this model has the potential to improve care coordination for dual eligible

patients, CHA urges CMS to consider lessons learned from Cal MediConnect, California's coordinated care initiative implemented under CMS' financial alignment demonstration. Under the initiative, participating managed care plans established Cal MediConnect plans and enrolled dual eligible beneficiaries, taking on responsibility to manage their Medicare, as well as their Medi-Cal, benefit. During the demonstration, CHA members reported frequent instances when Cal MediConnect plans demonstrated a limited understanding of covered Medicare services and regulations, resulting in denied access to medically necessary care for vulnerable dual eligible patients. This was most commonly reported by hospitals working to transfer patients to hospital level post-acute care services, such as admission to an IRF or a LTCH.

In the proposed rule, CMS clarifies that all primary and acute care services, including the Medicare cost-sharing covered by the state Medicaid program, must be covered by the fully integrated dual eligible (FIDE) SNP under the managed care organization contract. CHA urges CMS to exercise the appropriate oversight to ensure that dual beneficiaries enrolled in D-SNPs have access to the full range of Medicare benefits for which they are eligible, and that D-SNPs adhere to Medicare requirements for access to medically necessary services. As stated in the Medicare managed care manual, "MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services." In practice, however, MA enrollees are often denied access to medically necessary IRF or LTCH care through the MA prior authorization process. Our members report that some MA plans have limited understanding or knowledge of Medicare benefit and criteria, leading to inappropriate denials. Many also report that when they pursue a peer-to-peer discussion of the request, the majority of the initial denials are reversed, calling into question the validity of the original determination.

Addressing these access challenges is particularly important for D-SNPs, where the enrollees may be especially vulnerable and disproportionately impacted by these practices. In the aggregate, dually eligible beneficiaries have more chronic conditions and fewer resources than non-dual MA enrollees. As a result, these beneficiaries are both more vulnerable to inappropriate determinations and violations of MA policy. As California increasingly enrolls more older adults and persons with disabilities into D-SNPs, it is imperative that organizations operating D-SNPs are knowledgeable of and adhere to Medicare MA requirements. CHA strongly urges CMS to develop and implement regulatory mechanisms to ensure plan compliance with MA requirements. Additionally, we urge CMS to allow state Medicaid agencies greater authority over the operations of D-SNP plans, in particular on level of care determinations and access to medically necessary services. For example, state Medicaid agencies could address this issue by including certain reporting requirements in their state contracts and use that information in public reporting and when establishing ongoing agreements.

Medicaid Carve-Outs and FIDE SNP and Highly Integrated Duel Eligible (HIDE) SNP Status
Current policy permits limited carve-outs from the scope of Medicaid long-term services and supports (LTSS) and Medicaid behavioral health services that must be covered by FIDE SNPs and HIDE SNPs. CMS provides examples of permissible LTSS carve-outs, including services specifically limited to individuals with intellectual or developmental disabilities, individuals with traumatic brain injury, and children. CMS provides examples of permissible carve-outs that constitute a small part of the total scope of Medicaid behavioral health services, including inpatient psychiatric facilities and other residential services, such as payment of Medicare cost-sharing or coverage of days not covered by Medicare; substance abuse treatment, such as payment of Medicare cost sharing or coverage of services not

covered by Medicare; services provided by a federally qualified health center or rural health clinic; and Medicaid-covered prescription drugs for treatment of behavioral health conditions.

CHA requests additional clarification on how the agency views Medicaid carve-outs, including how CMS would address circumstances where a state's configuration of services and coverage differs, as is the case in California. CMS proposes that when LTSS are covered by a HIDE SNP or FIDE SNP they must include community-based LTSS and some days of coverage for institutional care. Under the CalAIM program, MCPs are required to cover institutional long-term care, while the vast majority of community-based services, including home care, would be provided by other entities. CHA requests clarification of CMS' expectation that the SNP cover community-based LTSS.

Similarly, CHA requests information on CMS' view of behavioral health carve-outs in California, where behavioral health services for individuals with serious mental illness are the responsibility of the county mental health plan.

Joint State/CMS Oversight

CHA strongly supports CMS' proposal to improve the ability of states to collaborate with CMS on oversight activities. Specifically, CMS proposes to grant state access to data to facilitate monitoring and oversight for new D-SNPs, including reviewing marketing materials, member complaints, plan benefits and more, and to codify coordination of program audits.

CHA's member organizations interact with plans on a regular basis and are often involved in communications around an enrollee's access to care and any related concerns or complaints. Currently, the complaint resolution process is fragmented and confusing, with some issues and plans addressed by the California Department of Managed Health Care (DMHC), others by the Department of Health Care Services, and concerns related to MA plans referred to CMS. As a result, consumers and providers alike are confused about how to seek resolution of problems and concerns, and many complaints and concerns go unreported or unresolved. Different entities frequently "pass the buck" to another group or level: the MA plan may say it is the responsibility of the MCP, or the delegated physician group may refer the complainant to the "parent" plan. As California and CMS move toward a model of aligned D-SNPs and MCPs, including the widespread adoption of additional delegated entities and subcontractors, it will be critical to establish a "no wrong door" policy for member concerns to ensure that complaints are captured, addressed, and reviewed to inform future policy and practice.

CHA also strongly supports CMS' proposal to require D-SNPs to establish a unified appeals and grievance process. Moreover, CHA urges CMS to establish additional requirements and mechanisms to streamline the prior authorization process, including requirements for timely responses to requests for prior authorization, particularly for services related to post-hospital care. Access to the right level of PAC services is essential to maximizing patient outcome and controlling overall costs. Too often, beneficiaries are denied access to the necessary level of care, even when it is recommended and validated by their attending physician. On other occasions, access may be delayed several days or more while the plan completes its review, resulting in extended hospital stays and compromising the patient's final outcome. These delayed discharges also limit the acute care hospital's capacity and ability to admit and treat other persons in need, as we have seen during the ongoing COVID-19 PHE.

More specifically, we recommend that MA plans — including D-SNP plans — be required to respond to prior authorization requests for services necessary for hospital discharge within a specified time frame. We encourage CMS to align specified time frames with state requirements for managed care contracts. For example, California's DMHC has established time frames for medical authorization, such as 30 minutes for post-stabilization services, five working days or fewer for concurrent review of authorization for a treatment regimen already in place, and 14 days for routine authorizations. DMHC also requires expedited authorization decisions within 72 hours when the patient's provider determines that following the standard time frame for prior authorizations could seriously jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function. Aligning MA and D-SNP prior authorization requirements would reduce burden and confusion for patients and providers alike.

Comment Solicitation on Financing Issues

Based on its experiences under the Financial Alignment Initiative, CMS is assessing whether there are ways to take two elements of the Medicare-Medicaid plan financial methodology and apply to D–SNPs: (1) integrated medical loss ratios (MLRs), and (2) consideration of the expected impact of benefits provided by MA organizations on Medicaid cost and utilization in the evaluation of Medicaid managed care capitation rates for actuarial soundness. CHA provides comments on both approaches below.

Medical Loss Ratios

CHA urges CMS to allow states considerable flexibility when considering the MLR requirements that best fit the markets they serve. There are considerable differences between Medicare and Medicaid MLR requirements, and states should be allowed to determine how to best integrate the requirements to minimize burden on the plans and any delegated partners (risked-based delegated partners). State flexibility will be critical — not every state has the same Medicaid MLR requirements, nor is there consistency among the states that contract with numerous Medicaid managed care plans. For example, in California where the state is providing flexibility for Medicaid plans to implement non-traditional services (e.g., housing deposits, medically tailored meals, sobering centers), there will be significant benefit differences for each integrated D-SNP plan, depending on the community needs. If states are required to align or limit Medicaid MLR requirements to that of more restrictive Medicare MLR requirements, it may not be flexible enough for California's Medicaid program. The downstream impact could be problematic and restrict the drive to whole-person care for the dually eligible populations.

Actuarial Soundness

CHA recommends that state Medicaid actuaries should be required to take into account the Medicare cost and utilization experience for covered benefits in their rate development process. Aligning the rate development process between Medicare and Medicaid actuaries will help eliminate any potential risk of duplication and/or assumptions that may be inadequate. When considering the impact on the Medicare side, Medicare actuaries should also take into account the impact of community supports/in-lieu-of-services that impact the Medicare cost and utilization experience. For example, Medicaid plans that provide community support services (e.g., medically tailored meals) very well may directly impact and reduce future inpatient hospital admissions, which would impact those duals enrolled in a MA plan. Increased coordination between states and CMS, including the requirement for advanced notification of changes in selection of community support services, should be considered in the rule-making process.

Request for Information: Prior Authorization for Hospital Transfers to PAC Settings During a PHE

During the COVID-19 PHE, CMS issued guidance permitting certain flexibilities for MA plans to assist plans and enrollees in avoiding delays and disruptions in care. In response to those flexibilities, many MA plans relaxed or waived prior authorization requirements with respect to patient transfers between hospitals and PAC facilities during certain periods of the pandemic, but generally reinstated prior authorization policies as hospitals continue to respond to the PHE. CHA appreciates that CMS is seeking comments on the impact of MA plans' use of prior authorization or other utilization management tools during the PHE.

Overall, hospitals welcomed the relaxation of prior authorization requirements for patient transfer, and where MA plans offered flexibilities, hospitals experienced improved ability to move patients through the continuum of care and maintain acute care hospital capacity during surges associated with the COVID-19 PHE. However, while CMS allowed and encouraged these flexibilities, it did not require plans to adopt them. As a result, some plans did not waive prior authorization requirements or only did so at the early stage of the pandemic. The continued use of prior authorization and other health plan utilization management policies by some plans throughout the pandemic prevented hospitals from moving patients to more appropriate levels of care and contributed to shortages in acute bed capacity during surges. As hospitals continue to respond to the ongoing COVID-19 PHE, it is imperative that plans offer flexibility and reduce the burdens of prior authorization policies.

Prior Authorization Delays and Impacts on Patient Outcomes

Unnecessary delays in the prior authorization process have significant impacts on patient experience and outcomes. A major contributor to these delays is a lack of timely responses to prior authorization requests. Hospital case managers report difficulty reaching health plan personnel, lengthy hold times, no return calls, and other delays in responses to requests for prior authorization. While a hospital is caring for patients 24/7, many plans do not have available personnel who can provide prior authorization during weekend hours. As such, requests made from Friday mid-day until Monday are frequently not resolved until Tuesday of the following week, resulting in a spike in avoidable days. While plan-provider communication and response times are long-standing problems, these issues were exacerbated during the pandemic. Hospitals and plans alike have been subject to staffing shortfalls, further adding to delays. The need to make multiple follow-up calls and respond to information requests contributed to significantly increased administrative burdens for a system and staff already experiencing burnout.

Providers also report that some plans make frequent and multiple requests for information and/or delay direct contact for additional discussion or review. The effect of these actions is to delay the determination, often to such a degree that the clinical condition changes and the discharge plan must be adjusted. Too often, for patients who need the more specialized treatment available in PAC settings, access delayed is access denied. This is particularly detrimental to patients recovering from severe manifestations of COVID-19 who require interdisciplinary and targeted PAC that combines medical care and rehabilitation. When a patient's post-acute plan of care is disrupted, progress toward their recovery can be impacted, resulting in unnecessarily prolonged hospital or PAC stays.

Lack of Transparency of Clinical Guidelines

Health plans commonly use medical necessity criteria and other clinical guidelines for general acute care hospital and post-acute admissions — which differ by plan, deviate from those used by fee-for-service Medicare, and are often deemed proprietary. Consequently, when a denial comes back supported by a

general reference to "lack of medical necessity," it is nearly impossible for providers to anticipate what the health plan might request as evidence of medical necessity. This results in a back and forth between providers and health plans in response to insurer requests for excessive amounts of documentation. Further, many plans apply their medical necessity criteria based on the subjective judgment of clinicians with limited or no knowledge of post-acute care. Notably, California inpatient rehabilitation facility providers report that when a request for prior authorization is denied, they typically pursue a peer-to-peer discussion. In most cases, the discussion results in a reversal of the denial. This trend suggests to us that the first line of review is not applying the relevant medical necessity criteria accurately or conducting the required internal review of denials at the first request. We urge CMS to consider policies that would improve transparency of MA plan denials, including requiring plans to request specific documentation related to the denial.

CHA appreciates the opportunity to comment on these important topics. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy