California Hospital Association

August 31, 2022

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

SUBJECT: CMS–4203–NC, Medicare Program; Request for Information on Medicare; Vol. 87, No. 146; August 1, 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 respond to the Centers for Medicare & Medicaid Services' (CMS) request for information regarding various aspects of the Medicare Advantage (MA) program. We believe there are many opportunities within the MA program to reduce outcome disparities, expand access for beneficiaries, and improve transitions to the appropriate setting of care.

In California, MA enrollment is increasing among Medicare beneficiaries, while enrollment in fee-for-service (FFS) Medicare is decreasing. In addition, California is home to 1.4 million individuals dually eligible for both Medicaid (Medi-Cal) and Medicare[1]. As part of the California Advancing and Innovating Medi-Cal initiative, the state is transitioning 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 to encourage voluntary enrollment for dually eligible beneficiaries. As more California hospital patients enroll in MA plans, it is important to ensure that MA organizations (MAOs) employ policies and practices that expand access to care, ensure care is provided in the most clinically appropriate setting, and address their enrollees' health-related social needs to support providers' efforts to improve health equity.

Below, please find CHA's detailed comments in response to select questions posed in the request for information.

[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

Advance Health Equity

Q1: What steps should CMS take to better ensure that all MA enrollees receive the care they need?

California's hospitals are on the front lines of mitigating health inequities. Within their communities, hospitals examine and work to address the social determinants of health — such as connecting individuals to things like housing and other supportive services, improving access to healthy foods, and alleviating community violence — that significantly affect health risks and outcomes. And they continually work to improve the experience and outcomes for everyone in their care through a variety of initiatives, including a statewide maternal health quality collaborative; data collection and analysis on race, ethnicity, language preference, and other sociodemographic data; cultural competency training; increasing diversity in leadership and governance; and improving and strengthening community partnerships. However, hospitals alone cannot eliminate health disparities, and MA plans can be important partners in achieving these goals.

For example, MA plans have a unique opportunity to manage and coordinate whole-person care for their enrollees by providing health benefits along with supplemental benefits that can help meet the patient's health-related social needs. CMS should consider policies that encourage MA plans to expand the availability of supplemental benefits such as nutritional assistance and transportation to medical appointments. In addition, CMS should consider broadening its definition of primarily health-related supplemental benefits and allow more special supplemental benefits for all MA enrollees beyond the chronically ill, with a focus on reducing disparities.

In addition, we encourage CMS to require MA plans to provide information on their strategic health equity goals, similar to hospital attestation under the Hospital Commitment to Health Equity measure that was recently finalized in the inpatient quality reporting program. We also urge CMS to require MA plans to collect and report data on the health-related social needs of their enrollees and incentivize plans to address those needs in their benefit design. Finally, we urge CMS to require MA plans to be transparent in monitoring the impact of these strategies on outcomes.

We also urge CMS to consider policies to increase oversight of MA plans to ensure that there is parity between benefits accessible to MA enrollees and Medicare FFS beneficiaries. CHA strongly urges CMS to develop and implement regulatory mechanisms to ensure plan compliance with MA requirements. Monitoring rates of overturned denials is one metric that CMS could monitor to determine if some form of corrective action plan or sanction (if part of a demonstrated pattern of non-compliance) is necessary.

CHA members report that some MA plans have limited understanding or knowledge of Medicare FFS benefits 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. These observations were validated by a 2018 U.S. Health and Human Services Office of Inspector General (OIG) report[2] that found MAOs overturned 75% of their own denials. Oftentimes these denials are related to prior authorization requests for post-acute care

[2] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp

services, particularly when a beneficiary needs access to hospital-level post-acute care settings such as admission to an inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH).

California hospitals experienced these issues while working to better coordinate care for their dually eligible patients 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. 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 dually eligible patients. Addressing these access challenges is important for all MA plans. However, this need is heightened for D-SNPs, where the enrollees may be disproportionately impacted by these practices. In the aggregate, dually eligible beneficiaries have more chronic conditions and fewer resources than non-dual MA enrollees and may have a harder time challenging care denials or seeking alternatives. As a result, these beneficiaries are both more susceptible to inappropriate determinations and violations of MA policy. As California increasingly enrolls more older adults and persons with disabilities into MA plans and D-SNPs, it is imperative that MAOs ensure their enrollees maintain access to the same benefits available to Medicare FFS beneficiaries.

CHA encourages CMS to closely monitor the number of denials that are overturned at any stage of the appeals process as an indicator that MA plans (or their staff) do not have a comprehensive understanding of the benefits the member is entitled to and the criteria for those benefits. Further, we ask CMS to make these data publicly available on a CMS website so that beneficiaries can incorporate rates of overturned denials into their decision-making process when they are enrolling in an MA plan.

Beyond ensuring that MA plans continually demonstrate knowledge of the medical services Medicare beneficiaries are entitled to, we respectfully recommend that CMS implement a more robust appeals process for MA beneficiaries. This will allow MA members (or providers and/or hospitals working on their behalf) to access the medically necessary care they are entitled to when it has been wrongfully denied to them by an MA plan. CHA believes that, at a minimum, a robust appeals process should include access to real-time assistance from the plan to resolve concerns. This is crucial as it relates to time-sensitive medically necessary services where delaying care will have detrimental effects on the quality of the patient's outcome. At a minimum, this could be similar to the current "important message from Medicare" process for appealing discharge decisions via a Quality Improvement Organization (QIO).

Q9. How are MA SNPs, including Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs) tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

CHA urges CMS to allow state Medicaid agencies greater authority over the operations of D-SNP plans, in particular on the 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.

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 experienced by Medicare dually eligible beneficiaries (and providers working on their behalf) 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 (DHCS), 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 managed care plan (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 efforts in the calendar year 2023 “…Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs” proposed rule 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 post-acute care services is essential to maximizing patient outcomes 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 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 public health emergency.

Expand Access: Coverage and Care

Q2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

CHA strongly encourages CMS to provide better materials to help educate its beneficiaries on the key differences between enrolling in an MA plan versus traditional Medicare and purchasing Medigap coverage. CHA’s members report that many beneficiaries are not aware that enrolling in an MA plan may reduce their access to certain specialized services or providers, particularly if the MA plan has an inadequate network as discussed below. Further, CHA believes that additional education must be provided to beneficiaries to help them understand the cost implications of enrolling in an MA plan and subsequently opting out of MA at a later date and enrolling in traditional Medicare. Many beneficiaries are unaware that this is considered “deferring” enrollment in Medicare Part B and will significantly increase the Part B premium they must pay for outpatient service coverage.

Q6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty

services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

CHA encourages CMS to add timeliness of access standards to the criteria it uses to ascertain if an MA plan's network is adequate. These metrics should measure the time from when a patient is referred to a provider or facility and when the services are provided, or the patient is admitted. California state law requires MCPs to meet certain timeliness of access standards. The table below provides an example of appointment and telephone wait times based on California state law.

Appointment Type	Appointment Must be Available By
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-doctor)	10 business days
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes
Triage—24/7 services	24/7 services—No more than 30 minutes

To ensure that MA plans are adhering to any access standards (or meeting existing network adequacy requirements) CHA strongly encourages CMS to implement "secret-shopper" surveys of timely access for appointment availability and that the network includes providers within the specified distances.

CHA also encourages CMS to add timely access standards for the admission to post-acute care, including inpatient rehabilitation, long-term acute care, skilled nursing, and home health. In 2019 and 2020, approximately 39% of hospitalized Medicare beneficiaries required one or more post-acute care services following discharge[3]; unnecessary delays in access increase overall costs and limit patient outcomes. Monitoring the length of time from the provider's request for authorization to the patient's admission to the next care setting will help identify delays related to network adequacy or unnecessary administrative processes.

Q10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not affect enrollees' access to medically necessary care?

[3] https://www.medpac.gov/wp-content/uploads/2022/07/July2022_MedPAC_DataBook_Sec8_SEC.pdf

In general, CHA's members' experience with MA plan prior authorization processes mirror those reported in the recent OIG report, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*[4]. In particular, our members continue to report difficulty obtaining prior authorization for certain post-acute services (e.g., inpatient rehabilitation and long-term acute care) even when the beneficiary in question clearly meets the established medical necessity guidelines for care in these settings.

CHA is deeply concerned that when "peer-to-peer" discussions about or appeals of these denials occur, many of these denials are overturned. Like the findings in the OIG report, these results call into question MA plans' initial review process and whether the plans are adhering to Medicare-established guidelines regarding access to benefits.

One of the challenges hospitals face when attempting to appeal a denial is MA plans' use of proprietary criteria (e.g., InterQual, which is owned by United Healthcare subsidiary Optum) to make medical necessity determinations. If a referring provider does not purchase a subscription to the proprietary tool owned by the health plan, it severely limits their ability to prosecute a successful appeal. Moreover, the plans' apparent reliance on such external criteria is in conflict with CMS' expectation that care determinations are made based on an assessment of the individual patient's clinical condition and goals of care and minimizes the role of the physician or non-physician provider in overseeing the patient's care plan.

Another challenge hospitals face is the elongated process many health plans use to adjudicate appeals. This is particularly concerning when the services in question are of a time-sensitive nature. A delay of even a couple of days may negatively affect the beneficiary's health outcome, as they were unable to fully benefit from the care recommended by their medical team.

The cumulative result of these unnecessary barriers to care has a significant "chilling effect" on the referral process for certain services. It is not uncommon for hospital case managers to learn that certain MA plans will not approve medically necessary care at an IRF or a LTCH, and these case managers may not fully understand the responsibilities of MA plans to ensure access to Medicare benefits for their members. As a result, these case managers may not initiate a referral to IRFs or LTCHs because they do not realize the beneficiary has a right to certain benefits, and/or they are not able to pursue a time-consuming discussion or request process.

Improving the Prior Authorization Process

CHA respectfully asks CMS to consider taking the following steps to ensure that prior authorization requirements do not limit MA beneficiaries' access to medically necessary care.

First, we recommend that MA plans — including D-SNPs — 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 less for concurrent review of authorization for a treatment

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

regimen already in place, and 14 days for routine authorizations. DMHC also requires expedited authorization decisions within 96 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. Recognizing the importance of timely access to post-acute services, DHCS has deemed such services to be subject to expedited authorization by managed Medi-Cal plans, requiring action within 72 hours of the request. Aligning MA, Managed Medi-Cal, and D-SNP prior authorization requirements would reduce the burden and confusion for patients and providers alike. If a decision is not provided within the allotted time frame, then the request should be deemed approved.

Second, CHA asks that CMS require MA plans to provide for a real-time appeal process where the QIO or other similar organizations would review requests within 24 hours. This real-time appeal process would extend to the level of care determinations to ensure that beneficiary outcomes were not put in jeopardy because the MA plan delayed care. CHA envisions that this process could be similar to the existing discharge appeals process.

Finally, we ask that CMS consider new approaches for streamlining utilization review of MA plans. While prior authorization and related requirements can play an important role in ensuring services are medically necessary, the recent OIG audit of MA plans shows that, in practice, utilization management policies and practices often reduce and delay access to needed care. To address these issues, CMS should consider implementing a number of policies, including:

- Ensuring that MA plans' prior authorization rules are no more restrictive than Medicare coverage rules
- Requiring that MA plans' prior authorization guidelines be accessible to providers
- Instituting a presumptive prior authorization approval requirement whereby a complete prior authorization request is deemed approved if the MA plan fails to approve or deny the request within established time frames
- Requiring or encouraging MA plans to establish policies that ease prior authorization requirements for providers with a strong track record of approvals

Q11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

As discussed briefly above, we believe that MA plan members should have access to data related to prior authorization approval, denial, and overturn rates. We believe these data should be provided by:

- Plan
- Service or medication
- Reason for denial
- Denial overturn rate following an appeal
- Timeliness of care access

Beyond prior authorization measures, we believe risk-adjusted data related to the utilization of certain services (e.g., IRF) would be invaluable. Plans that were outliers that exhibited low utilization could be flagged for a review of compliance with Medicare policies. In instances where non-compliance was found, CMS could request a corrective action plan.

Finally, as CMS continually evaluates the quality measures it makes available to MA plan members (and prospective MA plan members), CHA encourages the agency to focus on outcome measures, such as return to the community or return to functional status for beneficiaries who have been discharged from the hospital, that are meaningful to MA beneficiaries.

Drive Innovation to Promote Person-Centered Care

Q2. What are the experiences of providers and MA plans in value-based contracting in MA?

CHA is concerned that some MA accountable care organizations (ACOs) are not making beneficiaries aware of their right to access other levels of care if those levels of care are indicated when the ACO uses a "high-value" network. In these instances, the MA ACO uses a third-party administrator to drive utilization to lower-cost settings that may not necessarily be of higher value. A primary example of this is the consistent denial by some MA plans of IRFs in favor of care in a skilled-nursing facility (SNF), which is a lower-cost setting that does not provide the full capabilities of an IRF for patients who need this level of care. In this instance, the SNF is presented as "the care pathway" — without consideration of other levels of care that may be more appropriate based on the beneficiary's medical condition — resulting in longer patient stays and poorer outcomes. We encourage CMS to develop policies that ensure beneficiaries maintain access to the most appropriate level of care for their specific needs.

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