Minnesota Hospital Association

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February 13, 2023

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

Submitted electronically through www.regulations.gov.

RE: Comments on Proposed Rule CMS-4201-P: Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.

Dear Administrator Brooks-LaSure,

On behalf of our 140 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments regarding the proposed rule on the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program.

Overall, we greatly appreciate CMS' proposals to improve Medicare Advantage (MA) practices and policies. Some MA plans operating in Minnesota have impeded patient access to health care services, created inequities in coverage between Medicare beneficiaries enrolled in MA versus those enrolled in Medicare fee-for-service (FFS), and sometimes even directly harmed Medicare beneficiaries through unnecessary delays in care or outright denial of covered services. Recent data from the Kaiser Family Foundation shows that Medicare Advantage enrollment continues to grow, now with 52% of Medicare beneficiaries in Minnesota enrolled in a Medicare Advantage plan[1]. It is more important than ever to implement additional oversight provisions and patient protections to ensure that those enrolled in MA plans are not unfairly subjected to more restrictive rules and requirements than Medicare FFS.

Prior Authorization and Medical Necessity Determinations

CMS proposes several updates to reduce improper MA plan prior authorization processes and ensure MA beneficiaries receive timely and appropriate access to medically necessary care. MHA supports the clarification that MA plans may only utilize prior authorization processes to confirm whether a patient's care is medically necessary. Given that more than 35 million prior authorization requests were submitted to MA plans in 2021[2], MHA applauds any effort to reduce onerous and duplicative administrative requirements which add financial burden and strain onto

[1] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/
[2] https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

the health care system, require increased staffing and technology cost, and contribute significantly to health care worker burnout.

MHA supports the proposed requirement that MA plans adhere to Medicare FFS coverage policies when making a medical necessity determination and cannot utilize alternative criteria to deny coverage of an item or service that would have been otherwise approved. Specifically, hospitals and health systems in Minnesota have experienced this issue when medically justified inpatient stays have been denied or retroactively changed to observation stays, resulting in reduced provider reimbursement, and potentially impacting a patient's eligibility for needed post-acute care services. For further clarity and adherence, we urge CMS to offer greater specificity and delineate the specific rules that MA plans must follow pursuant to Medicare FFS coverage rules where possible.

Additionally, some MHA member hospitals and health systems have experienced significant delays in obtaining certain MA coverage for necessary post-acute care (PAC) services. These delays and denials erode the overall quality of care provided to patients in Minnesota, further stress health care capacity, and undermine cross-setting clinical coordination efforts. The proposed rule would prohibit MA plans from inappropriate coverage denials and increase transparency for services that do not have established coverage criteria in Medicare FFS, by requiring a publicly accessible summary of the evidence, a list of the sources, and an explanation of the rationale for the internal coverage criteria. Currently, MA plans often classify their medical necessity criteria as proprietary and do not share specifics, resulting in a "black box" when health care 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.

MHA also strongly supports the other proposed provisions to reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization including:

- A physician or other appropriate health care professional reviewing a request for prior authorization, or a coverage denial must have expertise in the field of medicine related to the service being requested.
- Plans must establish a Utilization Management Committee led by the plan's medical director to ensure compliance with Medicare rules and consistency with current clinical guidelines.
- Prior authorizations are valid for the entirety of a prescribed treatment and MA plans must have policies that permit no less than 90 days transition for new beneficiaries on established treatments prior to enrolling with the plan.

Access to Behavioral Health and Post-Acute Care Services

MHA supports the provisions in the proposed rule to establish standards for access to behavioral health services under MA. By requiring MA plans to have an adequate supply of clinical psychologists, licensed clinical social workers, and prescribers of medication for opioid use disorder in their networks, beneficiaries can access more appropriate care and avoid unnecessary hospitalizations. CMS also proposes to clarify that MA beneficiaries can receive medically necessary behavioral health services in a medical emergency, meaning it would not be subject to prior authorization requirements.

MHA also commends CMS for the significant steps it has taken in this proposed rule to address concerns regarding MA beneficiary access to medically necessary PAC services. To build on

these provisions and ensure the availability of appropriate PAC in MA networks, we recommend that CMS add a requirement that inpatient rehabilitation hospitals and units, long-term care hospitals, and home health agencies be explicitly added to MA network adequacy requirements.

Advancing Health Equity

MHA supports the CMS proposals to advance health equity for all enrollees. Specifically, we appreciate the proposal to identify beneficiaries with low digital health literacy and offer education to improve their ability to access telehealth services. This is especially important for rural communities in Minnesota, where the aging population may have barriers for accessing in-person care.

Marketing and Advertising

MHA strongly supports the proposals to restrict MA plan marketing practices that are misleading, including deceptive pressure tactics designed to facilitate enrollment. We appreciate the specific provision to prohibit MA plans from inappropriate use of the Medicare name, CMS logo, or other official products. In recent months, a Minnesota health system has experienced an increased number of complex dual-eligible Medicare-Medicaid patients who are being targeted by national MA plans, identifying as “Medicare.com.” The aggressive marketing tactics have led to patients unknowingly switching to higher cost plans with more narrow provider networks. For one patient alone, it took a hospital social worker an estimated 40 hours to rectify the issue and restore their original insurance coverage. CMS must implement the proposed policies to limit exploitation of vulnerable patient populations.

Changes to the Standard for Identifying Overpayments

MHA is concerned that 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 we 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 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 potential overpayment is identified, 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, sometimes the 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. And 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 we know 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.

In conclusion, MHA strongly supports the MA oversight provisions included in the proposed rule, and we appreciate the opportunity to provide comments to CMS. If you have any questions, please feel free to contact me at (651) 659-1415 or jschindler@mnhospitals.org.

Sincerely,

Joseph A. Schindler
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