Minnesota Hospital Association

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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-4203-NC: Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

On behalf of our 127 member hospitals and health systems, the Minnesota Hospital Association (MHA) offers the following comments regarding the Centers for Medicare & Medicaid Services' (CMS) request for information on the Medicare Advantage program.

We appreciate CMS' interest in exploring opportunities to advance health equity, expand patient access to care, drive innovation, support affordability and sustainability, and engage in collaboration with partners. In this context, we are writing to share serious concerns about the negative effects of some Medicare Advantage (MA) practices and policies, which impede patient access to health care services, create inequities in coverage between Medicare beneficiaries enrolled in MA versus those enrolled in Medicare fee-for-service (FFS), and in some cases, even directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services.

In Minnesota, some MA plans, more often the national insurers, frequently apply more stringent medical necessity criteria than Medicare FFS. Some plans also apply excessive prior authorization requirements, use inappropriate utilization management tools, and require onerous and duplicative clinical documentation submissions to substantiate the need for services. These practices result in delays in care and can cause direct patient harm. In addition, they add financial burden and strain onto the health care system, requiring increased staffing and technology costs to comply with plan requirements, while also contributing significantly to health care worker burnout.[1]

These pain points are only getting worse as enrollment in MA plans continues to increase rapidly. In 2022, 52% of Medicare beneficiaries in Minnesota are enrolled in a MA plan, with enrollment growing every year.[2]

[1] Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. 2022. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

It is more important than ever to implement desperately needed oversight provisions to ensure that those enrolled in MA plans are not unfairly subjected to more restrictive rules and requirements than Medicare FFS, which are contrary to the intent of the MA program.

Prior Authorization and Medical Necessity Determinations

We appreciate CMS' interest in MA prior authorization practices, as they often create a significant impediment to the ability to provide timely and efficient patient care. They also contribute to provider burnout, waste valuable health care resources, and increase costs across the health care system.

Specifically, MHA member hospitals and health systems have experienced a significant rise in requests for peer-to-peer reviews for certain MA prior authorization requests to be approved. One member has seen a 400% increase in physician peer-to-peer requests based on their last six months of data. Not only does this increase administrative burden to complete the requests, but often there is only a small window of time to complete the request. Physicians who have clinical care responsibilities and time constraints are challenged to return phone calls and voicemails within narrow timeframes. Many providers are frustrated that even after completing the onerous peer-to-peer review requirements the care is still denied in most cases.

Additionally, some MA plans often classify their medical necessity criteria as proprietary and do not share specifics, resulting in a "black box" for providers attempting to determine whether a service will be approved. This lack of transparency is a frequent reason that prior authorization and claims are delayed or denied, resulting in extensive back and forth between providers and plans about what information is needed to satisfy their proprietary criteria. One hospital in Minnesota cites CT/MRI authorization can take a week or more for a decision, and if it is denied then they must appeal. Patient care is being delayed unnecessarily and burdens staff with resource-intensive paperwork that could be easily avoided.

CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than Medicare FFS. However, Minnesota's hospitals and health systems have sometimes experienced differences in coverage for inpatient care. To give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established the two-midnight rule. Under that policy, hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Despite this clear CMS medical necessity rule, some MA plans have implemented policies that further restrict inpatient care by placing additional obstacles to admission or retroactively downgrading an inpatient stay to observation status, even when the clinical criteria for inpatient care have clearly been met. This sometimes even occurs for an inpatient stay lasting multiple days and far exceeding the criteria set forth by CMS' two-midnight rule for Medicare FFS.

These policies frequently lead to uncertainty for providers and patients, who's medically justified inpatient stays can be denied or retrospectively changed to observations, resulting in reduced provider reimbursement, and potentially impacting a patient's eligibility for needed post-acute care services. Not only is this affecting patient care, but the patient will also be responsible to pay for the inpatient care if the provider deems it necessary and their MA plan does not reimburse for the services. Some MA plans have justified their determinations by stating their ability to dictate their own payment methodology.

Hospitals and health systems in Minnesota have also experienced significant delays in obtaining certain MA coverage for necessary post-acute care (PAC) services. When appealing to the national MA plans for payment for appropriate care, MHA members have faced challenges in communication and unwillingness to determine a solution. Given the severe staffing shortages in long-term care facilities, there are often limited discharge options for PAC services, which is only exacerbated by restrictions imposed by some MA insurers. These delays and denials erode the overall quality of care provided to patients in Minnesota, further stress the health care system capacity, and undermine cross-setting clinical coordination efforts.

Many of these MA approval challenges are also seen in the context of behavioral health. Individuals who need critical mental health or substance use disorder services may be unable to access necessary care and instead spend extended periods of time in inappropriate hospital settings such as the emergency room.

MHA strongly urges CMS to require MA plans to align medical necessity and coverage criteria with Medicare FFS rules so that Medicare patients have equal access to care regardless of coverage type. CMS should also reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization, which is sometimes imposed by national MA plans without any state specific context.

Oversight and Transparency

MHA encourages CMS to increase oversight over MA plans, however we are concerned about the lack of transparency of health plan performance. Currently, there are limited reporting mechanisms available to provide CMS with important information about plan-level coverage denials, appeals, grievances or delays in care resulting from prior authorization and other administrative processes. These are important indicators of beneficiary access and are essential to proper oversight of MA plans. We strongly urge the agency to evaluate its data collection and address gaps.

Additionally, we recommend that CMS establish a provider complaint mechanism that allows providers to flag problematic plan behavior. Through the nature of our care relationships with patients, we have the most frequent interaction with plans, giving us greater insight into circumstances where plans have practices that inappropriately delay or deny patient access to care. To help ensure that patterns of inappropriate denials and delays are addressed as soon as possible, we need a mechanism to flag problematic MA plans on behalf of patients across Minnesota since there is currently no streamlined way to do this.

Increased oversight and transparency would also help advance health equity in MA plans by ensuring there is no discrimination in coverage. CMS could also better evaluate existing approaches to screening MA enrollees for individualized care. For example, CMS could compare the utilization of Z codes on MA claims to Medicare FFS claims to understand the varying approaches to documenting social determinants of health.

MHA strongly supports CMS' efforts to improve the MA program and urges the agency to advance rulemaking designed to increase oversight of the program and ensure enforcement of MA policies which may violate federal rules or circumvent program intent.

As always, we appreciate the opportunity to provide information 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
Vice President, Finance Policy & Analytics