MISSOURI HOSPITAL ASSOCIATION

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March 1, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (CMS-4192-P)

Dear Administrator LaSure:

On behalf of its 143 member hospitals, the Missouri Hospital Association offers the following comments in response to the request for information about Medicare Advantage prior authorization requirements for patient transfers to post-acute care settings during a Public Health Emergency.

MA plans often require prior authorization for the treatment of Medicare beneficiaries, and hospitals have grappled with MA prior authorization transfer policies for many years. Although the RFI is limited to comments about prior authorization practices during a PHE, the following comments not only are applicable during times of emergency, but also during times of no emergency. The difference is that the volume of complaints increases during a time of emergency when acute care available beds become a limited commodity.

MEDICARE ADVANTAGE PRIOR AUTHORIZATION OVERSIGHT

CMS historically has been reluctant to reign in problematic insurers who use prior authorization as a practice to delay care by inappropriately denying requests. Most of the reluctance seems to be to avoid breaching non-interference clauses and a belief that this is a contractual issue between the provider and insurer. **Prior authorization issues are not contracting problems.** MA prior authorizations apply to both providers who have contracts as well as those who do not have contracts with the insurer. Whether contracted or not, providers are left to the whims of the MA plan carrier to grant prior authorization for services. MHA urges CMS to take an active role to oversee MA prior authorization practices.

USE OF SUBCONTRACTORS FOR PRIOR AUTHORIZATION REVIEWS

A common practice by some MA plans is to utilize a subcontractor to perform initial prior authorization reviews. If the request is denied, hospitals are required to initiate an expedited appeal process in which the MA plan will review the authorization request. Hospitals often report that the

determination by the subcontractor is overly restrictive and often leads to the subcontractor's determination being overturned by the plan. In some cases, the plan owns the subcontractor who is inappropriately issuing denials that are later overturned by the parent company. As an example, one of MHA's members reported that one of these contractors had granted nine approvals out of a total of 55 prior authorization patient transfer requests. Of those denied, the provider appealed 18 to the carrier. On appeal, the carrier overturned their own contractor's initial decision, and all 18 patients were transferred. The use of subcontractors is clearly a tactic to delay transfer of the patient into the correct site of care. MHA urges CMS to reign in these distressing actions and requests clear and transparent information about the percentage of expedited appeals or initial appeals as a percent of initial denials. This information should be available to the public.

COVID-19

The COVID-19 pandemic has strained hospital capacity, specifically ICU capacity, to the point of needing to transfer patients to other provider settings to ensure capacity remains adequate to treat incoming surges of patients. Due to the volume of patients needing to be transferred, hospitals have become acutely aware of bottlenecks created by MA plans that are unwilling to grant a prior authorization request. The bottleneck is created by MA plans that either are slow in responding to or denying prior authorization requests.

Prior Authorization Waivers

MHA does appreciate the prior authorization waivers offered by some of MA carriers when surges of COVID-19 patients were entering hospitals. Although some insurers granted prior authorization waivers for hospitals to transfer patients into another in-network hospital or post-acute care setting, many facilities refused to take the incoming MA patient due to past waiver admissions not being paid. This distrust was underscored by the MA plan's requirement to notify the insurer when a patient has been transferred under the waiver. Such actions can and have been used to deny claims when other waivers were in place. MHA urges CMS to investigate claims for patients who have been transferred to ensure that both the primary admitting hospital and the receiving provider are receiving timely and fair payment for patients transferred when waivers are in place.

Network Adequacy

Many of the prior authorization waivers limited transfers to only in-network providers. Due to this, hospital staff had difficulty in locating in-network post-acute care beds. Hospitals reported suspicions and concerns about the lack of in-network post-acute bed availability, leaving many to question whether MA plans are meeting network adequacy standards. MHA urges CMS to investigate and ensure network adequacy standards are being met for each plan service area and ensure that not only physician and short-term acute care hospital network adequacy is being met, but also post short-term acute care provider network adequacy standards are met.

OIG FINDINGS AND CONGRESSIONAL ACTION

Although the COVID-19 pandemic placed a spotlight on prior authorization problems, the abuse from MA plans has been in place for years. In a September 2018 report by the U.S. Department of Health and Human Services' Office of Inspector General, the OIG concluded that "when beneficiaries and providers appealed preauthorization and payment denials, Ma Organizations (MAOs) overturned 75 % of their own denials during 2014-16." "During the same period, independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers." The OIG concluded that CMS should "(1) enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate; (2) address persistent problems related to inappropriate denials and insufficient denial letters in MA; and (3) provide beneficiaries with clear, easily accessible information about serious violations by MAOs." The report summary also stated that "CMS concurred with all three recommendations." MHA is asking CMS to follow the previously agreed-to recommendations from the OIG.

Congress also has recognized issues with the MA prior authorization process and has introduced legislation to begin MA prior authorization reform. Until such action is taken, hospitals will continue to be subject to the whims of MA plans. MHA is also asking CMS to follow the lead of Congress and OIG findings by compelling MA insurers to provide real-time prior authorization decision-making, review and audit the prior authorization denial activity as compared to secondary appeal decisions and apply sanctions or fines for MA plans that abuse the PA process to delay patient treatment or inappropriately deny care.

MHA understands the complexities in reforming MA prior authorization practices. Due to the complexities, we encourage CMS to develop a technical advisory committee consisting of clinicians and institutional provider professionals that would advise CMS about potential solutions. Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,

Andrew B. Wheeler
Vice President of Federal Finance

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