March 6, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
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 Benefit Programs (CMS-4192-P)

Dear Administrator Brooks-LaSure,

On behalf of its 123 member hospitals, the Kansas Hospital Association offers the following comments in response to the Centers for Medicare & Medicaid Services' proposed payment and policy updates for the contract year 2023 Medicare Advantage and Medicare Prescription Drug Benefit Programs (CMS-4192-P).

DECEPTIVE ADVERTISING OF MEDICARE ADVANTAGE PLANS

The issue:

Some of what is advertised on Medicare Advantage television ads is true. However, buried within the fine print is a host of exemptions that lead to prior authorization red tape, limits on selection of health care providers and dangerous and costly delays.

Kansas health care facilities hear numerous complaints from patients not realizing they surrendered their traditional Medicare coverage when they signed with a Medicare Advantage carrier. The limits of a Medicare Advantage become apparent when they realize their physician options are limited and they experience delays in receiving life-maintaining prescriptions and care.

Proposed solution:

- Consumers must be provided an unbiased representative that clearly describes the differences between traditional Medicare and the Medicare Advantage players.
- Place more restrictions on Medicare Advantage plan advertising.

PRIOR AUTHORIZATION REQUIREMENT LIMITS

The issue:

Many Medicare Advantage plans apply prior authorization requirements that lead to dangerous delays, clinician burnout and cost increases for the health care system. Medicare Advantage plans frequently apply prior authorization requirements to services for which there is a no clear clinical justification.

On average, a Medicare beneficiary has access to 39 Medicare Advantage plans. There are currently 3,834 Medicare Advantage plans available nationwide with every plan having different prior authorization requirements. Unnecessary

and knee jerk prior authorizations place tremendous pressure on an already over-burdened health care delivery system. This creates bottlenecks slowing urgently needed care and allows beneficiaries' conditions to worsen in the process.

Proposed solution:

KHA strongly encourages CMS to establish requirements outlining when prior authorization processes may be applied.

PRIOR AUTHORIZATION TIMELINESS

The issue:

Current CMS rules allow Medicare Advantage plans to take up to 14 days to respond to a prior authorization request. A patient waiting up to two weeks in the hospital to be moved to the next level care delays treatment, risks recovery odds and wastes hospital resources.

Proposed solution:

Require plans to deliver prior authorization responses within 24 hours.

OVERSIGHT AND ENFORCEMENT

The issue:

Medicare Advantage plans have an established history of inappropriately utilizing prior authorization to delay access and deny necessary treatment for patients. This practice has only increased during the COVID-19 pandemic with widespread inappropriate usage. Kansas hospitals reported extreme delays in transferring patients to skilled nursing facilities and other post-acute care sites, despite clear clinical justification and appropriate authorization requests. This prevents acute care beds from being available for incoming patients. Meanwhile, health insurance plans are posting record profits by exploiting this process.

Proposed solution:

In 2018, the Inspector General recommended increased oversight of Medicare Advantage plans prior authorization process. We ask CMS to be on the side of patient care by providing more oversight and enforcement on the scope of prior authorization practices.

KHA appreciates your consideration of these issues. We appreciate the opportunity to discuss how CMS could better protect Medicare Advantage enrollees from problematic prior authorization policies. Please feel free to contact Shannan Flach, Vice President of Health Care Finance and Reimbursement, at sflach@kha-net.org.

Sincerely,

Shannan Flach

Shannan Flach
Vice President, Health Care Finance and Reimbursement
Kansas Hospital Association