May 29, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Request for Information on Medicare Advantage Data (CMS-4207-NC)

Dear Administrator Brooks-LaSure:

On behalf of its 122 member hospitals, the Kansas Hospital Association (KHA) offers the following comments in response to the Centers for Medicare & Medicaid Services' request for information on Medicare Advantage Data.

KHA appreciates CMS's efforts to regulate and monitor the Medicare Advantage programs' intent and treatment of patients. We acknowledge the steps taken in the last few years in particular to begin an increase in oversight of Medicare Advantage plans and the services patients are receiving, but we believe there are additional steps that can be taken to ensure transparency, accountability, and oversight which ultimately protects patients and ensures beneficiaries can access the best plan for their specific needs.

DATA-RELATED RECOMMENDATIONS RELATED TO BENEFICIARY ACCESS TO CARE INCLUDING PROVIDER DIRECTORIES AND NETWORKS

Communication with beneficiaries about network providers

The Kansas Hospital Association recommends that CMS require annual communication to Medicare Advantage beneficiaries that clarifies the in-network providers in the community. We hear from our hospitals that patients are frequently surprised by providers that leave the Medicare Advantage plan, and the patient was never informed. Many Medicare recipients are not tech savvy enough to check network providers on a website, so individual communication with each beneficiary should be expected.

Reasonable definition of network adequacy

In Kansas, there are several Medicare Advantage plans sold in counties with no hospital or provider, within a reasonable distance, contracted. When discussing this with those plans, many times they are justifying network adequacy with telehealth providers. In our experience with rural beneficiaries, the utilization of telehealth providers is still neither feasible nor ideal. Rural broadband services continue to be a barrier.

KHA suggests a clear definition of network adequacy in regulation. KHA would recommend language that defines network adequacy as bricks and mortar access (not through telehealth/virtual care) of:

- At least one primary care hospital within thirty-five miles of the beneficiary
- At least one Level II trauma center within 120 miles of the beneficiary
- At least 50% of the primary care providers contracted within thirty-five miles of the beneficiary

PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT, INCLUDING DENIALS OF CARE AND BENEFICIARY EXPERIENCE WITH APPEALS PROCESSES AS WELL AS USE AND RELIANCE ON ALGORITHMS

Internal Policy Overrides

In the CY2024 Medicare Advantage rules, CMS set guidance for Medicare Advantage plans related to the two-midnight rule plus stronger communication with providers on reasons for denials. KHA appreciates CMS' efforts to resolve these issues, however, hospitals are not seeing accountability to these new guidelines. After release of those rules, insurance payers immediately released internal policy updates explaining that payers still have discretion related to a two-midnight stay and subjective decision-making will remain part of the authorization process. We continue to see hospital stays up to four days that are reimbursed at the observation status rate.

CMS must hold stricter enforcement of these rules, and KHA would like to suggest the following enforcement guidelines:

> A financial penalty of $2,000 will be imposed to the Medicare Advantage plan each time a denial or appeal is overturned by an external independent reviewer assigned by CMS. A financial penalty of $50,000-$1,000,000 will apply to any Medicare Advantage plan that is dodging the created Medicare Advantage Final Rules and demonstrates continuous infringement in the created rules. When a Medicare Advantage plan has been regarded to be out of compliance with the created rules more than three times in a 12-month period, they are disqualified from offering a Medicare Advantage plan for the next qualifying year.

Speed of prior authorization approval/denial

While KHA appreciates CMS' efforts to speed up the prior authorization process, many times hospitals receive a prior authorization denial or approval five days after the patient has been discharged. This is too late. Not only does the hospital take a gamble on whether they will be paid for this care, but it disrupts the patient's coordination of further services. While a patient may have benefited from home health, swing bed, rehabilitation, or additional nursing services, with no proper communication from the insurance payer, the patient is discharged with no further services. This increases the readmission to hospitals. A health equity injustice is recognized between patients on Original Medicare compared to patients on a Medicare Advantage plan.

Experience with appeals process

CMS has taken the position to usually not override prior authorization and denials reported to CMS by hospitals, rather relying on the contract agreed upon between the hospital and insurance

company to enforce. In Kansas, 83 of the 122 hospitals within our membership are considered Critical Access Hospitals. The size of these hospitals leaves no negotiating influence when working with a multi-billion-dollar insurance company.

Medicare Advantage payers dismiss appeals for unjust infractions. One example of an appeals dismissal included a physician that missed the return phone call from the Medicare Advantage payer because he was called into emergency surgery.

DATA ELEMENTS THAT CMS SHOULD MAKE PUBLIC FOR EVERY MEDICARE ADVANTAGE PLAN

Public data elements

Hospitals are required to report a large number of data elements weekly, monthly, and annually. Hospitals may be financially penalized for falling within the bottom quartile in comparison to their peers. Medicare Advantage plans must, also, be held to the same standards. Information and statistics that should be public knowledge include:

- Number of prior authorization requests by type of service and the approval rate
- Number of denials by type of service and denial rate
- Number of appeals and overturn rate of those appeals by type of service
- Enrollee characteristics
- Top twenty reasons for prior authorization denials by type of service
- Number and rate of prior authorization approvals that are overturned after the care is performed by type of service
- Average time for prior authorization decisions
- Definition of network adequacy by each payer and proof that they meet the standards
- Prior authorization policies
- Algorithms used in determining prior authorization requests

Having these above listed bullets collected and reported transparently by CMS would allow the public to be aware of payers with high prior authorization denial rates, the frequency of denials, and the reasons why prior authorizations are being denied. KHA believes this information will help ensure that Medicare Advantage plans are operating in the true intent of the Medicare Part C program and not deviating inappropriately from Original Medicare requirements.

Post audits by Medicare Advantage plans

Currently, hospitals and providers have timely filing rules that only allow billing to insurance plans no later than six months to one year (depending on state requirements) after a patient is discharged. However, Medicare Advantage plans continue to audit as far back as four years and recoup money from hospitals. They viewed these claims medically unnecessary four years after the service was performed. CMS must set a lookback deadline of no more than one year for post-audits by Medicare Advantage plans.

Medical Necessity Denials

There is a current injustice happening with Medicare Advantage plans that approve a prior authorization before service is performed but then deny the claim after discharge. The reason for the

denial is stated as 'medical necessity review now determines the service was unnecessary.' Medical necessity criteria should only be approved or denied before the service is performed. This could be compared to taking your car to a body shop to have the hail damage fixed. The insurance company approves the body shop to fix it, but after the fact, the insurance company decides not to pay the mechanic because they now believe the car would still drive without the fix.

COST AND UTILIZAITON OF DIFFERENT SUPPLEMENTAL BENEFITS

Reporting of data for supplemental benefits

KHA believes CMS' decision to begin collecting some data on use and spending for supplemental benefits offered by Medicare Advantage plans in 2024 was a positive step in the right direction. However, there are still gaps in CMS publishing detailed payment and spending data particularly by plan that we believe should be reported publicly to understand how much Medicare Advantage enrollees spend each year out-of-pocket on extra benefits.

Additionally, CMS currently receives data from Medicare Advantage plans on out-of-pocket spending for Medicare covered services, but that is not data that is published to the public. We recommend that CMS make this data public so organizations can evaluate what share of Medicare Advantage enrollees reach their out-of-pocket limit each year.

ALL ASPECTS OF MEDICARE ADVANTAGE MARKETING AND CONSUMER DECISION-MAKING

Continued confusion on Medicare Advantage enrollment

KHA continues to receive consistent complaints about patients unaware they have agreed to a Medicare Advantage plan. Patients believe they agree to an Original Medicare supplemental Medigap plan. KHA highly recommends that CMS consider taking the words 'Medicare' and 'Supplemental' out of the marketing and communications of Medicare Advantage products.

CMS already requires Medicare Advantage plans to submit disenrollment reasons by beneficiary characteristics. We recommend that this data is published. More transparency to better understand why beneficiaries disenroll from a Medicare Advantage plan and what backgrounds those beneficiaries come from is valued to know if certain groups of beneficiaries switch plans or disenroll for varied reasons than other groups of Medicare Advantage enrollees. This can also be used to evaluate equity within the Medicare Advantage program which can help to determine if there are improvements necessary to make the program more equitable, which benefits consumers.

Elimination of pre-existing conditions for supplemental insurance

While not explicitly asked about in this RFP, a top concern that Kansas hospitals have raised to KHA is that Medicare beneficiaries that enroll in a Medicare Advantage plan and remain in that plan for multiple years but later decide they want to re-enroll in Traditional Medicare are subjected to a medical review that could prohibit the obtaining of a supplemental Medicare policy because of a pre-existing condition. The Affordable Care Act made significant changes in how insurance works in the United States, and the wide elimination of consideration of pre-existing conditions to obtain a health insurance policy greatly benefited consumers and has ensured that when a consumer needs to obtain health care services, they can trust they will have an insurance policy that covers them that

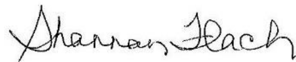
will not thrust the consumer into debt. One gap in the elimination of pre-existing conditions is within our Medicare eligible population. We encourage CMS to use this RFI as a launching pad for future rulemaking to eliminate the pre-existing condition rule to purchase a supplemental Medigap plan.

ENFORCEMENT OF CMS RULES

Kansas hospitals are concerned that while there are additional oversights on how Medicare Advantage plans use prior authorizations, when providers have concerns and want to report potential violations to CMS, is CMS equipped to address those concerns in a timely manner and actually enforce the rules in place to correct plans that are consistently violating CMS rules and policies. We recognize that CMS may not seek to intervene in contract disputes between Medicare Advantage plans and providers, but due to consistent violations of CMS rules being ignored by some Medicare Advantage plans, it is more important than ever for the agency to intervene in a timely manner and ensure that the rules CMS creates are followed by Medicare Advantage plans. CMS can take action that individual providers are unable to take which is to protect patients by preventing unnecessary delays of care, lack of prompt payment, and lack of payment in its entirety. These actions will ensure that providers can focus on providing the best care every time for every patient.

Thank you for the opportunity to comment and for your consideration of these issues.

Sincerely,



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