August 30, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW,
Room 445-G
Washington, D.C. 20201

RE: CMS-4203-NC; Medicare and Medicaid Programs; Request for Information on Medicare Advantage Program

Dear Administrator Brooks-LaSure,

On behalf of its 123 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) request for information on the Medicare Advantage (MA) program.

KHA appreciates 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 several serious concerns about the negative effects of Medicare Advantage Organization (MAO) 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 Traditional Medicare, and in some cases, even directly harm Medicare beneficiaries through unnecessary delays in care or outright denial of covered services.

II. A. ADVANCE HEALTH EQUITY

CMS defines health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes”. The CMS Framework for Health Equity lays out how CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served. While KHA supports the initiative to attain the highest level of health for all people, we offer the following suggestions.

Priority one of the CMS framework focuses on expanding the collection, reporting, and analysis of standardized data. While we understand why this data must be collected, the enormous administrative burden and cost placed on hospitals to collect more data is troubling. KHA requests
that CMS consider this immense reporting burden providers are tasked with and remove an equal or greater number of measures that may not demonstrate a positive impact or be less effective at demonstrating positive impact on healthcare outcomes.

While hospitals strive to provide comprehensive, person-centered healthcare, giving the freedom for each Medicare Advantage plan to frame their own definition and priorities for health equity may create unaligned goals and independent reporting requirements that do not line up with others. It will further add to hospitals’ reporting burden.

The COVID-19 pandemic has created extreme fatigue for health care professionals. This has led to some health care professionals leaving the industry and creating staffing shortages. Staffing shortages have not only affected patient care, but also provides challenges to perform the collection of data duties.

Also, KHA has heard an increasing number of accounts of Medicare Advantage beneficiaries being denied medically necessary services typically authorized for traditional Medicare beneficiaries. Medicare Advantage plan practices, such as more restrictive admission criteria, prior authorization denials, limitations on covered services, and denied claims, mean that Medicare beneficiaries are routinely being denied access to needed care. Denying medically necessary care for Medicare Advantage beneficiaries increases health disparities and worsens health equity outcomes.

KHA encourages CMS to investigate delays or the lack of medically necessary services by Medicare Advantage plans as beneficiaries have not received the care they need, ultimately jeopardizing their health outcomes. KHA also recommends CMS implement more stringent network adequacy standards in a plan’s service area to ensure access to necessary services, especially in rural and frontier areas.

II.B. EXPAND ACCESS: COVERAGE AND CARE

KHA strongly encourages CMS to create accountability standards and policies to stop the alarming practices that Medicare Advantage plans have created that hurt patients, contribute to clinician burnout and drive up the cost of care.

Insurers’ use of policies that deny or delay medically necessary care — often applauded by insurers as ways to control cost — have become extraordinarily burdensome on hospitals, providers and patients. More frequently they include excessive and unjustified application of utilization management tools and prior authorization requirements. Ironically the purchase of those additional information technology tools must be purchased through that same insurer. In other words, Medicare Advantage insurers have figured out how to recoup money from hospitals by selling more tools to meet their reimbursement requirements. KHA encourages CMS to review these complex relationships that appear to create a conflict of interest.

Prior Authorization Abuse
Medicare Advantage plans frequently apply prior authorization to services for which there is a clear evidence-based clinical pathway. The care delays and administrative costs associated with these prior authorizations by Medicare Advantage plans and the resulting impact on patients cannot be justified. On average, a Medicare beneficiary has access to 39 Medicare Advantage plans. In total, 3,834 Medicare Advantage plans are available nationwide in 2022. Every Medicare Advantage plan
has different prior authorization requirements. Each time an enrollee seeks service, contact to the
plan must be made to determine what authorizations are needed. Such different requirements places
tremendous additional pressure on an already over-burdened health care delivery system, creating
more bottlenecks from provider offices to hospitals, further slowing urgently needed care to
beneficiaries, and creates a situation where beneficiaries’ conditions worsen in the process.

Current CMS rules allow Medicare Advantage plans to take up to 14 days to respond to a prior
authorization request. This delay in patient care is unacceptable. In many instances, the patient is in
the hospital awaiting transfer to the next site of care to continue their treatment, such as inpatient
rehabilitation. These patients may sit unnecessarily in hospital beds for days and weeks as Medicare
Advantage plans process the prior authorization request which in many cases the plan may deny.
These delays contribute to a decline in the patient's condition and waste costly resources.

Medicare Advantage plans have an established history of inappropriately utilizing prior
authorization to delay access and deny necessary treatment for patients. In 2018, the Inspector
General recommended increased oversight of Medicare Advantage plans prior authorization
processes. During the COVID-19 pandemic, there has been widespread inappropriate usage of prior
authorizations by Medicare Advantage plans. 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 has prevented acute care beds from being
freed up to care for incoming patients. While this is taking place, health insurance plans are posting
record profits.

Claiming the inability to demonstrate medical necessary care is the standard message received from
insurance payers. However, the Medicare Advantage payer policies are often inconsistent with
widely accepted clinical guidelines, including traditional Medicare. When providers wish to
implement processes that meet the Medicare Advantage plans medical necessary procedures, they
are denied access because the insurer claims the procedures are proprietary information. These
dangerous practices can be demonstrated by patient harm examples witnessed during the COVID-19
pandemic. It was common for most Medicare Advantage patients with long-COVID to be denied post-
acute treatment. Many times, hospitals were forced to make difficult decisions to discharge a
vulnerable patient to home or keep them in the hospital with no pay from the insurer.

Recently, a Kansas hospital shared a story of an elderly patient with a Medicare Advantage insurance.
The patient had a severe infection that was being treated by an Infectious Disease physician. Because
of the severe infection, the patient was often confused and lethargic. The patient lived forty miles
away from any healthcare services. Although the patient easily would have met inpatient criteria
with a Traditional Medicare plan, the Medicare Advantage plan denied inpatient care. The Medicare
Advantage plan determined the patient should travel eighty miles roundtrip twice a day to receive
an IV infusion of the antibiotic. Although the Medicare Advantage plan advertised zero dollar
premiums, questionable practices such as this, shifted the cost away from the Medicare Advantage
plan to traveling costs for the patient in unsafe conditions.

KHA strongly urges CMS to require Medicare Advantage plans to align medical necessity and
coverage criteria with Traditional Medicare rules that Medicare patients have equal access to
care regardless of coverage type and to reduce unnecessary delays and burdens associated
with inappropriate or excessive use of prior authorization.
**Network Adequacy/ Site of Service Denials**

Medicare Advantage insurers limit where patients can receive care even when this practice disrupts a patient’s access to closer longstanding, in-network providers. This is increasingly happening for certain surgeries, diagnostics and specialty pharmacy medications administered by clinicians. The insurer requires the patient to go to another provider, often longer distances and without appropriate quality and safety controls in place. The insurer may benefit financially from referring patients to the new provider, such as specialty pharmacies and ambulatory surgical centers that the insurer owns or is affiliated with.

Most Kansas communities serve a high population of Medicare eligible patients. Many times Medicare Advantage insurers require these patients to travel 30 plus miles to a specialty pharmacy and ambulatory surgical center that the insurer owns to receive the care they need. Because of this practice, patients are making the choice to forego needed care. Patients deserve access to the care they need in their own community, when they need it. Clinicians should be able to focus their time on providing care instead of spending hours each day on costly bureaucratic hurdles.

KHA has heard of several rural Kansas hospitals that have denied signing a contract with a specific Medicare Advantage plan, however, the plan will continue to sell that product to a large population of the community with no network in place. Although Medicare Advantage plans are supposed to make sure patients have an adequate network before the product can be sold, this enforcement does not appear to be happening.

**KHA encourages CMS to extend its direct oversight of Medicare Advantage vendors and hold them accountable to network standards and appropriate education regarding their products.**

**Deceptive Marketing Practices**

KHA encourages CMS to place more advertising restrictions on Medicare Advantage plans. Some of what you hear on the Medicare Advantage TV ads is true, but the fine print shows that ‘free’ isn’t always ‘free’.

Kansas healthcare facilities hear numerous complaints from patients that did not realize they surrendered their traditional Medicare coverage when they signed with a Medicare Advantage carrier. Some Medicare Advantage plans have limited access to in-network providers and requires an approval for utilizing healthcare services other than an emergency room visit.

These patients must go beyond the commercials to understand the fine print of their Medicare Advantage plans because this is not explained to patients during enrollment. Information about Medicare coverage options produced is no longer neutral. Consumers must be provided an unbiased representative that will provide them all differences between traditional Medicare and the Medicare Advantage players.

While taking steps to stop incomplete or dishonest advertising would be helpful, beneficiary education is also needed. CMS should provide education at the national level with full detailed information on what Medicare Advantage plans cover, and what beneficiaries will be gaining and losing when choosing between a Medicare Advantage and traditional Medicare plan. Beneficiaries should be required to sign that they understand the limitations that their new Medicare Advantage plan has in the community they live in, such as network constraints in communities.
II. C. INNOVATION

Healthcare organizations consistently investigate ways to leverage health information technology to mitigate clinician burden and improve patient safety. However, the cost for each digital transformation can quickly sink an organization. Each insurer has aligned or created their own information technology application interfaces that have a fee associated to it. As described above, insurers create a conflict of interest by intentionally denying claims only to entice the purchase of their information technology application to help ‘solve the problem’.

**KHA encourages CMS to limit IT application fees and create one integrated electronic application to be utilized by all Medicare Advantage insurers.**

II.D. SUPPORT AFFORDABILITY AND SUSTAINABILITY

MedPAC noted that Medicare Advantage payments and benchmarks exceed fee-for-service Medicare spending. In 2022, Medicare Advantage payments are 104 percent of fee-for-service Medicare spending. This includes 3.6 percentage points of uncorrected coding intensity, without which Medicare Advantage payments match fee-for-service expenditures.

The largest Medicare Advantage carriers have shown record profits in 2019, 2020, and 2021 reaching over $17 billion per year and growing. Medicare Advantage plans have shown to be their most profitable line of business in those same years. In correlation, America’s largest healthcare systems have shown record losses. This is a telling story with these statistics.

**Sepsis Downcoding**

To continue explanation of deceptive Medicare Advantage practices, several Medicare Advantage health plans are now reimbursing providers for sepsis care using the Sepsis-3 clinical criteria, instead of the broadly-adopted Sepsis-2. The primary difference between the two sets of criteria is that Sepsis-3 recognizes only more severe forms of sepsis. This move is inconsistent with the CMS sepsis quality measure (“Severe Sepsis and Septic Shock: Management Bundle”), as well as some state laws. Indeed, CMS has expressly rejected adoption of Sepsis-3 However, by moving to Sepsis-3, these health plans are not reimbursing providers for early sepsis interventions. In other words, their adoption of Sepsis-3 is not intended to change how providers assess and treat patients; they simply will not pay for care provided to patients in the early stages of sepsis. Adoption of the Sepsis-3 criteria introduces conflict and confusion in the field around the right clinical pathway and signals a retreat on standardization of clinical care. Early treatment is critical to prevent the progression of sepsis and any reduction in early intervention could result in increased mortality. The misguided adoption of Sepsis-3 clinical criteria results in underpayment for these very critical early interventions. This change misaligns incentives among providers and insurers to achieve a shared goal of reducing sepsis.

**Emergency Room Downcoding**

UnitedHealthcare has led the way in continuing to downcode Emergency Room care. In a recent explanation by UHC on their Emergency Room Level 5 downcoding, they stated, “In an effort to reduce the administrative burden of requesting and submitting medical records for review, UnitedHealthcare will ... determine appropriate E/M professional coding levels based on data such
as patient’s age and conditions for the Medical Decision Making key component,” the payer writes in an announcement about the new policy. “UnitedHealthcare will presume the provider meets the requirements of the E/M code level they have submitted related to the History and Exam key components for the initial adjudication of the claim.”

Later in the statement, UHC says the E/M Pro tool basically calculates the appropriate E/M level based on submitted diagnosis codes, which “will result in fair and appropriate reimbursement for ED services rendered.” However, diagnosis codes don’t always tell the whole story. The diagnosis codes submitted on the claim in isolation do not give a complete picture of the medical complexity of the patient, or of the medical decision-making undertaken by the physician. There’s nearly a 90 percent overlap in symptoms between emergencies and non-emergencies. A final diagnosis may not indicate the differential diagnoses a physician is considering when ordering labs and making decisions. When providers ask for UHC to share the algorithms, they are once again told that the algorithms are proprietary information and cannot be shared.

**Acute Inpatient Downcoding**

A new and most concerning downcoding tactic utilized by Medicare Advantage plans is to deny all beneficiaries for inpatient status moving all patients to observation (outpatient) status. This is none other than a financial tactic by insurers to avoid post-acute coverage and other medical necessary treatments. While a hospitalization can be costly, approving the patient as observation allows the insurer to avoid full room charges which helps pay for the cost of overhead, staff time, technology utilized and much more.

A Kansas hospital recently shared with KHA that even patients admitted to the ICU are approved as observation by Medicare Advantage plans versus an inpatient status. By doing this, Medicare Advantage plans avoid paying for room and board fees which help pay the overhead expenses of the hospital, wages of the staff, housekeeping expenses, or food services. Although this reduces the cost to the Medicare Advantage plan, it does not reduce the cost to the patient nor the healthcare system. It shifts the cost to the other parties allowing more profit for the Medicare Advantage vendor.

**Payment to Rural Hospitals**

Payments by Medicare to rural hospitals in the Critical Access Hospital (CAH) program, and several other rural hospital Medicare supplemental payments (Medicare Dependent Hospital, Low Volume Adjustment) are based on how much Medicare business a hospital does. CMS does not consider Medicare Advantage to be Medicare for purposes of calculating these payments. As the Medicare Advantage program has grown in recent years, it is reducing the Medicare payments to CAHs and in some of the supplemental payment programs. **KHA recommends CMS add the Medicare Advantage patient days and outpatient revenue as Medicare in each hospital’s cost report when calculating payments to CAHs**, and in the supplemental programs, the problem would be solved with the Medicare annual cost report filing and settlement process.

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Further, under Medicare Advantage payment for CAH services provided to Medicare Advantage enrollees will be determined by Medicare Advantage plans, either through contractual arrangements or by a default decision to pay the CAH as an out of network provider. The law does not require that Medicare Advantage plans pay any certain amount or use any particular method to pay CAHs who participate in their networks. A 2005 Rural Health Policy brief by RUPRI reported that about two-thirds of signed cost-based contracts included provisions for annual cost settlement, but in most cases administrators had to negotiate to get settlement terms in the final contract. If a Medicare Advantage plan is paying for services rendered by a CAH not in its network, it must pay what Medicare would otherwise pay. However, lag time for cost settlement for correct payments under Medicare for non-contract CAHs are significantly delayed and/or non-existent within Medicare Advantage. **KHA asks that CMS require Medicare Advantage plans to pay hospitals cost (the same way that traditional Medicare does) and require Medicare Advantage plans to reimburse rural hospitals within 10 business days in order to address this discrepancy.**

**II.E. ENGAGE PARTNERS**

Regulators must do more to ensure that health plan enrollees have access to covered services. KHA urges CMS, the Department of Justice, and state insurance commissioners to increase their oversight and enforcement activities using existing statutory authority in the following ways:

- **Set thresholds.** Oversight bodies should establish thresholds for “appropriate” levels of prior authorization and payment delays and denials by Medicare Advantage plans in order to target potential bad actors for increased scrutiny.
- **Apply financial penalties for inappropriate denials by Medicare Advantage plans.** Regulators should create a financial disincentive for plans to inappropriately deny prior authorization requests or claims for reimbursement. Specifically, we recommend that plans be required to pay 50% above the normal payment rate if a denial is overturned by internal review and 200% of normal payment if a denial is overturned by external review or arbitration.
- **Test provider networks: Inadequate networks – particularly for behavioral health and post-acute care – may contribute to prior authorization delays.** We urge regulators to more routinely test health plan’s networks (or delegated network), including through “secret shopping” efforts to ensure that providers are indeed in-network and accepting patients from that health plan or a delegate.
- **Publish performance data by Medicare Advantage plans.** Regulators should make available statistics on health plan and third party administrator (TPA) performance on measures related to prior authorization and payment delays and denials, including the rate of denials overturned upon appeal.
- **Increase oversight to Medicare Advantage plans.** Regulators should increase the frequency of health plan and TPA audits for those found to exceed established thresholds for prior authorization and payment delays and denials. In addition, regulators should work toward real-time reporting for early intervention on issues that could negatively impact patient access to care.
- **Apply appropriate disincentives to Medicare Advantage plans.** Regulators should consistently apply penalties to plans and TPAs, which should also be applied to any contractors or delegates, found to be out of compliance with the identified thresholds.
- **Monitor adverse impact on Medicare beneficiaries due to Medicare Advantage plan policies.**
Federal agencies may need additional authority to conduct comprehensive oversight of health plans. For example, statutory language barring CMS from intervening in private contracts appears to have hampered the agency’s ability to address a number of systemic payment and prior authorization abuses by health plans. Federal law should not unduly restrict regulators’ abilities to ensure equitable access to quality care and coverage for patients and fair reimbursement for providers.

**CONCLUSION**

KHA is calling for greater congressional oversight to protect access to care for Medicare Advantage beneficiaries. We are in support of the American Hospital Association request urging the Department of Justice to establish a taskforce to conduct False Claims Act investigations into commercial health insurance companies that are found to routinely deny patients access to services and deny payments to health care providers, and we are asking the Centers for Medicare & Medicaid Services to take action to hold plans accountable for egregious practices that adversely impact patients through increased oversight.

Thank you for the chance to offer comments on Medicare Advantage insurers and for your consideration of our comments.

Sincerely,

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