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Always There for Healthcare

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically: www.regulations.gov

RE: Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, etc.; CMS-4201-P

Dear Administrator Brooks-LaSure:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the proposed changes to the Medicare Advantage and Part D programs for contract year 2024.

HANYS recognizes and appreciates CMS efforts to increase oversight of MA plans, better align their behavior with fee-for-service Medicare, address gaps in behavioral health services, further streamline the prior authorization process and provide specific protections for post-acute care services.

Participation in MA plans continues to grow; in 2022, more than 28 million Medicare beneficiaries were enrolled in an MA plan — nearly half of all Medicare beneficiaries. In New York, 52% of beneficiaries were covered by an MA plan that same year. This trend shows no signs of slowing down, as the Congressional Budget Office projects total MA enrollment will reach 61% of all Medicare beneficiaries by 2032.

Although the MA program offers some apparent advantages to beneficiaries, it also comes with unintended limitations that are inconsistent with Medicare FFS policy. Beneficiaries may not understand the differences between FFS and MA. HANYS and our members have long supported consumers having access to choice and innovation within a strong health insurance market.

Far too often, MA plans' policies and practices harm Medicare beneficiaries by denying and delaying care, which drives up the cost of care and adds unnecessary administrative burdens for hospitals and health systems.

Our hospital and health system members frequently encounter difficulties securing timely authorization and payment from MA plans for services provided to patients, resulting in unnecessary delays and increased administrative burdens. Therefore, we strongly support CMS efforts to improve the MA program by increasing health plan accountability and strengthening consumer protections.

However, we have concerns regarding several proposed provisions, including the proposed changes to the legal standard for identifying overpayments. HANYS recommends that CMS either withdraw that section of the proposed rule or restore the parts of prior CMS overpayment rulemaking that gave providers the needed time to investigate and properly identify overpayments.

HANYS offers the following specific comments on the proposed rule.

Health equity in MA

HANYS shares CMS' strong commitment to advancing health equity and we appreciate CMS' attention to health equity within the context of the MA program. HANYS and our members are committed to systematically and intentionally addressing social determinants of health and closing healthcare gaps in every New York community. HANYS believes that closing these gaps will enable every individual to achieve optimal health through the delivery of equitable health services.

CMS is proposing a number of provisions intended to advance health equity for all enrollees. Specifically, CMS proposes to:

- expand the list of populations to which MA plans must provide culturally competent services;
- require MA plans to identify enrollees with low digital health literacy and offer them digital health education to improve access to medically necessary covered telehealth benefits;
- require MA plans to include additional provider details in their provider directories, including cultural/linguistic capabilities, accessibility for people with physical disabilities, and whether the provider can provide medications for opioid use disorders; and
- require MA plans to incorporate one or more activities in their quality improvement programs targeted at reducing disparities in health and healthcare among their enrollees.

HANYS supports these proposals and urges CMS to finalize them.

Behavioral health in MA

Network adequacy is a major, longstanding obstacle to care for individuals with behavioral health needs. While limited provider networks can result in barriers to care in any field of medicine, they are particularly acute in behavioral health, impeding patient access to critical services. The need to invest in behavioral health and address network adequacy has never been more urgent.

CMS proposes establishing standards for access to behavioral health services within the MA program. Currently, MA plans are required to provide access to an adequate network of "appropriate providers," including primary care providers, specialists, hospitalists and others. This rule would explicitly add to this list clinical psychologists, licensed clinical social workers and prescribers of medication for opioid use disorder. In addition, CMS proposes to:

- include behavioral health services in the general access to services standards;
- codify wait time standards for primary care and behavioral health services;
- clarify that emergency services may include some behavioral health services (meaning prior authorization may not be applied to them); and
- require MA plans to add behavioral health services to their programs that coordinate covered services with community and social services.

HANYS strongly supports these efforts to improve access to behavioral health services for MA enrollees and urges CMS to finalize them.

MA network adequacy access to services

Currently, MA plans may establish provider networks but are supposed to ensure all covered services are available and accessible to enrollees under the plan. CMS has historically interpreted these requirements to mean that if an in-network provider or service is unavailable or inadequate to meet an enrollee's needs, the MA plan must arrange for out-of-network access to the services with in-network cost sharing for the enrollee. However, our members have often struggled with MA plans authorizing OON services. CMS proposes to clearly affirm that the MA plan is obligated to ensure access to medically necessary covered services by:

- expanding the regulatory scope from specialty care only to align directly with the statute — "appropriate providers, including credentialed specialists"; and
- codifying the requirement that MA plans have to maintain the in-network cost-sharing amount for OON services.

HANYS supports this proposal and recommends CMS finalize it. However, we also recommend that CMS explicitly add to the MA network adequacy requirements post-acute care providers, such as inpatient rehabilitation facilities and home health agencies.

Enrollee notification requirements for MA provider contract terminations

CMS proposes to revise the current requirements for MA plans to notify enrollees when a provider network participation contract is terminated, including no-cause and for-cause provider contract termination notices, and provide more detailed notices when primary care and behavioral health provider contract terminations occur.

Currently, MA plans must make a "good faith effort" to notify enrollees at least 30 calendar days prior to the termination effective date with a provider, regardless of whether the termination was for cause. MA plans and contracted providers are required to provide each other with written notice of termination at least 60 days before terminating the contract without cause. Therefore, CMS is proposing to permit the "good faith effort" flexibility in the case of for-cause terminations

only; without-cause terminations would require at least 30 days' notice before the termination effective date with a provider.
In addition, CMS proposes requiring MA plans to provide notice to enrollees at least 45 calendar days before the termination effective date for contract terminations that involve a primary care or behavioral health provider.

HANYS support these revisions, as they will provide greater clarity to enrollees regarding access to continued care. HANYS supports consumers' choice in accessing their preferred providers and supports increased communication between plans and enrollees.

Utilization management requirements

Clarifications of coverage criteria for basic benefits

CMS proposes to codify its longstanding guidance that MA plans are required to adhere to Medicare FFS coverage policies when making a medical necessity determination and cannot use alternative criteria to deny coverage of an item or service that would otherwise be approved under CMS rules. If a given service does not have established Medicare FFS coverage criteria, CMS would permit MA plans to adopt criteria based on widely used treatment guidelines or clinical literature, only if the plan creates a publicly accessible summary of the evidence, a list of the sources and an explanation of the rationale for the internal coverage criteria.

HANYS strongly supports limiting MA plans from adopting more restrictive rules than Medicare FFS.

MA plans routinely classify their medical necessity criteria as proprietary, hindering providers' ability to determine whether the MA plan will approve services. Hospital inpatient admissions/the two-midnight rule is a common area where MA plans administer proprietary medical necessity criteria that are inconsistent with Medicare FFS coverage rules.

HANYS believes that by codifying the provisions of 42 CFR 412.3 as a basic benefit for all MA enrollees, this proposal would require plans to abide by the provisions of the two-midnight rule and its associated regulations.

MA plans have continuously flouted CMS' two-midnight rule, which states that a hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. MA plans have implemented their own policies that 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. MA plans have even gone so far as to downgrade inpatient stays of more than four days to observation status, far exceeding CMS' two-midnight rule criteria. These "short stay policies" from MA plans result in patients losing their right to appeal discharges and other rights, such as placing them into a higher copayment situation.

HANYS recommends that CMS explicitly state that MA plans must follow the two-midnight rule.

A number of our health and hospital system members have reported situations where MA plans have relied on stricter criteria than Medicare FFS to deny care for patients who met FFS inpatient rehabilitation coverage criteria. For example, MA plans have denied coverage for stroke patients who needed inpatient rehabilitation services based on the plans' own criteria and only approved admission to a skilled nursing facility where the patient would receive fewer

therapy services. CMS' proposal would prohibit MA plans from denying coverage for skilled nursing facility care, home health services and inpatient rehabilitation facilities with proprietary medical necessity criteria that are more restrictive than Medicare FFS.

HANYS strongly supports this proposal.

Another area where MA plans significantly deviate from Medicare FFS is inpatient hospital readmissions. MA plans frequently claim to be following CMS rules, but instead establish readmissions policies that are more restrictive and often based on different timeframes from CMS, such as 14 or 21 days. Some MA plans will not cover readmissions within a health system and others deny coverage for an inpatient "readmission" for services completely unrelated to the original admission.

HANYS asks CMS to clarify that MA plans' inpatient hospital readmissions policies cannot be more restrictive than Medicare FFS.

Appropriate use of prior authorization

Inappropriate and excessive denials for prior authorization are pervasive among MA plans. Post-acute care services are among the three most frequently denied requests for prior authorization and payments. This is despite that, in most cases, the patient met both Medicare FFS coverage rules and MA plans' billing rules.

MA plans' use of prior authorization and other utilization management policies erodes the overall quality of care for patients and unnecessarily lengthens their time in an acute hospital setting. Our hospital members have faced increasing difficulties discharging patients to post-acute care settings.

Delays of three to seven days waiting for post-acute authorization have become commonplace, putting unnecessary pressure on hospital capacity and disserving new patients who need those beds. These delays not only contribute to a degradation of the patient's condition but also waste costly health system resources and prevent hospitals from freeing up inpatient capacity. Moreover, the MA plans are not available for authorizations over the weekends or holidays, further extending the length of stay for individuals within in the hospital when they no longer need hospital-level care.

Keeping patients in an inpatient bed while waiting for the MA plan's decision is not in the patient's best interest. These delays often result in missed clinical opportunities for patients to access the more specialized care typically provided in PAC settings. In addition, we have serious concerns about the behavior of some MA plans that approve prior authorization requests for PAC but later issue retrospective denials for the same services. This has been a longstanding and problematic issue for many of our PAC providers.

HANYS supports CMS' proposal requiring MA plans to use the substantive coverage criteria and benefit conditions found in Medicare FFS regulations when authorizing PAC services.

Continuity of care

If finalized, CMS' proposal would require MA plans' prior authorizations to be valid for the complete course of a patient's prescribed treatment and would require the MA plans to honor

existing prior authorizations for a minimum 90-day transition period post-enrollment. These requirements would stop the need for additional prior authorizations for each episode of care in a series of prescribed treatments, which can delay or interrupt ongoing treatment.

HANYS supports these important patient protections and urges CMS to finalize them.

Mandate annual review of utilization management policies by a utilization management committee

CMS proposes requiring MA plans to establish a UM committee, which would operate in a similar manner to MA plans' pharmacy and therapeutics committee. The UM committee would be led by the plan's medical director and:

- a majority of members would have to be practicing physicians;
- at least one practicing physician would have to be independent and free of conflict relative to the MA plan;
- at least one practicing physician would have to be an expert regarding care of elderly or disabled individuals; and
- members of the committee would have to include individuals representing various clinical specialties to ensure that a wide range of conditions is adequately considered in developing the MA plan's UM policies.

MA plans would not be permitted to use any UM policy or procedures for benefits that were not reviewed and approved by the UM committee. The UM committee would have to revise UM policies and procedures on an annual basis, at a minimum.

HANYS supports requiring MA plans to establish a UM committee that reviews all UM policies and procedures. To ensure equitable and independent representation on the committee, we recommend that CMS consider requiring additional stakeholders, such as current Medicare beneficiaries and other independent clinicians.

HANYS strongly supports all of the above provisions, as MA plans often use more stringent medical necessity criteria than Medicare FFS, employ excessive prior authorization requirements, use inappropriate utilization management tools and require onerous and duplicative clinical documentation submissions to substantiate the need for services.

HANYS urges CMS to finalize these proposals, with increased specificity and delineation of the specific rules Medicare FFS rules that MA plans must follow, to hold MA plans accountable and improve beneficiaries' access to medically necessary care.

Given the MA plans' history and current practices of deviating substantially from Medicare FFS, we anticipate that this area will require additional oversight and enforcement from CMS to ensure that MA plans follow the rules, once finalized.

Review of medical necessity decisions

CMS seeks to refine its current requirements that MA plans have appropriate healthcare professionals review initial determinations involving issues of medical necessity. Under the proposal, before an MA plan issues a denial it would be required to ensure that the physician (or

other appropriate healthcare professional) conducting the review has expertise in the field of medicine that is appropriate for the item or service being requested.

HANYS members have expressed many concerns about the qualifications of individuals reviewing prior authorization requests and medical necessity determinations. Another common and troubling practice is MA plans using subcontracted vendors to perform the initial prior authorization review. Often these vendors use even more strict criteria than the MA plans themselves; leading to denials that providers then have to appeal to the MA plan.

HANYS recommends that CMS finalize this proposal, with the additional clarity that this provision would also apply to expedited reviews and not just standard prior authorization requests. We urge CMS to require these rules to apply to peer-to-peer reviews as well.

In addition, to ensure that all prior authorization requests and medical necessity decisions are held to the same standard, HANYS recommends that CMS clarify that "appropriate healthcare professional" also includes subcontracted vendors.

MA and Part D Marketing

CMS proposes a number of changes designed to restrict MA plan and Part D marketing practices that are misleading, inaccurate or confusing for beneficiaries. If finalized, the rule would prohibit advertisements for MA plans that do not mention a specific plan name and those that use words or imagery (for example the Medicare name or logo) that could mislead or confuse potential beneficiaries, such as making it appear the information is from a government agency. CMS would also require that marketing materials developed by a third-party marketing organization for multiple plans be submitted to CMS for review.

HANYS supports improvements that help beneficiaries understand exactly what coverage they are purchasing and we urge CMS to finalize these rules as proposed.

Medicare Parts A, B, C and D overpayment provisions

CMS proposes changing the legal standard for identifying an overpayment from "reasonable diligence" to the False Claims Act definition of "knowingly." This change would remove the six-month investigative period providers currently have to reconcile potential overpayments prior to refunding the money. Under the current rules, providers must report and return overpayments within 60 days of identifying a Part A or Part B overpayment. Providers are obligated to use reasonable diligence to identify overpayments via proactive compliance activities and investigate potential overpayments in a timely manner.

Identifying and investigating overpayments is an onerous task that takes considerable time and effort. Providers devote significant resources to research and determine the cause and scope of a payment error. Once a provider identifies a potential overpayment the compliance, legal and revenue cycle teams (and others as needed) begin an internal audit to collect information and identify the possible issues: Was it a single charge entry error, a coder error, an issue with the claims scrubber, an issue with the chargemaster, a payer mistake, etc.? The provider then has to calculate how much money must be refunded.

With the reasonable diligence standard and the 2016 final rule, CMS acknowledged the complexities of these overpayment cases and clarified that providers have up to six months from

the time information is received about a possible overpayment to investigate. Decreasing the total time to report an overpayment from up to six months down to an unrealistically strict 60-day deadline is not operationally feasible.

HANYS requests that CMS withdraw this portion of the proposed rule and/or restore the portions of the 2016 final rule that gives providers the necessary time to investigate and accurately identify overpayments.

Additional areas for consideration and comment

Medicare FFS coding policies

Similar to the variations in coverage policies between Medicare FFS and MA plans, MA plans have unilaterally created separate coding and diagnosis grouping standards that are contrary to Medicare FFS. A key example of this relates to sepsis. MA plans follow Sepsis-3 criteria for determining provider reimbursement.

The Sepsis-3 criteria formulated by the Sepsis Definitions Task Force are not consistent with the Sepsis-2 criteria that otherwise have been universally adopted, most notably by CMS and New York state. This results in MA plans denying payment for early sepsis interventions. The use of Sepsis-3 by MA plans in New York also harms reimbursement for hospitals and health systems that are required to follow the Sepsis-2 criteria.

HANYS strongly urges CMS to align Medicare FFS and MA coding policies to ensure consistent use of Current Procedural Terminology coding practices and Diagnosis Related Group assignments.

Gold-carding

CMS seeks comments on "gold-carding" models, whereby MA plans relax or reduce prior authorization requirements for contracted providers that have demonstrated a consistent pattern of compliance with plan policies and procedures. CMS has expressed support for these types of policies. Within this proposed rule, CMS is actively encouraging MA plans to adopt gold-carding policies and allow providers to be exempt from prior authorization and provide a more streamlined medical necessity review process for providers who have demonstrated compliance with plan requirements.

HANYS supports the concept of gold-carding and similar policies. We strongly urge CMS to require MA plans to implement these types of policies to permit providers who consistently follow evidence-based guidelines or otherwise demonstrate high compliance with a payer's requirements to be exempt from onerous prior authorization requirements.

Enforcement and oversight

HANYS strongly believes that CMS needs to provide greater oversight of MA plan behavior. We have long advocated for CMS to exercise its authority and ensure that MA plans cover the same services and benefits as Medicare FFS.

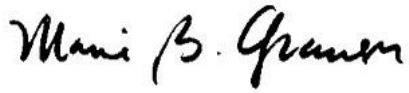
Throughout this proposed rule, CMS has responsively addressed many stakeholder concerns regarding the MA program and plan policies and practices that delay or restrict access to care.

However, as CMS notes in multiple places within the proposed rule, many of the provisions are restatements or codifications of existing CMS guidelines and policies. This highlights the importance of CMS holding MA plans accountable and ensuring compliance with the final rules as adopted. Without proper oversight and enforcement, MA plans have no determent to change their behavior and comply with CMS rules.

HANYS strongly urges CMS to create a mechanism for providers and other stakeholders to identify and report suspected violations. We also ask CMS to establish meaningful penalties for MA plan non-compliance.

If you have questions, please contact me at bgrause@hanys.org or 518.431.7765 or Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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