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March 4, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of our over 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) thanks you for the opportunity to comment on proposed rule, CMS-4192-P

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small critical access hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

OVERVIEW

Wisconsin's hospitals and health systems have had over two years of sustained effort battling during the COVID pandemic to provide high quality health care for all in our communities. As our members faced unprecedented challenges, the flexibilities offered by CMS on a number of regulatory fronts proved valuable in reducing red tape and getting care to those who needed it most. However, certain flexibilities were encouraged, but not mandated, on Medicare Advantage plans, limiting their effectiveness. It is from this vantage point that we offer comments in response to your request for information regarding prior authorization for hospital transfers to post-acute settings during a PHE. We also offer comments regarding the proposed rule's special requirements during a disaster.

Even before the pandemic, hospitals and health systems providing direct care to patients have been routinely impacted when health insurers fail to maintain adequate networks; work around medical loss ratio requirements; and due to cost-sharing accrual policies. We, therefore, offer comments on these aspects of the proposed rule as well.

1. PROPOSED RULE SECTION III: REQUESTS FOR INFORMATION A. REQUEST FOR INFORMATION: PRIOR AUTHORIZATION FOR HOSPITAL TRANSFERS TO POST-ACUTE CARE SETTINGS DURING A PUBLIC HEALTH EMERGENCY

In order to best care for our community during the COVID-19 pandemic, we needed to quickly turn over general acute-care hospital beds and create space for higher-need COVID-19 patients, as well as ensure access to the appropriate level of care for those recovering from the virus. This necessitated urgent modifications to traditional discharge processes and clinical pathways to optimize personnel, physical plant and other

resources. The flexibilities offered by CMS to relax or waive prior authorization requirements for Medicare Advantage (MA) plans were invaluable for general acute-care hospitals in implementing these modifications.

A substantial limitation of this flexibility, however, is that it encouraged, but did not mandate, that MA plans waive such processes. While many MA plans worked collaboratively with provider partners to waive or relax onerous prior authorization requirements during the PHE, others did not, or only did so during the initial stages. The continued use of prior authorization and other health plan utilization management policies by some plans throughout the pandemic has prevented referring hospitals from utilizing desperately needed health system capacity in PAC settings. This has been especially problematic when general acute-care beds have been filled to capacity and while hospitals contend with the demands of vaccine distribution and workforce shortages. It also can have unintended consequences for patients who are then forced to stay in acute care settings unnecessarily while waiting for health plan administrative processes to authorize the next steps of their care. Even today, these challenges persist.

The misuse and application of prior authorization during a PHE has caused a number of specific challenges that have negatively affected patient care and health system capacity during a global health crisis, which we outline briefly below.

- **Unwarranted Prior Authorization Delays Can Harm Patient Care.** It is clear that keeping patients in the emergency department or an inpatient bed while waiting for the health plan's decision or response to a prior authorization request is not in the best interest of the patient. These delays often result in missed clinical opportunities for patients to access the more-specialized care typically provided in PAC settings. Such delays due to prior authorization requirements also can interfere with patients' prescribed PAC plan of care, which is established by the referring hospital's treating physician and clinical team, and is intended to help patients return to their home or community sooner. Further, from a PAC perspective, there are widely-held concerns about the behavior of MA plans that approve prior authorization requests for PAC, but later issue retrospective denials for the same services. This has been a long-standing and problematic issue for many PAC providers and the resulting hesitancy also contributed to delays in patient transfers from general acute-care hospitals to PAC facilities during the PHE.

  These concerns are consistent with the findings of a September 2018 report by the Department of Health and Human Services Office of Inspector General (OIG), which warned that high rates of MA health plan payment denials and prior authorization delays could negatively impact patient access to care.[1]

- **Health Plans' Adding Administrative Burden to the National PHE Response.** Many MA plans use inconsistent administrative protocols and a dizzying array of timelines and requirements for prior authorization requests, reviews, approvals and communication, which are unnecessary at best, but rise to the level of unconscionable during a PHE. Excessive requirements and variation between them adds burden to the system as providers and their staff must ensure they are following the right set of rules and processes for each plan, which may change from one request to the next, and can also vary by plan, product and vendor. During a time of national emergency where workforce shortages and strained health system capacity have been persistent challenges, there is simply insufficient bandwidth to comply with such cumbersome administrative procedures.

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[1] U.S. Department of Health and Human Services, Office of Inspector General (OIG). "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials." September 25, 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

- **Overuse of Prior Authorization.** Some health plans require prior authorization even for services where there is no evidence of abuse and for which the standards of care are well established. Specifically for PAC services, health plans too frequently deny the presence of medical necessity for services that are supported by the literature and that are covered by FFS Medicare.

- **OIG Found Unwarranted MA Denials.** The majority of the prior authorization and coverage denials are for covered, medically necessary services that are rejected for administrative processing reasons as opposed to concerns about the legitimacy or appropriateness of the service Ultimately, many of these denials are overturned through time-consuming administrative appeals. The September 2018 OIG report referenced earlier found that among appealed cases, MA plans overturned 75% of their own denials between 2014-2016 (approximately 216,000 denials per year) through their own appeals processes.[2] These findings highlight a pattern of health plans inappropriately denying access to services and payment that should have been provided.

We encourage CMS, working with Congress as necessary, to require plans to waive these administrative processes during the public health emergency.

2. Proposed Rule Section 422.100(m): Special Requirements During a Disaster or Emergency

The proposed rule would clarify the period of time during which Medicare Advantage organizations must comply with the special requirements to ensure access for enrollees to covered services throughout a disaster or emergency. CMS proposes an additional condition – that there is a disruption in access to health for enrollees – for triggering the special requirements that Medicare Advantage plans must ensure access, at in-network cost sharing, to covered services even when furnished by noncontracted providers when disruption in their plan's service area during a state of disaster or emergency impedes enrollees' ability to access covered services from contracted providers.

CMS proposes that Medicare Advantage organizations would be initially responsible for evaluating whether there is a disruption of access to health care because CMS believes that Medicare Advantage organizations would be best positioned to evaluate if a state of disaster or emergency is disrupting access to care for their enrollees in their service area. Based on the experience of hospitals and health systems during the pandemic, we disagree. Clearly health insurers, companies that may not even have a local presence, were and are removed from the real-life experience of health care providers and patients. This has been illustrated in numerous ways over the past two years – their failure to help ensure patients were being discharged to post-acute settings; their failure to help quickly credential providers; their interest in imposing new and burdensome requirements on health care providers in the middle of the pandemic including implementing programs such as white bagging and a refusal to pay for emergency room claims if after the fact they determined that the diagnosis may not have been for an "emergent" condition; their imposition of increased number of prior authorizations, denials, and utilization management techniques. None of these actions were in the best interests of patients or providers grappling with the challenges of COVID.

We strongly encourage CMS to implement a process for health care providers and their patients to inform CMS of real-world, on-the-ground access issues that could necessitate triggering the special requirements, and to work with hospitals and other health care provider organizations on the most efficient methods of doing so.

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[2] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

3. Proposed Rule Section 422.100 and 422.101: Attainment of the Maximum Out-of-Pocket limit

Nearly ten years ago, the Wisconsin Medicaid program chose to stop paying hospitals for the Part A deductible costs incurred by dual eligible beneficiaries (referred by CMS in the proposed rule as the "lesser of" policy.) Unfortunately, this resulted in an annual reduction in funding for hospitals, which has only been exacerbated because Medicare Advantage plans were allowed to avoid counting those costs in the maximum out of pocket for dual eligible enrollees.

It is widely recognized that federal and state governments continue to pay less than cost for care for their enrollees. In Wisconsin, this practice has been dubbed "the Hidden Health Care Tax". It is a hidden tax on Wisconsin employers that has continued to grow, reaching over $1 billion annually. This tax is the result of Wisconsin's Medicaid program only paying for 65 percent of the cost of hospital care for patients, resulting in health care costs getting shifted over to private payers. This Hidden Health Care tax rivals what is paid by Wisconsin families and businesses through the state's motor fuel tax and through the corporate income tax.

The Hidden Health Care Tax was originally named by Wisconsin's state chamber, Wisconsin Manufacturers and Commerce (WMC) because of its impact on Wisconsin businesses and those that provide health insurance to their employees. In some areas of Wisconsin, the cost of government cost shifting results in up to 31 percent of the price paid by commercial health insurers for hospital care. The Hidden Health Care Tax has a significant impact on the cost of doing business in Wisconsin.

Similarly, in Wisconsin, the Medicare program adds to the hidden health care tax because Medicare pays providers less than cost, even when enrollee cost sharing is paid and factored in. Moreover, for enrollees who cannot afford cost sharing, providers must bear even more of a burden as a result of CMS policies that both have allowed Medicaid to avoid cost sharing payments through the "lesser of" policy and have further allowed Medicare Advantage plans to avoid counting those costs in the maximum out of pocket.

Providers have for too long been wrongly saddled with out-of-pocket costs that were not even theirs to bear. We not only support this corrected policy as proposed by CMS, but we urge CMS to go even further by reconsidering the "lesser of" policy and prohibit state Medicaid programs from implementing such policies for dual-eligible enrollees.

WHA strongly supports the proposed rule in correctly this erroneous maximum out-of-pocket policy. We also strongly encourage that CMS reconsider allowing state Medicaid programs to implement a "lesser of" policy and instead require state Medicaid programs to pay providers for this cost .

4. Proposed Rule Section 422.116: Amend Medicare Advantage Network Adequacy Rules

The proposed rule includes provisions intended to improve CMS oversight and effectiveness of network adequacy reviews for initial applications and when a Medicare Advantage plan is expanding their service area. WHA has long supported efforts that improve the adequacy and transparency of insurer networks.

Recent practices by insurers indicate their willingness to pull health care providers out of the network during the middle of the benefit year for patients, and without transparency to their enrollees. This can happen for specific health care providers – such as hospital pharmacies or labs – and are often unknown to patients until they need care. These practices present a significant disruption in care, fragmentation of care, as well as hidden costs and logistical challenges for patients. These practices need more oversight, whether they occur by Medicare Advantage plans or by health plans in the commercial market.

WHA supports CMS' efforts and the proposal to require compliance with applicable network adequacy standards as part of an application for a new or expanding service area. We encourage CMS to go further by updating the frequency with which it conducts ongoing reviews of health plan networks.

5. Proposed Rule Section 422.2460, 422.2490, and 423.2460: Greater Transparency in Medical Loss Ratio Reporting

CMS proposes to reinstate the detailed medical loss ratio (MLR) reporting of the underlying data used to calculate and verify the MLR, along with additional details regarding health plan expenditures.

The MLR, while well intentioned, can result in some perverse incentives for insurers. WHA is concerned that health insurers are able to inappropriately claim that their profits are capped, while finding ways to shelter profits – for example, under the allowances for quality improvement. More transparency in medical loss reporting, could help CMS understand and reveal these kinds of practices, and allow them to be more appropriately accounted for.

WHA supports CMS's proposed rule for insurers to report details regarding health plan expenditures and data used to calculate and verify the MLR.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Joanne Alig, WHA's Senior Vice President for Public Policy, at jalig@wha.org.

Sincerely,

Eric Borgerding
President & CEO