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March 7, 2022

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on the *Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a Public Health Emergency* request for information.

Hospitalists are front-line physicians in America's hospitals whose professional focus is the general medical care of hospitalized patients, many of whom are Medicare and Medicaid beneficiaries. Due to their focus on the hospital setting, hospitalists have been the backbone of the nation's COVID-19 response, caring for hospitalized COVID patients throughout the country. As the primary providers of care within the hospital, hospitalists are largely responsible for and involved in patient transfers between the hospital and other hospitals or settings. Prior authorization requirements vary among different Medicare Advantage (MA) plans. Hospitalists and other clinicians expend significant time and effort navigating these differing requirements to ensure patients are able to receive the care they need.

We are pleased to offer our comments on the *Prior Authorization for Hospital Transfers* RFI:

Hospitalists from across the country report that the relaxation of prior authorization requirements facilitated rapid transition of patients from inpatient status at a tertiary care center back to the patient's home region as soon as the higher-level tertiary services were no longer required. The ability to quickly move patients between the sites freed up badly needed tertiary care beds throughout the COVID-19 pandemic. However, as prior authorization requirements were reinstated, this flexibility to move patients as needed and as clinically appropriate diminished. Hospitalists have reported that MA plans are not authorizing lateral transfers from tertiary care centers. As a result, patients are being treated in facilities with inappropriate levels of care, in some cases far from their family and community. This has also left patients boarded in emergency rooms or treated in facilities with limited resources while waiting for scarce tertiary bed space to open.

MA plans can take anywhere from 24 hours to several days to give prior authorization for the transfer. Appealing denials further delays patients from receiving appropriate care. Acute-care hospitals are not rehabilitation facilities and, while some rehabilitation services are available in the acute care hospital, it is not the appropriate site of that care for patients, nor is it the primary purpose of acute inpatient beds. The quality and comprehensiveness of rehabilitation services provided in the acute care hospital are much lower than in a rehabilitation facility that specializes in providing this care. As a result, patients who are stuck waiting for transfer continue to weaken, which negatively impacts patient outcomes and safety. Unnecessary prolonged hospital stays also increase the risk of hospital-acquired infections and other complications and add to delays in patients' rehabilitation process, all of which are negative outcomes for patients. These delays also contribute to increased costs for patients, facilities, and the Medicare Trust Fund.

Additionally, MA plans consider the accepting facility as a new admission, further contributing to care delays. Prior authorization must be obtained each time a patient is transferred from the hospital to a post-acute facility, back to the hospital for a brief observation stay, and again when transferred back to the post-acute facility. Obtaining prior authorization delays patients' return to rehab facilities by several days, particularly when this needs to occur over holidays and weekends. These policies limit the ability to efficiently use limited tertiary care bed space, negatively impact care quality, and have a disproportionate effect on patients in remote and rural areas, where it is more difficult to transfer patients to facilities with appropriate levels of care closer to home.

The lack of consistency and transparency among MA plans further contributes to excessive administrative burden and unnecessary care denials and delays. Many hospitalists report significant difficulty transferring patients with MA plans, as opposed to patients under traditional fee-for-service Medicare, contributing to tiered quality of care between beneficiaries. While many MA plans claim to utilize standard guidelines, such as InterQual, they often impose arbitrary "local rules" driven more by cost containment than evidence-based practice or quality of care for the patient. For example, a hospitalist in Wisconsin reported an MA plan denying rehabilitation coverage for a patient who could not use the toilet on their own. The denial stemmed from the rationale that the patient could wear a diaper during the day. This denial fails to acknowledge the purpose of rehabilitation was to strengthen the patient and meet their goals of living more independently. While this denial was ultimately overturned upon appeal, the denial and subsequent appeals process delayed necessary care and contributed to significant anxiety and emotional distress for the patient.

Skilled nursing coverage and inpatient rehab are also denied frequently for arbitrary reasons, impeding or preventing beneficiaries from accessing medically necessary care. For example, a 24-year-old patient suffering from severe COVID-19 pneumonia spent several months on a ventilator and was denied inpatient rehab, despite being unable to walk. Since patients are responsible for beginning the appeals process, this patient had to appeal this arbitrary and medically unsound denial at a time they should have been focused on their health. Hospitalists or other members of the care team also spend significant time justifying medically necessary care for the appeal, directing time and resources away from direct patient care. An audit conducted by the Office of the Inspector General in 2018 found that 75% of prior authorization requests that were initially denied were

Society of Hospital Medicine

ultimately approved following an appeal.[1] The high rates at which denials are overturned in the appeals process demonstrates the urgent need to reform and regulate prior authorization under MA plans. Inconsistency and seemingly arbitrary decision-making among the various MA plans frustrates and confuses both patients and providers, which in turn negatively impacts the patient-physician relationship.

To reduce confusion and improve efficiency and care quality, CMS should explore and work to standardize policies across all payors. Establishing and requiring a standard set of guidelines would make it easier for hospitals and patients to understand prior authorization requirements, review approval and declination decisions, and submit appeals if needed. We believe public reporting would also help address these concerns with prior authorization. Consumers should have access to MA plan denial and overturn rates and average wait time for prior authorization requests, as this data would increase transparency and facilitate informed decision-making as beneficiaries choose an MA plan. Additionally, MA plans must clearly indicate to beneficiaries the number of in-network post-acute care facilities within a 100-mile radius. Finally, MA plans must be required to respond to prior authorization requests in a timely fashion, including requests submitted on weekends and holidays, seeing as illness does not take the weekend off.

All Medicare beneficiaries deserve access to timely, high quality medical care, regardless of whether they choose original Medicare or a Medicare Advantage plan. The lack of consistency and regulation surrounding MA plans harms patient care quality, contributes to unnecessary delays and barriers to care, and serves as a major source of frustration for patients and providers alike. Prior authorization processes must be streamlined and standardized to ensure all Medicare beneficiaries receive comparable care they need and deserve in a timely manner.

SHM appreciates the opportunity to provide comments on the *Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a Public Health Emergency* RFI and looks forward to continuing to work with the agency on these policies. If you have any questions or require more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org.

Sincerely,

Jerome Siy, MD, MHA, SFHM
President, Society of Hospital Medicine

[1] Levinson R., Daniel. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concern About Service and Payment Denials. *U.S. Department of Health and Human Services, Office of Inspector General.* Sept. 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf