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August 30, 2022

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS–4203–NC
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 *Medicare Program; Request for Information on Medicare* which seeks input from the public regarding various aspects of the Medicare Advantage (MA) program. As increasing numbers of beneficiaries are enrolled in MA plans, instead of traditional fee-for-service Medicare, it is increasingly important that we ensure the prior authorization process is streamlined and consistent across different MA plans and does not delay or deny necessary medical care.

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 beneficiaries enrolled in MA plans. Due to their focus on the hospital setting, hospitalists are largely responsible for and involved in patient transfers between the hospital and other hospitals or settings. As such, hospitalists frequently encounter issues with prior authorization requirements among MA plans and expend significant time and effort navigating these differing requirements to ensure patients receive the care they need.

We are pleased to offer our comments on the Medicare Program RFI:

Impact of Utilization Management: Prior Authorization
In the inpatient setting, MA plans use utilization management programs or prior authorization to approve post-acute care services before a patient's discharge from an acute care facility. The rationale behind prior authorization is to ensure a patient is deemed medically stable enough to receive care at a lower level. In reality, however, the prior authorization process results in increased and unnecessary time spent in the acute care setting. Patients in need of post-acute care, including Skilled Nursing Facility (SNF), Acute Inpatient Rehab, or Long-term Acute Care often wait three or more days for prior authorization under MA plans.

To further complicate matters, MA plans often utilize third-party reviewers to process prior authorization requests. Many hospitalists report these third-party reviewers contribute to prior authorization problems in the acute care setting. For example, a hospitalist administrator in Missouri noted one such contractor, utilized by two large MA payors, frequently denies or impedes physician requests for post-acute services. However, in her experience, the denials are usually overturned by the payor following an appeal. The time from request to denial and then subsequent appeal(s) constitutes significant additional work and further contributes to unnecessarily prolonged stays in the hospital, physician frustration, and increased patient distress.

Most importantly, the current state of prior authorization in MA plans is preventing patients from receiving appropriate care in a timely manner. Acute care hospitals are not rehabilitation facilities. While some rehabilitation services are available in the hospital, it is neither the appropriate site for that care, nor is it the purpose of limited acute inpatient beds. The quality and comprehensiveness of rehabilitation services provided in the acute care hospital are not interchangeable with a rehabilitation facility that specializes in providing this care. As a result, patients who are stuck waiting for transfer pending an initial prior authorization or for an appeal to be addressed can continue to weaken and are at heightened risk for hospital-acquired infections and other complications. This negatively impacts outcomes and can be detrimental to the rehabilitation process. More broadly, many hospitals are at or near capacity nearly all the time, so these delays take up valuable beds and negatively impact the quality and timeliness of acute care services for all patients (including both Medicare FFS and MA patients).

For example, a hospitalist reported a case example of an 80-year-old man whose lengthy stay in the hospital demonstrates systemic failings within the prior authorization process. He had been admitted to the hospital for a three-day hospital stay for concurrent COVID-19 and pneumonia infections. He was then readmitted to the hospital after sustaining a fall two days after discharge, where it was determined he was too weak to remain at home and subsequently began inpatient physical therapy treatment. Hospital staff determined the patient needed acute inpatient rehabilitation, but this care was denied by the MA payer. Following this denial, the care management team began searching for SNF placement, which was also denied. The hospital's utilization review team then attempted to contact the payor and did not receive a response for four days. Once contact was made, the payor then "expedited" the case, which was under review by one of their utilization review contractors. While the SNF placement denial was ultimately overturned, this patient was in the hospital 8 to 9 days longer than necessary. If the patient's initial rehabilitation had been approved, he would have received the recommended intensive physical therapy when it was needed and there was a distinct possibility of recovery and returning home instead of requiring placement in a SNF. It is also important to note that every day stuck in bed induces muscle atrophy, such that this man would be expected to lose 3-5% muscle mass EACH DAY. After 8-9 days of inactivity, the patient who could have been receiving therapy to become stronger will now begin therapies 30+ percent weaker. This is not the high-value, quality care our patients deserve.

As an additional 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 purpose of the requested

rehabilitation was to strengthen the patient and meet their goals of living more independently. However, the denial stemmed from the rationale that the patient could wear a diaper during the day. This denial failed to acknowledge the dignity of the patient and essentially abandoned their healthcare needs. 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.

We understand current policies exist to ensure patient safety and protect against fraud. However, the prior authorization process has lost sight of the patient and has led to the unintended consequences of delaying or denying medically necessary care. The above case examples are demonstrative of larger, systemic problems within the MA prior authorization process. Additionally, an audit conducted by the Office of the Inspector General in 2018 found that 75% of prior authorization requests that were initially denied were ultimately approved following an appeal.[1] The high rates at which denials are overturned in the appeals process and the inconsistency of decision making among the various MA plans demonstrates the urgent need to reform and regulate prior authorization under MA plans.

Recommendations to Reduce Delays

To reduce prolonged hospitalization caused by excessive delays or denials, we recommend CMS develop a policy that does not require prior authorization for patients who are returning to previous levels of care (i.e. transfer from SNF to acute-inpatient and back to SNF). If a patient requires skilled therapy or needs to be assessed for continuation of therapy, the patient should be assessed at the skilled nursing facility. This assessment and care should be provided by the attending physician at the facility.

We also recommend that CMS create a standardized processes across all MA payors to reduce administrative burden and billing complexity. CMS should provide clear guidance and oversight over Prior Authorization. This would include setting requirements on the time frame in which the payor must respond to a prior authorization request, inquiry, or appeal and establishing clear guardrails on when prior authorization should and should not be used. Weekend availability of MA staff and decision-making should be mandated as patient illness and subsequent need does not pause over the weekend.

Finally, many hospitalists report significant difficulty admitting and transferring patients with MA plans, as opposed to patients under traditional fee-for-service Medicare, which contributes to a tiered quality of care between beneficiaries. For example, the Medicare Two Midnight rule states there will be a "presumption" that hospital admissions that cross the two-midnight threshold are appropriate for inpatient status except for evidence of systemic gaming. CMS has also published guidance for Medicare Advantage Organizations (MAOs) that any utilization management tools used to determine inpatient versus observation cannot be more stringent than those used by CMS. However, MAOs routinely deny

[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

inpatient status for patients with extended hospital stays. And while many MA plans claim to utilize standard guidelines, such as InterQual and Milliman, they often impose arbitrary "local rules" that appear more driven by cost containment than evidence-based medical practice or patient centered quality of care. These discrepancies make it clear CMS must expand its level of enforcement with these plans and, at a minimum, ensure they are meeting Fee-for-Service (FFS) expectations.

We ask CMS to publish more specific guidance to MAOs around this issue, emphasizing that outside of systemic gaming or facility delays, admissions that cross two midnights are appropriate for inpatient status and make available direct communication capability to enable provider-to-provider communication when required. To assist with enforcement, MAOs could be required to publish denial rates of admissions greater than two days, with organizations that have the highest rates subject to meaningful audits and penalties.

Recommendations for Data Collection and Public Reporting

We recommend CMS publish MAO-specific medical necessity denial rates with direct comparisons to FFS Medicare and other MAOs. This data could be presented similarly to the Program for Evaluating Payment Patterns Electronic Reports (PEPPER). Each MAO should be given a percentile compared to their peers; MAOs with outlier status should have external audits. Penalties for outliers could also be considered. Furthermore, we believe both Medicare beneficiaries and medical providers will benefit from access to public reporting of denial rates, denial overturn rates, and the average wait time for prior authorization approval. This information will ensure beneficiaries are informed of the differences between MA plans and will help incentivize timely processing of prior authorization claims. All MA plans should also be required to report the number of in-network post-acute care facilities located within a 100-mile radius. Increased transparency will ensure beneficiaries are able to make informed decisions about selecting their plans.

Additional Comments and Conclusion

Throughout the COVID-19 pandemic, hospitalists have reported 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 care services were no longer required. For example, on August 20, 2021, in response to the Delta variant surge, CMS issued a Health Plan Management System memo to all MAOs and Medicare-Medicaid Plans. This memo strongly encouraged them to waive or relax plan prior authorization requirements and utilization management processes to facilitate the movement of patients from general acute-care hospitals to post-acute care and other clinically appropriate settings, including skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, and home health agencies.

The ability to quickly move patients between sites freed up badly needed tertiary care beds throughout the pandemic. However, as prior authorization requirements were reinstated, this flexibility to move patients as needed and clinically appropriate diminished. Hospitalists have reported that MA plans are not currently authorizing lateral transfers from tertiary care centers. As a result, patients are being

treated in facilities with inappropriate levels of care, and in some cases far from their family and community support systems. This has also left patients boarded in emergency departments or receiving treatment in facilities with limited resources while waiting for scarce tertiary bed space to open. Relaxed prior authorization requirements throughout the pandemic have demonstrated patients can be safely transferred between sites without a lengthy prior authorization process, and it allows clinicians to provide higher quality, more efficient patient care – all to the benefit of the patient.

For many patients in the MA population, a matter of days can impact recovery and continued quality of life versus worsening health status and a bad outcome. These delays also contribute to increased costs for patients, facilities, and ultimately, the Medicare Trust Fund. We must standardize and improve prior authorization policies under MA to protect beneficiaries' right to high quality, efficient, and timely care.

SHM appreciates the opportunity to provide comments on the Medicare Program 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.

Thank you for raising awareness on such an important issue.

Sincerely,

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine