

August 30, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-4203-NC  
PO Box 8013  
Baltimore, MD 21244-8013  
Submitted electronically via <https://www.regulations.gov>

**Re: Medicare Program; Request for Information on Medicare**

Dear Administrator Brooks-LaSure:

On behalf of our 475 member hospitals and health systems, Texas Hospital Association (THA) thanks you for the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) request for information regarding the Medicare Advantage (MA) program. With increasing penetration of MA plans into Texas hospital markets, our members are eager to offer suggestions based on direct experience with MA plans. We look forward to collaborating with CMS to ensure the program upholds Medicare's strategic aims for "equitable, high quality, and whole-person care that is affordable and sustainable."

**We offer the following recommendations responsive to questions in the RFI.** Each recommendation includes a tag in brackets with the RFI question(s) the response addresses.

1. CMS should pursue regulatory changes, enhance oversight, and publicize data on MA plans that have a history of inappropriate utilization management techniques. *[CMS questions B.10, B.11, A.2]*
  2. CMS should remedy reimbursement gaps in MA, including those that erode benefits of Critical Access Hospital status. *[CMS questions D.3, B.11]*
  3. CMS should raise network adequacy standards to prevent gaps in access to care. *[CMS question B.6]*
  4. CMS should increase telehealth rates MA plans pay for hospital-based rural health clinics. *[CMS questions B.5, D.1]*
- 1. CMS should pursue regulatory changes, enhance oversight, and publicize data on MA plans that have a history of inappropriate utilization management techniques. *[CMS questions B.10, B.11, A.2]***

**Background**

In April 2022, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a report documenting "widespread and persistent problems related to inappropriate denials of services and payment" across MA plans.<sup>1</sup> The OIG report closely resembles THA members' experiences, confirming

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<sup>1</sup> U.S. Department of Health and Human Services Office of Inspector General. (2022 April). Some Medicare Advantage Organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. Available at: <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>

inappropriate prior authorization denials are occurring both *before* care is delivered, interrupting medically necessary care for MA beneficiaries, and *after* care is delivered, denying payment and encumbering patients with unexpected financial obligations.

Our members describe MA plans as inflexible and difficult. Requests for diagnostic services and advanced imaging (e.g. MRIs and CTs) in medically appropriate situations are routinely denied because a more conservative treatment was not first tried. MA plans often do not authorize medically justified admissions to acute and/or swing bed services, or retrospectively deny authorization *after* pre-authorization was secured and care was already provided. Furthermore, patients are treated in hospital emergency departments around the clock, but MA authorizations typically cannot be obtained in the evenings or on weekends. An MA patient needing admission on a weekend must be admitted before pre-authorization can be requested on Monday morning, with no assurance the MA plan will authorize or pay on the admission. When plans deny an initial authorization request hospitals must often restart a new authorization request, further delaying care while the hospital determines what services an MA plan is willing to approve.

Some MA plans may also be motivated to keep patients in hospitals for longer than necessary because the plan is reimbursing acute care at a flat rate. Plans delay or attempt to avoid discharging the patient to the next site of care, which would require separate reimbursement. The hospital is obligated to care for the patient in an acute setting until a transfer is approved, even if the inpatient payment amount is exhausted. The result is that too many patients are being denied timely access to medically necessary skilled nursing, rehabilitation, or other care due to the practice of withholding post-acute transfer to boost plan profits. Hospital acute care beds stay occupied with sub-acute patients awaiting transfer and are unavailable for other patients with acute care needs. These extended stays in acute care inpatient facilities also increase patients' risk for exposure to infectious diseases.

While a portion of inappropriate denials are reversed after appeal, many Texas hospitals cannot keep up with the administrative burden of chasing prior authorizations and recovering payments that should not have been denied in the first place. Some Texas rural hospitals report employing staff whose sole job is to pursue authorizations and payments from MA plans for care that is routinely authorized under traditional Medicare. Rural hospitals in delicate financial positions would be much better off redirecting financial resources spent to resolve avoidable MA pre-authorizations and denials in service of other activities that further their patient care missions.

We provide below two examples from Texas hospitals demonstrating how misuse of utilization management practices directly jeopardizes lifesaving care. Each example corresponds to a major finding of the April 2022 OIG report.<sup>1</sup>

**Example 1.** A hospital in rural Texas shared a story of a patient over age 90 on blood thinners, who presented after falling and hitting their head. The MA plan denied authorization for a CT scan to check for a suspected brain bleed, stating it was not medically necessary. The hospital performed the CT scan anyway, confirming a brain bleed requiring transfer to a higher level of care. That night, the patient was flown to another facility and received treatment that saved their life. If the local hospital had abided by the CT scan denial from the MA plan, this patient would not have survived. This story is consistent with findings from the OIG report that advanced imaging services were the most common source of inappropriate MA denials:

*“Medicare does not have a blanket requirement that beneficiaries receive specific tests or treatments prior to receiving an MRI or CT scan. However, in several cases MAOs denied requests for advanced diagnostic imaging that our physician panel determined were medically necessary, and that health care coding experts determined met Medicare coverage rules, because the beneficiary had not first received a more basic imaging service or more conservative treatment.”*

**Example 2.** A different Texas rural hospital performed a partial lower limb amputation on an MA beneficiary with Type 2 diabetes. The hospital requested authorization for transfer to a long-term acute care (LTAC) facility. After five days the MA plan denied the request, approving a transfer to a skilled nursing facility (SNF) which did not offer the higher-level wound care and physician supervision available at the LTAC. Without approval for LTAC transfer, the patient refused SNF placement and wanted to go home with home-health skilled nursing and negative pressure wound therapy. Twice in two months, the patient was readmitted to the hospital with infection and necrosis at the wound site. After the second readmission, which required surgical wound revision, referral to an inpatient rehab facility (IRF) was requested. Again, after six days, the MA plan denied a request for IRF and approved SNF placement. The plan did not reverse its decision after peer-to-peer consultation. This patient’s multiple postoperative complications could have been avoided if the MA plan had initially authorized transfer to an appropriate level of care. This story aligns with findings from similar cases reviewed in the OIG report:

*“MAOs often claimed that the patients did not need intensive therapy or skilled care, and that their needs could be met at a lower level of care ... However, our physician panel determined in these cases that the patients met the clinical criteria for admission to the relevant facilities, that they would have benefitted from the higher level of care ordered by the requesting physician, and that the alternatives offered by the MAOs were not clinically sufficient to meet the patient’s needs.”*

## **Recommendations**

We recommend CMS consider the following actions under its statutory or administrative authority to address prior authorization concerns raised by OIG and experienced by Texas hospitals:

- A. Require plans to clearly describe and publish how their medical utilization management practices deviate from traditional Medicare guidelines. CMS should design a standard form to collect this information, require plans to furnish it to providers, and ensure it is kept current within six months.
- B. Draft standards to ensure pre-authorizations are timely, flexible in emergencies and potentially life-threatening circumstances, and available overnight and on weekends. Require or incentivize plans to implement electronic preauthorization with “real-time” decisions for routinely requested care. For non-routine requests, CMS could consider the following automatic authorization triggers to ensure timely determinations:
  - If a plan cannot provide a decision on an inpatient authorization within 24 hours, the inpatient stay should be automatically approved.
  - Post-acute authorizations should be approved within 48 hours, with no penalty to hospital or post-acute providers if transfer occurs after the 48-hour period.
  - Observation should not require pre-authorization.

- C. Collect and publish data to show denial rates of prior authorization requests and payment for common procedures under each MA plan as compared to traditional Medicare. Make this information available to providers and consumers shopping for MA plans.
- D. Standardize the complaint process for hospitals and other providers with grievances regarding the pre-authorization practices of MA plans. CMS should have transparency into all complaints, actively monitor complaints industry-wide, and formalize a role for the agency to intervene in complaints that are repeated, severe, or taking excessive time to resolve.
- E. Develop and enforce a tiered penalty structure for MA plans who consistently fail to authorize medically necessary care for beneficiaries. First-line actions may include written notices and corrective action plans, escalating through financial and administrative penalties up to and including termination of a MA organizational contract.

These steps ought to be least burdensome on MA plans already delivering medically appropriate care management consistent with Medicare guidelines, while introducing accountability for MA plans with inappropriate patterns of denials and delays that lead to poor patient outcomes. If implemented and enforced, these actions will keep hospital administrative costs reasonable and allow more resources to flow toward patient care. We also note the similarities between the above recommendations and certain proposals in the Improving Seniors’ Timely Access to Care bill,<sup>2</sup> which THA has endorsed and will continue to support.

In recommendation (C) we ask CMS to add to its consumer-facing, preenrollment shopping tools data on rates of service denials under MA plans compared to traditional Medicare. We note the equity considerations inherent in such an effort. Information should be conspicuous on all CMS online comparison tools, written in plain language, and accessible to consumers with primary languages other than English. If a consumer is not informed about services their plan will not pay for, or if the consumer faces barriers to understanding the information provided, they are more likely to experience interruptions in their care and incur unexpected liabilities for uncovered services. CMS should take steps to incorporate needs of consumers with lower health literacy as it acts on this recommendation.

**2. CMS should remedy reimbursement gaps in MA, including those that erode benefits of Critical Access Hospital status. [CMS questions D.3, B.11]**

**Background**

Texas hospitals often experience difficulties obtaining reimbursement for care delivered to MA beneficiaries, even once that care is authorized and approved. These difficulties are not characteristic of traditional Medicare services given in similar circumstances.

**Payment disruptions.** MA plans generally reimburse in-network hospitals at a rate indexed to their current Medicare rates. In practice, however, Texas hospitals report this does not always occur even after hospitals submit a copy of their current Medicare rate letter to the MA plans. Claims and payments are delayed, reversed, or recouped with little to no explanation from the plans. Adjustments and corrections – if they do occur – require lengthy correspondence, formal grievances, or other remedies. One small THA member hospital estimates one MA plan in their market is thousands of dollars in arrears on reimbursements this year, even after extensive correspondence and exhausting formal

<sup>2</sup> H.R.3173 — 117th Congress (2021-2022). Improving Seniors’ Timely Access to Care Act of 2021. Available at <https://www.congress.gov/bill/117th-congress/house-bill/3173/text>

processes for appeal. For a small hospital, thousands of dollars in unpaid claims can threaten their ability to remain operational.

***Contracting difficulties.*** With 47% of Medicare beneficiaries in Texas now enrolled in MA plans, including 50-80% in major population centers like Houston, Fort Worth, and El Paso,<sup>3</sup> providers who might otherwise decline to contract with MA plans face an increasingly risky choice: go out-of-network with MA plans in their area and disrupt patient care for a large share of older adults in their community, or go in-network and absorb underpayments and administrative burden that would not occur under traditional Medicare. Small hospitals face additional difficulties contracting with MA plans when they lack the leverage to negotiate fair contracts and rates because of their size. MA plan administrators negotiate contracts as a core function of their business, and by way of contracting with many providers, have access to information, personnel, and resources that small stand-alone facilities do not.

***Erosion of Critical Access Hospital benefits.*** Critical Access Hospital (CAH) status provides cost-based reimbursement in traditional Medicare. Cost-based reimbursement is essential to rural hospital viability because CAHs tend to care for a costlier patient population on average: older patients with multiple comorbidities and reduced access to primary care. CAHs are reimbursed on a per-diem rate for inpatient and swing-bed services and on a cost-to-charge ratio basis for outpatient services. At cost report filing, Medicare pays the difference between the hospital's true cost and what Medicare paid throughout the year, resulting in a "make-whole" payment to the hospital if costs exceed payments.

The benefits of CAH designation have gradually deteriorated for Texas' 86 critical access hospitals because MA plans, unlike traditional Medicare, do not have a process for reconciling payments to the hospital's Medicare cost report. With a doubling of nationwide MA enrollment in the past decade and no accompanying change in CMS's cost reporting or CAH reimbursement process, the shortfall in Medicare payments to CAHs has been significant. We believe Medicare has an interest in patching this "leak" in the CAH model, which predates MA and did not contemplate MA in its original design. Protecting the CAH designation promotes long-term survival of Texas rural hospitals, who run on thinner operating margins and serve geographically isolated communities.

## **Recommendations**

We recommend CMS consider the following actions under its statutory or administrative authority to address reimbursement challenges in MA affecting Texas hospitals:

- A. Draft clear regulatory standards that MA plans are expected to reimburse hospitals at least current Medicare rates for approved services. Clarify criteria on which plans may innovate and compete (patient experience, quality, outcomes, network composition) and on which they may not (100% coverage and reimbursement at current rates for all Medicare Part A and B services).
- B. Require MA plans to pay all components of Medicare's payment formula that are designed to help hospitals preserve access to care, including graduate medical education, indirect medical education, disproportionate share hospital, uncompensated care, etc.
- C. Study options to expand cost report filing, auditing, and settlement to include data for all MA plans including inpatient, outpatient, swing bed, and rural health clinic (RHC) visits. Establish a process to settle costs with hospitals to address payment shortfalls created by MA.

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<sup>3</sup> The Commonwealth Fund. (2022). Medicare data hub: Medicare Advantage. Available at: <https://www.commonwealthfund.org/medicare-data-hub/medicare-advantage>

- D. Protect cost-based reimbursement for CAHs, or allow CAHs to count MA patient days as traditional Medicare days for the purposes of the Medicare cost report. CAHs should be made whole on Medicare Part A (traditional) and Part C (MA) together.
- E. Standardize the complaint process for hospitals and other providers experiencing payment delays or denials from MA plans. CMS should have transparency into all complaints, actively monitor complaints industry-wide, and formalize a role for the agency to intervene in complaints that are repeated, severe, or are taking excessive time to resolve.
- F. Use claims and cost report data to determine which payers are underpaying providers on medically necessary care. Develop and enforce a tiered penalty structure for MA plans who consistently fail to pay timely and correctly. First-line actions may include written notices and corrective action plans, escalating through financial and administrative penalties up to and including termination of an MA organizational contract.

**3. CMS should raise network adequacy standards to prevent gaps in access to care. [CMS question B.6]**

**Background**

MA plans must meet network adequacy requirements as defined under 42 C.F.R. § 422.116. CMS defines network adequacy standards for MA plans and undertakes network adequacy reviews periodically. Presently, MA plans may request an exception to network adequacy criteria when the health care market landscape does not allow an organization to meet CMS’ network adequacy standards.<sup>4</sup> To obtain an exception, an MA plan must provide conclusive evidence of insufficient supply. CMS’s network adequacy guidance states, in a footnote, “CMS will generally not accept an organization’s unwillingness to contract with an otherwise qualified provider/facility due to the organization’s own internal standards.”

Based on our hospitals’ experiences with MA plans, we believe stronger and clearer prohibitive language may be warranted. As discussed earlier, many small hospitals experience information asymmetry and difficulty negotiating fair and reasonable contracts with MA plans. Exceptions obtained to network adequacy can remove an MA plan’s incentive to negotiate in good faith with certain providers.

**Recommendation**

We recommend CMS add a specific provision to its network adequacy guidance or regulation that prevents MA plans from using their inability to negotiate reasonable rate agreements with providers as a justifiable reason for network inadequacy gaps.

**4. CMS should increase telehealth rates MA plans pay for hospital-based rural health clinics. [CMS questions B.5, D.1]**

**Background**

During the COVID-19 pandemic, Medicare has paid a flat “telehealth” rate for services provided in physician offices and RHCs, including hospital-based RHCs. Most RHCs are paid on a cost-based per-visit rate. The fixed telehealth rate that Medicare & MA plans pay is significantly lower than an RHC’s cost-based per-visit rate.

<sup>4</sup> Centers for Medicare and Medicaid Services. (2022 June). Medicare advantage and section 1876 cost plan network adequacy guidance. <https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance06132022.pdf>

**Recommendation**

To correct the disparity between in-person visits and telehealth visits performed at a rural health clinic, we recommend CMS set the telehealth payment equal to each rural health clinic’s cost-based per-visit rate for at least the remainder of the public health emergency and retroactively to the date of implementation.

Thank you for consideration of our comments. If you have any questions, contact me ([astelter@tha.org](mailto:astelter@tha.org)) and Heather De La Garza, Assistant General Counsel ([hdelagarza@tha.org](mailto:hdelagarza@tha.org)).

Respectfully submitted,



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