August 31, 2022

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

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

RE: Medicare Program; Request for Information on Medicare [CMS–4203–NC]

Dear Administrator Brooks-LaSure:

The College of Healthcare Information Management Executives (CHIME) respectfully submits our comments to the Centers for Medicare and Medicaid Services (CMS) in response to the "Request for Information on Medicare" as published in the Federal Register on August 1, 2022 (Vol. 87, No. 146).

Background

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With over 5,000 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate for the effective use of information management to improve the health and healthcare in the communities they serve.

In our comments, CHIME provides responses to address the specific questions included in the Request for Information (RFI). Additionally, we offer feedback and recommendations to constructively improve Medicare Advantage (MA). Our comments reflect the views of our association, as well as input received from our provider members from across the country.

Key Recommendations

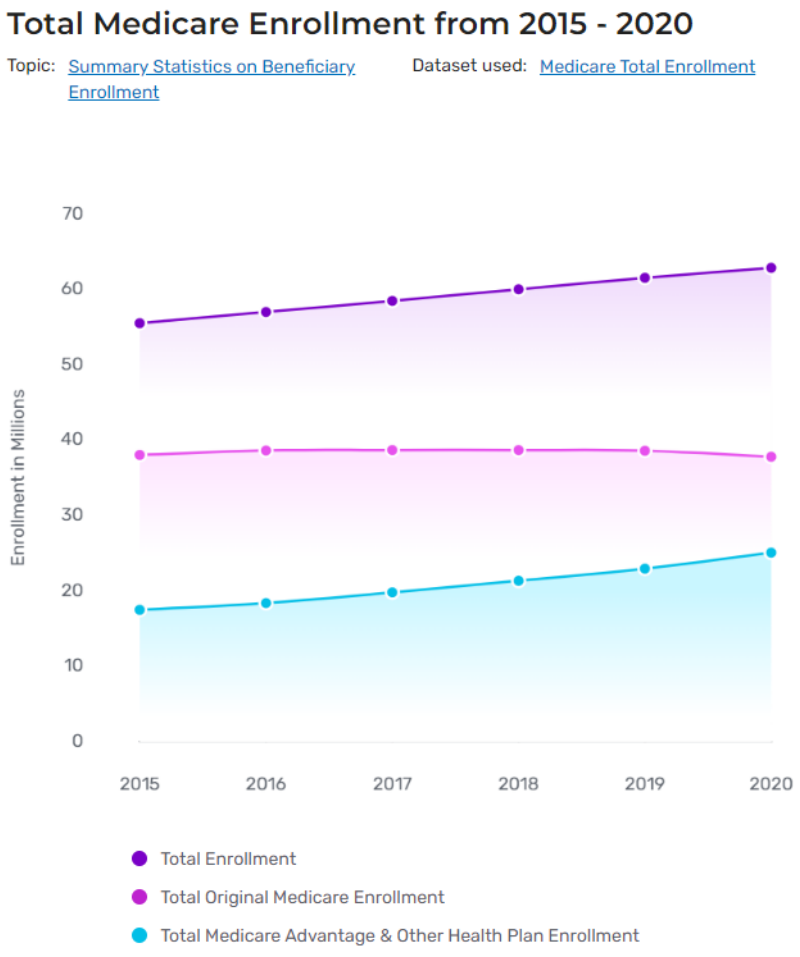
CHIME appreciates CMS' ongoing focus to put patients at the center of their care and issuing this critical Request for Information (RFI) on ways to strengthen Medicare Advantage (MA) in ways that align with the Vision for Medicare and the CMS Strategic Pillars. By creating this additional opportunity for stakeholders to engage – especially those that prioritize partners and communities served and impacted throughout the policy development and implementation process, we believe invaluable input will be garnered. We thank CMS for encouraging input from a wide variety of voices – including providers – on the questions listed in this RFI.

Our feedback can be distilled into one key topic – standardization. As detailed further below, the rapid growth of MA has left a lack of standardization and regulations between MA and those that currently govern the Medicare fee for service (FFS) program and its participants. While there are federal statutes and regulations governing MA and Medicare Advantage Organizations (MAOs), a fragment of them are applicable to the inherent association between MA and the healthcare providers caring for the beneficiaries of MA plans. **The standardization and additional oversight of MA would improve care for beneficiaries and better enable providers to coordinate care for their patients.**

Detailed Recommendations

CHIME supports CMS's Vision for Medicare – which puts the patient at the center of care, and is driving towards a future where Medicare beneficiaries receive more equitable, higher quality, and whole-person care that is affordable and sustainable. Subsequently, we appreciate this opportunity to provide feedback on ways to strengthen and improve the MA program, especially for patients and providers, as it continues to grow rapidly. CMS is seeking feedback on a wide variety of policies and included a list of numbered questions in the RFI. CHIME believes that there is significant overlap in our below recommendations and responses to questions under Sections – A. Advance Health Equity; B. Expand Access: Coverage and Care; C. Drive Innovation To Promote Person-Centered Care; D. Support Affordability and Sustainability; and E. Engage Partners.

Data.CMS.gov – Medicare Advantage & Other Health Plan Enrollment[1]



According to CMS, as of October 2021, 26.9 million beneficiaries out of 63.9 million Medicare beneficiaries overall are enrolled in MA plans.[2] The proportion of Medicare beneficiaries enrolled in MA plans has steadily increased since the early 2000s, increasing by about 10 percent between in 2020 and 2021, nearly the same

[1] Centers for Medicare & Medicaid Services Data. (n.d.). Data.CMS.Gov. Retrieved August 22, 2022, from https://data.cms.gov/browse-data-categories.
[2] Centers for Medicare & Medicaid Services. (2021, December 21). CMS Releases Latest Enrollment Figures for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) | CMS [Press release]. https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip.

growth rate as the year prior.[3] With more than four in 10 (42 percent) of Medicare patients currently enrolled in MA plans, **CHIME believes that it is incumbent upon CMS to assess how Medicare Advantage is impacting the healthcare industry, patients, and the Medicare program overall.** Importantly, how and if MA is lowering costs for patients, improving patient outcomes, increasing the quality of care, and improving access to providers – to name just a few of the critical factors CMS should consider and evaluate.
The Congressional Budget Office (CBO) projects that the share of all Medicare patients enrolled in Medicare Advantage plans will rise to about 51 percent by 2030.[4] As Medicare Advantage takes on an even larger presence in the Medicare program, and as the Medicare Hospital Insurance Trust Fund is projected to become exhausted in 2024, two years sooner than CBO previously estimated,[5] CMS is obligated to thoroughly evaluate the MA program's fiscal impact on the Medicare program.

In 2022, a record 3,834 Medicare Advantage plans were available across the country as alternatives to traditional Medicare – an increase of 8 percent from 2021, and the largest number of plans available in more than a decade.[6] Additionally, each MA plan can charge different out-of-pocket costs, has different rules for how patients can obtain services, including whether they need a referral to see a specialist, and if they have to go to doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care. These rules can and usually do change each year.[7] Given the totality of MA plans and wide variations in rules and how often they can change, this often leads to patient confusion and provider burden. Patients are often unsure of what services their MA plan covers and how to obtain coverage, and providers are constantly having to navigate the changing rules to ensure that their patients can obtain timely coverage for services. This can lead to delays in care and longer, unnecessary stays in a higher level of acuity care setting than clinically necessary – which leads to increased costs to the Medicare program and directly to patients.

CHIME believes that increasing standardization across the thousands of MA plans and MAOs – including, but not limited to, standardized submission processes, response times from MA and MAOs to providers regarding delays/denials of services, payment time frames, and time requirements to respond to appeals. Standardization across the policies regarding how MA plans are paid and administered would offer a significant reduction in burden on clinicians across the care continuum, decreasing the current urgent "clinician burnout" that our country is facing. Importantly, reducing the substantial time providers must spend navigating individual MA plans and their evolving rules would "unlock" countless hours of time that could be used to improve patient care and innovate new workflow and care processes.

CMS has taken a laudable approach in acknowledging that "advancing health equity is two-fold: improve operations and implement policies that address inequities" in their Vision for Medicare. CHIME is particularly appreciative of efforts to promote accessibility to healthcare services including technology and devices, and expand data collection, reporting, and analysis to identify disparities and track any improvements. CHIME also appreciates that CMS is focusing on enhanced payment policies in order to improve access to services for individuals who are at risk of multiple chronic conditions and adverse outcomes, those who experience social risk factors that impact their health outside of the four walls of their provider's office, and those who

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[3] Freed, M., Biniek, J. F., Neuman, T., & Damico, A. (2021, June 24). *Medicare Advantage in 2021: Enrollment Update and Key Trends*. KFF. Retrieved August 22, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

[4] Freed, M., Biniek, J. F., Neuman, T., & Damico, A. (2021, June 24). *Medicare Advantage in 2021: Enrollment Update and Key Trends*. KFF. Retrieved August 22, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

[5] *The Outlook for Major Federal Trust Funds: 2020 to 2030*. (2020, September 2). Congressional Budget Office. Retrieved August 22, 2022, from https://www.cbo.gov/publication/56541#_idTextAnchor024.

[6] *A Record 3,834 Medicare Advantage Plans Will be Available in 2022, Up 8 Percent From 2021, While the Number of Medicare Part D Stand-Alone Plans is Decreasing Mainly Due to Firm Consolidations*. (2021, November 2). KFF. Retrieved August 22, 2022, from https://www.kff.org/medicare/press-release/a-record-3834-medicare-advantage-plans-will-be-available-in-2022-up-8-percent-from-2021-while-the-number-of-medicare-part-d-stand-alone-plans-is-decreasing-mainly-due-to-firm-consolidations/.

[7] *How do Medicare Advantage Plans work? | Medicare*. (n.d.). How Do Medicare Advantage Plans Work? Retrieved August 22, 2022, from https://www.medicare.gov/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work.

may experience other barriers to accessing the care they need.[8] However, the importance of standardization and transparency in MA cannot be understated. Although MA data are not as widely available as Medicare FFS data, published research *suggests* that MA plans and the FFS program generally pay very similar prices for hospitals' and physicians' services[9] [emphasis added].

There are some peer-reviewed studies and reports available that specifically focus on comparing differences (e.g., outcomes and readmissions) for enrollees in MA versus the standard Medicare FFS program. One such report found that "FFS Medicare patients have substantially higher probabilities of entering higher-quality SNFs (those rated four or five stars by Nursing Home Compare) and those with lower readmission rates, compared to MA enrollees. The difference between MA and FFS Medicare SNF selections was less for enrollees in higher-quality MA plans than those in lower-quality plans, but Medicare Advantage still guided patients to lower-quality facilities."[10]

Firstly, these findings are in direct conflict with CMS's goals to advance health equity. Furthermore, this is extremely concerning not only to hospitals and higher acuity care settings, but critically – to the post-acute care providers including long-term care hospitals (LTCHs), skilled-nursing facilities (SNFs), and home health (HH) providers. Post-acute care is a critical part of the care continuum; and standardization of MA programs to align with traditional Medicare FFS would alleviate clinical burden. **Specifically, CHIME recommends a standardized "submission" process to be utilized in the MA program for prior authorization, post document review, claims tracking, etc.**

A recent report from the Department of Health and Human Services Office of Inspector General (HHS-OIG)[11] found that MAOs denied prior authorization and payment requests that met Medicare coverage rules by: 1) using MAO clinical criteria that are not contained in Medicare coverage rules; 2) requesting unnecessary documentation; and 3) making manual review errors and system errors. The HHS-OIG report also found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules (i.e., these services likely would have been approved for these patients under Medicare FFS).

The report found that the two common causes of the prior authorization denials were that MAOs "were using clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that [their] physician reviewers determined were medically necessary." Although HHS-OIG's review determined that the requests in these cases did meet Medicare coverage rules, they found that "CMS guidance is not sufficiently detailed to determine whether MAOs may deny authorization based on internal MAO clinical criteria that go beyond Medicare coverage rules." CHIME members urge CMS to issue guidance on the appropriate use of MAO clinical criteria in medical necessity reviews; preferably so that they are in line with Medicare FFS coverage rules as closely as possible.

The Medicare Payment Advisory Commission (MedPAC) "contends that under the right policies, MA plans could serve as vehicles to manage spending and quality of care more effectively than the fragmented FFS system. Although MA plans have the potential to provide good value for the program, the policies that govern how MA plans are paid and administered are deeply flawed and prevent that value from materializing."[12] The Commission further notes that as enrollment in Medicare Advantage continues to grow, MAOs play an

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[8] Seshamani, M., Fowler, E., & Brooks-LaSure, C. (2022, January 11). *Building On The CMS Strategic Vision: Working Together For A Stronger Medicare*. Health Affairs. Retrieved August 22, 2022, from https://www.healthaffairs.org/do/10.1377/forefront.20220110.198444/full/.

[9] *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*. (2022, January 20). Congressional Budget Office. Retrieved August 22, 2022, from https://www.cbo.gov/publication/57778.

[10] Meyers DJ, Mor V, Rahman M. Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees. Health Aff (Millwood). 2018 Jan;37(1):78-85. doi: 10.1377/hlthaff.2017.0714. PMID: 29309215; PMCID: PMC5822393.

[11] US 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* (OIE-09-18-00260). HHS-OIG. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[12] The Medicare Payment Advisory Commission (MedPAC). (2022, June 28). *Testimony: Improving the Medicare Advantage Program (Energy and Commerce)*. MedPAC.Gov. Retrieved August 22, 2022, from https://www.medpac.gov/wp-content/uploads/2022/06/EC-Medicare-Advantage-testimony-FINAL-v2_SEC.pdf.

increasingly critical role in ensuring that Medicare patients have access to medically necessary covered services and that providers are reimbursed appropriately.[13] **CHIME urges CMS to take actionable steps to ensure that patients have access to care without unnecessary and potentially harmful delays due to MAO error, and ensure providers are reimbursed in a timely manner.**

Another concern CHIME has heard from our members regarding MA is that the "submission" process currently does not utilize any standard transport mechanisms such as Fast Healthcare Interoperability Resources (FHIR) or application program interfaces (APIs). This leaves providers forced to utilize and complete "creative" forms, multiple facsimiles (i.e., faxes), and telephone calls to communicate with MA plans – and ultimately requiring vendors to develop these mechanisms, which is costly and time consuming. **CHIME urges CMS to implement standardized transport mechanisms MA must utilize, and an agreed upon standardized process, such as utilizing United States Core Data for Interoperability (USCDI) standards maintained by vendors (certified EHR technology aka CEHRT).**

CMS and the Office of the National Coordinator for Health Information Technology (ONC) currently create established standards and other criteria for structured data that providers must follow and vendors (EHRs) must meet and maintain to qualify for use in programs such as the Medicare Promoting Interoperability (PI) Program. Currently, MA and MAOs do not have to be in compliance with all applicable laws and regulations that other healthcare stakeholders – including hospitals and post-acute care providers – are required to comply with in order to participate in and can be penalized under, such as the quality measurement and interoperability programs. However, MAOs are still eligible to receive Promoting Interoperability (PI) Program payments**. CHIME encourages standardization and alignment across their quality and other programs in Medicare FFS throughout MA.**

Additionally, whenever one of the over 3,000 MA plans chooses to add new requirements or processes – which in many cases, are distinctly different from Medicare FFS requirements – providers must request and pay software vendors to create and implement ways to meet these new requirements or processes. Given that MAOs are allowed to and do change their rules annually, this is a costly and often unattainable annual deluge of work that providers and clinicians – and in turn, their patients – must endure. Further, HHS-OIG found that among the payment requests that MAOs denied, 18 percent met Medicare coverage rules and MAO billing rules. The report states that: "Most of these payment denials in their sample were caused by human error during manual claims-processing reviews (e.g., overlooking a document) and system processing errors (e.g., the MAO's system was not programmed or updated correctly)." Additionally, HHS-OIG found that "MAOs reversed some of the denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules" – and that these reversals occurred most often when a beneficiary or provider appealed or disputed the denial. In some cases – the MAOs identified their own errors.

Conclusion

CHIME appreciates CMS' issuance of this important RFI on ways to improve the MA Program. We are especially thankful to CMS for encouraging input from a wide variety of voices – including providers – on the questions listed in the RFI. In addition to the above recommendations focused on standardization, the continuity of care, and provider burden and burnout, we would like to echo the recommendations made in the HHS-OIG report, which CMS agreed with. We agree with HHS-OIG that their findings regarding circumstances under which MAOs have denied requests that met Medicare FFS coverage rules and MAO billing rules provides an ideal opportunity for improvement. This will ensure that MA patients have timely access to essential and necessary healthcare services, and that providers are paid appropriately.

CHIME also agrees with the three final recommendations made by HHS-OIG to: 1) issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews; 2) update its audit protocols to address the issues identified in their report – such as MAO use of clinical criteria and/or examining particular

[13] US 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* (OIE-09-18-00260). HHS-OIG. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

service types; and 3) direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

In closing, we would like to thank CMS for providing the opportunity to comment on this important request for information. Should you have any questions or if we can be of assistance, please contact Chelsea Arnone, Director, Federal Affairs at carnone@chimecentral.org.

Sincerely,

Russell P. Branzell, CHCIO, LCHIME
President and CEO CHIME