HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

May 29, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Brooks-LaSure,

On January 25, CMS published a Request for Information (RFI) focused on improving the use of data within the Medicare Advantage (MA) program.[1] HBMA is pleased to respond to the RFI for which we feel our knowledge and expertise will benefit CMS.

HBMA is a non-profit professional trade association for the healthcare revenue cycle management (RCM) industry in the United States. HBMA members play an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

This RFI is a clear acknowledgment from CMS that improvements are needed to the MA program. More than half of Medicare enrollees receive their coverage through MA and the rate of MA enrollment continues to grow at a rapid pace.[2] These enrollment trends add urgency to the need for CMS to make meaningful improvements to the MA program.

MA plans are among the largest sources of burden for RCM companies. MA is a private version of Medicare. However, the differences between MA and traditional Medicare make them appear as completely different programs. MA plans employ overburdensome and unnecessary administrative tactics such as prior authorizations, denials and inconsistent coverage policies to delay or avoid coverage of medically necessary Medicare services. While similar issues exist with traditional Medicare, they are present in MA at a scale far beyond what we experience with traditional Medicare. CMS must do more to align MA more with traditional Medicare.

The RFI focuses on the use of data collection and transparency to promote improvements in MA. HBMA is pleased to provide our recommendations on how data can achieve a better MA program for Medicare and enrollees.

[1] https://public-inspection.federalregister.gov/2024-01832.pdf
[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/

- **Provider Networks and Network Adequacy**

A health plan's provider network is how its enrollees access the healthcare system. Many MA plans lack transparency surrounding networks for enrollees. Greater transparency surrounding MA plan coverage and larger networks mean greater access to care for enrollees and therefore better care outcomes.

The simplest way to improve network adequacy is to require MA plans to pay providers more competitive reimbursement rates. This will attract more providers to the networks.

To make matters more complicated for both patients and providers, MA plans often change their networks throughout the year. It is common for MA plans to drop providers from their networks without any notice. This can cause avoidable treatment disruptions and reduce access to these services. Preventing this confusion for patients and providers alike requires additional auditing of MA plan networks. Enrollees might not understand that they have a network with MA plans. Changing and narrowing networks can be a barrier to accessing care. Furthermore, MA plans often market themselves as attractive free-to-enroll plans. This is extremely effective at getting senior citizens to enroll. However, it is common for seniors to realize after enrolling that their plan's network is very limited. To address this issue, **CMS should increase the frequency of its MA network adequacy and network accuracy compliance reviews from triennially to annually. CMS should also require MA plans to communicate changes to health plan networks to enrollees in a timely fashion.**

Provider networks are not static throughout the plan year. They are constantly changing due to clinicians switching practices or health plans dropping clinicians from their networks. MA plans do not allow enrollees to follow their doctors to another plan. This can disrupt patient care. **If a clinician with whom the enrollee has an ongoing care relationship leaves their network, the enrollee should have the option to select a new health plan that their clinician participates in so that they can maintain continuity of care from their clinician.**

We also request that CMS collect more data on geographic barriers to network adequacy. This will allow CMS to identify gaps in MA plan coverage to ensure all seniors have access to reliable MA plans.

Lastly, HBMA has long advocated for stronger enforcement of CMS regulations against MA plans. More transparency about enforcement actions against MA plans will give clinicians more assurance about participating in the program. **We urge CMS to improve how it publicizes enforcement actions against health plans.**

- **Prior Authorization**

MA plans are notorious for imposing overburdensome and unnecessary administrative barriers in the RCM process. We believe this is a deliberate tactic to delay or avoid paying claims for medically necessary services. CMS must address these issues before clinicians decide the burdens outweigh the benefits of participating in MA.

Prior authorization is the most notable example of an administrative barrier. The HHS Office of the Inspector General (OIG) has acknowledged MA plans' use of prior authorization poses issues.[3] While HBMA appreciates CMS MA Prior Authorization Final Rule to streamline prior authorizations in MA, there is still work to be done. This rule creates an electronic, real-time process for prior authorizations. It also requires MA plans to be more transparent about documentation requirements for prior authorizations.

However, the regulation does nothing to curtail how MA plans can use prior authorization. We believe more action is needed to limit how MA plans use prior authorization. For comparison, traditional Medicare only requires prior authorization for a very small number of services. It therefore makes no sense that MA plans, which are a private version of Medicare, can use prior authorization at such a large scale.

CMS regularly takes an active role in directing the actions of its contractors. For example, CMS determines what services Medicare Recovery Audit Contractors (RACs) can audit. Why is it that CMS cannot play a similarly active role in determining what services MA plans are subject to prior authorization requirements? **CMS should do more to align MA prior authorization policies with those of traditional Medicare.**

More transparency surrounding the prior authorization process is needed. It should be clear how plans determine why coverage is approved, denied and overturned. While the new final rule will help improve transparency, the rule does not hold health plans accountable for high rates of successfully appealed prior authorization and coverage determinations. **CMS should publish data on every MA plan's rate of appealed prior authorization determinations and establish stronger enforcement of prior authorization violations against MA plans.**

Another approach that should be taken by CMS is simplifying the process for providers who have a high percentage of their prior authorization requests approved. For example, providers who have over 90% of their prior authorization requests approved should not have to receive a prior authorization for every patient. This "gold card"-style program will have MA plans use prior authorization in a more targeted and efficient way.

- **Inconsistent Coverage Policies**

MA plans are required to cover the same benefits as traditional Medicare. However, we are aware of several MA plans that refuse to cover services that are covered by traditional Medicare. The most prevalent example is how many plans refuse to cover claims that use Modifier 25. **CMS should more actively ensure that MA plans cover correctly coded claims that include Modifier 25 since these claims would be covered by traditional Medicare.**

Similar to Modifier 25, in many cases, MA plans do not align with traditional Medicare on Medicare National Correct Coding Initiative (NCCI) edits. As CMS states on the NCCI website, "CMS developed the NCCI program to promote national correct coding of Medicare Part B

[3] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

claims."[4] We would therefore expect that MA plans will adhere to NCCI as well. However, it is the experience of our members that in many cases, MA plans do not adhere to NCCI policies.

For example, MA plans deny claims with modifier 59 at far higher rates than Medicare Administrative Contractors (MACs) do for traditional Medicare claims. "Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances."[5] This creates the need for us to appeal these denials for services that would typically be covered by traditional Medicare. It is another example of MA plans making clinicians fight through administrative hurdles to receive payment for medically necessary Medicare services.

We strongly urge CMS to collect and publish data that compares how MA plans compare to traditional Medicare on NCCI policies such as modifier 59. We hope this data leads to more enforcement of MA coverage policies to ensure they more closely align with traditional Medicare.

Furthermore, we request CMS to collect data on the timely filing requirements for traditional Medicare versus Medicare Advantage. Currently, traditional Medicare adheres to a one-year timely filing limit. In contrast, Medicare Advantage plans often impose much shorter timelines. **HBMA recommends that CMS mandate Medicare Advantage plans to follow the one-year timely filing requirement.**

The Medicare Manual for MA Plans gives too much flexibility to MA plans.[6] We believe there are many opportunities for CMS to update the manual to set more stringent requirements for MA plans to align their policies with traditional Medicare.

MA plans also have extremely burdensome documentation requirements. MA plans often mishandle pre-payment audits in ways that create additional burdens for providers. For example, plans sometimes deny receiving the supporting documentation from the provider even though it was correctly submitted to the plan. Sometimes aided by artificial intelligence, plans deny coverage and require providers to appeal and fight for coverage for medically necessary services. **CMS should collect and publicize data on MA coverage determinations appealed by providers.** This will ensure physicians understand the best ways to advocate for their patients and will publicize MA plans which are the most notorious for denying prior authorization requests.

HBMA reiterates that increasing payment rates to participating providers is the simplest and most effective way to promote high quality care for MA enrollees. Increasing payment rates will encourage more providers to participate in networks which will result in greater care access for enrollees.

Payment rates aside, MA plans engage in other activities that dissuade providers from participating in their networks. For example, MA plans are overly aggressive with their post-payment audits for paid claims. They sometimes look back years in the past and try to recoup

[4] https://www.cms.gov/medicare/coding-billing/ncci-medicare
[5] https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?_adf.ctrl-state=86hvagjfk_4&contentId=00144545
[6] https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019326

payments on trivial technicalities. Responding to these audits is incredibly burdensome on practices.

MA audits can also be overly aggressive in other ways. It is no secret that MA plans inflate enrollee risk scores for higher risk adjustment payments. We are aware of some plans posting reviewers in practices to "audit" charts in ways that increase risk scores by adding diagnosis codes. Further, because risk scores are not public information, providers have no way of knowing the effect of these audits. **CMS must prohibit – or, at the very least, significantly restrict – MA plans from conducting these reviews.**

Meanwhile, MA plans have their own coding compliance issues. It is common knowledge that MA plans inflate enrollee risk scores to earn higher risk adjustment payments from CMS. Program integrity is among the highest priorities for every aspect of the Medicare program. CMS dedicates significant resources to meet its program integrity goals. **CMS must apply increased program integrity scrutiny to MA plans.**

There is a significant opportunity for CMS to increase its audits and enforcement actions for these requirements which will save the Medicare program billions of dollars. It is unacceptable that MA plans can defraud the Medicare program in this way while physicians have faced decades of stagnating payment updates under the Medicare Physician Fee Schedule.

- **Consolidation**

The healthcare sector, including MA plans, is aggressively consolidating. This is leading to higher costs for patients without a positive impact on quality.[7] HBMA appreciates the Congressional attention this issue has received as of late. We encourage CMS to monitor consolidation within MA plans and what implications further consolidation could have on patients and providers. **HBMA recommends that CMS collect data on consolidation with MA plans and how this impacts the network adequacy and quality of care for MA beneficiaries.**

Further, the burdensome coverage policies and low reimbursement rates from MA plans are an incentive for medical practices and healthcare systems to consolidate. Larger systems have more leverage to negotiate with MA plans, which are already much larger entities than any healthcare system in the country.

- **Summary of Recommendations**

In summary, we are providing the following recommendations to CMS in response to this RFI.

  - CMS should increase the frequency of its MA network adequacy and network accuracy compliance reviews from triennially to annually. CMS should also require MA plans to communicate changes to health plan networks to enrollees in a timely fashion.

[7] https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

- If a clinician with whom the enrollee has an ongoing care relationship leaves their network, the enrollee should have the option to select a new health plan that their clinician participates in so that they can maintain continuity of care from their clinician.
- We request that CMS collect more data on geographic barriers to network adequacy.
- We urge CMS to improve how it publicizes enforcement actions against health plans.
- CMS should do more to align MA prior authorization policies with those of traditional Medicare.
- CMS should publish data on every MA plan's rate of appealed prior authorization determinations and establish stronger enforcement of prior authorization violations against MA plans.
- CMS should more actively ensure that MA plans cover correctly coded claims that include Modifier 25 since these claims would be covered by traditional Medicare.
- We strongly urge CMS to collect and publish data that compares how MA plans compare to traditional Medicare on NCCI policies such as modifier 59. We hope this data leads to more enforcement of MA coverage policies to ensure they more closely align with traditional Medicare.
- HBMA recommends that CMS mandate Medicare Advantage plans to follow the one-year timely filing requirement.
- CMS should collect and publicize data on MA coverage determinations appealed by providers.
- CMS must prohibit – or, at the very least, significantly restrict – MA plans from conducting chart reviews for purposes of upcoding to receive higher risk scores.
- CMS must apply increased program integrity scrutiny to MA plans. There is a significant opportunity for CMS to increase its audits and enforcement actions for these requirements which will save the Medicare program billions of dollars.
- HBMA recommends that CMS collect data on consolidation with MA plans and how this impacts the network adequacy and quality of care for MA beneficiaries.

- **Conclusion**

We thank CMS for seeking public feedback on various aspects of MA data use and collection. As MA covers over half of all Medicare enrollees, efforts to improve the utilization of data to improve patient care are incredibly important. We hope the responses from this RFI lead to meaningful policy changes to strengthen the MA program for its enrollees and the providers who participate in the program.

We appreciate the 120 day window to respond to this RFI, which has allowed stakeholders to compile meaningful feedback to improve the MA program. We encourage CMS to continue its outreach to stakeholders such as HBMA.

If you have any questions about our comments, please contact HBMA Director of Government Affairs, Matt Reiter (reiterm@capitolassociates.com) or HBMA Executive Director Brad Lund (brad@hbma.org).

Sincerely,

Kyle Tucker
President, HBMA