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January 27, 2025

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Acting Administrator Wu,

The Society of Hospital Medicine, representing the nation's more than 50,000 hospitalists, is pleased to offer comments on the proposed rule entitled *Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)*.

Hospitalists are physicians whose professional focus is the general medical care of hospitalized patients. They provide care to millions of hospitalized Medicare beneficiaries each year. They see firsthand how patients admitted to hospitals today are often sicker and more frail compared to those prior to the COVID-19 pandemic. They are committed to providing high-quality care to patients, often leading clinical quality, systems and operational improvement efforts in the hospital. In addition to managing clinical patient care, hospitalists also work to enhance the performance of their hospitals and health systems. Due to their positioning in the healthcare system, hospitalists are acutely aware of how prior authorization impacts care for Medicare beneficiaries as well as the ability of hospitals to assure their limited resources can be appropriately allocated to acutely ill patients. We offer comments on the following proposals:

U. Enhancing Rules on Internal Coverage Criteria §422.101

CMS proposes to build on and enhance regulations from the April 2023 final rule around internal coverage criteria for Medicare Advantage (MA) plans. They are proposing to make more explicit their intentions in the prior regulations to ensure Medicare beneficiaries can expect the same baseline general coverage in MA plans as in traditional Medicare.

Many hospitalists report that prior authorization policies in MA plans result in delays of care, often among the most medically fragile patients and those requiring post-discharge care. Patient experiences include unnecessary waits for admission to skilled nursing facilities (SNFs) or rehabilitation facilities and delayed discharges from the hospital while waiting for medication or durable medical equipment approvals. These delays prevent timely and safe transitions of care and exacerbate hospital access and capacity issues for other patients. Furthermore, hospitalist experience demonstrates there can be stark differences between what is covered for an MA patient compared to the benefits enjoyed by traditional Medicare patients. Patients who would meet the 2 midnight rule, for example, and would qualify for inpatient care in traditional Medicare are being denied care when their condition does not meet third party criteria.

SHM appreciates CMS' confirmation that beneficiaries under Medicare Advantage plans should reasonably be able to expect the same baseline coverage benefits as those under traditional Medicare, and should not be subject to onerous coverage or prior authorization rules designed solely to reduce costs and utilization for the MA plans.

First, CMS proposes to replace the term "general provisions" at §422.101(b)(6)(i)(A) with "the plain language of applicable Medicare coverage and benefit criteria." **SHM is supportive of this change.** As CMS notes, they intended to encapsulate the entirety of Medicare coverage and benefit rules with the broader term "general provisions." Internal coverage criteria is meant to supplement or interpret existing coverage criteria within Medicare's full set of rules. However, that has not be consistently implemented, particularly around National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). We believe this clearer language will help ensure more consistent application of Medicare coverage rules across MA plans.

Second, CMS is proposing to remove the existing standard requiring MA plans demonstrate that any additional coverage criteria provide clinical benefits that are highly likely to outweigh clinical harms. In its place, CMS proposes a requirement that MA plans must provide evidence that the additional criteria explicitly support patient safety. CMS notes, in proposing these changes, they received limited supportive evidence from MA plans to meet the existing standard and that the clinical benefits cited often relied on avoidance of potential harms or risks of the affected item or service. SHM appreciates the intent of the proposed language and believes it adds some clarity to the limitations on such criteria. However, SHM cautions this remains sufficiently vague that MA plans may still cite the same proposed potential risks or harms as a patient safety issue to deny coverage. Virtually every healthcare service or item carries some risk; healthcare providers make recommendations based on their clinical determination that the benefits outweigh the risks and will improve the patient's prognosis or quality of life. It may be more beneficial to focus on the specific quality of evidence that must be used by an MA plan, such as clinical guidelines published by medical organizations or supported by widespread peer-reviewed and published studies.

CMS also proposes two prohibitions for internal coverage criteria as guardrails, specifically prohibiting:

1. When a coverage criterion does not have any clinical benefit and only exists to reduce utilization; and
2. When the criterion is used to automatically deny coverage of basic benefits without the MA organization making an individual medical necessity determination as required.

SHM is supportive of these proposed prohibitions. They will be an important tool to ensure that coverage criteria are rooted in the clinical care of patients and their individual clinical needs. We have some concern over the vagueness of the term "any clinical benefit" as stated previously, and recommend coupling with a requirement regarding the quality of evidence to support it. We strongly agree that criteria designed to automatically, or blanketly, deny coverage without considering clinical benefit or the individual patient's needs results in worse care for patients.

For example, hospitalists report frequent situations for patients for whom the denial is overturned after a peer to peer is scheduled and the MA medical director or physician

reviewer finally looked at the specific patient's record. In some instances, it is clear the MA medical director or physician reviewer has not even reviewed the medical record prior to a peer to peer taking place. The patient's physician, who expended significant time and effort to schedule and join the peer-to-peer call, is then being used as essentially free labor to provide all information in bringing them up to speed, at which point the denial is overturned. This leads to days of unnecessary delays with no consequence to the MA plan, but with significant interruptions in patient care, onerous administrative burdens on providers who should be focused on patient care, and improper waste of limited hospital resources needed for other patients. We believe this is partly the result of overbroad application of AI and decision-making tools by plans to deny as much as possible and sort out the details later. We laud CMS' efforts to make it clear that blanket denials of coverage, including by third party tools, are unacceptable and do not account for an individual patient's clinical reality. We also applaud the prohibition of coverage criteria rooted solely in reducing resource use, as again, they would not account for patients' clinical needs.

SHM is also supportive of CMS' proposed changes to add more structure and detail to the requirement that MA plans' internal criteria are publicly available. We agree that currently this information is not readily available to the average healthcare provider or beneficiary despite the requirements of the April 2023 final rule. We believe these changes will help improve the transparency of the internal criteria and to allow healthcare providers to determine whether a particular healthcare item or service will be covered, and to provide the necessary information in the initial request. We also support the focus on "criteria" and "criterion" rather than "policies" to assure MA plans provide a simply and clearly defined list of requirements to determine whether the item or service is covered and the necessary information is presented.

SHM is fully supportive of CMS' efforts to ensure patients are protected under the Medicare Advantage program. While the steps contained within this proposed rule are all helpful and move in a positive direction, without a strong enforcement mechanism, meaningful change may be difficult to achieve. One of the most important statements made by CMS in this proposed rule is the following:

> *We have strengthened our audit processes and will consider new compliance and reporting activities to examine MA organization's compliance with these proposed rules.*

CMS must couple these strengthened audits with strengthened enforcement and transparency. With some MA plans showing denial overturn rates exceeding 70%, there is already evidence rules are at best not being followed, at worst, actively ignored. In addition, it is not uncommon for the plan physicians to not fully identify themselves or their credentials during peer to peers, which is contrary to CMS' policies and intentions. As such it is essential to have meaningful, consistent, and decisive enforcement. Steep penalties or even removal from MA altogether, should be seriously considered as a result of consistently failed audits or evidence of systemic skirting of rules. At the same time, numerous hospitals and health systems have been very successful in complying with plan rules and we believe requiring MA plans to give "gold card" status to high performing systems would help reduce administrative burdens associated with MA plan denials and appeals.

Transparency is also vital. We encourage CMS to consider requiring plans to publicly report their denial rates – to the CPT code and DRG levels – to provide maximal information to beneficiaries, policymakers and the public at large. This would help ensure plans comply with CMS rules and giving Medicare beneficiaries the care they deserve and are entitled.

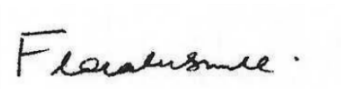
Our members have also reported other requirements or behaviors from MA plans that create impediments for ensuring patients get the care they need. For example, requiring that the physician be the one to schedule the peer to peer for an appeal, is a poor use of physician time, and detracts from time for clinical care. Another situation is when plans only offer narrow windows for peer to peers to occur, which commonly leads to the physician being pulled away from actual patient care (including care for patients not the subject of the peer to peer). These artificial barriers do not improve care for patients or streamline the care of patients in the hospital. We urge CMS to consider ways to encourage plans to create systems and policies that streamline and improve care, not detract and distract from care.

Conclusion

SHM appreciates the opportunity to provide input and comments on the Contract Year 2026 Medicare Advantage proposed rule. If you have any questions or require additional

information, please contact Josh Boswell, Chief Legal Officer/Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,



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