Society of Hospital Medicine
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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4201-P
P.O. Box 8016
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Dear Administrator Brooks-LaSure,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on the proposed rule entitled: *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4201-P).*

The proposed rule covers numerous topics aimed at strengthening beneficiary protections, improving access to behavioral health care, and promoting equity for millions of Americans with Medicare Advantage (MA) and Medicare Part D. We appreciate that CMS recognizes the burdens associated with MA and urge you to adopt these policies to support judicious, transparent, and clinically appropriate policies in MA that protect beneficiaries' access to treatment.

Hospitalists provide care to patients across the country in our nation's hospitals, and they see first-hand the challenges outpatient (observation) status creates. The Society of Hospital Medicine (SHM) has remained strongly committed to improving Medicare observation policy. As increasing numbers of patients are enrolling in MA plans, we have become concerned about the misuse of not only prior authorization but also of observation status under MA plans. **Medicare Advantage plans commonly use proprietary decision tools such as InterQual and MCG or other opaque criteria or standards to deny inpatient payments for patients who would otherwise clearly meet inpatient criteria under Medicare's Two Midnight Rule.** A recent Office of Inspector General (OIG) report highlighted "…widespread and persistent problems related to inappropriate denials of services and payment" under MA plans. Although not specific to observation, the audit found "…of the

payment requests that [Medicare Advantage Organizations] denied, 18 percent of the requests met Medicare coverage rules and MAO billing rules and should have been approved by the MAOs ...". [1]

In addition to the burden of reduced financial reimbursement for care, the rise in frequency and volume of denials has led to an untenable administrative burden in an already strapped workforce. For example, at one hospital, denials from a "… single payor have increased from 8.2% in 2016 to 11.03% in 2020 and alarmingly to 16.85% in 2021." This hospital overturned more than 70% of the denials they were allowed to appeal, which constituted a significant amount of additional work to recoup payment for claims that were inappropriately denied. [2] This additional and growing administrative burden is placed on an already stretched healthcare workforce.

Although MA plans commonly downgrade inpatient billing to observation to reduce hospital payments, MA has never generated savings for the Medicare program, [3] . At one hospital, one MA plan approved and paid $58,187 for a series of inpatient claims, but months after the patients discharged, the plan reclassified the claims as observation, authorizing payment of $13,174, which was only 22.6% of the original inpatient payment. The hospital was expected to refund the difference. In this case, "Necessity of the services, location of service delivery, or quality of the treatment provided, was not disputed by the payor in the audit. The only change was that the MA payor determined, through an opaque internal process, that the care should be designated as outpatient episodes and thus paid at a significantly lower rate." [4] This case example demonstrates the reality that MA plans usage of observation status are not in line with traditional Medicare requirements, creating unequal and often unpredictable coverage for patients and significant administrative burden.

A significant improvement would be standardization of observation criteria across all Medicare payors—mandating use of the Two Midnight Rule to determine inpatient or outpatient (observation services). For this reason, SHM fully supports the Centers for Medicare & Medicaid Services proposed rule reinforcing its longstanding policy that MA"…plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS. Further, we fully support the CMS proposal that MA plans cannot deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies.

MA plans have been permitted to use additional clinical criteria that were not developed by Medicare in determining whether to authorize payment for a service, as long as such criteria are "no more restrictive than original Medicare's national and local coverage policies." [1] However, SHM emphasizes that **once a patient has met the Two Midnight standard, (based**

upon the reasonable expectation that a patient, at the time of hospitalization, will require a medically necessary stay exceeding two midnights), inpatient status and payment should be granted and any additional criteria become irrelevant. CMS should directly state that Medicare Advantage plans must follow the Two Midnight Rule in determining hospital status in all applicable situations, not just for purposes of inpatient denials for short stays that are less than 2 midnights. As such, we further applaud the CMS proposal that MA plans cannot deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies.

In summary, in an effort to standardize and clarify inpatient and outpatient status determinations for hospitalized patients, SHM strongly supports CMS' reinforcing of its policy that MA plans must meet NCDs, LCDs, and general coverage and benefit conditions under Traditional Medicare and urges the agency to clarify that this includes meeting fee-for-service standards for inpatient admissions, i.e., the two-midnight rule**.**

SHM appreciates the opportunity to provide feedback on this proposed rule and we applaud the effort CMS is making toward establishing greater oversight of Medicare Advantage plans. If you have any questions, please contact Josh Boswell, SHM Director of Government Relations at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

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

References

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2) Singh S, Kolinski J, Alme C, Sinson G. The growing epidemic of insurance denials: a frontline perspective. J Hosp Med. 2022. 17: 132-135.

3) Medicare Payment Advisory Commission. June 2021 Report to Congress: Chapter 1: Rebalancing Medicare Advantage benchmark policy. Available at: https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/. Accessed January 28, 2023.

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