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Statement

of the

American Hospital Association

for the

Homeland Security and Governmental Affairs Committee

Permanent Subcommittee on Investigations

of the

U.S. Senate

"Examining Health Care Denials and Delays in Medicare Advantage"

May 17, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks the Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations for holding this important hearing on Medicare Advantage (MA) denials. We appreciate the opportunity to submit this statement for the record to highlight our concerns about some MA plans' inappropriate restrictions on beneficiary access to medically necessary care and urge Congress to increase its oversight of these plans.

Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the MA program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first requirements for imaging and therapies, and other direct patient harms. In addition, these practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan

requirements. They are also a major burden to the health care workforce and contribute to provider burnout. An advisory issued last year by Surgeon General Vivek Murthy, M.D., notes that burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.[1]

Many of the harms associated with inappropriate delays and denials are evidenced by the striking report issued in April 2022 by the Department of Health and Human Services Office of Inspector General (HHS OIG). MA plans are denying medically necessary, covered services that met Medicare criteria at an alarming rate. These problems with MA plan utilization management and coverage policies have grown so large — and have lasted for so long — that strong, decisive and immediate enforcement action is needed to protect sick and elderly patients, the providers who care for them and American taxpayers who pay MA plans more to administer Medicare benefits to MA enrollees than they do to the Traditional Medicare program.

Last year, in response to these developments, the AHA urged the Department of Justice to create a "Medicare Advantage Fraud Task Force" to conduct False Claims Act investigations into commercial health insurance companies that are found to routinely deny patients access to services and deny payments to health care providers. This would ensure that older Americans receive the care they need under MA and federal dollars are appropriately spent to provide, not deny, necessary services.

Additionally, addressing the disparities between Traditional Medicare and the MA program is a critical issue. The Traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MA plans. As of January 2023, the MA program includes more than 30 million enrollees, accounting for 50% of all Medicare beneficiaries.[2] Therefore, half of Medicare beneficiaries are not subject to the types of restrictions on access to care faced by beneficiaries enrolled in the MA program, which impedes progress towards equitable access to care and alignment between Traditional Medicare and MA. We believe all Medicare beneficiaries should have the same access to medically necessary care and consumer protections and that those enrolled in MA plans should not be unfairly subjected to more restrictive rules and requirements, which are unlawful and contrary to the intent of the MA program.

We appreciate recent rulemaking from the Centers for Medicare & Medicaid Services (CMS), which seeks to address a number of these concerns by better aligning MA coverage policies with Traditional Medicare. However, as CMS indicates, many of the regulatory provisions simply codify existing policies with which plans were previously

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[1] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/

expected to adhere. Given this historic noncompliance with these requirements by certain MA plans, rigorous enforcement is critical to achieving meaningful gains in patient access, as the rules intend. With this in mind, we urge Congress to pass legislation with further oversight of the MA program, including greater data collection and reporting on plan performance and more streamlined pathways to report suspected violations of federal rules, to ensure timely patient access, consumer protection and meaningful enforcement of new CMS rules.

Office of Inspector General Raises Concerns about Beneficiary Access to Care under Medicare Advantage

The MA program is designed to cover the same services as Traditional Medicare, and by law, MA plans may not impose additional clinical criteria that are "more restrictive than Original Medicare's national and local coverage policies."[3] However, the recent HHS OIG report found that some of America's largest MA plans have been violating this basic legal obligation at a staggering rate.

The report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and therefore were inappropriate. In a program the size of MA, improper denials at this rate are unacceptable. Yet, as the report explained, because the government pays MA plans a per-beneficiary capitation rate, there is a perverse incentive to deny services to patients or payments to providers to boost profits. As a result, many insurers have found the MA program to be their most profitable line of business and have sought expansion into MA as part of their growth strategy.[4,5]

Certain Egregious Health Plan Policies Remain Unchecked

Hospitals and health systems have raised concerns for many years about certain MA plan tactics that restrict and delay access to care while adding burden and cost to the health care system. The types of issues that threaten access to medically appropriate care include:

- **More Restrictive "Internal" Medical Necessity and Coverage Criteria.** CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than Traditional Medicare. However, the HHS-OIG report clearly details that MA plans are routinely doing exactly that. Additionally, MA plans often classify their medical

[3] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.
[4] https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/
[5] https://www.forbes.com/sites/brucejapsen/2021/10/01/parade-of-health-insurers-expand-medicare-advantage-into-hundreds-of-new-counties/?sh=591ab1106b69

necessity criteria as proprietary and do not share its specifics with providers, resulting in a “black box” methodology for determining whether a service will be approved. This leaves providers and patients unable to anticipate what the plan may require as evidence of medical necessity, leading to unnecessary delays and denials and unequal coverage of medically necessary care for MA beneficiaries.

- **Inpatient Care Downgrades to Observation Status.** To give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established that hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Many MA plans have applied more restrictive criteria for inpatient admissions that inappropriately limit patient access to medically necessary, covered hospital services. This is especially problematic in cases where a patient’s care requires multiple days in the hospital (far exceeding the two-midnight threshold required for Traditional Medicare to cover the hospital say) and certain MA plans continue to downgrade those stays to outpatient or observation care. This practice can also have the effect of eliminating a patient’s eligibility for certain post-acute care coverage and benefits that require a 3-day hospital stay prior to admission.

- **Post-acute Care (PAC) Admissions.** The HHS OIG report identified PAC as one of three services most frequently denied for prior authorization or payment when the requested service, in fact, met Medicare coverage rules and MA plan billing rules. Erroneous denials and delays such as these restrict access to care during both the PAC and prior hospital stages of care, for services that would otherwise be covered by Traditional Medicare. These delays and denials erode the overall quality of care provided to patients and undermine cross-setting clinical coordination efforts that are critical to high-quality, patient-centered care.

  It also appears that some Medicare Advantage Organizations (MAOs) may be motivated by financial reasons to keep a patient in the referring hospital for longer than is medically prescribed by the treating physician. In this case, the plan has already paid the hospital a flat rate for care and is either delaying or attempting to avoid discharging the patient to the next site of care, which would require a separate, additional reimbursement. AHA claims data analysis reflects that length of stay in the referring hospital is typically longer for MA beneficiaries than Traditional Medicare beneficiaries being discharged to a PAC setting.

  Additionally, stronger network adequacy requirements are needed for PAC sites of care. There are currently no network adequacy requirements for specific PAC provider types such as home health, inpatient rehabilitation facilities, and long-term acute care hospitals. To ensure MA beneficiaries have appropriate access to basic benefits covered by Traditional Medicare, it is important that providers who deliver these basic benefits are appropriately represented in MAO networks.

- **Sepsis Coverage.** Several MA plans do not adhere to CMS clinical guidelines for sepsis, instead utilizing standards that are not supported by current clinical best practices, nor recognized by current coding or payment methodologies used by CMS. Such policies reduce patient access to care and undercut quality improvement efforts to prevent, detect, treat and improve sepsis care.

- **Emergency Services.** Several large insurers have been denying or downcoding coverage of emergency services after the care is delivered upon reviewing the outcome and patient records, and not based on what the clinician knew at the time the patient presented to the emergency department. These policies can deter patients from seeking critical and urgent care, while also resulting in significant financial losses to providers when payments are clawed back after the fact for care that was legitimately provided.

- **Specialty Pharmacy Coverage.** Large insurers are increasingly requiring health care providers to obtain physician-administered drugs from the insurer's owned or affiliated specialty pharmacy instead of allowing the health care facility to provide the drug on site from its own inventory. This practice is known as white bagging and raises serious patient safety concerns, creates the potential for significant delays in time-sensitive medical care, and adds tremendous burden and cost to the health care system. The white bagging practice will be part of the subject of a recently announced investigation by the Federal Trade Commission into the vertical integration of pharmacy benefit managers and large health insurance companies who wholly own mail order specialty pharmacies, which are being used to steer patients for profit.[6]

- **Mid-year Contract Changes.** MA plans are increasingly implementing unilateral mid-year contract policy changes that have a material financial impact on providers. After the contract has been negotiated and hospitals and health systems develop an annual operating budget based upon the terms of the contract, the plan unilaterally issues a policy change that materially changes the amount the hospital is paid for the services. In some cases, the changes are clinical in nature but still include a financial implication. In other cases, they are strictly financial restrictions.

  A common mid-year change is a site of service policy where a plan will stipulate in the middle of a contract year that they will now only cover certain services in a specific setting going forward, which can interrupt and fragment ongoing care. For example, requiring a patient receiving ongoing chemotherapy in a hospital setting to continue receiving cancer treatment in another setting or facility. Mid-contract year changes can subject patients to unexpected changes in coverage, as they selected

[6] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry

their plan at the beginning of the year understanding that care would be covered in certain settings, with certain providers, and then later finding out that these material rules can be changed without their knowledge or consent. These changes create an unpredictable environment for treating patients and are unfair to patients and providers.

Prior Authorization Processes

Not only is achieving alignment of medical necessity and coverage criteria related to MA prior authorization policies critical, but also alleviating the burdensome prior authorization process is vital to MA reforms. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. The most common methods of prior authorization requests are fax machines and call centers. Additionally, plans that offer electronic submission methods most commonly use proprietary plan portals, which require significant time spent logging into a system, extracting data and completing idiosyncratic plan requirements. For each plan, providers and their staff must ensure they are following the correct rules and processes, which vary substantially between plans and by service, and are often unilaterally changed in the middle of a contact year.

This heavily burdensome process contributes to patient uncertainty regarding their care plan and can leave them in limbo, facing delays in care while the aforementioned steps are completed. According to a 2022 American Medical Association survey, 94% of physicians reported care delays associated with prior authorizations, while 80% indicated that prior authorization hassles led to patient abandonment of treatment.[7]

Greater Accountability Is Needed

The findings of the HHS OIG report, as well as the broader experience of MA beneficiaries, hospitals and health systems, clearly indicate that greater oversight of MA plans is needed to ensure appropriate beneficiary access to care. To address these concerns, the AHA specifically urges Congress to:

- **Establish Controls for MA Plan Usage of Prior Authorization.** The AHA supported legislation last Congress, The Improving Seniors' Timely Access to Care Act of 2021 (H.R.3173/S.3018), which would streamline prior authorization requirements under MA plans by making them simpler and uniform, and eliminating the wide variation in prior authorization methods that frustrate both patients and providers.

[7] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

- **Improve Data and Reporting.** We strongly urge Congress to establish standardized reporting on health plan performance metrics related to coverage denials, appeals and grievances by plan and to require that these be made publicly available.

- **Conduct More Frequent and Targeted Plan Audits.** Pursuant to the HHS OIG recommendations, we urge additional CMS audits be conducted and targeted to specific service types of MA plans that have a history of inappropriate denials.

- **Establish Provider Complaint Process.** Health care providers, including hospitals and health systems, act on behalf of their patients when working with insurers to obtain approval and coverage for medically necessary care. We encourage Congress to establish a process for health care providers to submit complaints to CMS for suspected violation of federal rules by MA plans.

- **Enforce Penalties for Non-Compliance.** Congress should ensure that CMS exercise its authority to enforce penalties for MA plans that fail to comply with federal rules, including the provisions regarding plan reporting and adherence to medical necessity criteria that are not more restrictive than Traditional Medicare. In the recent contract year 2024 Medicare Advantage Rule, CMS noted that a number of the established regulations were already requirements under the health plan terms of participation in the MA program. Given MAOs historic lack of adherence to these rules, Congress should establish stronger programs to hold plans accountable for non-adherence. Additional requirements are insufficient without enforcement action and penalties to support compliance.

- **Provide Clarity on the Role of States in MA Oversight.** One of the challenges in regulating MA plans is the split responsibility of insurance oversight between the federal and state governments. To ensure that CMS and states exercise their authorities as needed, we encourage Congress to delineate and strengthen the specific oversight and enforcement responsibilities of state and federal authorities.

Conclusion

The AHA appreciates your recognition of these issues and the need to examine the quality of coverage offered by Medicare Advantage plans. We look forward to continuing working with you to address these concerns and to ensure all Medicare beneficiaries have access to timely and appropriate care.