

May 19, 2022

The Honorable Brian M. Boynton
Acting Assistant Attorney General, Civil Division
Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20044

Dear Acting Assistant Attorney General Boynton:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, 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) **urges you to establish a 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.**

Earlier this month, the Department of Health and Human Services' Office of Inspector General (HHS-OIG) released an alarming report entitled "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care."¹ As you know, the Medicare Advantage program is designed to cover the same services as original Medicare, and by law, Medicare Advantage Organizations (MAOs) may *not* impose additional clinical criteria that are "more restrictive than original Medicare's national and local coverage policies."² HHS-OIG found that some of America's largest MAOs have been violating this basic legal obligation at a staggering rate.

Using a random sample of denials from the one-week period of June 1–7, 2019, the report estimates the rate at which MAOs deny prior authorization and payment requests that met Medicare coverage rules. Specifically, HHS-OIG found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and should have been granted. In a program the size of Medicare Advantage — with 26.4 million beneficiaries, or 42% of the total Medicare population in 2021 — improper

¹ It is available at <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

² CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.



denials at this rate is unacceptable. Yet, as the report explained, because the government pays MAOs a roughly \$1,000 per-beneficiary capitation rate, they have every incentive to deny services to patients or payments to providers in order to boost their own profits. As HHS-OIG's report shows, this is exactly what certain MAOs have been doing — again and again. And in a \$300-plus billion federal program, the losses to the public fisc are immense.

While the numbers alone tell a distressing story, the report also describes the harrowing human impact of these MAOs' behavior. Just consider the following few examples described in the report:

- A 72-year old woman presented with a cancerous breast tumor. The MAO denied her breast reconstruction surgery, stating “that the service was not covered.”³ That decision was reversed only after the OIG requested data from the insurer.
- An MAO refused to admit a 67-year old patient to an inpatient rehabilitation facility, even though he presented with an “acute right-sided ischemic stroke and [was] seen at the emergency department with new onset slurred speech.”⁴ “The beneficiary had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore,” according to the Medicare Benefit Policy Manual, “should have been under the frequent supervision of a rehabilitation physician.”⁵
- An MAO refused to pay \$150 a month for a hospital bed with rails, even though a 93-year-old patient had a history of epilepsy, early onset Alzheimer's, rheumatoid arthritis, chronic back pain, knee and joint stiffness, and limited range of motion.⁶ HHS-OIG's medical experts determined, however, that this bed request was medically necessary “due to the beneficiary's chronic conditions and movement limitations.”⁷

These harmful denials all occurred in a single week. Imagine what else the Justice Department might find if it conducted a more far-reaching investigation?

The HHS-OIG report offers several forward-looking recommendations to remedy this serious problem of improper denials. Those recommendations are sensible, and the AHA applauds them. But they are not enough. After all, as the report notes, HHS-OIG had identified similar problems with improper MAO denials in a September 2018 report, and as of March 2022, the Centers for Medicare & Medicaid Services had not yet acted on all of HHS-OIG's recommendations.

³ See Appendix B, Example D385.

⁴ See Appendix B, Example D270.

⁵ *Id.*

⁶ See Appendix B, Example D232.

⁷ *Id.*

It is time for the Department of Justice to exercise its False Claims Act authority to both punish those MAOs that have denied Medicare beneficiaries and their providers their rightful coverage and to deter future misdeeds. This problem has grown so large — and has lasted for so long — that *only* the prospect of civil and criminal penalties can adequately prevent the widespread fraud certain MAOs are perpetrating against sick and elderly patients across the country, as well as against the public fisc *every time* commercial insurers take \$1,000 per beneficiary while denying medically-necessary services.

When you first took office in early 2021, you gave remarks at the Federal Bar Association’s Annual Conference in which you highlighted the Civil Division’s False Claims Act priorities. Among those priorities, you listed “schemes that take advantage of elderly patients by providing them poor or unnecessary health care – *or too often no care at all.*”⁸ You also listed a variety of health care-related priorities, noting that “the Civil Division has increasingly been undertaking sophisticated analyses of Medicare data to uncover potential fraud schemes that have not been identified. Yet another important priority for the Department has been investigating and litigating a growing number of matters related to Medicare Part C, which is Medicare’s managed care program, whistleblower suits, as well as to help analyze and support the allegations that we do receive from such suits.”⁹ The fraud uncovered by HHS-OIG fall squarely within your priorities: Seniors are being regularly refused vital medical services, and the Department is well-equipped to use its sophisticated anti-fraud tools to go after this persistent misconduct by certain MAOs. This is why the Civil Division has indicated that “another important priority for the Department has been investigating and litigating a growing number of matters related to Medicare Part C, which is Medicare’s managed care program.”¹⁰

As the HHS-OIG report makes crystal clear, a more sustained Justice Department commitment is needed to fully tackle this problem. **And it is time for the Civil Division to focus more directly on the commercial insurers who commit this fraud.**¹¹ **The AHA therefore urges you to create a “Medicare Advantage Fraud Task Force” to investigate those MAOs that are failing to live up to the commitments they make to the federal government and the Medicare beneficiaries they have been entrusted to serve.** Doing so will ensure that our oldest Americans get the care they

⁸ Acting Assistant Attorney General Brian M. Boynton Delivers Remarks at the Federal Bar Association Qui Tam Conference (Feb. 17, 2021), <https://www.justice.gov/opa/speech/acting-assistant-attorney-general-brian-m-boynton-delivers-remarks-federal-bar> (emphasis added).

⁹ *Id.*

¹⁰ Remarks of Deputy Assistant Attorney General Michael D. Granston at the ABA Civil False Claims Act and Qui Tam Enforcement Institute (Dec. 2, 2020), <https://www.justice.gov/opa/speech/remarks-deputy-assistant-attorney-general-michael-d-granston-aba-civil-false-claims-act>.

¹¹ John C. Richter, Amy Boring, and Christina Kung, Top False Claims Act Developments (Aug. 12, 2021), <https://www.chamberlitigation.com/FalseClaimsAct3> (“[T]here have not been many FCA cases against Medicare Part C insurers historically, as compared with other entities in the healthcare space.”).

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need under Medicare Advantage, and commercial insurers can no longer take massive amounts of federal dollars while denying necessary services.

The AHA looks forward to working with you on this important effort.

Sincerely,

/s/

Melinda Hatton
General Counsel

cc: Vanita Gupta, Associate Attorney General
Michael Granston, Deputy Assistant Attorney General