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Advancing Health in America

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May 19, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: U.S. Department of Health and Human Services Office of Inspector General Report: Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns about Beneficiary Access to Medically Necessary Care

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including 3,000 post-acute care (PAC) providers, more than 270,000 affiliated physicians, two 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 CMS to take swift action to hold Medicare Advantage (MA) plans accountable for inappropriately and illegally restricting beneficiary access to medically necessary care.**

Inappropriate and excessive denials for prior authorization and coverage of medically necessary services is a pervasive problem among certain plans in the MA program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first imaging and therapies, and other direct patient harms. In addition, they 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. These harms are evidenced by the striking report issued last month by the Department of Health and Human Services' Office of Inspector General (HHS-OIG) entitled "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care."[1] As evidenced by the findings,

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

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 remedy the harm that certain MA plans are perpetrating against sick and elderly patients, the providers who care for them, and American taxpayers, who currently pay MA plans more to administer Medicare benefits to enrollees than they would to the traditional Medicare program.

Addressing the disparities between traditional Medicare and the MA program also is a critical equity issue. The traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MA plans. The MA program currently has 26.4 million beneficiaries or 42% of the total Medicare population in 2021. Therefore, a little more than half of Medicare beneficiaries are not subject to the types of restrictions on access to care faced by beneficiaries enrolled in the MA program. We believe **all Medicare beneficiaries should have equal 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.

In the following sections, we enumerate a number of issues and concerns regarding egregious MA plan policies in the context of this HHS-OIG report on access to care under the MA program. We then provide specific recommendations that we believe are necessary to hold MA plans accountable for complying with the law and protecting beneficiaries from harm. Finally, we request an opportunity to meet with you regarding the challenges hospitals and health systems face in trying to care for patients enrolled in the MA program.

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

The HHS-OIG recently released an alarming report entitled “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care.”[2] As you know, the MA program is designed to cover the same services as Original 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] The HHS-OIG found that some of America’s largest MA plans 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 MA plans deny prior authorization and payment

[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[3] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.

requests that met Medicare coverage rules. Specifically, the 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 MA, improper denials at this rate is unacceptable. Yet, as the report explained, because the government pays MA plans a 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 the HHS-OIG's report shows, this is exactly what certain MA plans have been doing—again and again. It is no surprise, therefore, that 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]

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

- A 72-year old woman presented with a cancerous breast tumor. The MA plan denied her breast reconstruction surgery, stating "that the service was not covered."[6] That decision was reversed only after the HHS-OIG requested data from the insurer.
- A MA plan 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."[7] "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."[8]
- A MA plan 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.[9] HHS-OIG's medical experts determined, however, that this bed request was medically necessary "due to the beneficiary's chronic conditions and movement limitations."[10]

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[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
[6] *See* Appendix B, Example D385.
[7] *See* Appendix B, Example D270.
[8] *Id*.
[9] *See* Appendix B, Example D232.
[10] *Id*.

These harmful denials all occurred in a single week in 2019. According to a 2021 AHA member survey, 78% of hospitals and health systems reported their current experience with commercial and MA plans was getting worse, and more than 80% reported that the time required for prior authorization approval had increased in the last three years. Imagine what other medically necessary care has been missed as a result of these MA plan practices.

Egregious Health Plan Policies Remain Unchecked

Hospitals and health systems have been raising concerns for many years about MA plan tactics that restrict and delay access to care while adding burden and cost to the system. Below we expand on the types of issues highlighted by the HHS-OIG: inappropriate application of proprietary or "internal" clinical criteria used to adjudicate prior authorization and payment claims, and inappropriate use of utilization management tools. We also highlight several other concerning MA plan policies.

More Restrictive "Internal" Medical Necessity and Coverage Criteria. As noted above, CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than fee-for-service (FFS) Medicare. However, the HHS-OIG report clearly details that MA plans are routinely doing exactly that. Additionally, MA plans often classify their medical necessity criteria as proprietary (or "internal") 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 unable to anticipate what the plan may require as evidence of medical necessity and this lack of transparency is a frequent reason that prior authorization and claims are delayed or denied. Leaving providers in the dark about what documentation they must provide results in extensive back and forth between providers and plans in response to insurer requests for different (and, as noted by the HHS-OIG, often excessive) documentation to substantiate the need for particular services. Below are just five examples of the types of policies some MA plans have adopted that result in unequal coverage of medically necessary care for MA beneficiaries.

- **Sepsis Coverage.** Several MA plans have unilaterally stopped reimbursing providers for the care necessary to treat certain cases of early sepsis occurring in inpatients. Specifically, these plans are choosing to no longer follow the "Sepsis 2" guidelines, which have been adopted by the vast majority of practicing physicians and serve as the CMS standard for sepsis coverage. Instead, these plans have unilaterally applied a different standard ("Sepsis 3") for purposes of determining provider reimbursement only. This standard more specifically focuses on later stages of sepsis and has been validated only in early retrospective studies and only as an outcome/mortality predictor. It is not

supported by current clinical best practices, nor is it recognized by current coding or payment methodologies used by CMS. In short, plans' adoption of Sepsis 3 does not change the way providers care for patients with sepsis, it simply enables the plan to decline reimbursement for early sepsis interventions.

This policy has the potential to reduce the quality of care patients receive and undercut quality improvement efforts to prevent, detect, treat, and improve sepsis care. It also results in inappropriate underpayment to providers who continue to deliver the medically necessary care. In short, the benefit of these policies accrues only to the plan, and the motivation is purely financial, not clinical. The adoption of these changes in policy during the COVID-19 pandemic has been a particular affront to patients and their providers in the midst of a national health emergency for which sepsis is a common corollary condition to COVID-19. Further, these policy changes are often adopted in the middle of contract years, outside of standard contract negotiations, and without consultation with network providers.

- **Inpatient Care Downgrades to Observation Status.** Given the significant hospital resources involved during a substantial stay in a hospital, inpatient care is typically reimbursed at a higher rate than outpatient care and observation status. Additionally, inpatient stays entitle patients to certain benefit categories, such as post-acute care facility services after discharge. In order to give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established the two-midnight rule. Under that policy, hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Despite this bright-line CMS medical necessity rule, many MA plans have implemented policies that further restrict inpatient care by placing additional obstacles to admission, including, as reported to the AHA by member hospitals, directly pressuring providers to classify patients as "under observation" prior to the submission of claims in order to reduce the plan's reported rate of denials of inpatient claims.

  These policies frequently lead to uncertainty for providers and patients, whose medically-justified inpatient stays are often denied or changed to observations. Such classifications misrepresent the care received by the patient, impede a patient's ability to receive coverage for certain benefits and care plans, and require lengthy appeals processes that increase the cost of care delivery. They also can change a patient's cost-sharing amount and potentially expose them to higher cost-sharing depending on the patient's benefit structure.

Eligibility for Post-Acute Care. The HHS-OIG report identified PAC as one of three services most frequently denied requests for prior authorizations and payments that, 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 Original Medicare. Indeed, our general acute-care hospital members report that delayed and denied MA coverage for downstream PAC services are a frequent burden, even though such MA decisions contradict the professional judgment of the referring physician. We note that the HHS-OIG report actually highlights multiple examples of medically-necessary inpatient rehabilitation facility (IRF) care that should have been covered, raising the profile of this issue and the negative effects on Medicare beneficiaries. 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.

In addition, MA plans with narrow networks of PAC providers present challenges for patients referred for downstream specialized care that is not provided by the referring hospital, such as services covered by Original Medicare for IRFs and long-term care hospitals. These settings provide care through inter-disciplinary care teams with specialized clinical training and treatment programs that are critical to achieving patients' rehabilitation and recovery goals. Insurance constructs that result in inadequate PAC provider networks are a critical barrier to patients accessing these specialized services to which they are entitled.

With regard to financial incentives, it also appears that some MA plans may be motivated to keep a patient in the referring hospital for longer than is medically prescribed by the treating physician because the plan is reimbursing the hospital a flat rate. In this case, the plan is either delaying or attempting to avoid discharging the patient to the next site of care, which would require separate reimbursement. The result is that too many patients are being denied timely access to medically-necessary PAC care at the expense of MA plan policies, which, in some cases, are specifically designed to restrict coverage and payment to the greatest extent possible in order to boost plan profits.

- **Emergency Services.** Several large insurers have been denying or downcoding coverage of emergency services if the health insurer unilaterally determines that the condition did not warrant emergency-level care. Importantly, the plan makes this determination *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 (ED). Although this policy was purportedly designed to discourage inappropriate use of the ED (a goal hospitals and health systems share), it has instead been used as a blunt tool that causes patients to fear accessing medical services in the context of an emergency.

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.

In addition, these policies completely ignore hospitals' responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to assess and stabilize anyone who presents to the ED. They also ignore the application of the prudent layperson standard, which is established in federal law, and requires that the need for emergency services be evaluated based on what an average "prudent" person deems an emergency. It also requires health plans to provide coverage for emergency care based on symptoms presented at the time of the emergency, not based on the final diagnosis. It is often not known whether certain symptoms are the result of an urgent or non-urgent condition without medical examination and testing — and to determine if the situation was actually an emergency based on only the final outcome is wildly unreasonable and unfair to patients who go to a hospital seeking help when they think something is seriously wrong. It is particularly unconscionable that certain insurers have introduced these policies during the COVID-19 pandemic, at a time when policies that discourage patients from seeking care have the potential to be uniquely destructive and counter to the national public health response.

These policies are also introduced in the apparent absence of other more appropriate interventions which could discourage inappropriate use of the ED in ways that are not harmful to patients and health care providers. For example, health plans could work with network providers to ensure that primary and urgent care is available after hours or during non-business hours, or help to ensure greater access to same-day appointments with network providers.

The AHA deeply appreciates CMS addressing this issue in recent regulations related to the No Surprises Act. However, we continue to hear that some plans are effectively disregarding these regulations, including through inappropriate downcoding of claims or line-item denials that do not appear to regulators as a full denial.

- **Specialty Pharmacy Coverage.** Several MA plans, leveraging their owned or affiliated pharmacy benefit managers (PBMs), are implementing new specialty pharmacy coverage policies that are upending patient access to their medically-necessary medications and, in some cases, restricting access to their longstanding in-network providers. Specifically, these plans are no longer covering many physician-administered therapies unless the provider either agrees to use a drug provided by the plan's preferred pharmacy or the patient

goes to the plan's own or affiliated pharmacy for the administration of the drug. In the most egregious cases, the health plans are shipping medications directly to patients to either self-administer or to bring with them to their physician's office.

These actions pose significant risks to quality of care, while adding tremendous burden and cost to the health care system. Under these approaches, providers have inadequate control in ensuring the necessary drug supply will be available on the day of patient care or that the drugs it receives from the insurer's pharmacy have been appropriately stored and handled. Numerous delays in patient care — sometimes as long as weeks' long delays in cancer treatment — have been reported to the AHA by member hospitals. Increasingly, many hospitals and health systems are simply refusing to comply with these policies and caring for their patients with their own drug supply — having to absorb the financial losses of doing so. With respect to burden, these policies require providers to develop and manage separate inventory systems; coordinate delivery of individual patient medications from external pharmacies with which they do not have a contractual relationship; educate patients about their insurance benefits and delays to obtain needed medications elsewhere; and expend administrative resources to seek waivers.

These policies have grown as health plans have acquired or tightly partnered with PBMs. Three of the largest PBMs, which account for nearly 80% of PBM business across the country — CVS Caremark, Optum-Rx, and Express Scripts — all are owned by or aligned with major insurance carriers (Aetna, UnitedHealthcare and Cigna, respectively), two of which are substantial providers of MA plan coverage. And, while these plan-mandated specialty pharmacy policies are often justified as creating efficiencies in the health care system, the numbers point to another story. Between 2017 and 2019, PBM gross profit increased 12% to $28 billion and gross profit from PBM-owned mail order and specialty pharmacies increased more than 13% to $10.1 billion.[11] During the same time period, health insurance premiums increased by nearly 11%.[12] These figures suggest that such arrangements are not driving health system savings, but rather are increasing health plan profits and, therefore, overall health care system spending.

The HHS-OIG report specifically acknowledges that "CMS guidance is not sufficiently detailed to determine whether MAOs [Medicare Advantage Organizations] may deny authorization based on internal MAO criterial that go beyond Medicare coverage rules," and recommends new guidance on the appropriate use of MA plan clinical criteria in

[11] https://www.beckershospitalreview.com/pharmacy/pbms-profits-are-increasing-while-their-revenue-sources-remain-unclear-report-says.html
[12] https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf

medical necessity reviews.[13] This is a loophole that must be forcefully closed for the protection of patients and for the integrity of the Medicare program. **We strongly urge CMS to address the above five scenarios in this guidance by directing MA plans to align medical necessity and coverage criteria in these scenarios to traditional Medicare rules.**

Prior Authorization Processes. While alignment of medical necessity and coverage criteria is the single biggest challenge related to MA prior authorization policies, the actual process of complying with MA plan processes is in dire need of reform. Generally, providers must take the following steps to comply with prior authorization requirements, which are now applied to a wide range of care, including even the most routine and lower cost services:

- The clinician, or one of their office staff, must consult the MA plan's website to determine whether any part of the proposed care plan requires prior authorization. This is a manual process of staff culling through lists of "provider bulletins," which insurers generally issue on a monthly basis. The answer may be different for the same service being covered by the same insurer if the patient's specific plan applies different rules.
- The provider or their office staff must then collect relevant documentation that they believe establishes the patient's medical need for the particular service. However, as described above, because the plan's do not generally share which documentation is required nor the criteria used to determine patient eligibility, the initial document submission is generally the provider's best guess at what the MA plan will want to see.
- This information is then submitted according to the plan's unique submission requirements, which may include using its proprietary online portal, fax machines, or even sending via the US postal service.
- The provider must then await a response, which can often take multiple days and result in an inconclusive answer through a request for additional documentation or a call with the MA plan's clinical team, often referred to as a "peer-to-peer."
- If the authorization is approved, the provider generally proceeds with the care regimen. However, prior authorization does not ensure that the service will be covered. Once the provider submits the claim for reimbursement, the plan may require providers to undergo a similar process of submitting documentation to determine whether the plan will cover the care.
- If the authorization is denied, which they frequently are, the provider often initiates an appeal on behalf of the patient, which requires further documentation or peer-to-peer calls.

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

This heavily burdensome process contributes to patient uncertainty as to their prospective care plan and can leave them in limbo, facing delays in care while the aforementioned steps are completed. According to a 2021 American Medical Association survey, 93% of physicians reported care delays associated with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment.[14] We strongly encourage you to view how this impacts patients and their providers directly through this video compiled by Atrium Health.[15]

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 indicates that greater oversight of MA plans is needed to ensure appropriate beneficiary access to care. The HHS-OIG report provides several recommendations to begin to remedy the serious problem of improper denials, including for CMS to issue new guidance on the appropriate use of clinical criteria in medical necessity reviews, update audit protocols to identify abuses and direct plans to take steps to prevent and remedy both manual and system errors. Those recommendations are sensible, and the AHA applauds them. However, we urge CMS go further. Specifically, we urge the agency to:

1. **Work with Congress to Streamline MA Plan Prior Authorization Processes.** In recognition of the care delays and administrative burdens caused by MA plan prior authorization programs, a bipartisan group of senators — (Senators Roger Marshall (R-KS), Krysten Sinema (D-AZ), and John Thune (R-SD) — introduced the Improving Seniors' Timely Access to Care Act of 2021.This bill and its House companion aim to 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. We encourage CMS to support this legislation and to enact programmatic reforms to streamline MA plan prior authorization programs.

2. **Improve Data and Reporting.** While CMS is charged with overseeing and administering the Medicare program, we understand there are limited data reporting mechanisms available to provide CMS with information about plan-level coverage denials, appeals and grievances, or delays in care resulting from plan administrative processes. These are important indicators of beneficiary access and are necessary to ensure meaningful oversight of MA plans. We strongly urge CMS to establish standardized reporting on metrics related to coverage denials, appeals, and

[14] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[15] https://www.youtube.com/watch?v=RRbfEFJU_Ws

grievances. The data should be made publicly available and be stratified by insurer. CMS should more frequently audit plans that fail to report data or have a high rate of coverage denials, which may be an indicator of inappropriate practices.

3. **Conduct More Frequent and Targeted Plan Audits.** Pursuant to the HHS-OIG recommendations, we urge that CMS consider targeting audits to specific service types or MA plans that have a history of inappropriate denials. For example, given the pervasive concerns about inappropriate denials and delays for transfers to PAC settings, it is imperative that audit protocols be updated to address the issues identified in the report and ensure timely access to PAC services. Inappropriate denials for these services can have a significant impact on beneficiary health and well-being and should be the focus of greater plan audits to ensure appropriate oversight and enforcement of CMS rules, as suggested by the HHS-OIG. In addition, for audits of plan denials, we urge CMS to ensure that it utilizes reviewers with expertise in the relevant medical specialty being reviewed. This is especially important in the case of audits for PAC and IRF services, among others, where there is compelling evidence that auditors have inappropriately upheld IRF denials, in part due to a lack of training on IRF-specific admissions and coverage criteria.[16]

4. **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. As a result, providers are in the best position to help identify bad actors based on their own claims experience, but there is currently no streamlined or direct way for providers to report this information to CMS. We encourage CMS to establish a process for health care providers to submit complaints to CMS for suspected violation of federal rules.

5. **Align Traditional Medicare and Medicare Advantage Medical Necessity Criteria.** All Medicare participants, whether enrolled in an MA plan or traditional Medicare, deserve to have the same access to essential medical services. As reflected in the HHS-OIG report and discussed above, MA plans frequently adopt medical necessity criteria that are more stringent than FFS Medicare, restricting

[16] There is evidence that auditors have a track record of inaccurately upholding IRF denials, in part due to lack of training on IRF-specific admissions and coverage criteria, which requires unique and specialized knowledge. For example, it its October 2018 compliance review of Mobile Infirmary Medical Center, the HHS-OIG identified numerous IRF claims as wrongly billed. Ultimately a different contractor was retained to re-review the claims. The HHS-OIG agreed with the findings of the second review that 50% of its own reviewer findings (8 of 16) were incorrect. These findings underscore the importance of having IRF-trained personnel involved in audits of MA denials for coverage and payment and highlight the potential for inappropriate plan denials in PAC settings to go underreported. https://www.aha.org/lettercomment/2021-10-08-aha-comments-cms-review-choice-demonstration-inpatient-rehabilitation

access to services for MA enrollees, including inpatient admissions and post-acute care. The lack of transparency in the criteria for what constitutes medical necessity is a critical problem, and reflects the subjective nature of the criteria that plans commonly use to determine whether beneficiaries are eligible for services. The standardization in these criteria is an important step to ensure equity and appropriate access to covered services for all Medicare beneficiaries, regardless of enrollment type. We urge CMS to explicitly prohibit MA plans from utilizing medical necessity criteria that is more restrictive than the criteria used in traditional Medicare and particularly encourage you to point to examples discussed above in this guidance.

6. **Enforce Penalties for Non-Compliance.** While CMS already has broad authority to sanction or otherwise penalize plans for inappropriate care delays and denials, we encourage CMS to exercise this authority in instances in which MA plans fail to comply with federal rules, including the provisions recommended above regarding reporting and adherence to medical necessity criteria that are not more restrictive than traditional Medicare. Additional requirements are insufficient without enforcement action and penalties to support compliance.

7. **Provide Clarify on the Role of States in MA Oversight.** One of the challenges in regulating MA plans is the split responsibility between the federal and state governments. Generally, states regulate insurance carriers, including through rules related to consumer protections and market conduct. However, MA standards set forth in regulation by CMS pre-empt and supersede any state laws, regulations, contract requirements or other standards, except for provisions related to financial solvency and licensure. While there is a strong case for the pre-emption of state laws related to MA given the federal nature of the program, this structure underscores the need for comprehensive and timely oversight of MA plans by CMS. Without it, state regulators have no recourse to address problematic insurance practices to protect the consumers in their state. We are aware of several instances where states were interested in acting to hold MA plans accountable but lacked clarity on the scope of their authority.

8. **Reduce Incentives for Plans to Skimp on Coverage.** Some CMS policies may inadvertently incentivize plans to deny medically necessary care. Specifically, CMS policy allows plans to submit for risk adjustment purposes diagnoses codes for which care was either not delivered or for which care was delivered but coverage was denied. In other words, MA plans are permitted to submit diagnosis codes to bolster their own payments through the risk adjustment program but then turn around and deny payment to the provider for services to care for those diagnoses. This occurs frequently when payers either strike certain diagnoses when calculating

reimbursement on a claim or deny coverage altogether. We urge CMS to explicitly prohibit MA plans from claiming diagnoses for risk adjustment purposes if the plan has denied coverage for services provided to treat that diagnosis.

Conclusion

Thank you for your attention to the concerns we have raised. As the HHS-OIG report makes crystal clear, more sustained CMS oversight is needed to fully tackle this problem. **As a follow-up to this letter, we would like to request a meeting to further discuss our concerns and the next steps in addressing these issues.** We will follow-up with your office with a request to schedule a time for this discussion. We thank you in advance for the opportunity to meet and look forward to working with you on this important effort.

In the meantime, please contact me if you have any questions, or feel free to have a member of your team contact Michelle Kielty Millerick, senior associate director of policy at mmillerick@aha.org or Terrence Cunningham, director of policy at tcunningham@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President