American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 27, 2022

The Honorable Diana DeGette
Chair
U.S. House of Representatives
Oversight and Investigations
Subcommittee
Energy and Commerce Committee
Washington, DC 20515

The Honorable H. Morgan Griffith
Ranking Member
U.S. House of Representatives
Oversight and Investigations
Subcommittee
Energy and Commerce Committee
Washington, DC 20151

Re: Energy and Commerce Subcommittee Hearing on Medicare Advantage plans

Dear Chair DeGette and Ranking Member Griffith:

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) writes to thank you for holding an oversight hearing today on Medicare Advantage (MA) plans. We remain concerned about some MA plans' inappropriate restrictions on beneficiary access to medically necessary care, including those highlighted in a recent report issued by the Department of Health and Human Services' Office of Inspector General (HHS-OIG), and urge Congress to increase its oversight of these plans.

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, 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 worker burnout. An advisory issued last month 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 these harms are evidenced by the striking report issued in April by the HHS-OIG. As demonstrated by the findings, 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 enrollees than they would to the traditional Medicare program.

The AHA recently 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.

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.

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."[2] 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.

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[1] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.

The report 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, there is a perverse incentive to deny services to patients or payments to providers in order 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.[3,4]

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 health care system. Below is additional information on the types of issues that threaten access to medically appropriate care.

More Restrictive "Internal" Medical Necessity and Coverage Criteria. CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than fee-for-service 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 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.

- **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 a policy reduces patient access to care and undercuts quality improvement efforts to prevent, detect, treat, and improve sepsis care.

- **Inpatient Care Downgrades to Observation Status.** 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 that hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least

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

two midnights. Many MA plans have implemented policies that further restrict inpatient care by placing additional requirements to admission, which eliminate a patient's eligibility for post-acute care coverage and other benefits.

- **Eligibility for Post-Acute Care (PAC).** 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 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.

- **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.[5]

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. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. For each plan, providers and their staff must ensure they

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

are following the right 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 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.[6]

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 supports 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.

- **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.

- **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. We urge Congress to create legislative protections that prohibit MA plans from utilizing

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

medical necessity and coverage criteria that is more restrictive than the criteria used in traditional Medicare.

- **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 recommended above regarding plan 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.

- **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. In order 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 continue working with you to address these concerns and to ensure all Medicare beneficiaries have access to timely and appropriate care.

Sincerely,

/s/

Stacey Hughes
Executive Vice President