American Hospital Association™
Advancing Health in America

Fact Sheet: Improving Access to Care for Medicare Advantage Beneficiaries

The Issue

More than half of all Medicare beneficiaries rely on the Medicare Advantage (MA) program for their health care coverage. Hospitals and health systems have long supported the choice and innovation that a strong commercial health insurance market can provide. Unfortunately, some MA plan policies can hurt Medicare beneficiaries, drive up the cost of care and contribute to clinician burnout.

Specifically, some MA plans apply more stringent medical necessity criteria than Traditional Medicare, excessive prior authorization requirements and other utilization management tools that can limit patient access to timely care and require onerous and duplicative clinical documentation submissions to substantiate the need for services. These practices result in unnecessary delays and denials in care that can cause direct patient harm. A recent survey of patients found that 62% reported they had medical care delayed because of their insurance provider in the last two years. And nearly half of those patients (43%) say their health has gotten worse as a result.[1] In addition, these insurer practices add financial burden and strain to the health care system, requiring increased staffing and technology to comply with plan requirements, while also contributing significantly to health care worker burnout.

Background

Denying access to Medicare-covered services. The MA program is designed to cover the same services as traditional Medicare, and the Centers for Medicare & Medicaid Services (CMS) regulations require that MA plans not impose additional clinical criteria that are "more restrictive than Original Medicare's national and local coverage policies."[2] However, there has been mounting evidence from government agencies in the last few years highlighting how some of America's largest MA plans have been violating this basic legal obligation at a staggering rate. For example, a 2022 Department of Health and Human Services Office of Inspector General report found that 13% of MA prior authorization denials and 18% of MA payment denials actually met Medicare coverage rules and therefore were denied inappropriately.[3]

CMS addressed these challenges with provisions in the calendar year (CY) 2024 MA final rule, requiring that plans follow Medicare coverage rules and criteria and limiting plans from using their internal coverage criteria except for a limited set of circumstances. However, some of America's largest MA plans continue to apply more restrictive policies than Traditional Medicare. These divergent policies result in significant inequities in coverage between MA and Traditional Medicare and limit access to covered services for many MA plan beneficiaries, such as denials for inpatient level of care or post-acute stays after hospitalization. They also place substantial burdens on providers, who often must spend hours on the phone with insurers or resend documentation making the case that the patient needs the medical care they prescribed according to a set of rules that may not be fully transparent to them.

Greater audit and enforcement action is needed to ensure compliance with the new rules and to achieve parity with Traditional Medicare in coverage and access to services as intended.

American Hospital Association™
Advancing Health in America

Inappropriate and excessive prior authorization requirements that delay and deny care. Inefficient prior authorization requirements are a pervasive problem among certain plans in the MA program that result in delays in care and add financial burden and strain to the health care system. Plans vary widely on accepted methods of prior authorization requests and how to submit supporting documents. Many insurers continue to rely on fax machines and call centers to process prior authorization requests.

Plans that offer electronic submission methods often use proprietary plan portals, which each require a significant amount of time to access and upload electronic health record (EHR)-based clinical information. 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 contract year.

This heavily burdensome process contributes to patient uncertainty regarding their care plan and creates harmful delays in care. According to a 2023 American Medical Association survey, 95% of physicians reported care delays associated with prior authorizations, while 78% indicated that prior authorization hassles led to their patients abandoning treatment as a result.[4] These statistics indicate that prior authorization is often used in ways that are not in the best interest of patients and can actually have detrimental effects on their care and clinical prognosis.

In addition, it has been a longstanding challenge that health plan clinician reviewers who are reviewing prior authorization requests often do not have expertise or training in the requested service. Despite this, they are frequently put in a position to overrule a treating physician who has personally evaluated the patient and may have greater expertise or credentials in the service area. To address this concern in the 2024 MA final rule, CMS established a requirement that clinicians denying care based on medical necessity grounds have sufficient expertise in the applicable field of medicine for the service being requested. However, challenges persist in enforcing this important provision because health plan clinicians are not required to sign denial letters.

Lack of data on denials, appeals and grievances limits oversight and enforcement. While CMS is charged with overseeing and administering the Medicare program, 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 necessary to ensure meaningful oversight of MA plans. For example, plans with excessively high rates of service and payment denials compared to other plans, or plans with unreasonably high rates of beneficiary grievances, may indicate inappropriate behavior that warrants further inquiry or audit. Establishing standardized reporting on these metrics, developing a process for providers to submit complaints to CMS for suspected violations of federal rules, and penalizing plans for non-compliance could help enhance consumer protection and ensure appropriate oversight and enforcement.

AHA Take

The AHA greatly appreciates recent CMS rulemaking to streamline prior authorization and better align MA with coverage requirements under Traditional Medicare, which are important steps forward in protecting patients and reducing the cost and burden of prior authorization on patients, clinicians and our health care system. However, congressional action is needed to ensure greater oversight of MA plans as these rules are implemented and to enable CMS to enforce existing regulations designed to protect beneficiary access to medically necessary services.

Specifically, we urge Congress to:

1. **Streamline prior authorization processes to protect timely access to medical care and drugs covered under the medical benefit**. To accomplish this, the AHA supports the Improving Seniors' Timely Access to Care Act, which would streamline prior authorization requirements in MA. The legislation would make significant progress toward reducing complexity and promoting uniformity in prior authorization processes and requirements that frustrate both patients and providers. Additionally, the bill would significantly increase the specificity of prior authorization data reported by plans, which will give the Department of Health and Human Services greater insight into problematic plan processes and enable more targeted enforcement of policies designed to protect patient access to necessary care. The legislation also would apply provisions that streamline prior authorization to clinic-administered drugs covered under the medical benefit, such as injections typically used to treat cancer and other complex diseases.
2. **Require MA plan clinician reviewers who review coverage denials (adverse determinations) to sign their full name and credentials and attest they meet existing CMS rules and have relevant training and expertise in the requested service.**
3. **Improve data collection, reporting and transparency in the MA program with a focus on metrics that are meaningful indicators of patient access, such as appeals, grievances and denials.**
4. **Conduct more frequent and targeted plan audits based on the data collected.**
5. **Establish a more streamlined patient and provider complaint pathway for stakeholders to report suspected violations of CMS rules.**
6. **Apply penalties for non-compliance among plans that are consistently not acting in good faith to comply with CMS rules.**
7. **Expand network adequacy requirements for certain post-acute sites of care.**

End Notes:

1 aha.org/press-releases/2023-07-11-new-surveys-find-majority-patients-doctors-nurses-say-health-insurer-policies-reduce-access-care

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

3 oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

4 ama-assn.org/system/files/prior-authorization-survey.pdf