

## The Issue

Millions of Americans rely on commercial insurers for their health care coverage, including in the Medicare program through Medicare Advantage (MA) plans. 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, contribute to clinician burnout and drive up the cost of care.

Specifically, some MA plans frequently apply more stringent medical necessity criteria than traditional Medicare, apply excessive prior authorization requirements, use inappropriate utilization management tools, and require onerous and duplicative clinical documentation submissions to substantiate the need for services. These practices result in delays in care and can cause direct patient harm. In addition, they add financial burden and strain onto the health care system, requiring increased staffing and technology costs to comply with plan requirements, while also contributing significantly to healthcare worker burnout.<sup>1</sup>

## Background

**Denying coverage for patients' critical care.** 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."<sup>2</sup> However, a recent report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) 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 should have been granted.<sup>3</sup> Because the government pays MA plans a per-beneficiary capitation rate, there is a perverse incentive to deny services to patients and 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.<sup>4,5</sup>

**High rates of denials and prior authorization delays negatively affect patient care.** While prior authorization, when used appropriately, can help align patients' care with their health plan's benefit structure, it is frequently applied inappropriately in ways that delay care and harm patients, as evidenced by the HHS OIG report findings. Further, a 2021 survey by the American Medical Association of more than 1,000 physicians underscores the negative impact on patient care resulting from prior authorization. The survey found that more than one-third (34%) of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability or even death, for a patient in their care. Also, more than nine in 10 physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients abandon treatment due to authorization struggles with health insurers.<sup>6</sup> These statistics indicate that prior authorization policies are routinely not in the best interest of patients and can actually have detrimental effects on their care and clinical prognosis.

**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

<sup>1</sup> <https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf>.

<sup>2</sup> CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.

<sup>3</sup> <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

<sup>4</sup> <https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief/>.

<sup>5</sup> <https://www.forbes.com/sites/brucejapsen/2021/10/01/parade-of-health-insurers-expand-medicare-advantage-into-hundreds-of-new-counties/?sh=591ab1106b69>.

<sup>6</sup> American Medical Association, "2021 AMA Prior Authorization (PA) Physician Survey.", <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>.

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. 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 be indicative of 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.

**Overly restrictive and non-transparent medical necessity criteria.** MA plans commonly use medical necessity criteria and other clinical guidelines for determining whether to cover hospital services and admissions. These criteria often differ significantly by plan, and as the HHS OIG report found, are often more restrictive than those used by traditional Medicare. In addition, plans frequently do not share with providers the details of proprietary tweaks they make to standard clinical guidelines. As a result, patients seeking services and procedures considered clinically appropriate by traditional Medicare standards are frequently denied coverage. As a result, patients and their providers are largely blind to the rules by which they will be held. These divergent applications of medical necessity result in significant inequities in coverage and limit access to covered services for many MA plan beneficiaries. They also place substantial demands on providers who, in addition to facing constant questioning of their medical judgement by health plan administrators, must spend considerable time collecting and sending supporting documentation, as well as waiting to speak with health plan staff to finalize an approval. Standardizing medical necessity for Medicare patients regardless of enrollment type is needed to eliminate the subjective “black box” criteria that plans may use to impede beneficiary access to care.

## AHA Take

**The AHA urges Congress to pass legislation to improve the oversight of MA plans and the ability of CMS to enforce existing regulations that are intended to ensure appropriate beneficiary access to medically necessary services.** Congressional action is necessary to improve the timeliness and quality of MA data reported to the Secretary of Health and Human Services on coverage denials, appeals and grievances, which are important indicators of beneficiary access. We also call on Congress to create a pathway for health care providers to identify specific concerns about plan compliance with existing regulations and laws related to utilization management policies. These reporting mechanisms are necessary to ensure that federal regulators have sufficient data to provide meaningful oversight of MA plans and ensure compliance with the rules and laws that exist to protect beneficiary access to healthcare services.

**Additionally, congressional action is needed to specifically prohibit MA plans from using medical necessity criteria that is more restrictive than the criteria used for patients enrolled in traditional Medicare.** This effectively results in patients being denied medically necessary care that should be covered and creates inequities in access to care between those enrolled in MA plans versus traditional Medicare.

## Proposed Legislative Action

The AHA supports the **Improving Seniors’ Timely Access to Care Act (H.R.8487/S.3018)**, which would **streamline prior authorization requirements under MA plans**. We also believe additional legislation is needed to provide greater oversight of MA plans to ensure appropriate beneficiary access to care.

Specifically, we urge Congress to:

- **Establish penalties on plans when prior authorization processes leads to care delays**
- **Increase CMS oversight and enforcement**
  - Increased plan reporting on coverage denials, appeals and grievances
  - Public availability of plan performance data
  - Targeted audits based on plan performance
- **Create a process for providers to submit complaints to CMS**
- **Align medical necessity criteria across MA and the traditional Medicare program**
- **Expand network adequacy requirements for certain post-acute sites of care**