American Hospital Association™
Advancing Health in America

Health Plan Accountability Update

March 2023

TOP NEWS

AHA urges CMS to finalize prior authorization rule

AHA March 13 urged the Centers for Medicare & Medicaid Services to quickly finalize a proposed rule that would require Medicare Advantage, Medicaid and federally-facilitated Marketplace plans to streamline their prior authorization processes, but urged the agency to adequately enforce and monitor the requirements and test and vet any electronic standards before mandating their adoption.

"The proposed rule is a welcome step toward helping patients get timely access to care and clinicians focus their limited time on patient care rather than paperwork," AHA wrote. "However, to truly realize these benefits, we urge CMS to ensure a baseline level of enforcement and oversight. In addition, while hospitals and health systems appreciate CMS' effort to improve the electronic exchange of care data to reduce provider burden and streamline prior authorization processes, we urge CMS to ensure that any electronic standards are adequately tested and vetted prior to mandated adoption."

OIG: CMS should require MA plans to identify denied claims

The Centers for Medicare & Medicaid Services should require Medicare Advantage organizations to definitively indicate when they deny payment of a claim for service, the Department of Health and Human Services' Office of Inspector General recommended March 2.

"We found that adjustment codes are not a definitive method for identifying denied claims in the MA encounter data," OIG said. "The descriptions for some adjustment

codes are too vague to clearly identify whether the MAO denied payment for a service. … We also found that most 2019 MA encounter records contained at least 1 adjustment code and 55 million of these records contained codes that may indicate the denial of payments by MAOs. However, without a definitive method for identifying denied claims in the MA encounter data, the full scope of payment denials in the data is unclear."

In a separate report last year, OIG said CMS also should take steps to prevent MAOs from denying coverage and payment for medically necessary care.

AHA has urged CMS and the Department of Justice to hold MAOs and other commercial health insurers accountable for inappropriately and illegally restricting beneficiary access to medically necessary care, and CMS to strengthen data collection and reporting of plan performance metrics meaningful to beneficiary access, including denials, appeals and grievances.

AHA voices support for CMS proposals to strengthen MA oversight

Commenting Feb. 13 on the Centers for Medicare & Medicaid Services' proposed policy and technical changes to the Medicare Advantage program for contract year 2024, AHA voiced strong support for proposals to strengthen MA organization oversight and consumer protections and ensure greater equity between Traditional Medicare and the MA program.

"We especially appreciate CMS' proposals and clarifications to align and ensure greater equity between Traditional Medicare and the MA program and to explicitly codify that MAOs cannot indiscriminately deny services that would have been covered under Traditional Medicare," AHA wrote. "We believe the proposed changes will go a long way in ensuring that Medicare beneficiaries have equal access to medically necessary care and consumer protections and that those enrolled in MA will not continue to be unfairly subjected to more restrictive rules and requirements."

AHA urged CMS to quickly finalize and rigorously enforce these provisions.

"While these proposals are all critical steps forward in advancing patient access and holding MAOs accountable for adhering to federal rules, we believe a heightened level of enforcement and oversight is needed to facilitate meaningful change," AHA wrote.

Among other comments, AHA urged CMS to give hospitals and health systems a reasonable timeframe to quantify and return any potential government overpayments once identified.

AHA comments on proposed HIPAA transaction standards for health care attachments

The Department of Health and Human Services should adopt its proposed standard for claims attachments to help improve claims processing and eliminate unnecessary burdens on health care providers, AHA said in comments submitted March 21. However, AHA recommends HHS refrain from proceeding with its proposed standard for prior authorization attachments, which it called inconsistent with a recently proposed Centers for Medicare & Medicaid Services standard for prior authorizations.

HHS March 21 extended the comment deadline for the proposed HIPAA transaction standards for health care attachments through 5 p.m. ET April 21.

AHA releases 2023 Advocacy Agenda

America's hospitals and health systems are dedicated to providing high-quality care to all patients in every community across the country. The commitment to caring and devotion to advancing health has never been more apparent than during the last three years battling the greatest public health crisis in a century.

At the same time, hospitals and health systems are dealing with unprecedented challenges as they manage the aftershocks and aftermath of COVID-19. These include historic workforce shortages, soaring costs of providing care, broken supply chains, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden, just to name a few.

The American Hospital Association has been working to educate policymakers and the public about the significant challenges facing our field. The AHA in 2023 will work with Congress, the Administration, the regulatory agencies, the courts and others to positively influence the public policy environment for patients, communities and the health care field for years to come.

Building on the critical support obtained for hospitals and health systems in 2022, our 2023 Advocacy Agenda is focused on:

- Ensuring Access to Care and Providing Financial Relief
- Strengthening the Health Care Workforce
- Advancing Quality, Equity and Transformation
- Enacting Regulatory and Administrative Relief

We will work hand in hand with our members, the state, regional and metropolitan hospital associations, national health care organizations, and other stakeholders to implement our advocacy strategy and fulfill our vision.

NEW RESOURCES

- Video: AHA Reacts to CMS' 2024 Medicare Advantage Proposed Rule
- Webinar: CMS Proposed Rules on Medicare Advantage and Prior Authorization (Jan. 23, 2023)

WORTH A LOOK

- HealthCare.gov health plans denied 17% of in-network claims in 2021, Kaiser Family Foundation, Feb. 9. 2023
- When Medicare Advantage plans refuse to preauthorize care for patients, eight in 10 of those denials are overturned on appeal, Kaiser Family Foundation, Feb. 2, 2023
- Feds, states appeal UnitedHealth-Change Healthcare merger, Nona Tepper, Modern Healthcare, Nov. 18, 2022

TELL US YOUR STORY

We want to hear about your experience with commercial health plans and how inappropriate use of prior authorization, payment delays and other harmful policies are affecting your patients. We welcome submissions in writing or by video or image upload. We will not use any information publicly without your permission.

Login to our AHA member site, Health Plan Accountability page and scroll to the bottom to submit your story or experience. You may also upload documents, videos or other supporting material.

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