American Hospital Association™
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Health Plan Accountability Update

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TOP NEWS

CMS finalizes prior authorization rule; hospital event highlights need for rule

The Centers for Medicare & Medicaid Services Jan. 17 released a final rule requiring Medicare Advantage, Medicaid and federally facilitated Marketplace plans to streamline their prior authorization processes. AHA has urged the agency to finalize the rule to alleviate provider burden and ensure timely access to care for patients.

In a statement shared with the media, AHA said, "The AHA commends CMS for removing barriers to patient care by streamlining the prior authorization process. Hospitals and health systems especially appreciate the agency's plan to require Medicare Advantage plans to adhere to the rule, create interoperable prior authorization standards to help alleviate significant burdens for patients and providers, and to require more transparency and timeliness from payers on their prior authorization decisions.

"With this final rule, CMS addresses a practice that too often has been used in a manner that leads to dangerous delays in patient treatment and clinician burnout in the health care system. AHA is grateful to CMS for its efforts to improve patient access to care and help clinicians focus on patient care rather than paperwork."

CMS Administrator Chiquita Brooks-LaSure Jan. 17 visited Inova Fairfax Medical Campus in Virginia for a tour and roundtable discussion featuring hospital leaders and AHA staff. The event illustrated the patient impact of current prior authorization practices and procedures and the need for reform.

Perspective: Protecting Patient Care with Enhanced Medicare Advantage Oversight and Prior Authorization Changes

Stated in the Jan. 19 Perspective column, "The good news is that some MA plans live up to their responsibility to support patient care and access. The bad news is that not all of them do, including some of the largest commercial insurers."

MEDICARE ADVANTAGE NEWS

House letter on AI use in Medicare Advantage denials

Over 30 members of the House of Representatives Nov. 3 urged the Centers for Medicare & Medicaid Services to monitor and evaluate how Medicare Advantage plans use artificial intelligence and algorithms to guide their coverage decisions, and ensure these tools comply with Medicare rules and do not create barriers to care. Among specific actions, they urged CMS to require MA plans to report prior authorization data (including the reason for denial) by type of service, beneficiary characteristics and timeliness of prior authorization decisions, and attest that their coverage guidelines are not more restrictive than traditional Medicare. The House members also urged CMS to compare "guidance" generated by these tools with actual MA coverage decisions, and assess the data used to make coverage determinations and whether the AI/algorithms self-correct when a plan denial or premature termination of services is reversed on appeal.

"Medicare Advantage plans are entrusted with providing medically necessary care to their enrollees," they wrote. "While CMS has recently made considerable strides in ensuring that this happens, more work is needed with respect to reining in inappropriate use of prior authorization by MA plans, particularly when using AI/algorithmic software."

Report: U.S. hospitals face diminished reserves, mounting reimbursement challenges

Payment denials by Medicare Advantage plans jumped 56% for the median health system between January 2022 and June 2023, contributing to a 28% decline in median cash reserves, according to the latest analysis of data from over 1,300 hospitals and health systems by Syntellis Performance Solutions and the AHA. At the same time, maintenance expenses jumped 90% due to facility needs deferred during the COVID-19 pandemic, utility expenses rose 35%, professional fee expenses rose 33%, drug expenses rose 30%, and total labor expense rose 24% due to long-running labor shortages and other workforce challenges, the analysis found.

"The latest data highlight the persistent challenges that hospitals and health systems face in having the financial resources needed to maintain access to care for their patients, and to be prepared for the next crisis that may arise at any time," the report notes. "…Such challenges will only worsen unless regulatory agencies conduct greater oversight of problematic payer practices and address other administrative hurdles that further strain hospital resources, deplete cash reserves, and inhibit medically necessary care."

UnitedHealthcare clarifies new hospital services review process for Medicare Advantage plans

UnitedHealthcare has released a FAQ to clarify its hospital services review process for Medicare Advantage products effective Jan. 1, 2024, under the calendar year 2024 Medicare Advantage final rule. The FAQ explains a policy the insurer posted last November on hospital, emergency and ambulance services, which took effect Jan. 1.

MEDICARE ADVANTAGE RULEMAKING

CMS seeks input to strengthen Medicare Advantage data, transparency

The Centers for Medicare & Medicaid Services seeks input through May 29 on ways to strengthen Medicare Advantage data to guide policymaking and advance transparency. The request for information, which builds on a similar request in 2022, particularly expresses interest in data recommendations related to: beneficiary access to care, including provider directories and networks; prior authorization and utilization management, including care denials, appeals processes and use of algorithms; cost and use of supplemental benefits; MA marketing and consumer decision-making; care quality and outcomes; the impact of mergers, acquisitions and vertical integration; and special populations, such as individuals dually eligible for Medicare and Medicaid or with complex conditions.

AHA has urged CMS to hold MA plans accountable for inappropriately restricting beneficiary access to medically necessary care, including in comments responding to the 2022 RFI and recent comments on MA proposals for contract year 2025, which include recommendations on improving data collection and reporting necessary to conduct appropriate oversight of the MA program.

CMS proposes Medicare Advantage, Part D payment changes for CY 2025

The Centers for Medicare & Medicaid Services accepted comments through March 1 on its advance notice of proposed changes to Medicare Advantage plan capitation rates and Part C and Part D payment policies for calendar year 2025, which the agency estimates will increase MA plan revenues by an average 3.70%. This amounts to a $16 billion increase in overall payments but represents a -0.16% reduction in the 2025 benchmark rate compared to current policy. The notice proposes updating the Part C risk adjustment model through a phased approach to reflect ICD-10 condition categories, 2018 fee-for-service diagnoses and 2019 FFS expenditures; and Part C and Part D Star Ratings to reflect the latest regulations. It also describes changes and additions to the standard Part D drug benefit under the Inflation Reduction Act of 2022. CMS expects to publish the final 2025 rate announcement by April 1.

CMS releases FAQs on 2024 Medicare Advantage rule

The Centers for Medicare & Medicaid Services Feb. 6 released FAQs clarifying coverage criteria and utilization management requirements for Medicare Advantage plans under its final rule for calendar year 2024, which includes provisions intended to increase program oversight and create better alignment between MA and Traditional Medicare. Topics addressed by the FAQs include medical necessity determinations; algorithms and artificial intelligence; internal coverage criteria; post-acute care; the two-midnight benchmark for inpatient admission criteria; prior authorization; and enforcement.

AHA has urged CMS to increase oversight of the MA program and conduct rigorous enforcement of the new rules, highlighting the need for additional clarification of specific policies to ensure plan compliance.

CMS warns MA, Part D plans and PBMs to comply with new access requirements

The Centers for Medicare & Medicaid Services will closely monitor Medicare Advantage and Part D plans for compliance with new requirements effective Jan. 1 to ensure timely access to care, medications and vaccinations, the agency warned plans and pharmacy benefit managers Dec. 14.

"We remind plans that CMS will be conducting robust oversight to ensure Medicare Advantage organizations are complying with these new requirements, and we continue to review comments received on the additional proposals from the second rulemaking," the letter notes. Among other concerns, CMS said, "We urge plans and PBMs to engage in sustainable and fair practices with all pharmacies — not just pharmacies owned by PBMs — and we are closely monitoring plan compliance with CMS network adequacy standards and other requirements."

AHA has urged CMS to swiftly correct plans that appear to violate the MA final rule for calendar year 2024.

LEGISLATIVE ACTIVITY

AHA releases 2024 advocacy agenda

AHA Feb. 1 released its 2024 advocacy agenda, which details the association's key priorities for Congress, the Administration, regulatory agencies and courts. The agenda is focused on ensuring access to care, addressing government underfunding and providing financial sustainability; strengthening the health care workforce; advancing health care quality, equity and innovation; and relieving administrative burden.

Senators call for CMS to increase MA plan oversight, reporting requirements

The Centers for Medicare & Medicaid Services should require Medicare Advantage plans to submit additional data and the agency should publicly release the MA data it already collects, a bipartisan group of senators told the agency in December.
The letter requested a staff-level briefing by Dec. 27 on CMS' plan to improve its data collection and reporting practices for MA plans.

"Without publicly available plan-level data on prior authorization requests by type of service, timeliness of determinations and reasons for denials; claims and payment requests denied after a service has been provided; beneficiary out-of-pocket spending; and disenrollment patterns, policymakers and regulators are unable to adequately oversee the program and legislate potential reforms," wrote Sens. Elizabeth Warren, D-Mass.; Bill Cassidy, R-La.; Catherine Cortez Masto, D-Nev.; and Marsha Blackburn, R-Tenn.

AHA has urged CMS and the Department of Justice to hold Medicare Advantage plans accountable for inappropriately restricting beneficiary access to medically necessary care; and CMS to rigorously enforce changes included in the calendar year.

Committee probes Medicare Advantage marketing tactics

Senate Finance Committee Chairman Ron Wyden, D-Ore., Jan. 23 asked five third-party marketing organizations that participate in Medicare Advantage enrollment to provide certain information by Jan. 31 about their business practices as the committee continues its inquiry into problematic MA marketing practices. The request to eHealth, GoHealth, Agent Pipeline, SelectQuote, and TRANZACT seeks information on how the organizations use insurance agents, lead generators and other data.

"It has become clear that the lead generation industry remains a significant factor in the outrageous practices seniors have reported and TPMOs are complicit in these practices through the purchase of leads," the letter states.

PRIOR AUTHORIZATION

Prior Authorization Final Rule Will Improve Patient Access, Alleviate Hospital Administrative Burdens

Andrea Preisler, AHA's senior associate director of administrative simplification policy, wrote Feb. 15 why the recent final rule requiring Medicare Advantage, Medicaid and federally facilitated Marketplace plans to streamline their prior authorization processes should help reduce the burden on hospitals and clinicians and speed needed care for patients.

Survey: MA enrollees more likely to report care delays due to prior authorization

People enrolled in Medicare Advantage are more likely than those in traditional Medicare to report delays in care due to needed insurance approvals, according to a survey released Feb. 22 by the Commonwealth Fund, with 13% of traditional Medicare enrollees reporting associated delays compared with 22% of MA enrollees. The survey also included findings related to wait time to see a doctor, beneficiary use of supplemental benefits and overall coverage satisfaction.

NEW RESOURCES

- Handbook: CY 2024 Medicare Advantage Final Rule Implementation Handbook
- Podcast: The Effects of Medicare Advantage on Rural Hospitals With St. Bernards Healthcare
- Webinar: Medicare Advantage: Hospital Perspectives and Next Steps on the CY24 MA Final Rule
- Study: Commercial health insurance markets becoming more concentrated

WORTH A LOOK

- Seventy-three percent of U.S. commercial health insurance markets were highly concentrated in 2022, according to the latest annual report on health insurance

competition by the American Medical Association. In 90% of metropolitan statistical area markets, at least one insurer had a commercial market share of 30% or more, and in 48% of MSAs a single insurer's share was at least 50%. Fifty-three percent of markets that were highly concentrated in 2014 became even more concentrated by 2022, the study found. Among Medicare Advantage plans, UnitedHealth Group was the largest insurer by market share in 42% of MSAs.

- United Health is on a buying spree of outpatient surgery centers, STAT, Bob Herman, March 11

LETTERS, ADVISORIES AND STATEMENTS

- AHA Urges CMS to Swiftly Correct Medicare Advantage Plan Policies That Appear to Violate CY 2024 Rule, Nov. 20
- AHA Urges CMS to Swiftly Correct Medicare Advantage Plan Policies That Appear to Violate CY 2024 Rule, Nov. 20
- AHA Expresses Support for the No Fees for EFTs Act, Nov. 28
- AHA Urges MedPAC to Examine Medicare Advantage Denials, Hospital Market Baskets, Nov. 30
- AHA Comments on CMS' Proposed Medicare Advantage Policies for 2025, Jan. 5
- AHA Statement on "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers," Jan. 31
- CMS Issues Frequently Asked Questions Related to CY 2024 Medicare Advantage Final Rule, Feb. 21

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.

CONTACT US

Michelle Kielty Millerick
Senior Associate Director
Health Insurance and Coverage Policy
mmillerick@aha.org

Molly Smith
Group Vice President
Public Policy
mollysmith@aha.org

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