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

Statement

of the

American Hospital Association

for the

Committee on the Budget

of the

U.S. Senate

Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, 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) appreciates the opportunity to provide comments on ways to reduce administrative burden and costs in the health care system.

PRIOR AUTHORIZATION

Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the Medicare Advantage (MA) program. This results in delays in care, wasteful and potentially dangerous utilization of fail-first requirements for imaging and therapies, and other direct patient harms. These practices also add financial burden and strain to the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan requirements. Additionally, plan prior authorization requirements are a major burden to the health care workforce and contribute to provider burnout. In fact, Surgeon General Vivek Murthy, M.D., issued a recent advisory that notes that burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.

Many of the harms associated with inappropriate care delays and denials are evidenced by the striking report issued in April 2022 by the Department of Health and Human Services Office of Inspector General (HHS OIG). MA plans are denying medically necessary, covered services that met Medicare criteria at an alarming rate. The report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and therefore were inappropriate. In a program the size of MA, improper denials at this rate are unacceptable.

Streamlining the prior authorization process is vital to MA reform. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. The most common methods of prior authorization requests are fax machines and call centers. Additionally, plans that offer electronic submission methods most commonly use proprietary plan portals, which require significant time spent logging into a system, extracting data and completing idiosyncratic plan requirements. 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 contact year.

This heavily burdensome process contributes to patient uncertainty regarding their care plan and creates harmful delays in care. According to a 2022 American Medical Association survey, 94% of physicians reported care delays associated with prior authorizations, while 80% indicated that prior authorization hassles led to patient abandonment of treatment.

We greatly appreciate the new regulations issued by the Centers for Medicare & Medicaid Services, which will significantly reduce the burden associated with the prior authorization process. However, greater oversight of MA plans is needed to ensure appropriate access to care. 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, which would codify many of the reforms in the Interoperability and Prior Authorization Final Rule to streamline prior authorization requirements under MA plans by making them simpler and more uniform and eliminating the wide variation in prior authorization methods that frustrate both patients and providers. Additionally, we recommend that MA plans be required to deliver prior authorization responses within 72 hours for standard, non-urgent services and 24 hours for urgent services.

Conduct More Frequent and Targeted Plan Audits. We urge additional CMS audits be conducted and targeted to specific service types of MA plans that have a history of inappropriate denials or delayed prior authorization response timeframes.

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.

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 regarding plan reporting and adherence to medical necessity criteria that are not more restrictive than Traditional Medicare. In the recent contract year 2024 Medicare Advantage Rule, CMS noted that a number of the established regulations were already requirements under the health plan terms of participation in the MA program. Given MAOs historic lack of adherence to these rules, Congress should establish stronger programs to hold plans accountable for non-adherence. 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. 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.

PROMPT PAYMENT

In addition to challenges with inappropriate denials of care, hospitals and health systems are increasingly reporting significant financial impacts from insurers' failure to pay promptly. An AHA member survey found that 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old. Among the 772 hospitals surveyed, these delays amounted to more than $6.4 billion in delayed or denied claims that are more than six months old.

These delays add unnecessary cost and burden to the health care system, as combatting inappropriate delays and denials cost valuable time and resources, including resources needed to comply with insurer requests for additional documentation, physician peer-to-peer consultations and onerous appeal processes — and these processes may still be subject to other types of insurer audits or post-pay reviews that recoup payment to start the process all over again.

To address these concerns, the AHA urges Congress to add statutory prompt payment requirements for MA plans when services are furnished by in-network providers to enrollees of the MA plans and to subject the MA plans to interest penalties on the amounts owed if they fail to make timely payments.

GOLD CARDING

Gold carding programs substantially reduce administrative burdens and costs by streamlining access to care for Medicare beneficiaries. These programs help eliminate unnecessary delays in care by enabling providers who have demonstrated consistent

adherence to evidence-based guidelines to be granted exemptions for prior authorization requirements.

The AHA supports the GOLD Card Act of 2023 (H.R. 4968), which would exempt providers from requiring prior authorization for a MA plan year if the provider had at least 90% of prior authorization requests approved the preceding year.

CLAIMS ATTACHMENTS STANDARDIZATION

Health care providers are currently forced to use burdensome manual processes including mail, fax and online portals when they respond to documentation requests from health plans. The lack of standardization in the claims attachment process has created a significant source of administrative complexity and burden for hospitals and other providers. Standardization of the transmission of clinical data to support claims would greatly reduce the burden created by these inefficient manual processes and eliminate unnecessary claims processing delays.

The AHA supports CMS's proposed rule to standardize claims attachments under HIPAA. Requiring the use of a standard would improve the timeliness of patient billing and provider cash flow by reducing processing times between when a claim is submitted and when a health insurer issues payment. This would increase efficiency and help alleviate some of the financial strain facing many hospitals and health systems due to delays in payment. If CMS does not finalize a claims attachment standard rule, we urge Congress to explore ways to leverage its authority to address this issue.

CONCLUSION

Thank you again for your interest in increasing access to care while reducing unnecessary burdens and costs in the health care system. We look forward to working with you to support and advance these important issues.