American Hospital Association™
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Health Plan Accountability Update

October 2024

TOP NEWS

CMS releases new Medicare Advantage question and complaint process

The Centers for Medicare & Medicaid Services released a new complaint process for providers seeking assistance from the agency in resolving Medicare Advantage claims issues. MA oversight occurs across ten regional offices; however, with the new complaint process, MA provider inquiries and complaints will be processed through a centralized email, replacing the current process. While CMS reminds providers that the agency's role is not to determine medical necessity or payment amounts in disputed cases, the agency will seek to identify trends in provider complaints to investigate and address broader issues with MA plans where appropriate. AHA members can see the AHA's Member Advisory for more details on the new CMS process.

Report: Skyrocketing hospital administrative costs, burdensome commercial insurer policies affecting patient care

Hospitals and health systems are seeing significant increases in administrative costs, including due to burdensome practices by commercial insurers that often delay and deny care for patients, according to a new report released Sept. 10 by the AHA. Among other findings, the report highlights recent data from Strata Decision Technology showing that administrative costs alone account for more than 40% of total expenses hospitals incur in delivering care to patients. In addition, between 2022 and 2023, care denials increased an average of 20.2% and 55.7% for commercial and Medicare Advantage claims, respectively. For more on the significant financial pressures that continue to challenge hospitals' ability to provide 24/7 care for the patients and communities they serve, see the recent AHA Costs of Caring Report.

Agencies release final rule requiring mental health coverage parity

The departments of Labor, Health and Human Services and the Treasury Sept. 9 released a final rule ensuring commercial health plans comply with the Mental Health Parity and Addiction Equity Act of 2008 and require mental health and substance use disorder benefits at the same level as medical and surgical benefits. The rule finalizes standards for determining network composition and out-of-network reimbursement rates; adds protections against more restrictive, Non-Quantitative Treatment Limitations in coverage; and prohibits plans from using biased or non-objective information and sources that may negatively impact access to MH/SUD care when designing and applying an NQTL.

Report highlights unforeseen health care bills and coverage denials by commercial insurers

A Commonwealth Fund report published Aug. 1 examines how frequently insured, working-age adults are denied care by insurers; how often they are billed for services they believed were covered; and their experiences challenging such bills or care denials. The report shows that 45% of insured, working-age adults reported receiving a medical bill or being charged a copayment in the past year for a service they thought should have been free or covered by their insurance. Among other findings, 17% of respondents said that their insurer denied coverage for care that was recommended by their doctor, and nearly six of 10 adults who experienced a coverage denial said their care was delayed as a result.

MEDICARE ADVANTAGE: NEWS

AHA urges HHS OIG to further scrutinize Medicare Advantage organizations' use of prior authorization for post-acute care

The AHA Sept. 17 urged the Department of Health and Human Services' Office of Inspector General to further scrutinize policies and practices by certain Medicare Advantage Organizations (MAOs) that impede patient access to post-acute care and circumvent rules designed to ensure access and coverage parity between MA and Traditional Medicare. HHS OIG in June initially announced it would examine MAOs' prior authorization denials for post-acute care after a qualifying hospital stay.

CMS accepting comments on data collection, audit requirements for Medicare Advantage plans regarding compliance with CY 2024 final rule

The Centers for Medicare & Medicaid services Sept. 10 announced the opening of a 60-day public comment period regarding its proposed plan for new data collection and audit requirements for

Medicare Advantage plans in relation to compliance with the contract year 2024 MA final rule. CMS will accept comments until Nov. 12.

Analysis: Medicare Advantage prior authorization requests increase by 9 million in 3 years

More than 46 million prior authorization requests were submitted to Medicare Advantage insurers in 2022, according to KFF analysis released Aug. 6 examining data submitted by MA insurers to the Centers for Medicare & Medicaid Services on prior authorization requests, denials and appeals from 2019 through 2022. The 46 million requests in 2022 increased from 37 million in 2019. MA insurers fully or partially denied 3.4 million (7.4%) prior authorization requests in 2022, which is a larger share of denied prior authorization requests by MA plans compared to previous years. Only one in 10 (9.9%) denials from that year were appealed, however, a majority of those appeals (83.2%) resulted in overturned denials.

PRIOR AUTHORIZATION

UnitedHealth Group creates gold card program

UnitedHealth Group Aug. 1 announced the creation of a gold card program for qualified practices. Under the program, the practices that earn gold card status will not be required to submit prior authorization requests for certain medical, behavioral and mental health services. On Sept. 1, UHG said it will provide a full list of eligible services under the program and publish details on how to determine if your provider group has qualified for the program. The program is set to launch Oct. 1.

LEGISLATIVE ACTIVITY

House Education and Workforce Committee holds hearing on contracting provisions, telehealth legislation

The House Education and Workforce Committee advanced several bills Sept. 11, including legislation that would empower commercial insurance companies at the expense of patients and a bill that would ban facility fees for telehealth visits. The AHA sent the committee a statement opposing these bills. "This bill includes harmful contracting provisions that would prevent doctors and hospitals from negotiating reasonable agreements with commercial health insurance plans," AHA said about the Healthy Competition for Better Care Act. AHA also opposed the Transparent Telehealth Bills Act of 2024, which would cut hospital reimbursements for telehealth services since payment — including facility fees and any additional services — would be capped for facility-based providers at non-facility rates.

Senate Aging Committee holds hearing on transparency, health care costs

The AHA submitted a statement July 11 for a Senate Special Committee on Aging hearing on health care transparency and lowering health care costs. The AHA highlighted commercial insurer operating methods and prescription drug costs as cost drivers incurred by hospitals and health systems. AHA urged Congress for additional oversight of Medicare Advantage plans to stop tactics that restrict and delay care access and called for regulatory and legislative solutions to improve prior authorization processes.

NEW RESOURCES

Fact Sheet: Improving Access to Care for Medicare Advantage Beneficiaries

Data-driven strategies to combat MCO denial tactics

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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