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Advancing Health in America

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**Statement**

**of the**

**American Hospital Association**

**for the**

**Committee on Ways and Means**

**Subcommittees on Health and Oversight**

**of the**

**U.S. House of Representatives**

# Medicare Advantage: Past Lessons, Present Insights, Future Opportunities

**July 22, 2025**

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 strengthen the Medicare Advantage program to ensure that seniors have appropriate and timely access to care.

## STREAMLINE 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.

Streamlining the prior authorization process is vital to MA reform. MA plans widely vary in accepted prior authorization requests and supporting documentation submission methods. MA 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, thereby requiring significant resources. Currently, the most common methods of prior authorization requests are fax machines and call centers. Additionally, providers and their staff must follow plan-specific rules and processes, which vary substantially between plans and by service, and are often unilaterally changed in the middle of a contract year.

This heavily burdensome process contributes to patient uncertainty regarding whether they can access the care prescribed by their provider and leads to harmful delays in care. According to a 2024 American Medical Association survey, 93% of physicians reported care delays associated with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment.[1]

We greatly appreciate the regulations issued by the Centers for Medicare & Medicaid Services (CMS) in the Interoperability and Prior Authorization Final Rule, which will significantly reduce the burden associated with the prior authorization process.[2] However, greater oversight of MA plans is needed to ensure appropriate access to care. Our specific recommendations follow.

**Establish Controls for MA Plan Usage of Prior Authorization**

The AHA supports The Improving Seniors' Timely Access to Care Act (S. 1816/H.R. 3514), bipartisan legislation that 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. Specifically, this bill would establish an electronic prior authorization standard to streamline approvals, reduce the time a health plan is allowed to consider a prior authorization request, require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials, and encourage MA plans to adopt policies that adhere to evidence-based guidelines. The bill also would apply provisions that streamline prior authorization for clinic-administered drugs covered under the medical benefit, such as injections typically used to treat cancer and other complex diseases. **We urge Congress to pass this important bill to improve access to care for seniors.**

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[1] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[2] Centers for Medicare & Medicaid Services (CMS), Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals in the Medicare Promoting Interoperability Program; Final Rule, 89 Fed. Reg. 8758 (Feb. 8, 2024) (CMS-0057-F).

### Streamline Prior Authorization Processes for Post-acute Providers

One of the biggest challenges facing post-acute care providers and their patients is the ongoing restrictions MA plans place on access to care through the imposition of prior authorization. The issue has been well-documented by the Senate Homeland Security Committee and the Department of Health and Human Services Office of Inspector General and congressional investigations.[3,4] Delays experienced while awaiting an authorization slow down the patient's recovery, prevent the patient from recovering in a setting most appropriate to meet their needs, and tie up acute-care beds and resources that could be used for other patients in need. Accordingly, prior authorization practices for post-acute care are directly harmful to Medicare beneficiaries.

MA plans' practices have directly contributed to the growing discharge delay problems plaguing acute-care hospitals. The average length of stay (ALOS) prior to discharge to post-acute care settings has grown by 11.3% for MA patients between 2019 and 2024. For patients in Traditional Medicare, the ALOS has grown by only 5.2% according to industry benchmark data from Strata Decision Technology, LLC. Despite steps taken by CMS in recent years, providers have seen little to no meaningful change in MA plan behavior and no increased access for beneficiaries. Additionally, post-acute care providers still face challenges with MA plans listing them within their networks. CMS should conduct regular audits to ensure that MA plans include robust post-acute care options with sufficient bed spaces and resources to provide the in-network care that patients need.

**As MA enrollment continues to grow, we urge Congress to continue to rein in these harmful practices to ensure that post-acute care beneficiaries are not denied the timely care to which they are entitled.**

## INCREASE OVERSIGHT AND ENFORCEMENT OF EXISTING RULES

### Conduct More Frequent and Targeted Plan Audits

We appreciate CMS' recent efforts to strengthen the agency's audit capabilities to target risk adjustment overpayments to MA plans. We urge CMS to conduct additional programmatic audits targeting specific service types of MA plans that have a history of inappropriate denials or delayed prior authorization response timeframes. Data-driven, risk-based oversight of MA plan behavior allows CMS to respond promptly to issues that may impact beneficiary access to timely, medically necessary care.

### Enforce Penalties for Non-Compliance

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[3] https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf
[4] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Congress should ensure that CMS exercises its authority to enforce penalties for MA plans that fail to comply with federal rules, including 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 several established regulations were already required under the health plan terms of participation in the MA program. **Given the historic lack of adherence to these rules by MA plans, Congress should establish stronger programs to hold MA 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 insurance oversight responsibility between the federal and state governments. **To ensure that CMS and states exercise their authorities as needed, we encourage Congress to adjust the delineation of specific state and federal authorities' oversight and enforcement responsibilities by expanding the state authorities' role beyond oversight of state licensure and plan solvency.**

**Ensure Benefits Parity Between MA and Traditional Medicare**

The MA program is designed to enable commercial insurers to administer the Medicare benefits to plan enrollees. CMS regulations require MA plans to provide coverage of all services covered under Medicare Parts A and B, and direct MA plans to comply with CMS coverage rules — meaning that a beneficiary enrolled in an MA plan is entitled to coverage for any care that a similarly situated Traditional Medicare enrollee would receive. Despite these programmatic rules, providers and patients routinely report coverage denials for care to which they are entitled, indicating that plans frequently apply more restrictive coverage rules than CMS.

Many of the harms associated with inappropriate coverage denials are evidenced by the striking report issued in April 2022 by the Department of Health and Human Services Office of Inspector General. MA plans are denying medically necessary, covered services at an alarming rate that meet Medicare criteria. The report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and therefore were inappropriate.[5] The report highlights over 50 examples of such cases, including a 78-year-old patient diagnosed with pancreatic cancer who was inappropriately denied radiation treatment. In a program the size of MA with over 32 million enrollees, improper denials at this rate are simply unacceptable.

CMS has provided clear guidance to MA plans that they must apply the same inpatient admission criteria used in Traditional Medicare, including the Two-Midnight Benchmark. Under the standard, if a physician reasonably expects a beneficiary to require hospital

[5] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

care spanning at least two midnights and this expectation is supported by documentation in the medical record, then the admission is generally considered appropriate for inpatient status. Despite CMS' guidance, some MA plans continue to buck compliance by overriding physician judgment and denying inpatient claims that meet the Two-Midnight Benchmark by relying on internal algorithms or manual reviews that do not rely on CMS criteria. These practices result in inappropriate downgrades to outpatient status, delayed payments, increased administrative burden for hospitals, and barriers to patient access to timely, medically necessary care.

**We recommend that Congress require CMS to conduct more frequent audits of MA plan coverage criteria to ensure that it is not more restrictive than or inconsistent with CMS coverage rules. Additionally, CMS should enforce its regulations mandating parity across Traditional Medicare and MA, with penalties assessed on plans with a history of violations, including but not limited to Corrective Action Plans, civil monetary penalties, intermediate sanctions, and programmatic suspension or disenrollment.**

## STRENGTHEN THE MA PROGRAM TO INCREASE EFFICIENCY AND IMPROVE ACCESS TO CARE

### Prompt Payment Standards in MA Plans

In addition to challenges with inappropriate denials of care, hospitals and health systems are increasingly reporting significant financial impacts from MA plans' failure to pay promptly for services provided to patients for medically necessary, covered services. An AHA member survey found that 50% of hospitals and health systems reported having more than $100 million in unpaid claims from commercial health insurers 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.[6]

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. Many hospitals and health systems are forced to dedicate staff and clinical resources to appeal and overturn inappropriate denials, which alone can cost billions of dollars every year. Recent data from Strata Decision Technology show that administrative costs now account for more than 40% of the total expenses hospitals incur in delivering care to patients.[7]

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[6] https://www.aha.org/infographics/2022-11-01-survey-commercial-health-insurance-practices-delay-care-increase-costs-infographic

[7] https://www.aha.org/guidesreports/2024-09-10-skyrocketing-hospital-administrative-costs-burdensome-commercial-insurer-policies-are-impacting

**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**.

**Increase Network Adequacy for Post-Acute Care Providers**

In addition to prior authorization issues, patients and providers struggle with inadequate MA plan networks for post-acute care (PAC) providers. It is critical for providers who deliver basic benefits covered by Medicare to be appropriately represented in MA plan networks. Current MA network adequacy rules do not include specific requirements that inpatient rehabilitation facilities (IRF), long-term acute care hospitals (LTCH), and home health agencies (HHA) be included in provider networks. These settings provide rehabilitative care through interdisciplinary teams with specialized clinical training and treatment programs critical to achieving patients' rehabilitation and recovery goals. Insurance constructs resulting in inadequate PAC provider networks are a critical barrier to patients accessing these specialized services to which they are entitled.

CMS has explicitly stated that MA plans must cover IRF, LTCH, and HHA services when appropriate coverage requirements are met. For this care access to meaningfully be achieved, MA plans must be required to include these providers in their networks. **We recommend that Congress mandate that IRFs, LTCHs and HHAs be explicitly added to MA network adequacy requirements and that standards be adopted to ensure a sufficient number and type of each PAC facility available to the plans' MA enrollees.**

**MA Payment Parity for Critical Access Hospitals**

The MA program has grown significantly in the past decade. MA enrollment, which traditionally has grown more slowly in rural areas, is now surpassing the growth rate in urban areas. For example, MA enrollment quadrupled between 2010 and 2023 in rural counties, compared to metropolitan areas, which doubled in enrollment during the same period. Yet, MA plans are not required to pay critical access hospitals (CAHs) on the same cost basis as fee-for-service Medicare. Rather, they often pay below costs, straining the financial viability of many rural providers. Further, MA plans have the additional burden of prior authorization and other health plan requirements with which rural providers must increasingly contend — requirements that do not exist to nearly the same extent in Traditional Medicare and add additional costs for rural providers to comply. **We support legislation to ensure CAHs receive cost-based reimbursement for MA patients**.

**Inappropriate Downcoding**

MA plans increasingly auto-downcode emergency department claims after care has been delivered. These plans routinely reclassify high-acuity emergency department

visits to lower-level codes — often using proprietary algorithms rather than the clinical records — and then reimburse providers at the reduced, lower-acuity rate. The practice shifts costs onto providers who are forced into lengthy, costly appeals. Ultimately, it imposes unnecessary administrative burden and erodes the financial stability of providers. **We urge Congress to take steps to ensure that MA plans reimburse for care at appropriate levels rather than forcing providers to engage in overly burdensome appeals processes.**

**Require Transparency in MA Plan Denial Signatures**

Existing MA regulations require health plan clinicians who review and sign off on adverse medical necessity determinations to have relevant medical expertise and training in the field of medicine for the service being requested. However, there is limited transparency or accountability for this important provision because most health plan clinician reviewers do not sign denial letters or may only provide their initials, if anything, on the denial notice to the patient and/or provider. There are no requirements for the reviewer authorizing the denial to be identified or to attest that they have appropriate medical expertise to comply with CMS rules for reviewing adverse determinations. Therefore, neither the treating provider nor the patients can have confidence that an appropriate practitioner decided to deny coverage. Given the substantial role these clinicians play in patients' access to care, it is imperative that they and their providers have sufficient information to know whether their decision may have been appropriate and to follow up, if necessary. In addition, we believe this approach creates added accountability for clinicians working for health plans to put patients' needs first.

**The AHA supports legislation to require documentation of a medical review's identity and credentials as part of an adverse determination or denial notice that would be sent to the patient or provider, as applicable.**

**CONCLUSION**

Thank you again for your interest in strengthening the MA program to increase and improve access to care for seniors. We look forward to working with you to support and advance these important issues.