

The Issue

Hospitals and health systems increasingly report that Medicare Advantage (MA) plans are delaying payment for medically necessary care that has already been delivered, even when the care has been authorized. The plans frequently dispute whether a claim is “clean” and repeatedly request duplicative documentation or hold claims for reasons unrelated to whether the service was covered or payable. While federal rules impose prompt payment requirements for certain out-of-network MA claims, there is no comparable uniform federal standard for in-network MA claims.

AHA Take

The AHA supports legislation to close the MA prompt payment loophole to ensure that hospitals and health systems are paid in a timely manner for medically necessary care they have already delivered, including:

- **The Medicare Advantage Prompt Pay Act** (H.R. 5454/S. 2879), which would require MA plans to pay at least 95% of clean claims — that are clearly defined — within 14 days for in-network claims and 30 days for out-of-network claims. It also creates accountability for the MA plans by assessing civil monetary penalties if plans miss the deadline for prompt payment and requires the plans to publicly report compliance data, including the number of claims paid on time.
- **The Medicare Advantage Improvement Act** (H.R. 8375/S. 4384), which requires all qualifying claims for authorized items and services to be deemed as clean claims and paid consistent with Original Medicare’s prompt payment standard, which requires payment within 30 days.

Background

Currently, a “clean claim” is defined as one without a “defect or impropriety including any lack of any required substantiating documentation.” This broad definition gives MA plans discretion to unilaterally determine when a claim is clean and allows them to restart the prompt payment timeline by requesting additional materials or stating that the documentation was lost or not received, requiring providers to mail hundreds of pages of medical records. Plans may take these actions multiple times, meaning that a claim can be held up for weeks or months until the payer ultimately deems it clean.

An [AHA survey](#) found that 50% of hospitals and health systems report 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. These delays threaten hospitals’ and health systems’ ability to sustain services, support their workforce and invest in patient care. Additionally, plans generally do not face a uniform federal interest penalty when payment for in-network claims is delayed. This means delayed payment can operate as an interest-free loan from hospital and health systems to plans.

The Medicare Part D prescription drug program and Original Medicare have strong prompt payment standards that prevent payment delays in those programs. Medicare Advantage has a standard for out-of-network services but no similar standard currently exists for in-network services in the MA program.