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AHA Asks CMS and DOJ for Strong Action Against Excessive Insurer Prior Authorizations and Denials

The American Hospital Association (AHA) is calling on the federal government to provide greater oversight of Medicare Advantage plans as many "egregious health plan policies remain unchecked."

Coming off the heels of a report by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) finding that Medicare Advantage insurers often inappropriately deny prior authorization requests for covered services, the AHA has asked DOJ to establish a task force to investigate these practices under the authority of the federal False Claims Act.

AHA's General Counsel Melinda Hatton said in the May 19 letter, "As you know, the Medicare Advantage program is designed to cover the same services as original Medicare, and by law, Medicare Advantage Organizations (MAOs) may not impose additional clinical criteria that are 'more restrictive than original Medicare's national and local coverage policies.' OIG found that some of America's largest MAOs have been violating this basic legal obligation at a staggering rate."

Among the examples AHA cited from the OIG report were a 67-year-old stroke patient who was denied access to an inpatient rehabilitation facility even though the Medicare Benefit Policy Manual specifically mentioned his condition and symptoms should have been under the frequent supervision of a rehabilitation physician and a 93-year-old epilepsy and Alzheimer's patient who was denied access to a hospital bed with rails.

AHA noted this report was not the first time the OIG has found improper denials of covered services; a September 2018 OIG report had similar findings that the Centers for Medicare & Medicaid Services (CMS) has still not acted on. Given the problem has been allowed to continue and even increase since then, Hatton suggested "only the prospect of civil and criminal penalties can adequately prevent the widespread fraud certain MAOs are perpetrating against sick and elderly patients across the country, as well as against the public fisc every time commercial insurers take $1,000 per beneficiary while denying medically-necessary services."

In addition to calling for this action from DOJ, AHA is also encouraging the CMS to intervene. In a letter to CMS dated May 19, AHA warns about inappropriate insurer practices extending beyond Medicare Advantage plan violations.

Through a 2021 survey of AHA members, 78% of hospitals and health systems reported that their experience with both commercial and Medicare Advantage plans was worsening, and more than 80% reported increases in the time required for prior authorization approvals.

Separately, in a 2021 American Medical Association survey, 88% of physicians reported the burden of prior authorizations as high or extremely high, and 34% said the process has led to a serious adverse event for a patient in their care.

AHA details several policies that are of particular concern including declining payment for sepsis treatment, downgrading inpatient care to observation status, denials and delays for post-acute care services, denying or down-coding coverage of emergency services and restricting patient access to specialty pharmacies. AHA's letter emphasizes the concerns about patient harm from delayed care, and the overall unnecessary costs that are added to the health care system.

To address these issues, AHA offers several recommendations, including working with Congress to support the "Improving Seniors' Timely Access to Care Act of 2021." The bill, which is supported by WHA, would address prior authorization requirements under Medicare Advantage plans by eliminating wide variation in prior authorization policies and processes.

AHA also suggests improving collection of health plan data and reporting about denials, appeals and grievances, establishing standard metrics and publicly reporting insurer level information. Plans that have a history of inappropriate denials could be

targeted for audits. To help obtain this information, AHA encourages CMS to establish a process for health providers to submit complaints to CMS.

Other recommendations include aligning the medical necessity criteria used by Medicare Advantage plans with the criteria for traditional Medicare to ensure that plans are not using more stringent criteria and all beneficiaries are treated the same; enforcing penalties for noncompliance; reducing incentives for plans to deny medically necessary care; and clarifying the state role in oversight of Medicare Advantage plans.

AHA seeks “swift” action, saying that, “As evidenced by the findings, problems with MA plan utilization management and coverage policies have grown so large—and have lasted for so long—that strong, decisive, and immediate enforcement action is needed to remedy the harm that certain MA plans are perpetrating against sick and elderly patients, the providers who care for them, and American taxpayers, who currently pay MA plans more to administer Medicare benefits to enrollees than they would to the traditional Medicare program.”