



Charles N. Kahn III
President and CEO

June 27, 2022

The Honorable Diana DeGette
Chair
House Energy and Commerce Oversight and Investigations Subcommittee
2111 Rayburn House Office Building
Washington, DC 20215

The Honorable H. Morgan Griffith
Ranking Member
House Energy and Commerce Oversight and Investigations Subcommittee
2202 Rayburn House Office Building
Washington, DC 20215

Dear Chairman DeGette and Ranking Member Griffith,

On behalf of the Federation of American Hospitals (FAH), I am pleased to offer our strong support for the House Energy and Commerce Oversight and Investigations Subcommittee's efforts to examine potential abuses by Medicare Advantage (MA) plans in the hearing entitled, "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans."

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

As noted in the hearing's briefing memorandum¹, recent reports have raised concerns about program abuses by Medicare Advantage organizations (MAOs) and MA enrollees' ability to access medically necessary care. We especially support the recommendations made by the Office of the Inspector General (OIG) in its recent report, "Some Medicare Advantage

¹ Briefing Memorandum, June 24, 2022,
https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Briefing%20Memo_OI%20Hearing_2022.06.28_0.pdf

Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (OIG Report).² MAOs systemically apply problematic operating policies, procedures and protocols in addition to the problematic MAO practices identified in the OIG Report. We, therefore, urge Congress to exercise its broad oversight authority over MAOs to ensure beneficiaries maintain adequate access to their entitled benefits in the medically appropriate health care service setting.

As part of efforts to provide guidance to MAOs regarding the appropriate use of MAO clinical criteria for medical necessity reviews, the FAH asks Congress to urge CMS to clarify that MAOs, their downstream risk providers and their contracted hospitalists must provide their beneficiaries with inpatient coverage and providers with inpatient reimbursement (1) when appropriate under Medicare’s Two-Midnight Rule, and (2) when beneficiaries undergo procedures on the inpatient-only (IPO) list. These two Medicare fee-for-service clinical standards should be applied consistently to all MA beneficiaries since the MA program and the Medicare fee-for-service program serve the same demographic population and each of these beneficiaries are entitled to the same benefits as required by 42 C.F.R. § 422.100. In addition, the FAH urges Congress to examine MAO practices that particularly burden beneficiary access to specific types of care or facility types (especially inpatient rehabilitation facilities (IRFs) and long term care hospitals (LTCHs) because, as the OIG notes, MAOs may have an incentive to deny such care over cost concerns) by (1) issuing new guidance to ensure MAOs do not disproportionately burden beneficiary access to particular provider types or care through the use of more restrictive clinical criteria or requests for unnecessary documentation, and (2) undertake targeted audits focusing on IRF and other specific service types that have a history of inappropriate denials. Finally, the FAH urges Congress to examine and address MAO abuses more broadly to promote MA beneficiary access to timely and appropriate care.

I. Inappropriate MAO Utilization Controls Limit and Delay Beneficiary Access to Care.

The OIG Report identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from Medicare Advantage beneficiaries. Specifically:

- *Improper prior authorization denials.* The OIG found that thirteen percent (13%) of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that eighteen percent (18%) of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care

² Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General (“OIG”), OEI-09-18-00260, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>

for MA beneficiaries. FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, and deploy inappropriate pre- and post-payment denial policies, and even denying claims for previously approved services. These activities are often carried out by way of MAOs' downstream at-risk physicians and contracted hospitalists. All of these activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.

Many of these harmful practices arise from MAOs' adoption of inappropriate clinical criteria, and attention must be provided to protect beneficiaries by ensuring MAOs adhere to critical Medicare coverage rules. For example, instead of consistently and transparently applying CMS' Two-Midnight Rule, many MAOs use a variety of standards (including unique standards they develop and promulgate on their own) to determine whether a particular hospital stay meets their criteria for an inpatient admission. MAOs deny authorizations for inpatient admissions ordered by physicians and reclassify them as outpatient observation stays with troubling frequency, often using non-transparent, remote means of assessing medical necessity and overriding the treating medical professional's clinical decision. In addition, our members report that MAOs create financial incentives for contracted physicians to change the admission status before discharge and reduce the MAO's payment obligation to hospitals for services and care. Furthermore, members have reported MAO denials of inpatient coverage for procedures included on the Medicare IPO list, which is the single definitive source of guidance as to which procedures must be performed, for patient safety reasons, in an inpatient setting to be covered by Medicare. These practices are not appropriate utilization review activities; instead, they dilute the benefits provided to MA beneficiaries and undermine the benchmarking process used to fund MA coverage and ensure actuarial equivalence. *The FAH, therefore, urges Congress to recommend that CMS require MAOs and their contracted physicians—including their employed group physicians, downstream at-risk physicians and their hospitalists—follow the Two-Midnight Rule in determining patient status and the medical necessity of an inpatient admission and provide inpatient coverage and payment for each procedure on Medicare's IPO list.* The consistent application of these requirements across the Medicare program would promote transparency in and fiscal oversight of the MA program.

MAO clinical criteria and review practices may particularly burden beneficiary access to specific types of care, and the FAH supports the OIG's recommendation that CMS undertake targeted audits of particular service types that have a history of inappropriate denials. For example, some MAO plans use proprietary, non-CMS-endorsed standards to determine coverage for IRF services. These standards may direct beneficiaries to less intensive care settings, delaying or denying MA beneficiary access to the intensive, comprehensive, IRF-level care indicated by their condition and reducing access to their entitled benefits. The use of these proprietary standards creates confusion and administrative challenges for beneficiaries and providers and results in an inappropriate misalignment between the treatment of Medicare beneficiaries under the fee-for-service program and those in an MA plan. The OIG's report identified a number of cases in which the MAO improperly denied a request for prior authorization of IRF services. *Therefore, Congress should urge CMS to (i) issue new guidance to ensure MAOs do not use more restrictive clinical criteria or request unnecessary documentation, and (ii) undertake targeted audits focusing on IRF and other specific service types that have a history of inappropriate denials.*

In order to protect MA beneficiaries, the FAH urges Congress to implore CMS to exercise its broad MAO oversight authority and ensure beneficiary access to their entitled benefits by addressing MAO authorization and payment denials of care that meets Medicare coverage rules. As the OIG observed:

Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Further, beneficiaries enrolled in Medicare Advantage may not be aware that there may be greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.³

The FAH appreciates the OIG's recommendations, including the recommendations to issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews and to update CMS's audit protocols to address the issues identified by the OIG. We urge Congress to recommend the same to CMS.

II. Steps to Address Broader MAO Abuses and Protect Beneficiaries.

In addition to addressing the OIG findings concerning MAOs' inappropriate prior authorization denials, denials for lack of documentation, and payment denials, there are several other items to be addressed to prevent broader MAO abuses. By way of example, the FAH believes that the following MAO activities inappropriately burden providers and may adversely impact beneficiaries:

- **Network Adequacy:** As stated by the Subcommittee, a 2015 GAO report found that CMS does little to assess the accuracy of network data and reviews only one percent of all provider networks.⁴ MA beneficiary access to services and care is often more limited than it would appear in an MAO's Health Service Delivery (HSD) submission or provider directory that a beneficiary reviewed and relied upon during their open enrollment decision making process to choose an MAO. MAOs often use downstream organizations which direct care to a far narrower provider network, rendering network access to certain providers illusory. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups and their sub-capitation arrangements create a financial incentive to direct care to a particular provider or group, creating a *de facto* provider network at the downstream organization level that is far more limited than the MAO's advertised network. The FAH continues to recommend that action is needed to foster MAO network transparency to protect MA beneficiary's access to care by implementing audit protocols to identify and review the adequacy of downstream organizations' provider networks and taking appropriate network enforcement actions for noncompliance with network adequacy standards. In addition, the FAH believes that network adequacy should be incorporated in the Star Ratings Program.

³ OIG Letter at 20 (emphasis added).

⁴ Government Accountability Office, Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy (Aug. 2015) (GAO-15-710).

- Access to Post-Acute Care:** MA beneficiaries routinely experience inappropriate delays in discharge from the inpatient hospital setting due to MAOs' (1) lack of an adequate post-acute network, (2) lack of post-acute providers in MAOs' networks willing to accept beneficiary discharges, and (3) MAOs' utilization review activities, which include prior authorization to the post-acute setting. When a patient is ready for transfer from an acute-care setting to a post-acute environment (including LTCHs, IRFs, and skilled nursing facilities (SNFs)), the most appropriate course is the prompt and safe transfer of the beneficiary so s/he may begin to receive post-acute care (e.g., rehabilitation) in the most suitable environment. MAOs, however, often are financially incentivized to prolong beneficiaries' hospital stays (often paid at a case rate such as the MS-DRG system) rather than incurring the additional cost of post-acute provider days, and may delay discharges based on the lack of available or willing post-acute providers or utilization review activities. In addition, MAO's post-acute networks often do not include an adequate number of post-acute facilities to ensure that the appropriate facility is available and post-acute care is not delayed or disrupted. The FAH urges Congress to recommend that MAOs be required to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in MA beneficiary inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities. In addition, MAO practices should be audited associated with approving timely discharges to an appropriate post-acute setting. In contrast to FAH member experiences with MAOs, FAH members generally do not routinely experience these post-acute care issues in the Medicare fee-for-service beneficiary population.
- Risk Adjustment Claim Encounter Submissions:** The FAH understands MAOs currently include MA encounter data from denied (in part or in full), pended, and underpaid claims in their risk adjustment data submissions to CMS, resulting in increased risk adjustment payments that do not reflect the costs incurred by the MAO. This behavior is inconsistent with the purposes of the Part C Risk Adjustment Program and inflates Medicare spending without any corresponding beneficiary benefit. MA encounter data should be limited for the Risk Adjustment Program to data derived from fully paid claims or, in the case of a provider that accepts capitation, provider encounter data.
- Use of Third-Party Contractors to Perform Audits.** MAOs often hire private contractors on a contingency fee basis to conduct a variety of audits on a pre-payment or post-payment claims basis. These audit types include (1) charge audits, where the contractors inappropriately remove Medicare covered charges from claims; (2) MS-DRG audits, where the contractors use proprietary software to downgrade the underlying diagnoses necessary to support a DRG by inappropriately removing or rebundling billed ICD-10 codes; and (3) medical record audits, where the contractors question the accuracy of physician documentation regarding the beneficiary's health and associated comorbidities that support the underlying diagnosis and medical necessity. These audits are undertaken without any clinical basis and regularly fail to include an adequate explanation for the contractor's conclusions. Through this process, remote third-party contractors overrule the professional opinion of the treating professionals, despite often lacking the relevant clinical training or expertise. MAOs' delegation to these contractors frequently creates confusion due to poor communication between MAOs and their contractors. These issues are exacerbated

due to convoluted appeal processes, as discussed below. While the FAH acknowledges that MAOs are obligated to conduct reasonable audits, we are concerned that contingency fee audits conducted by MAOs' contractors are improperly motivated by financial incentives, fueling a "bounty hunter" mentality, and inappropriately burdening providers caring for MA beneficiaries. CMS acted several years ago to curb these types of unfair practices under the Medicare fee-for-service recovery audit contractor (RAC) program and Congress should urge CMS to exercise similar oversight of these practices under the MA program.

- **Appeal Rights:** MA providers' appeal rights are typically governed by their agreements with MAOs. The MAOs' appeals processes are complex, cumbersome, not standard across plans, often not automated, and require significant administrative resources and staffing for health care providers.
- **Improving Transparency and Quality Incentives for MA Stars Ratings Program:** In addition to our recommendations on policy improvements to protect patients in MA, we request that Congress urge CMS to consider further refinements to its MAO oversight by developing new quality measures for MAO operations that could be included in the Star Ratings Program, as current data suggests that the MA quality bonus program as it is has not improved MA plan quality⁵. New quality measures should be developed to rate and report on patient access problems related to Level 1 appeals and denial overturn rates for prior authorization, appeals and overturn rates for payment denials, network adequacy, and service delays. This will greatly improve transparency regarding MAO operations and help reduce patient access issues due to inappropriate MAO initial determinations.

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The FAH appreciates the opportunity to offer these insights. We are committed to working with Congress to ensure America's seniors in MA plans have improved access and better care. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "Nigam", written over a horizontal line.

⁵ See Briefing Memorandum (June 24, 2022) at page 7.