AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. Hrg. 118–144

EXAMINING HEALTH CARE DENIALS AND DELAYS IN MEDICARE ADVANTAGE

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MAY 17, 2023

Available via the World Wide Web: http://www.govinfo.gov

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

EXAMINING HEALTH CARE DENIALS AND DELAYS IN MEDICARE ADVANTAGE

S. Hrg. 118–144

EXAMINING HEALTH CARE DENIALS AND DELAYS IN MEDICARE ADVANTAGE

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MAY 17, 2023

Available via the World Wide Web: http://www.govinfo.gov

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

U.S. GOVERNMENT PUBLISHING OFFICE
52–437 PDF WASHINGTON : 2023

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

GARY C. PETERS, Michigan, *Chairman*

THOMAS R. CARPER, Delaware	RAND PAUL, Kentucky
MAGGIE HASSAN, New Hampshire	RON JOHNSON, Wisconsin
KYRSTEN SINEMA, Arizona	JAMES LANKFORD, Oklahoma
JACKY ROSEN, Nevada	MITT ROMNEY, Utah
ALEX PADILLA, California	RICK SCOTT, Florida
JON OSSOFF, Georgia	JOSH HAWLEY, Missouri
RICHARD BLUMENTHAL, Connecticut	ROGER MARSHALL, Kansas

DAVID M. WEINBERG, *Staff Director*
ZACHARY I. SCHRAM, *Chief Counsel*
WILLIAM E. HENDERSON III, *Minority Staff Director*
CHRISTINA N. SALAZAR, *Minority Chief Counsel*
LAURA W. KILBRIDE, *Chief Clerk*
ASHLEY A. GONZALEZ, *Hearing Clerk*

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

RICHARD BLUMENTHAL, *Chairman*

THOMAS R. CARPER, Delaware	RON JOHNSON, Wisconsin
MAGGIE HASSAN, New Hampshire	RICK SCOTT, Florida
ALEX PADILLA, California	JOSH HAWLEY, Missouri
JON OSSOFF, Georgia,	ROGER MARSHALL, Kansas

JENNIFER N. GASPAR, *Staff Director*
BRIAN DOWNEY, *Minority Staff Director*
KATE KIELCESKI, *Chief Clerk*

CONTENTS

	Page
Opening statements:	
Senator Blumenthal	1
Senator Johnson	3
Senator Marshall	18
Prepared statements:	
Senator Blumenthal	33
Senator Johnson	35

WITNESSES

WEDNESDAY, MAY 17, 2023

Megan H. Tinker, Chief of Staff, Office of Inspector General, U.S. Department of Health and Human Services	6
Jeannie Fuglesten Biniek, Ph.D., Associate Director, Program on Medicare Policy, KFF	7
Christine Jensen Huberty, Lead Benefit Specialist Supervising Attorney, Greater Wisconsin Agency on Aging Resources	9
Lisa M. Grabert, Visiting Research Professor, Marquette University College of Nursing	10
Gloria Bent, Widow of Gary Bent, Medicare Advantage Enrollee	12

ALPHABETICAL LIST OF WITNESSES

Bent, Gloria:	
Testimony	12
Prepared statement	99
Fuglesten Biniek, Jeannie Ph.D.:	
Testimony	7
Prepared statement	45
Grabert, Lisa M.:	
Testimony	10
Prepared statement	87
Huberty, Christine Jensen:	
Testimony	9
Prepared statement	55
Tinker, Megan H.:	
Testimony	6
Prepared statement	37

APPENDIX

Chair Blumenthal Exhibit—Patient denied poster	104
Chair Blumenthal Exhibit—Average 2021 Gross Margins per Enrollee poster	105
Chair Blumenthal Exhibit—2021 Medicare Advantage Price Authorization Denials	106
Chair Blumenthal Exhibit—naviHealth Predict	81
Ranking Member Johnson Exhibit—Health Care: Who Pays Chart	107
Senator Marshall exhibits	108
Statements submitted for the Record:	
American Academy of Dermatology Association	120
Alliance of Specialty Medicine	126
American Hospital Association	131
Bristol Health	138
American Medical Rehabilitation Providers	145
Medical Group Management Association	165

EXAMINING HEALTH CARE DENIALS AND DELAYS IN MEDICARE ADVANTAGE

WEDNNESDAY, MAY 17, 2023

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2 p.m., in room 562, Dirksen Senate Office Building, Hon. Richard Blumenthal, Chair of the Subcommittee, presiding.

Present: Senators Blumenthal [presiding], Hassan, Ossoff, Johnson, Scott, Hawley, Marshall, and Lankford.

OPENING STATEMENT OF SENATOR BLUMENTHAL[1]

Senator BLUMENTHAL. I would like to call to order the meeting of the Permanent Subcommittee on Investigations (PSI). Our first hearing of this session. I want to recognize the extraordinary and distinguished history of this panel in rooting out waste and fraud and abuse in government, and thank my Ranking Member, partner in this effort, Senator Johnson.

It has been a bipartisan effort in the history of this panel, and we are seeking to continue that tradition. When I was appointed earlier this year, I pledged to continue the work of this Committee in insisting on accountability.

Our work is already underway, and we are meeting today to protect seniors who are enrolled in Medicare Advantage (MA) plans who face unacceptable barriers in accessing necessary care and treatment. Medicare is the safety net that ensures that all American seniors receive the health care they need.

Medicare Advantage, run by insurance companies, is becoming an increasingly integral part of that program. As of 2023, more than 30 million Americans were enrolled in Medicare Advantage plans, representing more than half of Medicare eligible Americans. This number is only continuing to grow. I want to be clear, I support Medicare Advantage programs, the flexibility that they provide for seniors across the country.

Many seniors are very happy with Medicare Advantage and want to continue with them. But the reason we are here today is that all too often the big insurance companies that run Medicare Advantage plans have been failing seniors when they need treatment and care.

[1] The prepared statement of Senator Blumenthal appears in the Appendix on page 33.

Medicare Advantage insurers are required to provide beneficiaries with the same minimum level of coverage as traditional Medicare. Yet we have seen evidence indicating that in many instances, they are failing to do so.

In fact, failing entirely because they are denying or delaying care. Tragically we have heard from many families who faced denials in the middle of major medical crises, forcing them and their loved ones to fight even as they are fighting for their lives. The fight for insurance coverage is detracting from the fight for their health.

Perhaps most troubling of all, there is growing evidence that insurance companies are relying on algorithms, rather than doctors or other clinicians, to make decisions to deny patient care.

In a report released last year, the Inspector General (IG) of the Department of Health and Human Services (HHS) identified a large number of instances where Medicare Advantage companies refused to authorize treatment for care that clearly met Medicare coverage requirements. In one case,[1] a cancer patient had a common scan, needed to determine if the disease had spread, delayed by their insurer for more than a month.

Another an insurer refused a walker to a 76 year old patient. The insurance company argued that this patient had been provided a cane within the past 5 years and therefore did not need a walker. In each of these cases, the insurer's decision overlooked the treating physician's assessment of what their patient needed.

Our Subcommittee has been hearing from patients and providers alike who have stories of care being delayed or denied. Many of these stories involve patients who have been hospitalized for serious medical issues, and who need nursing home or rehabilitative care before they are ready to return home.

These denials have become so routine that some patients can predict the day on which they will come. Advocates who have helped patients appeal denials of medically necessary care have uncovered documents showing that these decisions are not being made by doctors or other trained professionals at all. Instead, companies are using algorithms that have been programed to predict how much care a patient needs without ever meeting a patient or their doctor.

Insurers may refer to these algorithms as tools used for guidance, but the denials they generate are too systematic to ignore. All too often, black box algorithms—artificial intelligence (AI) and algorithms have become a blanket mechanism for denial, and the insurance companies insist that those AI mechanisms are proprietary.

But part of what needs to happen is to make them more transparent so that patients and providers know, along with the public, how they are being used. Major insurance companies who run Medicare Advantage plans are making record profits. Gross margins for Medicare Advantage[2] enrollees are well over double those

[1] The poster referenced by Senator Blumenthal appears in the Appendix on page 104.
[2] The Gross Margin poster referenced by Senator Blumental appears in the Appendix on page 105.

for individual market, group market, or Medicaid managed care enrollees.

The largest Medicare Advantage provider, even said in its most recent report, that a major reason for their increase in revenue between 2021 and 2022 was, in fact, the growth of Medicare Advantage. This chart speaks volumes about the burgeoning profits of Medicare Advantage plans, in part because of the denial or delay of care.

Insurers are, in effect, denying Americans necessary care in order to fatten and pad their bottom lines, and that phenomenon is unacceptable. The information that this Subcommittee has uncovered so far, and that we will hear today, demonstrates the need for additional investigation into the practices of these powerful insurance companies.

I want to put these companies on notice. If you deny lifesaving coverage to seniors, we are watching. We will expose you. We will demand better. We will pass legislation if necessary, but action will be forthcoming. Today, we sent bipartisan letters to the nation's largest Medicare Advantage insurers, UnitedHealth, Humana, and Consumer Value Store (CVS).

They collectively cover more than 50 percent of Medicare Advantage beneficiaries. We are asking for internal documents that will show how decisions are made to grant or deny access to care, including how they are using AI. Our nation's seniors should not have to fight to receive medically necessary care. I look forward to hearing from today's witnesses.

I want to thank each of you for being here, because each of you has an important aspect of this story to illuminate. Again, I want to thank the ranking member for his involvement and contribution and turn to him now for his comments.

STATEMENT OF SENATOR JOHNSON

Senator JOHNSON. Thank you, Mr. Chairman. I want to welcome you to the Permanent Subcommittee on Investigations. This is a long bipartisan tradition of uncovering waste, fraud, abuse, and outright corruption.

The Subcommittee's previous work provided much needed transparency to the public, and I look forward to continuing that tradition with you as the new chairman. What I would like to do is enter my prepared remarks in the record[1] and speak extemporaneously here.

The hearing today is going to be focusing on what I would consider an issue caused by a third-party payer system. When I was in the private sector, I would be renewing my insurance coverage year after year. It was amazing how every year had to talk to the insurance agent, OK, what is been excluded this year. It never made any sense.

But that is what insurance carriers are trying to do, they are trying to exclude things based on the actuarial tables to try and limit the cost of the insurance. We see the exact same phenomenon when insurance carriers, in this case Medicare Advantage carriers, are

[1] The prepared statement of Senator Johnson appears in the Appendix on page 35.

trying to limit the abuse potentially of some services. They get into this pre-certification process.

But what I would argue is that we will probably addresses this through some kind of government bureaucratic action, which I would say probably is not going to work. Part of the problem here is a trend over time, where we have pretty well removed the benefit of free market competition from health care.

I was trying to point out there are two areas of our economy that we are habitually dissatisfied with, health care and education. They are largely monopolies. We have driven the benefit of free market competition out of them. To reiterate what free market competition does, it generally guarantees—it is not perfect, but it generally guarantees the best possible price, the best level of customer service, the best quality of service.

That is what a free market does. We are not getting that in Medicare Advantage necessarily. We are not getting it oftentimes in education. I do have the chart[1] right here, shows you the trend over time.

As you go further back in time, this is even more stark, but these are numbers are pretty solid. Back in 1949, $0.68 for every dollar in health care was paid for by the patient, and $0.32 was paid by some third-party payer, primarily back then, some kind of insurance system. Now, only $0.11 of every health care dollar is paid for by a consumer and $0.89 is paid for largely by government or by third party payer insurance companies.

When you have consumers not worried about the cost of things, the prices go out of control. If we had the same system, for example, operating in food, we would all be eating filet mignon every night, or in autos, we would all be driving Maseratis.

We need to look at the root cause. The root cause of this problem, truthfully, is we have driven consumerism out, which has then driven insurance carriers to have these pre-authorization programs, pre-certification, and they are always far from perfect. Yes, I am going to try and continue in this Subcommittee to focus on the root cause and actually fix these problems rather than always be looking at very expensive Band-Aids.

We have a lot of problems. I think the Coronavirus Disese 2019 (COVID–19) pandemic exposed an awful lot of problems within our medical establishments and our Federal health agencies who have been captured by big pharma.

Talking to the Chairman, I think there is an awful lot of agreement we have. I am highly concerned about the negative impact of pharma companies spending billions of dollars, capturing our media, as they have captured our health agencies as well.

I fully support what we are doing here in this hearing. Taking a look at the abuses of the pre-certification process and denials, of unnecessary treatment in Medicare Advantage, but there is so much more we have to look at, and I really hope that we can work together in a nonpartisan fashion because these are problems we need to fix for the American public. Again, thank you. Look forward to your testimony.

---

[1] The chart referenced by Senator Johnson appears in the Appendix on page 107.

Senator BLUMENTHAL. Thank you very much. Let me introduce the witnesses, and then as we customarily do, I am going to swear you in before your testimony. Welcome to Megan Tinker, Chief of Staff of the Department of Health and Human Services, Office of Inspector General (OIG). In that role, Ms. Tinker serves as the Deputy Inspector General for the IOG's immediate office, and oversees OIG Office of Congressional Affairs, Office of Communications, and Office of Operations.

Dr. Jeannie Fuglesten Biniek is Associate Director of the Program on Medicare Policy at Kaiser Family Foundation (KFF). Dr. Fuglesten Biniek previously worked as an Economist on the Staff of the Senate Budget committee and has held positions with an economic consulting firm and numerous nonprofit policy organizations.

Christine Jensen Huberty is the Lead Benefit Specialist Supervising Attorney for the Greater Wisconsin Agency on Aging Resources (GWAAR). Ms. Huberty provides free legal assistance to seniors in Northern Wisconsin on issues including Medicare, Medicaid, Social Security, Supplemental Nutrition Assistance Program (SNAP) benefits, housing law, and consumer law.

She has represented numerous seniors who have faced denials of care in their Medicare Advantage plans.

Lisa Grabert is a visiting Research Professor at Marquette University College of Nursing. Her research focuses on Medicare with an emphasis on post hospitalization. She has previously handled health care policy while on the staff of the House's Ways and Means committee.

Gloria Bent is the widow of Gary Bent, a Medicare Advantage plan enrollee. Ms. Bent is a former registered nurse, a retired director of religious education, and the mother of four children. Ms. Bent was married to Gary Bent for 56 years until his death on March 3 of this year. During his life, Gary Bent served as an ordinance corps officer in the United States Army, high school physics teacher, and he spent 23 years as a professor in the physics department of the University of Connecticut.

Ms. Bent spent much of her time during Mr. Bent's last year of life advocating for him to receive needed benefits under his Medicare Advantage plan, and we look forward to hearing more from her about that experience today.

If you would, please rise, I will swear you in. Do you swear that the testimony that you are about to give will be the truth, the whole truth, and nothing but the truth so help you, God?

Ms. TINKER. I do.

Dr. FUGLESTEN BINIEK. I do.

Ms. HUBERTY. I do.

Ms. GRABERT. I do.

Ms. BENT. I do.

Senator BLUMENTHAL. Thank you. Ms. Tinker, why don't you begin.

TESTIMONY OF MEGAN H. TINKER,[1] CHIEF OF STAFF, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. TINKER. Good afternoon, Chairman Blumenthal, Ranking Member Johnson, and other distinguished Members of the Subcommittee. I am Megan Tinker, Chief of Staff for the HHS Office of Inspector General. I appreciate the invitation to discuss OIG's important Medicare Advantage work.

Today, I will highlight a critical issue assessed by OIG reports, potential barriers seniors may face when accessing care under Medicare Advantage. Based on data released this month, 30 million individuals, or 50 percent of all Medicare enrollees are now in Medicare Advantage. That is a significant number of Americans who rely on plans to authorize and pay for the care they need.

This expansion has been rapid. A decade ago, only 29 percent of Medicare enrollees were in Medicare Advantage. Fast growth has increased vulnerabilities and the need for robust program integrity measures. OIG work has demonstrated that the risks of fraud, waste, and abuse in managed care are significant.

Last month, Inspector General Christy Grim spoke to a group of managed care plan executives. She emphasized that Medicare Advantage plans need to step up their efforts and focus on preventing the types of issues OIG work continues to find. One area of concern highlighted by OIG work and raised by this Subcommittee, are plan practices that impede access to care. I would like to highlight some of OIG's work on this topic.

In an evaluation published in April 2022, OIG found that Medicare Advantage plans sometimes delayed or denied enrollees' access to medical care, even though the care was needed and met Medicare coverage rules.

In other words, these services likely would have been approved by original Medicare. For many of these denials in our review, Medicare Advantage plans used internal clinical criteria that are not required by Medicare. For example, a plan denied a request for a computerized tomography (CT) scan that was medically necessary to rule out a life-threatening aneurysm. The denial was because the beneficiary did not first have an X-ray.

But Medicare has no such requirement. In another case, a plan denied a request for a walker for a 76-year-old patient with post-polio syndrome. Having a right knee that buckled, the patient was at risk for falls, and denying the claim went against Centers for Medicare & Medicaid Services (CMS's) policy to cover equipment that is medically necessary.

Medicare Advantage plans' internal criteria are supposed to be no more restrictive than original Medicare. However, the capitated payment system in Medicare Advantage creates a potential incentive for insurers to deny access to services for enrollees. Plans are paid a fixed amount of money each month for each enrollee, regardless of the number or cost of services that are provided.

To address these issues, OIG recommended that CMS issue new guidance on the appropriate use of clinical criteria and that CMS assess the use of these criteria in its audits of Medicare Advantage

[1] The prepared statement of Ms. Tinker appears in the Appendix on page 37.

plans. OIG work has already had impact. Last month, CMS issued a final rule that puts in place new requirements to protect enrollees from an inappropriate use of prior authorization.

The rule streamlines prior authorization requirements and strengthens protections against denials for medically necessary services. OIG appreciates and shares your interest in ensuring that Medicare Advantage enrollees get the medical care they need. However, with our limited resources, comprehensive oversight of HHS programs is challenging. We only have $0.02 to oversee every $100 HHS spends.

We conduct efficient, consequential, high impact oversight work with our limited resources, but much more needs to be done to thwart fraud, identify misspent funds, and protect people from harm. To be candid, without more resources, we will be unable to keep pace with the threats to the department's programs.

That is especially true for Medicare Advantage. OIG is turning down between 300 and 400 viable, criminal and civil health care fraud cases each year. These uninvestigated cases represent unchecked fraud and the potential for patients to be put in harm's way, including individuals enrolled in Medicare Advantage.

Notwithstanding rigorous efforts by OIG, HHS, and Congress, serious fraud, waste, and abuse continue to grow and threaten HHS programs. If enacted, the President's Fiscal Year (FY) 2024 requested resources for OIG would go a long way toward addressing shortfalls, particularly with respect to combating fraud and increasing our oversight of Medicare Advantage plans. Thank you, and I am happy to answer any of your questions.

Senator BLUMENTHAL. Thanks, Ms. Tinker. Ms. Fuglesten Biniek.

TESTIMONY OF JEANNIE FUGLESTEN BINIEK, PHD,[1] ASSOCIATE DIRECTOR, PROGRAM ON MEDICARE POLICY, KFF

Dr. FUGLESTEN BINIEK. Good afternoon, Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee. Thank you for inviting me to testify today about Medicare Advantage, including the prior authorization, payment, and appeals process. I am Jeannie Fuglesten Biniek, an Associate Director in KFF's program on Medicare policy.

KFF provides nonpartisan health policy analysis, polling, and journalism. We are not affiliated with Kaiser Permanente. My testimony will describe the Medicare Advantage market today, the use of prior authorization by Medicare Advantage insurers, and gaps in data that make our understanding of the impact of prior authorization on Medicare Advantage enrollees difficult.

In recent years, as has already been mentioned a couple of times today, Medicare Advantage enrollment has grown rapidly, and as of January this year, over half of all eligible Medicare beneficiaries are enrolled in a private Medicare Advantage plan. As enrollment has grown, so has the number of plans available.

This year, the average Medicare beneficiary has 43 Medicare Advantage plans to choose from offered by 9 different insurers. The increase in enrollment and the number of plans is due to several

[1] The prepared statement of Dr. Fuglesten Biniek appears in the Appendix on page 45.

factors, but largely the attraction of extra benefits usually offered for no supplemental premium and the potential for lower cost sharing drives Medicare beneficiaries to these plans.

Medicare Advantage insurers are able to offer plans with extra benefits and potential for lower out-of-pocket spending because they are supported by a generous payment system. According to Medicare Payment Advisory Commission (MedPAC), Medicare Advantage insurers receive $2,300 per person above their costs of covering Medicare covered services.

They use this money to pay for extra benefits like vision, dental, and hearing, lower cost sharing, and reduced premiums, as well as add to their profits. Medicare Advantage plans are able to have lower costs than traditional Medicare for Medicare covered services, in part because they use tools that are rarely, if ever, employed in traditional Medicare to manage utilization. One example is prior authorization.

Virtually all Medicare Advantage enrollees are in a plan that requires prior authorization for at least some services. Usually, high-cost services like chemotherapy or skilled nursing facility (SNF) stays, services that people use at some of the most medically fragile points in their lives.

We used data reported to CMS to examine the use of prior authorization and Medicare Advantage. We found that in 2021, over 35 million prior authorization requests were submitted to Medicare Advantage insurers, of which 2 million were denied, or 6 percent.

Though a small share, 11 percent, were appealed. When Medicare Advantage insurers reconsidered their initial decision, they overturned that decision more than 80 percent of the time. The low rate of denied prior authorization requests may mean that the prior authorization process is not well targeted.

Additionally, the high success of appeals suggests that maybe more of those initial decisions should have been favorable to the enrollee in the first place. The process is thus potentially leading to inefficiencies and the use of provider staff, resources, and time, unnecessary delays in patient care, and increased burden on Medicare Advantage enrollees during a point in their lives when they are potentially in very poor health.

The publicly available data on prior authorization and Medicare Advantage has substantial gaps that limit transparency into how the program is performing. For example, there is no information about what services are denied, whether certain beneficiaries are denied prior authorization requests more often, or how long it takes the Medicare Advantage insurers to respond to a prior authorization request.

As a result, policymakers do not have the information they need to conduct oversight. Importantly, Medicare beneficiaries are left without important information when making a decision between traditional Medicare and Medicare Advantage, or between Medicare Advantage plans.

CMS finalized a rule recently to clarify coverage of prior authorization in Medicare Advantage, the coverage criteria, and the duration for which those authorizations have to be valid. However, it will be difficult to assess both the current impact of prior author-

ization policies, as well as changes on enrollees without better data.

As enrollment in Medicare Advantage continues to grow, better information about prior authorization, as well as other tools to manage utilization and contain costs will be necessary. Thank you.

Senator BLUMENTHAL. Thank you very much. Ms. Huberty.

TESTIMONY OF CHRISTINE JENSEN HUBERTY,[1] LEAD BENEFIT SPECIALIST SUPERVISING ATTORNEY, GREATER WISCONSIN AGENCY ON AGING RESOURCES

Ms. HUBERTY. Thank you, Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee. My name is Christine Huberty, and I have served as an Attorney at the Greater Wisconsin Agency on Aging Resources since 2015.

As an advocate for senior residents of Wisconsin, part of my job is to provide legal assistance to residents experiencing Medicare coverage denials. I am here today to share my experiences with Medicare Advantage plans routinely denying coverage of skilled nursing facility stays, which endangers the health and safety of beneficiaries, causes unnecessary stress and financial hardship, and many times shifts expenses to the State's Medicaid program.

Skilled nursing facilities are intended to be a temporary rehabilitation or nursing care facility after a hospital stay. For example, if a person breaks a hip and needs surgery, their doctor generally recommends several weeks in a skilled nursing facility until they are ready to safely go home.

If a senior has Original or Traditional Medicare, they can expect to receive up to 100 days of coverage for their stay with no hassle. If a senior has a Medicare Advantage plan, however, they can expect to receive a denial well before their doctors even say they are ready to go home. This is despite the requirement that has been discussed that Advantage plans must offer the same benefits and apply the same coverage criteria as Original Medicare.

When a patient first receives a denial, they are thrown into a maze of red tape that is dizzying even to our experienced legal team. The initial denial is made not by the Advantage plan, but a third-party contractor using an algorithm. A computer determines what a patient's predicted length of stay (PLOS) should be based on millions of past beneficiary data points, not the patient's plan of care or the advice of their doctors.

Then, at each additional level of appeal—if the patient actually chooses to fight it—the denials are upheld by quality improvement organizations with little to no explanation. If a patient is successful with an appeal while still in the facility, they can expect a new round of denials to start in a matter of days.

Patients caught in this maze are forced to make a devastating decision: stay in the rehab facility and pay thousands of dollars out of pocket, or go home against medical advice. In Wisconsin, we have a unique legal services program with attorneys able to take these cases at no cost.

When we represent clients at Federal hearings, more often than not, the denials are overturned. But this is after months of docu-

[1] The prepared statement of Ms. Huberty appears in the Appendix on page 55.

ment gathering, preparation of summary briefs, rounding up witnesses, and a telephone hearing against a team of representatives brought by the Advantage plans, if they show up at all.

Even if a patient is successful at hearing, it can still take well over a year to get reimbursed. This issue has even hit me personally. This past holiday season, a family member called me and explained that his 89-year-old mother had fallen, was hospitalized, and entered a skilled nursing facility for rehab.

They received a denial after a week, and they did not know what to do because her doctor said she still was not ready to go home. My first question was, does she have an Advantage plan? When the answer was yes, my heart sank because I knew immediately what this family was going to be up against.

After a total of three falls, two hospital stays, and repeated denials, she ultimately went home against medical advice and decided that the appeals process was too stressful to pursue. Fortunately, this family had enough money to pay for the denied charges and lived close enough to help locate safe housing options and home care.

But what does this situation look like for an individual with no family or friends or legal representation? In Wisconsin, the average cost of just 1 day in a skilled nursing facility is over $300. The individuals who cannot afford to stay will likely be advised to spend down their assets, forcing poverty to qualify for the State's Medicaid program.

Now, these are not uninsured individuals. These are individuals who have chosen and paid for a Medicare product that was heavily marketed and aggressively sold to them. They are not getting the coverage that they paid for, and they are met with hurdles at every turn.

Nor are these patients abusing the system. No one truly wants to be in a skilled nursing facility. Patients are actively trying to get home. In the case examples that I have provided your investigative team, you will note that in nearly all situations the patients returned home on the timeline prescribed by their doctors and sometimes even earlier.

Not the unrealistic—at times unconscionable timeline forced upon them by their Medicare Advantage plan. Our most vulnerable citizens are up against an impossible system, and I want to thank you for your time to investigate these practices. Thank you.

Senator BLUMENTHAL. Thanks so much. Lisa Grabert, please.

TESTIMONY OF LISA M. GRABERT,[1] VISITING RESEARCH PROFESSOR, MARQUETTE UNIVERSITY COLLEGE OF NURSING

Ms. GRABERT. Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee, I am Lisa Grabert, a visiting Research Professor in the College of Nursing at Marquette University. I am a former congressional staffer for the U.S. House of Representatives Committee on Ways and Means, and I am honored to testify before the Subcommittee today.

Medicare Advantage is an important part of the Medicare program. Two weeks ago, MA enrollment surpassed fee for service

[1] The prepared statement of Ms. Grabert appears in the Appendix on page 87.

(FFS) for the first time in the history of the program. Medicare beneficiaries are voting with their feet and are increasingly revealing their preference for MA, which now represents 50.2 percent of the market.

Beneficiaries select MA for a variety of reasons, including improved financial protections, additional benefits, prior experience with managed care, and choice simplicity. As part of the tradeoff of receiving a comprehensive benefits package, MA beneficiaries accept a provider network and some utilization review requirements, such as prior authorization.

It is important to remember the context of the deployment of utilization review. Our country spends a significant portion of its economic power, nearly one-fifth of our gross domestic product (GDP) on health care.

The MA program was designed to shift financial risk from the government to private plans. In exchange for taking that financial risk, MA plans are also afforded tools such as prior authorization to assist in managing that risk. If those tools are altered, risk will shift back to the taxpayer in the form of higher costs.

This is the economic dynamic in the Medicare program, and it is our expectation that a Medicare beneficiary has a basic understanding of this when they elect their choice of coverage. However, it may not be clear to beneficiaries what they are agreeing to when it comes to prior authorization.

Further, it may not be clear to a variety of stakeholders what prior authorization exactly is. There is no statutory definition, and until a month ago there was no regulatory definition of prior authorization. On April 12, CMS finalized new regulatory changes for prior authorization, which will become effective for the first time on June the 5th of this year.

Now that the rules of engagement on prior authorization have been clearly articulated, it is worthy to note, without a healthy push from Congress, CMS may not have been motivated to make these changes. In the 117th Congress, two companion bills, the Improving Seniors Timely Access to Care, were introduced.

The Senate version was introduced by a Member of this Subcommittee, Senator Marshall. These bills focus on many of the same changes CMS recently finalized, as well as changes included in a separate proposal by CMS for an electronic system.

Prior to advancing the bill in the House, the Congressional Budget Office (CBO), released a budgetary score for the bill of $16.2 billion over the 10-year budget window. CBO score represents a warning that tinkering with utilization review tools such as prior authorization can have significant financial downsides to the solvency of the Medicare program.

H.R. 3713 alters the economic agreement between the MA plans and the Federal Government. To better understand the unintended consequences of this policy change, we need to examine some failures in the fee for service side of Medicare.

The testimony provided by Megan today provides the necessary background on a service frequently targeted by prior authorization, inpatient rehab facilitation (IRFs) facilities. On an annual basis, CMS spends $60 billion on fee for service post-acute care.

In the last decade, three of the four post-acute payment systems have been comprehensively reformed, including home health, nursing homes, and long-term care. IRFs have yet to be reformed. To receive the highest level of payments, IRFs must maintain a 60 percent of their annual census, treating patients across 13 complex medical conditions, including stroke, traumatic brain injuries, and spinal cord injuries.

Yet policymakers have questioned the so-called 60 percent rule and have recommended it be increased to 75 percent. Policymakers have also questioned the profitability of IRFs. The fee for service IRF Medicare margin is 13.5 percent.

Compare this margin to long term care hospitals (LTCHs), IRF's closest competitor, with a margin of just 2.9 percent. The difference between these two hospital types is that Congress has done the hard work to reform LTACHs, but not IRFs. Where fee for service has failed, Medicare Advantage has filled the gap with prior authorization.

We do not know the median American Medical Association (AMA) compliance rate for these 13 conditions, and I strongly recommend the Subcommittee compels CMS to publicly release this information. If the median MA compliance rate is higher than the fee for service rate, Congress should consider altering the 60 percent rule.

Such a policy change would ensure parity between fee for service and MA and would obviate the need for additional prior authorization of IRF discharges. Thank you for the opportunity to share my perspective with the Subcommittee. I look forward to continuing to work with you on these important issues.

Senator BLUMENTHAL. Thank you very much, Ms. Grabert. Ms. Bent.

TESTIMONY OF GLORIA BENT,[1] WIDOW OF GARY BENT, MEDICARE ADVANTAGE ENROLLEE

Ms. BENT. Thank you, Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee for the opportunity to come here today and speak on behalf of my late husband. You ask in your invitation if seniors enrolled in Medicare Advantage plans face barriers accessing necessary care and treatment.

My answer based on our experience of getting and maintaining rehabilitation and skilled nursing care for my husband is yes, yes, they do. The barrier we encountered was a third-party company hired by our Medicare Advantage plan to authorize or deny care and treatments.

My husband had been treated with immunotherapy for 2 years for melanoma. A year passed without treatment and no sign of melanomas returned. We thought we were in a major remission, and we celebrated.

Then last Memorial Day, when he could not remember how to tie his shoes, my husband asked to be taken to the emergency room. In the emergency room, we learned that there was a lesion in his brain, and it was bleeding.

[1] The prepared statement of Ms. Bent appears in the Appendix on page 99.

The lesion and the hematoma were removed surgically on June 1st, and pathology confirmed what we all feared. It was melanoma. Gary came out of surgery with significant cognitive and mobility deficits. He had upper body weakness. He could not walk. He had left neglect. That means that his brain no longer registered that he had a left side to his body. He was heartbreakingly confused and disoriented.

His neurosurgeon wanted him transferred to an acute rehabilitation and skilled nursing hospital for intense physical, occupational, and speech therapy. Acute rehabilitation services were denied. The third-party authorization party determined that my husband could not withstand intense therapy, even though his neurosurgeon felt it was appropriate.

A transfer to short term rehab and skilled nursing was approved and he was transferred there on the 14th of June. But before the staff of the facility could even evaluate my husband or develop a plan of care, I was contacted by someone who identified themselves as my naviHealth care coordinator and told that my husband would be discharged on July 4th.

My job, she told me, was to find the safest possible location for him to be brought home to on that discharge date. She strongly suggested that we consider he would be permanently wheelchair bound, and therefore highly recommended a skilled nursing facility, self-pay.

If I lived in a home that was not handicapped accessible, which ours was not, then I needed to move. I shared my concern about the July 4th discharge date with the Seabury staff, and I was told that I had entered a battlefield that I was going to be on in an attempt to keep my husband at that facility as long as he needed to be there.

They told me that I could expect regular reviews of his health notes, that I could expect a series of notices of denial of Medicare payment accompanied by a discharge date—that would be 2 days after I got that notice, and they told me that I could appeal.

But if we won a couple of appeals, then we could expect that the frequency with which these denials were going to come would increase. In the 7 weeks that Gary was at the Seabury Health Services Center, we received three of those notices of pending Medicare nonpayment.

The last two came 4 days apart. We won two of the appeals. We lost the third. My husband was discharged on August 7th. He came home by ambulance and was accompanied by an emergency medical technicians (EMT) who told us he seemed to have a low-grade fever and had complained about headaches and neck pain with every bump in the road.

He was disconnected, disoriented. He was experiencing great difficulty in making the transfers from chair to walker to bed that he had mastered at Seabury. The next morning, we had to call emergency services because my husband did not know who he was, where he was, or who we were.

He was taken to the University of Connecticut Health Center, where he was admitted and where he stayed for 3 weeks because he was discharged with bacterial meningitis. The reappearance of melanoma in 2022 pulled a rug out from under my husband and

my family. Then came the added trauma, which piled on steadily, of having to fight to keep him receiving the care he needed.

This should not be happening to families and patients. It is cruel. Our family continues to struggle with the question that I hear you asking today, why are people who are looking at patients only on paper or through the lens of an algorithm making decisions that deny the services judged necessary by health care providers who know their patients and are interacting with them personally, and in some cases, have been working them for months or even years. Thank you for your time.

Senator BLUMENTHAL. Thank you, Ms. Bent. I am going to begin with questions. We are going to have 7-minute question rounds. We are in the middle of votes right now, as you may have gathered.

You will see Members come and go, including myself and Ranking Member Johnson. If we need to take a brief recess, we will. But this is a really important panel on a critically significant topic.

Thank you for being here and thank you for bearing with us. Ms. Bent, I particularly appreciate your powerful story of the real-world consequences, as you have put it so well, of this broken system.

It is a system that is failing people like yourself, your husband, and your entire family. Because as you have put it so well, the trauma hit not just your husband, but your entire family——

Ms. BENT. Yes.

Senator BLUMENTHAL. You were on a battlefield, as you have called it. A battlefield that involved not only your husband's fight for his recovery, but your fight for the resources necessary to provide care.

One of my questions is whether you were ever given an explanation by this naviHealthcare coordinator for the reasons that he was discharged against the advice of your surgeon.

Ms. BENT. The denial of the acute rehabilitation services, I did get a letter after he was in Seabury telling me why that service had been denied. It was that he could not withstand the intense therapy.

The other denials, I would appeal through Kepro, and the response I got was from them, which was a reiteration of what the paperwork from naviHealth, I guess, had said about my husband, and then whether the reviewer agreed or disagreed.

Senator BLUMENTHAL. I do not know whether you know, but naviHealth actually relies on algorithms, not on a clinician's review, not on a physician or a surgeon examining the medical records of your husband, but on an algorithm.

Ms. BENT. Right.

Senator BLUMENTHAL. In fact, a lot of money has been made as a result of selling naviHealth and its system from one company to another. Now UnitedHealthcare, where it is a subsidiary. You mentioned the possibility of an appeal.

I want to show you a poster[1] which sets forth the numbers given by Ms. Fuglesten Biniek. They may have been noticed less than they should have been when you mentioned them in your testimony, but I think they are probably the most important numbers

[1] The poster referenced by Senator Blumental appears in the Appendix on page 106.

that we will consider today, at least for me as a juror here, sitting in judgment of this system.

Thirty five million requests for care, 2 million were denied completely. Only 11 percent of those denials were appealed. But, of the number appealed, 80 percent were granted. In other words, the vast majority of appeals were found meritorious, but only a small percentage had the wherewithal, the patience, the time, the resources, or the simple fortitude in the face of this battlefield, as Ms. Bent has described it, to actually take it to an appeal. What do those numbers tell you?

Dr. FUGLESTEN BINIEK. The relatively small share of appeals, I think can point to several things. People may not know how to appeal. They may not believe they have a case to appeal. People are often very ill when they are doing this, and if they do not have a caregiver or somebody else to assist them, or access to legal services, going through that process can be difficult.

It is a strikingly low number once you see how many are granted upon appeal. Of course, if all of them were appealed, 80 percent may not be favorably determined. We do not know what would happen in the cases for those that were not appealed.

But it is striking that such a large number—we looked across insurers and this was consistent across nearly every insurance firm that offers Medicare Advantage plans. They overturned the vast majority of their initial decisions upon appeal.

Senator BLUMENTHAL. Striking is the right word. Actually, I think it is shocking and stunning. Ms. Huberty, with your practical experience, what do these numbers tell you?

Ms. HUBERTY. They confirm everything that we see on a daily basis, absolutely. We are usually involved in that bottom 80 percent. When clients are able to come to us, we can explain the appeal process and we can walk with them through it.

If they have an advocate who has been able to access our services and speak for them, and help again while they are injured or ill, we can be that support system. But that is absolutely what we see in our practice.

Senator BLUMENTHAL. The denials, those 2 million, that are then successful in being overturned when they are appealed, are often the result of algorithms. Could you talk about how you have seen in your practical experience, the real-world effects of these algorithms?

Ms. HUBERTY. Right. You mentioned the naviHealth system and their use of algorithms. The only reason I know about the document and that use of algorithms is because of taking these cases to the Federal hearing stage, the Administrative Law Judge (ALJs) hearings.

It is only then when I have requested the hearing file, the case file that would have been provided by the advantage plan, that I have seen that document. But now that I have seen it, and I know what it looks like and how it is referenced, I see it referenced often when the Advantage plans do work with a medical reviewer or a medical director, they will often reference that predicted length of stay.

You will see the acronym PLOS, and you will also notice it too, it is decimal points. A predicted length of stay of 16.6 days, and they will receive the denial on the 17th day. We see that repeated.

Senator BLUMENTHAL. In fact, I am going to hold up a document that I am going to ask to be included in the record,[1] without objection.

It refers to an anticipated stay in length of days of 16.6, and that is the date, in fact, on the 17th day when in one case you were handling a discharge resulted. Does this reflect your experience?

Ms. HUBERTY. Yes. Yes it does.

Senator BLUMENTHAL. Ms. Bent, you were never shown a document like this, and you were never given an explanation about how the algorithm was the basis for a decision regarding your husband?

Ms. BENT. No.

Senator BLUMENTHAL. My time has expired on this first round. I am going to turn to the ranking member.

Senator JOHNSON. Thank you, Mr. Chairman. First of all, let me describe this as a real problem. My definition of real problem is something that does not have an easy solution. First of all, Ms. Bent, my sincere condolences on the passing of your husband.

It seems to me, and I have years of experience buying private health care, watching these exclusions being added to the policies, trying to bring the cost down—I have all kinds of questions, and I am trying to figure out how to zero in.

My overall question is, how does this kind of prior authorization compare with private insurance, and truthfully, what people try to do with normal Medicare as well? I had in-laws that were being booted out of hospitals way before they were supposed to be on Medicare.

I do not think that is Medicare Advantage. Can somebody speak to how this compares to private insurance and how it compares to Medicare.

Dr. FUGLESTEN BINIEK. I can start. I have colleagues that have looked at similar questions in the health insurance marketplaces, but what we have found is that the data are not comparable.

You cannot actually figure out how things compare. They have other data that would be nice to have in Medicare Advantage, such as the reason for the denial of payments, but the data for your first question simply is not available.

Senator JOHNSON. Let me ask about the services being denied. It seems like an awful lot of what we are talking about here is long term rehabilitation care. Is that most of the 35 million requests, or what else is being pre-authorized and being denied?

Dr. FUGLESTEN BINIEK. So that data does not tell us the particular services. I think other people on the panel can speak from other data they have looked at, or their experience, what they have seen with that data. One of the big gaps is it doesn't tell us the services.

Senator JOHNSON. We are always missing information. Ms. Tinker, what can you add?

Ms. TINKER. When we looked at this data, we took a month in June 2019, and we really looked very closely at those prior author-

[1] The information referred to by Senator Blumental appears in the Appendix on page 81.

ization denials, and what we found is they fell into sort of three main buckets.

One was post-acute care, which you were just mentioning, transfers from hospitals to either skilled nursing facilities or inpatient rehabilitation facilities. Another bucket that we found was significant or imaging services, specifically things like computed axial tomography (CAT) scans and magnetic resonance imaging (MRIs).

Then the last was injections generally for issues dealing with pain along the spine. In addition, when we looked at our work and tried to make that comparison against original Medicare, what we found was with those prior authorization denials, 13 percent of them actually met original Medicare requirements.

One of the Medicare Advantage requirements is that it provide the same level of service that original Medicare does.

Senator JOHNSON. Again, I am trying to get to why are these services chosen for prior authorization? I would think with long term rehabilitative care, that is a big dollar amount, correct, in Medicare Advantage?

The other two buckets you mentioned do not necessarily fit in that category, or some of these services are generally abused or used when they are not needed?

Ms. TINKER. We have other evidence that shows that there are issues around fraud in the injection space, and so that may be one reason that prior authorization is there. That is not something we looked at explicitly in that particular study. But yes, it is not as expensive as issues around post-acute care.

Senator JOHNSON. Are you seeing similar types of problems in primary Medicare?

Ms. TINKER. We do not have any work that looks specifically at primary Medicare on those particular issues, and prior authorization is not used as prevalent.

Senator JOHNSON. Right. But denial of service or being booted out of a hospital early. Those are probably issues of Medicare as well, correct?

Ms. TINKER. Specifically in the report that we did in the study from April 2022, what we did, though, is looked at Medicare Advantage prior authorization denials and how they compared to the rules in original Medicare.

The findings that 13 percent of the time, original Medicare would have paid, raised significant concerns.

Senator JOHNSON. Is that 13 percent in appeals, or is at 13 percent across the board in terms of the denials?

Ms. TINKER. That was across the board in terms of denials.

Senator JOHNSON. OK. Ms. Grabert, I think you were putting your finger on why this is occurring. People trying to control costs. Do you have any idea in terms of what the total dollar amount that is at stake? I know you mentioned one figure. If you can kind of restate that.

Ms. GRABERT. Sure. If you take one of the examples that Megan just illustrated in post-acute care, we do not know the full amount on the Medicare Advantage side, but on the fee for service side, that is about $60 billion in annual spending.

If it is a 50/50 kind of figure, that is the same equivalent on the Medicare Advantage side. You are probably looking at a total of roughly $120 billion in annual spending just in post-acute care.

Senator JOHNSON. The chairman pointed out how much money Medicare Advantage is making per patient. If you wiped out those profits, kind of what would happen to Medicare Advantage, where would they try and make things up?

Ms. GRABERT. They might try to make it up on the fee for service side.

Senator JOHNSON. Describe that a little bit more.

Ms. GRABERT. On the fee for service side, and in my testimony, I referenced some of the margins that providers enjoy from the fee for service rates. There is certainly a discrepancy there as well.

I think the Medicare Advantage plans are paying attention to that on the fee for service side, and they are using tools like prior authorization to get at making changes and to bring some of those margins down.

That is their ability to do that, on the Medicare Advantage side. Whereas on the fee for service side, we cannot really get at those costs and inefficiencies in the Medicare program unless Congress authorizes it.

Senator JOHNSON. Are they also using the savings to the prior authorization and then denial? Either justify denial or unjustified. They are using that to fund the other benefits like dental and vision, that type of thing.

Ms. GRABERT. Yes, they are reinvesting the money that they get from the Medicare program in a variety of different things. Supplemental benefits such as vision, dental, and hearing, and a whole host of other things that are offered to beneficiary on the Medicare Advantage side that they are not able to get on the fee for service side.

Senator JOHNSON. A solution to this problem would be, first of all, we are not going to let Medicare Advantage plans do prior authorizations. We are not going to allow them to deny coverage based on prior authorizations.

What would end up happening is what probably one or two things. Either the cost to the taxpayer could go up pretty dramatically or Medicare Advantage plans would have to pare back in terms of what they cover. I would think those are the two most likely scenarios, correct?

Ms. GRABERT. Yes, I would say that both of those things would happen.

Senator JOHNSON. OK. I have no further questions. Thank you.

Senator BLUMENTHAL. We will turn to Senator Marshall. I am going to go vote. Hopefully, I will be back before he finishes. Senator Johnson is going to stay and preside while I run or walk to vote.

OPENING STATEMENT OF SENATOR MARSHALL

Senator MARSHALL. Thank you, Mr. Chairman. Let me start by thanking you for co-sponsoring our legislation on prior authorization that would help solve some of the problems here. Thank you for your leadership, and many other folks from this Committee as well. Ms. Bent, thank you for sharing your harrowing story.

I cannot imagine in your worst days, what it would be like to have a 600-pound, 2,000-pound gorilla that you were fighting with as well. Standing beside your husband, as your vows said that you would do.

I just cannot imagine what that was like. I want you to know that you have some fighters up here that are fighting for this issue. It was probably 10, 12 years ago, I was leaving the office and my nurse told me, hey, by the way, your surgery for tomorrow was canceled. Your 7:30 case.

I said, oh, really? How come? Is the patient sick? They said, no, her insurance company canceled it. I said, why? They said, it is canceled, and you have to make an appointment to talk to a person to see if they will approve it. What was the name of the doctor that disapproved?

It was not a doctor. It was some type of a clerical person that had canceled the case. I want to submit for the record a couple of documents.[1] One is from a doctor, Ronald Chen, who was one of the most respected radiation oncologists in the Nation. He is a regular caller of our office, needing help with this issue.

All cases—an 85-year-old man with bladder cancer who had completed radiation and chemotherapy but needed a CAT scan. Again, this is a doctor who follows the guidelines. Radiation oncology.

There are specific guidelines to standard of care to get a CAT scan, 6 months after that therapy that was denied. Another 69-year-old man with metastatic prostate cancer, the wanted proton therapy it was denied. A 74-year-old person with aggressive prostate cancer was denied proton therapy. Another 79-year-old with prostate cancer that needed a follow up position emission tomography (PET) scan that were all denied. Here are some other ones.

Patient with cancer denied bloodwork. Patient with heart disease denied an electrocardiography (EKG). Heart disease, EKG, imagine that. Patient recovering from a stroke, denied physical therapy. A patient with multiple sclerosis (MS) and a tibia fracture denied a wheelchair. A patient with glaucoma, denied eye exam and treatment.

A patient with breast cancer denied reconstructive surgery. I could not imagine. I remember 1 month I had to tell three women in there, one was 29, two were 32, that they had metastatic breast cancer.

I could not imagine having to argue why these women wanted reconstructive surgery done at the same time as their treatment. Someone who never went to medical school, someone who has never touched a patient making decisions.

That is why we have been fighting for this issue now, up here for, I believe, 4 years. In our legislation, Improving Seniors Timely Access to Care Act, is bipartisan, it is bicameral. I believe it is the most co-sponsored bill and endorsements of any legislation up here. But unfortunately, it got a CBO score of $10 billion, and we will maybe have time to talk about that later.

Ms. Tinker, I want to thank you for your professionalism, your understanding and an in-depth knowledge of this has helped us to

[1] The documents submitted for the Record by Senator Marshall appears in the Appendix on page 108.

take what we thought was good legislation and make it better. That is the way the process up here is supposed to work, and we appreciate your help as well.

As you know, our bill requires—and this is for you Ms. Tinker. As you know, our bill requires you to MA plans to report on detailed metrics related to prior authorization delays. By the way, that is how prior authorization is being used now. It is being used to delay care and deny care.

That is what it has become a tool to be, is to delay care, hoping the patient dies so they do not have to give anymore care, I guess. Our bill requires MA plans to report on detailed metrics related to prior authorization delays, denials, and appeals, in the aggregate, at the individual service. The proposed rules, however, merely require aggregate data.

In light of your work, do you think reporting by current procedural terminology (CPT) code and, or individual service level would help the Office of Inspector General better assess and ensure that MA plans are complying with Medicare coverage rules? That is a complex question. Sorry.

Ms. TINKER. That is a very complex question. Thank you very much. I would say anytime we can have more data and more information that is timely, complete, and accurate, it will help us to do a better job.

Very recently, we issued a report that specifically noted that denial of data is not included in Medicare Advantage encounter data, and that that hampers the ability of both OIG and other law enforcement agencies to do their jobs and to truly look at the data and find areas where fraud, waste, and abuse is occurring.

Senator MARSHALL. I think the misconception is the physicians office are very willing to do some type of pre-approval process, but most of this is streamlined. Ninety percent of my procedures are the same procedure. The same prerequisites. When should you replace someone's knee? When should you replace someone's hip? That we could do this all electronically. My next question, Dr. Fuglesten Biniek, help me out. I want to get it right.

Simple question for you, in your statement, you noted that the Kaiser Family Foundation analysis on prior authorization in MA demonstrated a significant difference in the denial rates reported by the MA plans.

Do you agree that more detailed individual service level reporting on delays and denials would help seniors better navigate which plans will meet their personal health care needs?

Dr. FUGLESTEN BINIEK. Yes.

Senator MARSHALL. You want to extrapolate?

Dr. FUGLESTEN BINIEK. Yes. Right now, Medicare beneficiaries can choose from 43 plans. That is a lot, and the information that is available right now, you have to dig very deep to get any information on whether a prior authorization may or may not be required. It is certainly not at the service level.

Now, with 43 plans, it might still be pretty difficult to compare across plans, but it would be a step in a direction that would help for people who were or interested, who knew they needed certain services, had particular conditions to at least be able to start on that endeavor.

Senator MARSHALL. Thank you. Ms. Grabert, are you aware of the Support Act?

Ms. GRABERT. I am not.

Senator MARSHALL. OK. Anyway, it requires CMS to establish electronic prior authorization in Medicare Part D. CBO said it would be negligible. Further, CMS estimated that implementing the regulations would produce savings for plans and providers. Faxes have to be more expensive, and the appeals process even more expensive.

Just want to make sure that to be clear, that our bill does not limit prior authorization, it streamlines it. Do you believe that making the system more efficient is better and cost effective for patients, providers, and health plans?

Ms. GRABERT. Yes, I do. Also, I believe in the regulation that CMS just finalized in April, they were prohibiting the use of prior authorization for prescription drugs.

Senator MARSHALL. OK. Thank you. Ms. Grabert, I will stay with you. Senators Thune, Brown, Sinema, and I are circulating a letter to CMS urging them to finalize the prior authorities, modeled after our bill.

As a former congressional staffer, congratulations. I do appreciate it. It is a tough life up here. I appreciate you going on and taking that skill set to what you are doing now. You understand the CBO scoring, which I do not. The proposed rules reduce the score to $10 billion. When finalized, and if they do adopt a real time decisions and transparency requirements, we think it will be $0.

Here is our question, how do you consider this a warning sign for Medicare if the regulations, which produce savings, change the baseline so the score would drop down to something negligible? Good luck.

Ms. GRABERT. I was going to say first, I think what you told me may not be publicly available because I did not know about the reduction in score to $10 billion. Also, I have not been privy to those conversations with CBO, so I do not know that the score would go down to $0. The only thing that I had available to me was a publicly available $16 billion score from the bill that was scored last Congress.

Senator MARSHALL. Do you understand their logic and how they came up with those types of numbers?

Ms. GRABERT. I certainly do. Usually, CBO will discount the scores that they issue when CMS has an active proposed rule in place, which they do right now for the electronic system, which is my assumption as to how they got from $16 billion down to $10 billion.

If CBO were to finalize it, it may drop further. We do not know what their assumptions are to get in there. If CMS was not to finalize that verification rule, I would assume that the score would go back up to $16 billion over time again.

Senator MARSHALL. In my mind, I cannot figure out where the CBO would think that this would cost the government money. It is a more efficient process. How did they come up with, you think, with the $16 billion? Where is the cost coming from?

Ms. GRABERT. They assumed that the restrictions and the reporting requirements may encourage plans to change their behavior, so they will be doing less prior authorization. Less prior authorization will result in more costly services and services being billed.

It might change, actually, the bid rates that Medicare Advantage plans submit on an annual basis, all of which is greater cost to the taxpayer. Those are the assumptions that CBO built into their score.

Senator MARSHALL. OK. Thank you. Let me review my notes. I will be yielding back about right now, but I think I am about ready to wrap things up. I am going to move to recess, then it sounds like. We will see if anyone else is coming back. Thank you so much, everybody. We will see if anybody else is coming back from voting. The staff will let you know soon.

[Recess.]

Senator JOHNSON. This gives me a good opportunity here. What I would like to do with the witnesses is go through the basic problem-solving process. I come from a manufacturing background, do this all the time. We have taken the first step. We have admitted we have a problem here.

I think the next step is find the problem. If we have time, what is the root cause of that, and then what are the solutions? Again, if the first of you gets the definition right, you don't have to redefine it, but I guess I would like to start with you, Ms. Tinker. How would you define the problem?

Ms. TINKER. What our work showed is that prior authorization was being used at times when original Medicare would have paid for the service.

Senator JOHNSON. Do you think prior authorization itself is the problem, or just not administered properly, people are not following the guidelines?

Ms. TINKER. Our work looked at and showed that while prior authorization is useful as a tool in Medicare Advantage, it is that 13 percent of the time when original Medicare would have in fact paid for those services that created the problem.

Our recommendations are really key toward how do you make prior authorization work better, and how do you eliminate those times when original Medicare would have paid.

Senator JOHNSON. Ms. Fuglesten Biniek, would you agree with that definition? Would you change it slightly?

Dr. FUGLESTEN BINIEK. I agree with most of what Ms. Tinker just said.

I would also add that from the perspective of policymakers conducting oversight, I think there is a lack of information to really then narrow in on what types of policies you might propose or other types of oversight you might do, because we do not know the specific services unless you go and get the very detailed data and conduct a very labor intensive audit who is being affected, how often they are being affected, are things being denied because they are deemed not medically necessary, or providers are not providing sufficient documentation?

Those lead to very different solutions, and without that information, it is hard to know how to solve the problem.

Senator JOHNSON. You have a sub-problem here. You do not have enough information to really define the problem properly and then find a solution. Again, we are honing in on it. Actually, Ms. Huberty, you missed this. Ms. Grabert, we are going through the problem-solving process, trying to figure out what is the definition of this problem. Ms. Grabert.

Ms. GRABERT. Yes, I think there are certainly problems on the fee for service side that need to be addressed because MA plans are using prior authorization to actually get at some of those things. I do not think the problem is necessarily prior authorization. I think there is some fee for service things.

Senator JOHNSON. Now, when you say fee for service, is that you are going into the private sector, or just fee for service—and I mean, describe what you are talking about there.

Ms. GRABERT. Fee for service is the option in Medicare that beneficiaries elect, that allow them to get services directly without having a plan put together——

Senator JOHNSON. That is traditional Medicare is what you are talking about then.

Ms. GRABERT. Yes.

Senator JOHNSON. OK.

Ms. GRABERT. But I would also maybe challenge the 13 percent number that Megan offered. Thirteen percent does not actually seem all that high to me in the way that she is using it. For example, for inpatient rehab facilities, 19 percent of what they are billing is actually on the fee for service side is an error every year.

A lot of the services in the 13 percent number that Megan used come from an audit for at least four of those services were for inpatient rehab facility. If you are looking at the 19 percent that I mentioned on the fee for service side versus 13 percent on the MA side, I feel a little bit more comfortable with that 13 percent because it is less error than what we are actually observing for some of those same services on the fee for service side.

Senator JOHNSON. Ms. Bent, having gone through this, how would you define this problem?

Ms. BENT. I would say that for my family, when this first came up, I went to the Medicare website and looked at what I might expect for my husband, and I saw the figure of 100 days. I think you can imagine how surprised I was when I was told after a considerably smaller number of days he was going to be discharged. For me, the problem becomes an issue of trust.

Senator JOHNSON. Even 100 days is the limit. What would happen after 100 days? Do you get discharged to a long-term care facility where there is no hope for rehab? What is the next step then?

Ms. BENT. These ladies could all correct me if I am wrong, but what I read was after 100 days, we would have had the option of leaving him there and there would have been a co-pay that came into place.

Senator JOHNSON. OK.

Ms. BENT. I would have had the option of saying, yes, I can cover this percentage of this fee and he can stay there.

Senator JOHNSON. Ms. Huberty, do you want to take a crack at how you define the problem we are dealing with here today?

Ms. HUBERTY. I think the main issue is that the Advantage plans are deferring the decisionmaking to a lot of third parties. None of those third parties are the doctors that are meeting with the patients or their treating therapists. They are rarely even looking at their medical records.

Often it is that algorithm that starts the process, and there is very little oversight. They are rubber stamped denial as they go through the process.

Senator JOHNSON. I think you are kind of making the point I was making earlier in terms of our entire health care financing system is, we are deferring all these decisions to a third party. What we are saying is, we want it all, we want the best, and we do not care what it costs. That is a problem.

I will throw out kind of a guideline or an outline of a solution first. Try and reintroduce consumerism into health care as best as possible. For my examples, that would be the low end. The things you can really make a choice on, and say, I know I had an MRI last week and I would like another one this week, but it is not worth it, OK.

Then have high deductible insurance plans that are actually insurance plans, healthy exclusions, without pre-authorization plans that are being violated and denied. That is kind of the thought process that goes through my head.

But, do you all acknowledge that this really is a problem? We are spending so much, and in the end, people do not care what it is costing because either the government is paying for it up to a point or the insurance. We are best at causing costs to run higher than really any other country in the world. That is a real problem, a real issue here.

I threw out my outline of a solution. What are your overall solutions? I will start with you, Ms. Bent. By the way, I have all the sympathy in the world because we have had, my in-laws—my parents, fortunately did not have—my mother passed within 24 hours, a massive stroke.

But my mother-in-law and father-in-law just went through hospitalization after hospitalization, and getting booted out before they certainly felt they were ready to go home. It is a horrible process. You have my deepest sympathy. But what do you think?

Ms. BENT. I would like to see the people who are actually giving the care and know the patient, not being overridden in their decisions by a third party that is perhaps using software to make their decisions.

Anecdotally, I will tell you that when it was time to stop, my husband's primary care was very clear with him and us about that. He knew when it was time to stop treating and stop pursuing an elongation of something that was not going to change. I think they are trustworthy. I would go with them.

Senator JOHNSON. The pushback would be that there are going to be some people that are going to game the system. They might have some financial gain by having people there. But I would agree with you.

I think you are making that point is, we ought to put trust in the doctors and nurses who are going to abide by the Hippocratic Oath, have the primary responsibility to the patient, not to Medi-

care, not to Medicare Advantage plan, but let them make the call. I think that is what most Americans would agree with.

Then we have to address the cost at a different level. Then we have to figure out, that is where I keep going down to the, high deductible plans that are true insurance, and you really let the care providers do that. Then try and bring consumers into the process for the little stuff, where you do have time—you can make a decision.

You say, OK, I will take the generic drug, or I will do this. This is going to work, but it is a lot cheaper than that. Does that make sense to you? Ms. Grabert, what do you think?

Ms. GRABERT. I am going to stick to my theme on looking at fee for service Medicare again, because that is the part of the program that has very little consumerism.

Right now, beneficiaries who are in fee for service typically elect a Medicare plan for supplemental coverage as a wraparound service for them.

There is absolutely no consumerism built into that model because they are shielded from almost all of the costs and out-of-pocket that you are looking at within that model.

Medicare Advantage really is well above fee for service in that respect. If you really want to put consumerism in, I would say target Medigap plans on the fee for service side.

Senator JOHNSON. What is the cost per enrollee—again, I do not have this on top of my head. I always heard that Medicare Advantage is really popular because it offers better benefits, but it costs in general the government more because it has that. Is that true?

Dr. FUGLESTEN BINIEK. Yes. MedPAC estimates this year it is about 106 percent of what traditional Medicare were spend on similar beneficiaries. It is about $27 billion in one year.

Senator JOHNSON. OK. I would have thought maybe it is higher than 6 percent, but, OK.

Dr. FUGLESTEN BINIEK. To be fair—enrollees get something for that. They get lower cost sharing. They get extra benefits. But plans also benefit from that. The key question is how much of the savings they generate, should they get to keep? Should enrollees benefit and should the government get back? Right now, the government gets none of it.

Senator JOHNSON. Again, what you are saying Ms. Grabert is, rather than trying pinch pennies and resolving the kind of abuses that Ms. Bent had to put up with, you would rather focus on traditional Medicare and try and bring some kind of consumerism, some kind of cost saving measures there. Now, you do not want to apply the same thing. You want to figure out a better way of controlling costs. Ms. Huberty, what do you say?

Ms. HUBERTY. I think we have touched a lot on the differences between what fee for service or original Medicare is paying versus Advantage plans. The biggest issue that we are seeing and that has been highlighted too, is that the standards are being applied so drastically differently.

If you have an original Medicare plan and you had the situation that she had or a supplement, her husband would not have gone through that. There has to be some sort of oversight or we have to be able to know why they are applying these standards dif-

ferently and why someone with original Medicare is getting a better benefit that Advantage plan with this particular service.

Senator JOHNSON. What standards because there is no prior authorization with fee for service. There are standards or is this simply whether Medicare is going to reimburse, regardless of whether it is preapproved. This is just whether you get reimbursed as a provider. Is that what you are talking about, in terms of the standards?

Ms. HUBERTY. You might be able to speak better to the provider reimbursement, but in terms of standards for a skilled nursing facility stay, it is very basic where if a person needs 5 days a week of physical therapy or any types of therapy, they get coverage under original Medicare. If they have an Advantage plan, they might get a denial and that no one is even looking at the records. No one is even counting the days.

Senator JOHNSON. A different question. As a consumer, when you get to be an old guy like me, what are you going to choose?

If it was the same plan today, would you take traditional Medicare or would you take Medicare Advantage?

Ms. HUBERTY. Choosing a health insurance plan is a highly individualized process. I do not know enough about your medical history.

However, what I will say, though, is if, and this would be to anyone with an Advantage plan, I would say that can be great, and they are important, and they do offer those supplemental benefits at times.

But if you ever need skilled rehab the way that Ms. Bent's husband did, do expect this to happen. Do absolutely expect it.

Senator JOHNSON. Is that the main problem in rehab? I mean in terms of definition of a problem here today, is that the main problem?

Ms. HUBERTY. I am here today to speak on that because our agency has become overwhelmed with these cases to the point that we have started turning them away. For me here personally, yes, this is a huge problem for beneficiaries.

Senator JOHNSON. We are seeing the baby boom generation. You look like you wanted to say something, Ms. Grabert.

Ms. GRABERT. I was going to say I would choose Medicare Advantage today, and I put both of my parents in Medicare Advantage.

Senator JOHNSON. OK. Anybody else have a different opinion to that? Would you also take Medicare Advantage? I don't think it could be held to the standard of giving advice to consumers. I am stalling for time here. No, I really was not.

Mr. Chairman, I was going through the problem-solving process here, OK. Asking them to define it, to find the problem. I think, we pretty well came to the conclusion that it really is this prior authorization not necessarily following the rules, seems mainly with rehabilitative cares is the main issue.

We were starting to talk through some solutions. Again, I appreciate your absence. Gave us some opportunity.

Senator BLUMENTHAL. I apologize for my absence. I got stalled on a train that stopped and then we had a second vote. I have now voted twice. Senator Johnson will have to leave at some point, but

maybe I can pick up a little bit where we left the conversation on the new CMS rules.

I have looked at those rules. I have a hard time making sense of them. Maybe somebody can explain to me what those rules actually do, because I will read you the summary.

The new rules include the following requirements. Prior authorization may only be used for one or more of the following purposes, to confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service, or for basic benefits, to ensure an item or service is medically necessary based on standards specified in Section 422.101[c][1], or for supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

I do not see how those rules guarantee that everything covered under Medicare will be covered under Medicare Advantage without the rigmarole and the runaround that people have been experiencing. Ms. Tinker, maybe you can enlighten me.

Ms. TINKER. In response, in part to our report from April 2022, CMS issued a rule in April of this year. That rule confirms that Medicare Advantage Organizations (MAOs) must comply with original Medicare criteria. In addition, some of the recommendations we made in our report were that those same issues be incorporated into the audits that CMS does of Medicare Advantage plans. Checking to make sure, in fact, those things are occurring.

Senator BLUMENTHAL. But there is nowhere in this rule that says you have to get everything under Medicare Advantage that you would under Medicare. In fact, as we have heard, because I think, looking at my notes, Dr. Fuglesten Biniek said it, we do not have enough data to know at this point. Is that right?

Dr. FUGLESTEN BINIEK. Yes, I think it is challenging to assess.

Senator BLUMENTHAL. Challenging to assess, is absolutely right. For people in Ms. Bent's position, that is going to have real world consequences in terms of uncertainty, unknowability, unenforceability, and potentially more appeals, more red tape. Correct?

Dr. FUGLESTEN BINIEK. Yes, potentially.

Senator BLUMENTHAL. Ms. Huberty, could you give me your assessment of whether these rules are going to clarify and solve all these problems?

Ms. HUBERTY. I do not know enough about the proposed rules or the enacted rules to speak on that, but I do not know that it needs to clarify, because it is already a rule that Medicare Advantage plans must provide at least the same benefits as the original Medicare.

Senator BLUMENTHAL. That is exactly my point. That it is not a problem with rules, it is a problem with compliance and enforcement. In other words, the Medicare Advantage plans basically have been flouting their obligations under existing law without a new rule. Correct?

Ms. HUBERTY. Absolutely correct. Yes.

Senator BLUMENTHAL. A new rule is only as good as their being willing to change their real-world practices and CMS enforcing those obligations, which it has been failing to do. Correct?

Ms. HUBERTY. Correct. Yes.

Senator BLUMENTHAL. Ms. Grabert, Senator Johnson asked you a question about—let me hold up the profits poster.[1] He asked you in effect whether Medicare Advantage might be taking some of their additional revenue and putting it into dental and vision and other services that come with Medicare Advantage but not with Medicare. Correct?

You remember your testimony and you said that was true. But the additional profits from going to Medicare Advantage are after those expenses, are they not?

Ms. GRABERT. Yes, they are.

Senator BLUMENTHAL. OK. They have already made the investment, and they are in fact, let me put it in layman's terms, they are making a ton more money than those other categories of insurance, even after the benefits that they provide.

Ms. GRABERT. I guess I would need clarification on your response because I do not really understand the methodology. I do not know what the actuarial value is for dental, vision, and hearing. I do not know that those things could have been taken into consideration and removed from those numbers.

Senator BLUMENTHAL. If I tell you that the profits, and I think this point is largely un-contradicted, that profits for Medicare Advantage exceed those in other types of plans, despite having invested in those additional services.

It leaves me to conclude that they could maybe reduce some of their profits and provide some additional services, for example, to Ms. Bent's husband, and still make pretty good profit, but just not as large as they would otherwise. Does that make sense?

Ms. GRABERT. Yes, certainly. I think there are a number of different policies that Congress can take on. For example, the quality bonus payments that are made to Medicare Advantage plans that were instituted in the Affordable Care Act (ACA) really led to a lot of those numbers.

Congress could address some of those policies to reduce some of those profit margins if they so choose to.

Senator BLUMENTHAL. We could reduce the profits for Medicare Advantage? Would you recommend that?

Ms. GRABERT. I think there is a lot of people that would encourage Congress to specifically look at those quality bonus payments that were included in the Affordable Care Act, yes.

Senator BLUMENTHAL. But as an alternative, maybe Medicare Advantage plans could include care for Ms. Bent's husband, which is what they promised to do. Correct?

Ms. GRABERT. Certainly.

Senator BLUMENTHAL. OK. Let me ask you, in your report, Ms. Tinker, a central concern that you expressed was about payment models like the one used for Medicare Advantage, as you know, and the, as you call it, potential incentive for insurers to deny access to services, or for payments in an attempt to increase their profits, which we have been discussing.

KFF has analyzed how much insurers make for each Medicare Advantage enrollee as compared to enrollees in other kinds of in-

[1] The poster referenced by Senator Blumenthal appears in the Appendix on page 105.

surance, as we have demonstrated here. Can you tell us why insurers have that incentive?

Ms. TINKER. Yes. In original Medicare, providers are paid based on the specific services they provide. However, in Medicare Advantage, Medicare Advantage plans are paid a capitated rate, so a single amount per member per month, to provide services regardless of the cost or the number of the services. As a result, unlike in original Medicare, plans make more money by providing fewer services.

Senator BLUMENTHAL. I am going to interrupt my questions to let Senator Johnson——

Senator JOHNSON. I am sorry, I apologize. I have to go vote, then Speaker Paul Ryan is getting his portrait unveiled, so I have to go to that ceremony. But real quick, going back to the profit per enrollee, it sounds like there is a reasonably robust competitive market, though.

You have 9 companies, 33 different plans. Are they colluding to drive up profits or do we need to encourage more competition as opposed to trying to lower costs by some government edict? I mean, generally competition works pretty well.

Dr. FUGLESTEN BINIEK. I will say this market has exploded in the last several years. The 43 plans this year is twice as many as was available in 2018. In some markets, the same insurer offers a dozen or more different plans. I do not think more plans is probably the answer.

Some places have 80 plans. It is really helping the beneficiary figure out what the meaningful differences are between those plans and what would best suit their needs and preferences.

Senator JOHNSON. It is not one company having 10 plans. It is nine different companies——

Dr. FUGLESTEN BINIEK. Having 7 to 10 plans.

Senator JOHNSON. If it is only one company in a region, that is not competition. Is that what is happening?

Dr. FUGLESTEN BINIEK. No, most markets, over 50 percent of markets have at least nine different firms participating and offering plans.

Senator JOHNSON. I am scratching my head. Then what does it look like if there is better competition in this thing? But anyway, appreciate the indulgence. Again, thanks for holding this hearing, and thank all the witnesses. Take care.

Senator BLUMENTHAL. I will follow up on that question. The insurers make more than double for each Medicare Advantage enrollee, than for other insured individuals, like people in employer sponsored plans. All of these so-called competitors know they can make more money with Medicare Advantage plans. Is that right?

Dr. FUGLESTEN BINIEK. Yes.

Senator BLUMENTHAL. OK. If their goal is to make money, they are all going to, in effect, benefit from the products while their beneficiaries are put at a disadvantage by the prior authorization.

Dr. FUGLESTEN BINIEK. I will also add that they compete for their enrollees by offering these extra benefits. The way they are able to offer the extra benefits is by lowering the bid for Medicare covered services. To the extent they can use prior authorization or networks, referrals, other types of utilization and cost management

tools, they will be able to get a larger rebate from CMS and be able to offer more extra benefits.

Senator BLUMENTHAL. It is a kind of bait and switch plan. They bait people to come in with the promise of providing more. But in fact, many of the beneficiaries receive less. Correct?

Dr. FUGLESTEN BINIEK. I certainly would not put it that way.

Senator BLUMENTHAL. I am going to put it in the way that one of your clients, Ms. Huberty, put it, which is, after the denial, I read in one of the articles about the work that you do that—I think it was one of your clients, said it works until you need the big stuff. Maybe you can explain what that means.

Ms. HUBERTY. Yes, absolutely. To the point of the supplemental benefits, enticing people into taking them, that is the short term. We all have short term goals. It is easy to save money at the beginning and to say, I am going to get these extra things that original Medicare does not cover.

That is really enticing for me to take this plan. There might be a low premium as well, but most of us do not think about the larger problems when they are actually going to need help. Like in Ms. Bent's case, they looked, and they saw 100 days of coverage.

That is what they expected to need when the time came. Absolutely, I would say it is a bait and switch because you get to that point when you do actually need those bigger things and you are denied.

Senator BLUMENTHAL. It looks like a good plan as long as all you need is dental or vision. Everybody needs dental or vision. Nobody plans on melanoma.

Ms. HUBERTY. Correct, yes.

Senator BLUMENTHAL. Or on other kinds of acute, rehabilitative, or long-term rehabilitative care.

Ms. HUBERTY. Yes, that is correct.

Senator BLUMENTHAL. Ms. Bent, when you signed up for Medicare Advantage, obviously you had no idea that this tragedy was going to befall your family.

Ms. BENT. Actually, Gary was a retired State employee, and his benefits are determined by the Office of the State Comptroller. Looking at the website for State retirees, it appears to me that if you are of an age that makes you eligible for Medicare, you are on a managed Medicare plan.

Senator BLUMENTHAL. That was almost automatically as a result of your being on the state—

Ms. BENT. Correct. Someone else made the decision for us that we would be on a Medicare Advantage plan. Periodically, someone else makes the decision for us that that plan will be administered by a different company.

Senator BLUMENTHAL. Your husband taught physics at the University of Connecticut when he retired?

Ms. BENT. Yes, he was at the University of Connecticut for 23 years.

Senator BLUMENTHAL. By the way, I am a retiree from University of Connecticut as well.

Ms. BENT. Yes. You have some of the same issues.

Senator BLUMENTHAL. I want to go back to the appeal questions, Ms. Huberty, because I think we began talking about them, and I

am not sure that you had the opportunity to explain what the barriers and the hurdles are to overcoming a denial. Maybe explain a little bit why only 11 percent of people actually appeal when the results are seemingly so positive.

Ms. HUBERTY. In the cases of skilled nursing facility denials, you are getting the denials and the appeal instructions in real time.

In Ms. Bent's case, they are getting them as they are trying to recover from the illness. It is not like you get an x-ray, and then 3 months later you get the bill, and then you try to deny it at that time or try to appeal that denial at that time.

You have people who are very vulnerable, who are very sick, very ill, trying to recover, trying to get back home, getting appeals thrown at them, not knowing usually what they are signing or what is being asked of them. They will do whatever is thrown at them. Usually, it is appealing by phone.

Once you get to those first two levels of phone appeals, generally, because those are handled immediately, the next step is requesting a Federal administrative law judge hearing. I would say most people assume that they need an attorney to do that, or if they do not realize that, they just think that process sounds far too daunting to continue.

Again, they are trying to recover. They are trying to get better. Ms. Bent and I were speaking before the hearing, and it sounded like my experience is exactly what she experienced, too. Even if you are successful in an appeal while you are still in the facility, you can expect another denial in a matter of days, and that review will continue about every 3 days.

Senator BLUMENTHAL. Even if you are successful in appealing on a first round, you can be stuck on later rounds with the same algorithm driven denial.

Ms. HUBERTY. Generally, the algorithm is first applied when the person is first admitted in the skilled nursing facility. I have not seen it come up since then.

But what happens is it is almost once you have been flagged as someone who might need to leave now or does not meet these care coverage criteria anymore, you are kind of in the system for those denials and they are having these reviews.

I believe it is between naviHealth and the provider as well, are going through reviews every 3 days.

Senator BLUMENTHAL. As far as the potential for competition is concerned. My understanding is that there are a small number of companies that dominate this market. Is that correct?

Ms. HUBERTY. In terms of the third-party contractors?

Senator BLUMENTHAL. Exactly.

Ms. HUBERTY. Yes. I know of two.

Senator BLUMENTHAL. We are going to have to leave it now, but you have given us a lot of really good information. This investigation will continue. There is a lot here that needs to be known. We are going to investigate within the goal of not only making Congress know it, but also the public, and people like Ms. Bent and everyday Americans who have a real stake, real world stake, in what the outcomes are.

We have been talking a lot here at a 30,000-foot level, but many of you, Ms. Huberty, Ms. Bent, have seen it up close and how it

impoverishes and deeply impacts people, impoverishes them financially, but also spiritually when they have to be on the battlefield, when at the same time their loved ones are fighting for their lives. The battlefield simply should not be there.

They should not have to fight an insurer at the same time as their loved one is fighting for his life. We want to know how these algorithms work, how these profits are so high, why people are potentially deceived into thinking that Medicare Advantage will be there for them, because the fact of the matter is, it works until you need it. It works fine, so long as you do not need it for the big stuff like melanoma, like long term care, like certain kinds of injections and other kinds of needs that everyday Americans have.

We are going to adjourn this hearing. The record will remain open for 15 days for any additional comments or questions by any Subcommittee Member. I would invite any of you, if you have additional thoughts or responses to questions that have been asked here that maybe you feel you did not get an opportunity to answer fully, I encourage you to submit written response as well.

Thank you all very much. The hearing of this subcommittee is adjourned.

[Whereupon, at 3:49 p.m., the hearing was adjourned.]

APPENDIX

Opening Statement of Chair Richard Blumenthal
"Examining Health Care Denials and Delays in Medicare Advantage"
U.S. Senate Permanent Subcommittee on Investigations
Homeland Security and Governmental Affairs Committee
May 17, 2023

I'd like to call to order the meeting of the Permanent Subcommittee on Investigation, our first hearing of this session. I want to recognize the extraordinary and distinguished history of this panel in rooting out waste and fraud and abuse in government, and thank my Ranking Member and partner in this effort, Senator Johnson. It has been a bipartisan effort in the history of this panel, and we are seeking to continue that tradition.

When I was appointed earlier this year, I pledged to continue the work of this committee in insisting on accountability. Our work is already under way, and we're meeting today to protect seniors who are enrolled in Medicare Advantage plans who face unacceptable barriers in accessing necessary care and treatment. Medicare is the safety net that ensures that all American seniors receive the health care they need. Medicare Advantage run by insurance companies is becoming an increasingly integral part of that program. As of 2023, more than 30 million Americans were enrolled in Medicare Advantage plans, representing more than half of Medicare-eligible Americans. This number is only continuing to grow.

And I want to be clear—I support Medicare Advantage programs, the flexibility that they provide for seniors across the country. Many seniors are very happy with Medicare Advantage and want to continue with them, but the reason we're here today is that all too often the big insurance companies that run Medicare Advantage plans have been failing seniors when they need treatment and care.

Medicare Advantage insurers are required to provide beneficiaries with the same minimum level of coverage as traditional Medicare, and yet we've seen evidence indicating that in many instances, they are failing to do so—in fact, failing entirely because they are denying or delaying care.

And, tragically, we've heard from many families who faced denials in the middle of major medical crises, forcing them and their loved ones to fight even as they are fighting for their lives. And the fight for insurance coverage is detracting from the fight for their health. And perhaps most troubling of all, there is growing evidence that insurance companies are relying on algorithms rather than doctors or other clinicians to make decisions to deny patient care.

In a report released last year, the Inspector General of the Department of Health and Human Services identified a large number of instances where Medicare Advantage companies refused to authorize treatment for care that clearly met Medicare coverage requirements. In one case, a cancer patient had a common scan needed to determine if the disease had spread delayed by their insurer for more than a month. In another, an insurer refused a walker to a 76-year-old patient. The insurance company argued that this patient had been provided a cane within the past 5 years and therefore didn't need a walker.

In each of these cases, the insurer's decision overlooked the treating physician's assessment of what their patient needed. Our subcommittee has been hearing from patients and providers alike who have stories of care being delayed or denied. And many of these stories are patients who have been hospitalized for serious medical issues and who need nursing home or rehabilitative care before they're ready to return home. These denials have become so routine that some patients can predict the day on which they will come.

Advocates who have helped patients appeal denials of medically necessary care have uncovered documents showing that these decisions are not being made by doctors or other trained professionals at all. Instead, companies are using algorithms that have been programed to predict how much care a patient needs without ever meeting a patient or their doctor. Insurers may refer to these algorithms as tools used for guidance, but the denials they generate are too systematic to ignore. All too often, black-box AI and algorithms have become a blanket mechanism for denial. And the insurance companies insist that those AI mechanisms are proprietary. But part of what needs to happen is to make them more transparent so that patients and providers know along with the public how they are being used.

Major insurance companies who run Medicare Advantage plans are making record profits. Gross margins for Medicare Advantage enrollees are well over double those for individual market, group market, or Medicaid managed care enrollees. The largest Medicare Advantage provider even said in its most recent report that a major reason for their increase in revenue between 2021 and 2022 was in fact the growth of Medicare Advantage.

This chart speaks volumes about the burgeoning profits of Medicare Advantage plans, in part because of the denial or delay of care. Insurers are in effect denying Americans necessary care in order to fatten and pad their bottom lines. And that phenomenon is unacceptable.

The information that this subcommittee has uncovered so far and that we will hear today demonstrates the need for additional investigation into the practices of these powerful insurance companies. And I want to put these companies on notice. If you deny life-saving coverage to seniors, we are watching, we will expose you, we will demand better, we will pass legislation if necessary. But action will be forthcoming.

Today, we sent bipartisan letters to the nation's largest Medicare Advantage insurers: UnitedHealth, Humana, and CVS Aetna. They collectively cover more than 50 percent of Medicare Advantage beneficiaries. We are asking for internal documents that will show how decisions are made to grant or deny access to care, including how they are using AI. Our nation's seniors should not have to fight to receive medically necessary care.

I look forward to hearing from today's witnesses. I want to thank each of you for being here because each of you has an important aspect of this story to illuminate. And, again, I want to thank the Ranking Member for his involvement and contribution and turn to him now for his comments.

Opening Statement of Ranking Member Ron Johnson
"Examining Health Care Denials and Delays in Medicare Advantage"
Permanent Subcommittee on Investigations
May 17, 2023

As submitted to the record:

I would like to begin by welcoming Chairman Blumenthal to this subcommittee. The Permanent Subcommittee on Investigations (PSI) has a long bipartisan tradition of uncovering waste, fraud, abuse, and outright corruption. This subcommittee's previous work brought much-needed transparency to the public and I look forward to continuing that tradition with PSI's new chairman.

At PSI we rely on facts and data to drive our investigatory efforts. Today's hearing about Medicare Advantage is part of the subcommittee's initial information-gathering phase that will assist our subsequent inquiries.

The primary subject of today's hearing concerns health care being denied when treatments and other health services require pre-approval by Medicare Advantage insurance carriers. This is a problem caused by our growing third-party payment system that has largely eliminated the benefits of free market competition and consumerism from health care. Over the last 60 years, patients have been separated from the direct payment for health care products and services, with third parties (government and insurance) taking over the primary role of payer. In 1960, out of pocket expenses amounted to 52 percent of health consumption expenditures. By 2021, out of pocket expenses had declined to nearly 11 percent. Inversely, third party payers—like insurance and the government—accounted for 48 percent of health consumption expenditures in 1960. In 2021, third party payers covered 89 percent of health expenditures.

When someone else pays for what a consumer purchases, the consumer has little, if any, incentive to make wise and cost-effective choices. Under a third-party payment system, everyone wants the best quality treatment and couldn't care less what it costs. That is what is driving our health care costs through the roof. Pre-approval programs for some treatments and tests are the third-party payer's attempt to limit wasteful spending. As this hearing will demonstrate, the pre-approval process is not perfect.

To me, the solution is obvious—reintroduce consumerism and free market competition into health care. Unfortunately, we have been heading in the wrong direction for decades, and the emphasis of most lawmakers and bureaucrats in Washington will be to grow government even larger, which will only make matters worse.

To see how much worse, we need to look no further than our miserable failure of a response to COVID-19. We spent and borrowed trillions of dollars and ended up with some of the worst outcomes of any nation on earth. The U.S. has approximately 4 percent of the world's population, yet we account for over 16 percent of reported global pandemic deaths. The human toll and the economic devastation caused by shutdowns that didn't work, plus the harm and loss of learning inflicted on our children, only underscore the failure of our response.

Oversight of the government's role in health care, not just as it relates to access to care for seniors, has been an ongoing priority of this subcommittee. Throughout the COVID-19 pandemic, federal health agencies have not been honest or transparent with the public, wasted hundreds of billions of dollars, and caused irreparable harm to Americans. The government has shown little compassion toward Americans who were injured by the COVID-19 vaccines. I have sent over 50 letters to the federal health agencies, insurance companies, and pharmaceutical companies, among other entities, seeking information about their failed COVID-19 policies.

It is my sincere hope that our subcommittee will work in a non-partisan way to uncover the truth about failures of our federal health agencies in their response to COVID-19 as well as those effecting Medicare Advantage. The facts that we will discuss at today's hearing will inform the subcommittee's work on examining the obstacles seniors and others may face in obtaining health care through Medicare. I thank the witnesses for coming forward today and setting the stage for this important work.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony Before the
United States Senate Committee on Homeland Security and Governmental Affairs
Permanent Subcommittee on Investigations

Examining Health Care Denials and Delays in Medicare Advantage

Testimony of:
Megan Tinker
Chief of Staff
Office of Inspector General
Department of Health and Human Services

May 17, 2023
2:00 p.m.
SD-562 Dirksen Senate Office Building

Testimony of:
Megan Tinker
Chief of Staff
Department of Health and Human Services, Office of Inspector General

---

Good morning, Chairman Blumenthal, Ranking Member Johnson, and distinguished Members of the Subcommittee. I am Megan Tinker, Chief of Staff, at the Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to appear before you today to discuss our work examining the potential barriers that seniors may face when accessing health care under Medicare Advantage.

In 2023, Medicare Advantage plans currently cover 30 million people—slightly more than half (50.4 percent) of all Medicare enrollees.[1] For the first time, Medicare Advantage has surpassed traditional Medicare in enrollment. One of OIG's top priorities is ensuring that the Medicare Advantage program works effectively and provides quality health care for enrollees and value for taxpayers. This priority includes ensuring that Medicare Advantage enrollees have access to appropriate and medically necessary health care.

Today, I will focus my testimony on OIG's work examining Medicare Advantage plan practices that may impede access to health care for seniors. In summary, we have identified the following concerns.

Medicare Advantage Organizations (MAOs) sometimes delayed or denied enrollees' access to medical services, even though the requested care was medically necessary and met Medicare coverage rules. In other words, these Medicare Advantage enrollees were denied access to needed services that likely would have been approved if these individuals had been enrolled in original Medicare. These denials likely prevented or delayed needed care for enrollees. In addition, MAOs sometimes denied payments to health care providers for services that they had already delivered to patients, even though the requests met Medicare coverage rules, MAOs' own billing rules, and should have been paid by the plan.

In my testimony, I will provide further details and context on these findings and highlight the actions that OIG has recommended the Centers for Medicare & Medicaid Services (CMS) take to better ensure that Medicare Advantage enrollees have timely access to all necessary health care services. Additionally, I will highlight the resource challenges that OIG faces to provide comprehensive oversight of Medicare Advantage and other HHS programs.

[1] Kaiser Family Foundation, "Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans," May 2023. Available at https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/.

MEDICARE ADVANTAGE DENIALS OF SERVICES AND PAYMENTS

In April 2022, OIG published a report examining MAO denials of requests for prior authorization, which is preapproval for a service or item before the enrollee receives it, and denials of payment requests from a provider for a service already delivered to the enrollee.[2]

Why Focus Oversight on Medicare Advantage Denials

Incentives. A central concern about capitated payment models, including Medicare Advantage, is the potential incentive for insurers to deny access to services for enrollees and deny payments to providers to increase profits. MAOs are paid a fixed amount of money each month for each enrollee, regardless of the number or cost of services they pay for on behalf of that enrollee.

Volume of Denials. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year. In 2021, MAOs denied 2.2 million prior authorization requests (5.5 percent of all prior authorization requests) and 56.2 million payment requests overall (9.5 percent of all payment requests) in the Medicare Advantage program.

Prior Evidence of Problems. OIG's previous analysis of Medicare Advantage appeals outcomes raised concerns about MAO denials.[3] When enrollees and providers appealed service and payment denials, MAOs overturned 75 percent of their own denials during 2014–2016. Independent reviewers at higher levels of the appeals process overturned additional denials in favor of enrollees and providers. At the time the report was issued, the high rate of overturned denials raised concerns that some enrollees and providers were initially denied services and payments that should have been provided. This is especially concerning because enrollees and providers appealed only 1 percent of denials. In addition, OIG found that CMS's annual audits of MAOs from 2012 through 2016 commonly identified problems related to denials.

How OIG Assessed Medicare Advantage Denials

For our 2022 report, we selected a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs by enrollment during June 1−7, 2019.[4] Health care coding experts reviewed case files for all cases, and physician reviewers examined medical records for a subset of cases that warranted medical necessity review. From these results, we estimated the rates at which these MAOs denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules.[5] We also examined the reasons for these denials in our sample.

---

[2] OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, (OEI-09-19-00260), April 2022.
[3] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*, (OEI-09-16-00410), September 2018.
[4] These 15 MAOs accounted for nearly 80 percent of Medicare Advantage enrollees.
[5] Our sampling method enables us to project these rates to the universe of all denials by the 15 largest MAOs during this time period. However, it does not enable us to estimate MAO-specific rates or to project the reasons for denials from our sampled cases to the universe of denials.

OIG Findings Raise Concerns About MAO Denials of Services

13% of prior authorization denials were for services that met Medicare coverage rules

Among prior authorization requests that MAOs denied, 13 percent were for requests that met Medicare coverage rules. In other words, these services likely would have been approved in original Medicare. This rate projects to 1,631 prior authorization denials for requests that met Medicare coverage rules for these MAOs during the first week of June 2019.[6] Such denials can have a range of negative impacts, such as enrollees not receiving needed care, delays in receiving needed care, enrollees receiving an alternative service that may be less effective for their needs, enrollees paying out-of-pocket for care, and/or administrative burden for enrollees or their providers who choose to appeal the denial.

IMPACT: Denials likely prevented or delayed needed care

MAO use of internal clinical criteria contributed to many of these denials in our sample. For many of the denials of prior authorization requests in our sample for services that met Medicare coverage rules, MAOs denied the requests by applying MAO clinical criteria that are not required by Medicare. MAOs must follow Medicare coverage rules, which specify what items and services are covered and under what circumstances. However, at the time of our evaluation, they were also permitted to use additional clinical criteria that were not developed by Medicare, as long as such criteria were "no more restrictive than original Medicare's national and local coverage policies."[7]

CMS guidance on the appropriate use of such criteria was insufficient. In several cases, we were unable to determine whether the prior authorization denials that met Medicare coverage rules would be considered appropriate by CMS because CMS's guidance regarding MAO use of internal clinical criteria was not sufficiently detailed.

CMS has announced new requirements intended to protect MA enrollees from inappropriate use of prior authorization, to take effect in 2024. In our 2022 report, OIG recommended that CMS issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews. In April 2023, CMS issued a final rule that cited OIG's report in addressing this recommendation. The final rule provisions, which take effect in 2024, confirm that MAOs must comply with traditional Medicare's benefit and coverage conditions. They clarify that MAOs may only use internal criteria when traditional Medicare's coverage criteria are not fully established. MAOs must ensure that their internal criteria are publicly accessible and provide clinical benefits that are highly likely to outweigh any clinical harms, including from

[6] For an annual context, if these MAOs denied the same number of prior authorization requests in each week of 2019, they would have denied 84,812 requests for services that met Medicare coverage rules that year.
[7] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16, p. 28. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

delayed or decreased access to items or services. CMS is also requiring MAOs to establish Utilization Management Committees to review policies annually and ensure consistency with traditional Medicare's national and local coverage decisions and guidelines.[8]

In addition, CMS's final rule sets forth other prior authorization requirements intended to remove barriers to appropriate care for MA enrollees, including adding continuity of care requirements and reducing disruptions for enrollees. For example, the rule requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation. The rule also requires that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan.[9]

We found denials of services that met Medicare coverage rules caused by other MAO practices. For example, MAOs requested copies of documentation already contained in the case file. In other cases, some prior authorization denials in our sample resulted from MAO requests for unnecessary documentation. The following example illustrates this issue:

Denial of Admission to a Skilled Nursing Facility Illustrates a Need for CMS To Direct Additional Attention to Requests for Unnecessary Documentation

An MAO denied a request for a skilled nursing facility (SNF) admission, stating that it needed to review the enrollee's most recent therapy records. However, our physician panel determined that the medical records available to the MAO were sufficient to demonstrate that the enrollee's deteriorating functional status and morbidities warranted admission to a SNF with access to physical and occupational therapy. This denial was reversed upon appeal.

Requests for unnecessary documentation may prevent or delay Medicare enrollees 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 enrollees, providers, and MAOs. CMS should update its audit protocols for MAOs to better identify these denials. For example, it could add a question for auditors examining denial cases to determine whether MAOs requested unnecessary information.

[8] 42 CFR § 422.137(d); *see also* 88 FR 22120, 22122 (April 12, 2023).
[9] 42 CFR § 422.112(b)(8); *see also* 88 FR 22120, 22206 (April 12, 2023).

OIG Findings Raise Concerns About MAO Denials of Payments

18% of payment denials were for claims that met Medicare coverage rules and MAO billing rules

An estimated 18 percent of payment denials met Medicare coverage rules and MAO billing rules and therefore the provider payments should not have been denied by the MAOs. This projects to 28,949 payment denials that met Medicare coverage rules and MAO billing rules for these MAOs during the first week of June 2019.[10] Denying payment requests that meet Medicare and MAO rules delays or prevents providers from receiving payment for services that they have already delivered to enrollees.

IMPACT: Denials prevented or delayed payments to providers for services already delivered

Human errors during manual reviews contributed to these payment denials. MAOs relied on their staff to manually review some requests for payments before approving or denying them. These reviews were susceptible to human error, such as a reviewer's overlooking a document in the case file or inaccurately interpreting CMS or MAO coverage rules.

System programming errors also contributed to payment denials. MAOs denied some payment requests because of inaccurate programming of claims processing systems. System errors can cause greater harm because they could generate large volumes of incorrect denials until the MAO notices and fixes the error.

OIG Recommends Additional Ways for CMS To Better Protect Enrollees and Providers From Inappropriate Denials

In addition to our recommendation that CMS issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews, our report included two recommendations that remain open. We continue to recommend that CMS:

- **incorporate the issues identified in our evaluation into its audits of MAOs, and**
- **direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.**

CMS agreed with each of these recommendations and indicated that it plans to implement them.

In addition, two of OIG's recommendations remain open from our 2018 report on outcomes of Medicare Advantage appeals. These recommendations are that CMS:

[10] For an annual context, if these MAOs denied the same number of payment requests each week of 2019, they would have denied 1.5 million payment requests that met Medicare coverage rules and MAO billing rules that year.

- **enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate; and**

- **provide enrollees with clear, easily accessible information about serious violations by MAOs.**

Although CMS agreed with these recommendations, it has not yet fully implemented them. CMS implemented our third recommendation from that 2018 report. In 2019, CMS revised its Civil Money Penalty calculation methodology to include a new aggravating factor for inappropriate delay or denial of medical services, drugs, and/or appeal rights, and new aggravating factors for prior offenses—all changes that better hold MAOs accountable for ensuring appropriate access to care.

LOOKING FORWARD: KEEPING PACE WITH FRAUD, WASTE, AND ABUSE IN HHS PROGRAMS

HHS-OIG's oversight portfolio is vital, vast, and varied. In fiscal year (FY) 2022, HHS-OIG was responsible for oversight of more than $2.4 trillion in HHS expenditures. With a FY 2023 enacted budget of $432.5 million, OIG has about 2 cents to oversee every $100 of HHS spending. In particular, effective oversight of Medicare and Medicaid is complex, challenging, and resource intensive because of the intricacy and breadth of these programs. That is especially true in Medicare Advantage, which includes nearly 4,000 plans, 30 million enrollees, and more than $350 billion in annual expenditures.

Despite extensive reviews and enforcement, our limited resources do not allow us to provide comprehensive oversight of Medicare and Medicaid. Notwithstanding rigorous efforts by OIG and support from Congress, the Administration, and HHS for OIG work and resources, serious fraud, waste, and abuse continue to threaten HHS programs and the people they serve. HHS-OIG lacks a sufficient number of agents to work cases and auditors, data scientists, and analysts to detect trends, outliers, and program vulnerabilities. OIG is turning down between 300 and 400 viable criminal and civil health care fraud cases each year. Each case means unaddressed potential fraud and missed opportunities for deterrence. This includes the growing trend of fraudsters targeting Medicare Advantage plans as the program continues to expand.

Every day we make tough choices on cases and issues to decline. OIG's Regional Offices reviewed and evaluated more than 1,780 hotline complaints in FY 2021 and more than 3,562 hotline complaints in FY 2022 that might have developed into viable cases, but we did not have resources to open additional cases. In addition to the cases noted above, last year OIG turned down 648 cases from the major case coordination effort we have with CMS, a nearly 10-percent increase in cases declined from the prior year. These uninvestigated cases represent real, potential unchecked fraud and the potential for patients to be put in harm's way. I do not want to give the impression that we are not addressing serious fraud and abuse. We are, and our

statistics and return on investment show it. However, with current resources we cannot keep up with the level of threat to HHS, patients, and taxpayer dollars.

The FY 2024 President's Budget requested resources for OIG that, if enacted, would go a long way toward addressing this shortfall, particularly with respect to combating fraud, waste, and abuse in Medicare and Medicaid, for which the President's Budget requests approximately $52.5 million in additional funding. With additional resources, OIG would expand its work examining critical issues in Medicare Advantage, including additional work examining access to care issues, increased oversight of the billions in dollars in risk adjustment payments, and additional targeted efforts to root out fraud that threatens the integrity of the Medicare Advantage program.

CONCLUSION

As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare enrollees have appropriate access to needed care and that providers are reimbursed appropriately. However, our evaluations raise concerns about how MAOs fulfill these critical responsibilities that affect enrollee health and the value of taxpayer investments in the program.

Denied service requests that meet Medicare coverage rules may prevent or delay enrollees 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 enrollees, providers, and MAOs. Further, enrollees in Medicare Advantage may not be aware that they may face greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.

It is vital that CMS continue to take action to ensure that Medicare Advantage enrollees have timely access to all necessary health care services. We have recommended several ways for CMS to do this and will continue to push for progress. OIG will also continue to be vigilant in our oversight and enforcement work to promote payment integrity, enrollee access, and quality of care in Medicare Advantage.

We appreciate the attention that the Subcommittee is bringing to these important issues and the opportunity to testify before you today. I welcome your questions.

Prior Authorization in Medicare Advantage

Jean Fuglesten Biniek, Ph.D.

Associate Director, Program on Medicare Policy

KFF

Prepared for the Permanent Subcommittee on Investigations of the Committee on Homeland Security & Governmental Affairs

United States Senate

Hearing on

Examining Health Care Denials and Delays in Medicare Advantage

May 17, 2023

KFF

Introduction

Good afternoon, Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee. Thank you for inviting me to testify about Medicare Advantage, including the prior authorization, payment, and appeals process.

I am Jeannie Fuglesten Biniek, an associate director in KFF's Program on Medicare Policy. KFF is a non-profit organization providing non-partisan health policy analysis, polling, and journalism (KFF Health News) for policymakers, the media, the health policy community and the public. We are not associated with Kaiser Permanente.

In recent years, enrollment in Medicare Advantage has grown rapidly, with just over half of all eligible Medicare beneficiaries enrolled in Medicare Advantage this year. Virtually all Medicare Advantage enrollees are enrolled in a plan that requires prior authorization before the insurance company will cover some services. While prior authorization plays a role in helping Medicare Advantage plans reduce costs and prevent people from receiving unnecessary or low-value services, there are some concerns that current prior authorization requirements and processes may create barriers and delays to receiving necessary care, as well as exacerbate complexity for patients and providers.

My testimony will describe what the Medicare Advantage market looks like today, the use of prior authorization by Medicare Advantage insurers, and gaps in data that limit oversight and the ability to understand and assess how the use of prior authorization impacts Medicare Advantage enrollees.

Medicare Advantage Today

Medicare Advantage, the private plan alternative to traditional Medicare, covers Medicare Part A and Part B benefits, and often also includes Part D prescription drug coverage. As of January 2023, half of eligible Medicare beneficiaries are enrolled in a private Medicare Advantage plan. That reflects a dramatic increase in enrollment in recent years. In 2007, just 19% of eligible Medicare beneficiaries were enrolled in a private plan (Figure 1).

The increase in enrollment is due to a number of factors, including the attraction of extra benefits offered by most plans, such as coverage of vision, hearing, and dental services, and the potential for lower out-of-pocket spending, particularly compared to traditional Medicare without supplemental coverage. Often, Medicare Advantage plans offer these benefits for no additional premium, other than the part B premium. In 2022, more than two-thirds (69%) of Medicare Advantage enrollees in plans that included Part D prescription drug coverage available for individual purchase paid no additional premium. Medicare Advantage plans also offer the simplicity of one-stop shopping, in that enrollees do not need a separate Part D prescription drug plan or supplemental coverage.

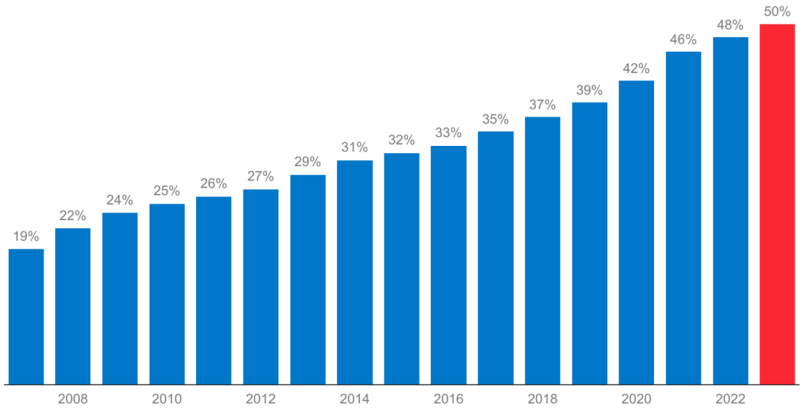
This year, the average Medicare beneficiary can choose from 43 Medicare Advantage plans, more than double the average number available in 2018. A majority of Medicare beneficiaries can choose from plans

offered by at least 9 different firms. Despite most beneficiaries having access to plans operated by several different insurers, nearly half of all Medicare Advantage enrollees are in a plan operated by UnitedHealthcare or Humana.

Figure 1

Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans

Medicare Advantage Enrollment as a Share of the Medicare Part A and B Population, 2007-2023



NOTE: Includes Medicare Advantage plans: HMOs (including POS), PPOs (local and regional), PFFS, and MSAs. Excludes cost plans, PACE plans, HCPPs, and MMPs. About 59.82 million people are enrolled in Medicare Parts A and B in January 2023.
SOURCE: KFF, "Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans," May 2023.

KFF

One reason Medicare Advantage insurers can offer plans with extra benefits and the potential for lower out-of-pocket spending is because they are supported by a generous payment system. The Medicare Payment Advisory Commission reports that while it costs Medicare Advantage insurers 83% of what it costs traditional Medicare to pay for Medicare-covered services, they receive payments from CMS that are 106% of spending for similar beneficiaries in traditional Medicare, on average (including the estimated effects of higher coding intensity in Medicare Advantage). Thus plans retain more than $2,300 per person above the costs of paying for Medicare-covered services, which they use to lower cost sharing, pay for extra benefits, and reduce premiums, as well as add to their profits.

Consistent with the generous payments to Medicare Advantage insurers, gross margins, or the amount by which total premium income exceeds total claims costs, are consistently higher in the Medicare Advantage market than in other health insurance markets on a dollars per enrollee basis. In 2021, gross

margins for Medicare Advantage plans averaged $1,730 compared to $768 for Medicaid managed care plans, $745 for individual market plans, and $689 for group plans.

Medicare Advantage Plans Have Several Tools to Manage Utilization and Costs

Medicare Advantage plans have lower costs for Medicare-covered services than traditional Medicare, in part, because they use tools to manage utilization and costs. These include requiring prior authorization for certain services, requiring referrals for certain types of providers (such as mental health providers), denying payment for services not deemed medically necessary, establishing networks (including for hospitals, post-acute care facilities, physicians and other providers), entering into risk-based contracts that hold providers responsible for cost and quality, and the use of care coordination and care management programs for enrollees with particular conditions.

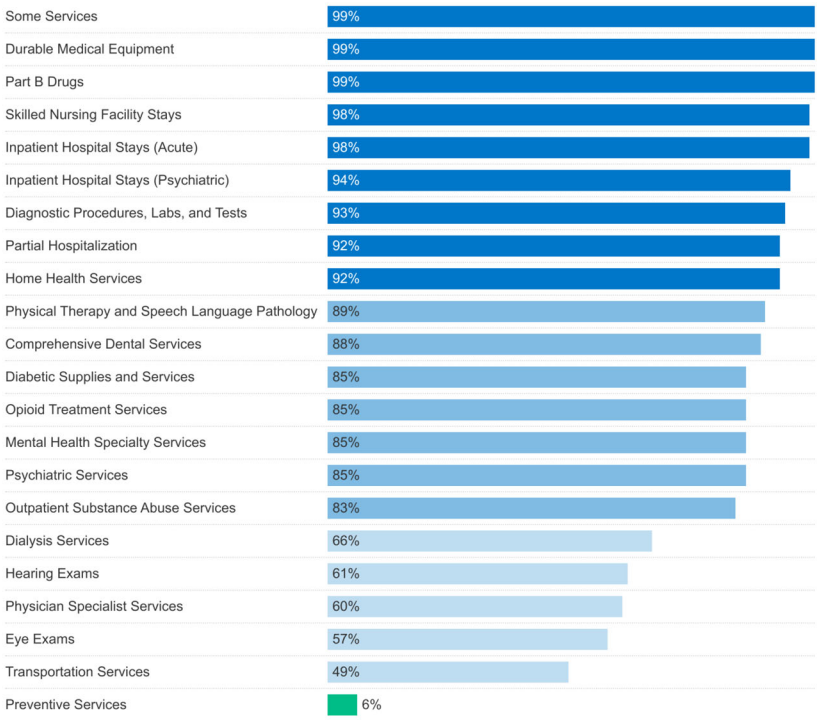
Prior authorization is intended to ensure that health care services are medically necessary and has long been used as a tool to contain spending and prevent people from receiving unnecessary or low-value services. Recently, the use of prior authorization has gained attention, prompted in part by findings from the U.S. Department of Health and Human Services Office of Inspector General that raise concerns that the requirements and processes for obtaining approval may create barriers and delays to receiving care.

Prior authorization requirements are common in Medicare Advantage, with 99% of Medicare Advantage enrollees in a plan that requires prior authorization for at least some services. Higher-cost services require prior authorization more often than lower-cost services. For example, in 2022, prior authorization was required for Part B drugs (including chemotherapy), skilled nursing facility stays, inpatient hospital stays, and home health services for more than 90% of Medicare Advantage enrollees, while just 6% of Medicare Advantage enrollees were in a plan that required prior authorization for preventive services (Figure 2).

Figure 2

Share of Medicare Advantage Enrollees Required to Receive Prior Authorization, by Service, 2022

Most enrollees are required to receive prior authorization for the highest cost services and fewer enrollees need to receive it for preventive services



NOTE: Excludes employer group health plans. Preventive services are Medicare-covered zero-dollar cost-sharing preventive services. For supplemental benefits, including dental, hearing, vision, and transportation, the share of enrollees required to receive prior authorization are based on the enrollees in plans that offer those benefits.
SOURCE: KFF, "Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings," August 2022.

KFF

Use of Prior Authorization in Medicare Advantage

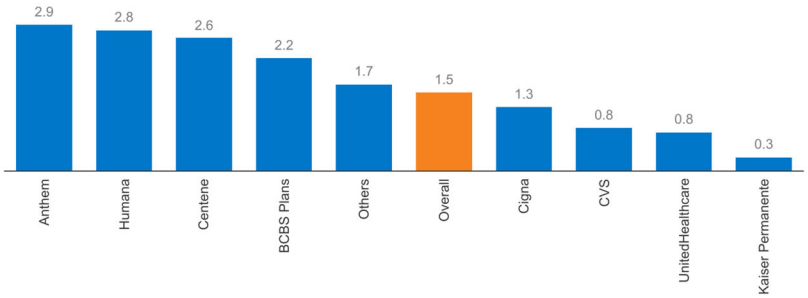
As part of its oversight of Medicare Advantage plans, CMS requires Medicare Advantage insurers to submit data for each Medicare Advantage contract (which usually includes multiple plans) that includes the number of prior authorization determinations made during a year, and whether the request was approved. Insurers are additionally required to indicate the number of initial prior authorization decisions that were reconsidered, and whether the appeal was successful. We used these data to examine the use of prior authorization in Medicare Advantage during the 2021 calendar year (the most recent year for which data are available). Note, the data we analyzed do not include prior authorization requests for prescription drugs covered under Medicare Part D.

We found that in 2021, Medicare Advantage plans made over 35 million prior authorization determinations. On average, that translates into 1.5 requests for prior authorization per Medicare Advantage enrollee. Across Medicare Advantage insurers, the number of prior authorization requests ranged from a low of 0.3 requests per enrollee for Kaiser Permanente to a high of 2.9 for Anthem (Figure 3).

Figure 3

Prior Authorization Requests Are More Common Among Certain Medicare Advantage Firms

Requests for prior authorization of services per Medicare Advantage enrollee in 2021



NOTE: Excludes requests that were withdrawn or dismissed. Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021," February 2023.

KFF

Differences across Medicare Advantage insurers in the volume of prior authorization requests likely reflects some combination of differences in the range of services that are subject to prior authorization requirements and the frequency with which contracted providers are exempted from those requirements, such as through “gold carding” programs. Gold carding programs exempt providers with a history of

complying with the insurer's prior authorization policies. Differences across Medicare Advantage insurers may also reflect the relationship between insurers and providers. Kaiser Permanente is atypical among insurers in that it generally operates its own hospitals and contracts with an affiliated medical group.

Of the over 35 million prior authorization requests, 6% (2 million) were denied in full or in part. The denial rate ranged from 3% for Anthem and Humana to 12% for CVS (Aetna) and Kaiser Permanente (Figure 4). In general, insurers that had more prior authorization requests denied a lower share of those requests.

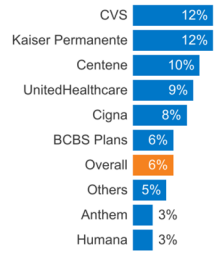
Medicare Advantage enrollees have the right to appeal a denial, but just 11% of denied prior authorization requests were appealed. As with other measures we examined, the share of denials that were appealed also varied across insurers. For example, the share of denials that were appealed was almost twice as high for CVS (20%) and Cigna (19%) than the average across all insurers (11%) (Figure 5).

Among the small share of prior authorization denials that were appealed, 82% were overturned either fully or partially. The relatively high rate of appeals that were overturned was consistent across insurers. Only Kaiser Permanente overturned less than half (30%) of the prior authorization determinations that were appealed. Two insurers – Centene and CVS – overturned at least 9 in 10 denials with UnitedHealthcare not far behind (Figure 6).

Figure 4

Firms Denied Between 3% and 12% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2021



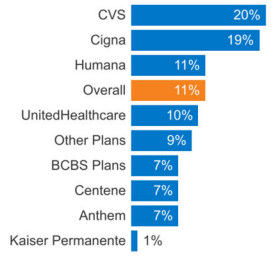
NOTE: Denied requests include determinations that were partially favorable or adverse. Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021," February 2023.

KFF

Figure 5

About 1 in 10 (11%) Prior Authorization Request Denials Were Appealed

Share of adverse and partially favorable prior authorization determinations that were reconsidered in 2021



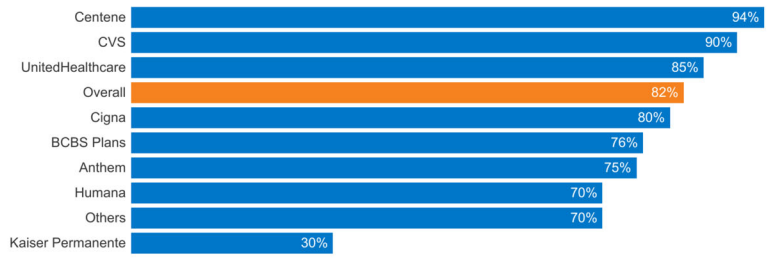
NOTE: Anthem BCBS plans are not included in the analysis because of data quality issues.
SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021", February 2023.

KFF

Figure 6

Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2021



NOTE: Includes reconsiderations that were fully or partially favorable. Anthem BCBS plans are not included due to data quality issues.
SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021", February 2023.

KFF

Gaps in Prior Authorization Data

The publicly available data on the use of prior authorization in Medicare Advantage has several notable limitations, primarily due to gaps in what CMS currently requires Medicare Advantage insurers to report. For example, we could not answer the following questions:

- **Do prior authorization requests, denials and appeals vary by type of service?** CMS requires plans to report the aggregate number of prior authorization determinations (approved and denied requests) and reconsiderations (appeals) and their outcome (approved in full, approved in part, denied). However, plans are not required to report the number of prior authorization requests, denials or appeals by specific service or service category. For example, it is not possible to assess whether insurers deny use of post-acute skilled nursing facility care more frequently than home health services?
- **Why are prior authorization requests denied?** Medicare Advantage insurers are not required to indicate the reason a denial was issued in the reporting to CMS, such as whether the service was not deemed medically necessary, whether the provider seeking approval provided insufficient documentation, or whether other requirements for coverage (such as trying a more basic service first) were not met.
- **Do prior authorization requests, denials and appeals vary across subgroups of enrollees?** No information about the characteristics of enrollees for whom prior authorization requests are submitted is included in the data, such as race/ethnicity, sex, age, or diagnosed health condition.
- **Do denial rates vary by type of plan?** The data are reported at the contract level. Medicare Advantage contracts include plans of different types (i.e., HMO and PPO), as well as plans that are offered to different groups of beneficiaries, including plans that are generally available for individual purchase, special needs plans, and plans sponsored by employers/unions.
- **How timely were initial prior authorization determinations and appeal decisions?** Medicare Advantage insurers are not required to provide any information about the time between the prior authorization request or appeal and when a determination was made. Whether prior authorization requirements create barriers to care depend in part on how timely determinations are made.
- **What share of providers are exempt from prior authorization requirements?** Insurers can waive prior authorization requirements for certain providers, for example as part of “gold carding” programs.

In addition to the gaps in data on prior authorization, several other key pieces of information that would be useful in conducting oversight and assessing the performance of Medicare Advantage plans are not publicly available. For example, Medicare Advantage insurers do not report the use of extra benefits and associated spending or the share of Medicare Advantage claims for which payment is denied after a service has been provided. Additionally, CMS does not publish out-of-pocket spending or other payment information for Medicare-covered services, nor reasons why people disenroll from Medicare Advantage by beneficiary characteristics.

Conclusion

Private plans now provide Medicare coverage to just over half of all eligible Medicare beneficiaries. These plans typically require prior authorization for at least some services. In 2021, insurers made more than 35 million decisions in response to requests for prior authorization on behalf of enrollees in Medicare Advantage plans, of which 2 million, or 6%, were denied. Among the small share (11%) of denials that was appealed, insurers overturned more than 80% of their initial decisions when they were reconsidered.

The relatively low rate of denied prior authorization requests may mean that the prior authorization process is not well targeted. Nevertheless, each prior authorization request requires providers to allocate time and staff resources that could instead be used for patient care. These requirements can also be a burden on beneficiaries who are already navigating a complex health care system, and lead to delays in care even if the prior authorization request is ultimately approved.

Additionally, though we do not know the reason prior authorization requests were initially denied, the high frequency of favorable outcomes upon appeal raises questions about whether a larger share of the initial requests should have been approved. Each initial denial that was subsequently approved represents medical care that was ordered by a doctor or other health care provider and ultimately deemed necessary by the plan. The potential delay that results from a prior authorization request, and the additional step of appealing a denial, may have negative effects on beneficiaries' health.

Prior authorization is one of many ways insurers manage utilization of health care services by their enrollees and our analysis finds that Medicare Advantage insurers vary in their use of prior authorization. Recently, several Medicare Advantage insurers have announced they are revising their prior authorization policies in an effort to simplify the process. Those changes could potentially reduce the burden on both providers and enrollees, depending on how the specific changes are implemented. CMS has also recently finalized several policies aimed at streamlining the prior authorization process in Medicare Advantage by clarifying the criteria that may be used to establish prior authorization policies and the duration for which a prior authorization in valid.

It is difficult to assess the impact on Medicare Advantage enrollees of both current policies and processes and planned changes to prior authorization because the necessary data are not available. For example, information about which services are most likely to be denied, how frequently different insurers issue denials for particular services, and whether certain enrollees are subject to more denials than others are not reported to CMS by Medicare Advantage insurers. As the number of Medicare beneficiaries enrolled in Medicare Advantage continues to grow, a better understanding of the use of prior authorization and other tools to contain spending and manage utilization will be important in evaluating the implications of these policies on utilization and quality, including variation across Medicare Advantage plans and compared to traditional Medicare.

Testimony for the United States Senate Permanent Subcommittee on Investigations

At a Hearing Entitled
"Examining Health Care Denials and Delays in Medicare Advantage"

May 17, 2023

Statement by Christine J. Huberty, Attorney

Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR)

Dear Mr. Chairman and Members of the Subcommittee:

My name is Christine J. Huberty. I have served as an attorney at the Greater Wisconsin Agency on Aging Resources (GWAAR) since 2015. The Elder Law and Advocacy Center at GWAAR provides free legal services to adults over age 60 under Title IIIB of the Older Americans Act. As an advocate for senior residents of Wisconsin, part of my job is to provide legal assistance to residents experiencing Medicare coverage denials.

The purpose of my testimony is to share my experiences with Medicare Advantage plans routinely denying coverage of skilled nursing facility (SNF) stays, which endangers the health and safety of beneficiaries, causes unnecessary stress and financial hardship, and many times shifts expenses to the state's Medicaid program.

Imagine you receive a call that your mother has fallen and has been admitted to the hospital for treatment. After four days in the hospital, your mother's doctors determine that it is unsafe for her to return home. Instead, they recommend transferring her to a skilled nursing facility (SNF) for rehabilitation. Her doctors order physical and occupational therapies for six to eight weeks to regain strength, balance, and mobility. However, on the seventh day of her stay, your mother's Medicare Advantage plan issues a notice that it will no longer provide coverage.

Your family is blindsided because although your mother is making progress, she is nowhere near ready to go home.[1] No doctor or therapist has even suggested this.

Neither the hospital nor the SNF is surprised because they rarely see patients with Advantage plans get more than two weeks of coverage, regardless of medical orders and diagnoses. Your mother is given appeal instructions and your family scrambles to do them on time. The appeals are denied. Your mother returns home against her doctors' orders out of fear of paying out of pocket.

After just four days at home, your mother falls a second time, and is hospitalized yet again. Her doctor's advice is the same: she needs physical and occupational therapies in a SNF until it is safe for her to return home. This time, her Advantage plan issues a denial while she is still hospitalized.[2] Your family again starts the appeal process. This time it is successful, but not for long. Your mother is able to transfer to the SNF with Medicare coverage but receives yet another denial after just nine days, even though she has fallen a third time at the SNF. Again, against doctors' orders, she returns home rather than furthering an appeal or paying out of pocket.

This is not just a client story – this is Audrey's[3] story – a family member of mine. Despite my continued advice and free legal services, Audrey's family decided that continuing to appeal was too stressful. Fortunately, Audrey's family had enough money to pay for the denied charges and lived close enough to help locate safe housing options and home care.

---

[1] Medicare coverage in a skilled nursing facility does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition. *Jimmo v. Sebelius* settlement agreement approved by the U.S. District Court for the District of Vermont (January 24, 2013).

[2] This is called a Prior Authorization denial, which differs only slightly from Post-Admission denials.

[3] Name has been changed to protect anonymity.

For beneficiaries who do continue to appeal, it is up to them to collect hundreds of pages of medical records from the hospitals, SNFs, and treating physicians to plead their cases – all while trying to recover from an illness or injury. If settlements are reached, the Advantage plans often admit they lacked these records when issuing their original denials. It can take anywhere from months to over a year to get through an Administrative Law Judge (ALJ) hearing and receive a decision, and even longer to get a reimbursement if the ALJ decision is favorable.[4]

Beneficiaries are expected to navigate several levels of appeal all while trying to recover from the incident that caused them to enter the SNF in the first place.[5] Patients first learn of a denial when they are issued a Notice of Medicare Non-coverage (NOMNC) from the SNF. (Ex. A). This notice has no information or reasoning provided for the denial. Most patients will call to request an appeal immediately because a NOMNC gives only two days' notice before coverage ends. When beneficiaries request an immediate appeal, it is automatically sent to a Quality Improvement Organization (QIO),[6] which issues a Determination Letter. (Ex. B). This first Determination Letter provides scant information regarding the specific reasons for a denial.

At the same time, beneficiaries receive a Detailed Explanation of Non-coverage letter from the Advantage plan. (Ex. C). However, contrary to its name, the "Detailed" Explanation of Non-coverage contains no more than a few sentences particular to the beneficiary. After

[4] Unfavorable ALJ decisions can be appealed at a fourth level (Medicare Appeals Council), however, to date our agency has not received decisions – favorable or unfavorable – for any MAC appeals.
[5] *See* https://www.hhs.gov/about/agencies/omha/the-appeals-process/level-1/part-c/index.html (last visited May 10, 2023).
[6] According to the Centers of Medicare and Medicaid Services (CMS), "Beneficiary and Family Centered Care (BFCC)-QIOs help Medicare beneficiaries exercise their right to high-quality health care. They manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider's decision to discharge them from the hospital or discontinue other types of services. Two designated BFCC-QIOs serve all 50 states and three territories, which are grouped into ten regions." Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs (last visited May 11, 2023).

receiving the first Determination Letter, the patient can appeal again with the QIO. Unfortunately, the QIO generally performs a cursory review and upholds the denial in a second Determination Letter. (Ex. D). Even in the cases where the QIO overturns the Advantage plan's denial, another denial is usually issued just a few days later, forcing the beneficiary to appeal again and again.[7]

At this point, the patient must decide whether to further the appeal by formally requesting a hearing before an ALJ. This is a critical stage where most people either find an advocacy resource or give up. Requesting a federal ALJ hearing not only sounds intimidating, but many individuals believe they are required to find an attorney to proceed. The hearing request must be in writing, and when the patient receives a Notice of Hearing, they must respond within five days, provide all documents (medical records), and prepare a list of witnesses. (Ex. E). Prior to the hearing, the patient will not know who will be attending the hearing. It is not unusual for the 'other side' to have upwards of six individuals on the telephone hearing ranging from legal counsel, other representatives, medical professionals not associated with the patient's care, and "observers." If the patient is still in the facility, they must also find a way to attend this telephone hearing from their bedside. Many hearings need to be rescheduled or postponed due to the patient's inability to obtain medical records. The burden to provide such records is on the beneficiary, not the Advantage plan. To say the appeals process is unbalanced in favor of the Advantage plans is an understatement.

Continuing an appeal is daunting, if not insurmountable, and even more so when you learn that patients are fighting an uphill battle before they even start rehab. In most cases,

[7] This practice has become so prevalent that advocacy groups have developed a grievance procedure. https://medicareadvocacy.org/new-from-the-center-form-to-contest-multiple-medicare-denials-issued-by-medicare-advantage-plans/ (last visited May 15, 2023).

Advantage plans utilize third-party contractors that apply algorithms in order to predict when a patient will be ready to go home - before they even begin to receive care in a SNF. (Ex. F). This prediction is based on millions of past beneficiary data points.[8] The Advantage plan itself rarely, if ever, speaks with a patient's doctors or reviews records. Instead, the Advantage plan defers decision-making to these third-party contractors. A handful of medical records may be reviewed by the contractors, but a full review does not take place unless the beneficiary advances through the appeals process, and sometimes not even then. Despite its claims, the results of the algorithm's predictions are not shared with the beneficiaries themselves.

Consider what this situation looks like for an individual with no family, friends, or legal representatives. How does this story unfold for an individual with dementia, a stroke victim, or a person who has lost a limb? In Wisconsin, the average cost of just one day in a SNF is over $300.[9] The individuals who can't afford to stay in the SNF will likely be advised to deplete their funds – forcing poverty – to qualify for the State's Medicaid program.

Our agency rarely encounters Original Medicare denials of SNF stays, despite the requirement that Advantage plans offer the same benefits and apply the same coverage criteria and standards.[10] Original Medicare covers up to 100 days in a SNF. [11] Our clients with Advantage Plans are lucky to receive 14. This discrepancy is largely due to Advantage plans' overwhelming reliance on, and often incorrect application of, the "custodial care" exclusion.[12] The Medicare Benefit Policy Manual defines "custodial care" as those services that:

---

[8] nH Predict Video, available at https://navihealth.com/nh-predict-video/, (last visited May 10, 2023).
[9] Wisconsin Medicaid Eligibility Handbook § 39.4.6.
[10] 42 C.F.R. § 422.100.
[11] 42 C.F.R. § 409.61(b) Posthospital SNF care furnished by a SNF, or by a hospital or a CAH with a swing-bed approval. Up to 100 days are available in each benefit period after discharge from a hospital or CAH. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility.
[12] Medicare Benefit Policy Manual, Chapter 16, § 110.

> "assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the A/B MAC (A) or (B) considers the level of care and medical supervision required and furnished. It does not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential."

Some examples of denials based on the custodial care exclusion include:

1. A 79-year-old brain cancer patient experiencing weakness, inability to walk, and multiple falls had surgery to drain fluid on his brain. His doctors recommended six to eight weeks in a SNF for therapies, incision care, and medication monitoring. He was denied on day 28 despite falling numerous times in the SNF. He was ultimately able to return home on day 57.

2. A 71-year-old patient had a seizure, pneumonia, and a broken hip. Her doctors recommended at least four weeks in a SNF for therapies. She was denied on day seven. One of the reasons she was denied was due to her "inability to think clearly and reason." She was ultimately able to return home on day 50.

3. An 82-year-old patient with two broken ankles entered a SNF for rehab after an accident. His doctors recommended at least four weeks in the SNF. He was denied on day 15. He was able to return home on day 30.

4. A 75-year-old patient suffered a stroke and was admitted to a SNF for rehab. As a result of the stroke, he was paralyzed on one side, and had difficulty swallowing, understanding, speaking, reading, and writing. His doctors ordered at least nine weeks in the SNF. He was denied on day 33. He was ultimately able to return home after 134 days. However, his doctors attested that had he not had a gap in therapies while he was dealing with his appeal, he would have likely been able to return home weeks earlier.

5. A 78-year-old patient broke his shoulder and needed both rehab and daily nursing care because he could not properly care for his colostomy bag one-handed. His doctors recommended at least six to eight weeks at the SNF. He was denied on day 17. It ultimately took until day 41 before he could care for his colostomy bag himself and return home.

6. An 80-year-old patient had hip surgery and was admitted to a SNF for rehab. His doctors recommended eight weeks in the SNF. He was denied on day 24 despite experiencing multiple falls. He was only discharged from the SNF on day 70 because he suffered a stroke.

7. An 86-year-old patient in a wheelchair fell and broke her upper arm. Her doctors recommended eight weeks at a SNF for rehab. She was denied on day 17. She was able to return home safely after day 78.

8. An 81-year-old patient using a wheeled walker received treatment at a hospital for COVID-19 and was transferred to a SNF for rehab. At the first SNF, he developed a stage IV (volleyball-sized) bed sore and was re-hospitalized. His doctors ordered a second SNF stay for rehab and wound care. He received a denial on day 67. His wound still had not healed.

9. An 89-year-old patient who lived independently at home fell and broke her leg. After hospitalization, she was admitted to a SNF for rehab. Her Advantage plan issued a denial after three weeks stating that she would need custodial care for the rest of her life. After two more months of rehab, she was able to return home and continue an active lifestyle.

For these examples, the Advantage plans determined the patients were ready for a "lower level of care" using the custodial care exclusion. Note, however, that in nearly all cases, the patient's medical need for their SNF stay ended when their doctors' had predicted, and sometimes earlier. Furthermore, in these instances, the patients experienced no difference in care; they stayed in their same beds, their same rooms, and received the same therapies. The only thing that changed for the patient is the Advantage plan no longer covered room and board – the most expensive portion of their stay. In these cases, the choice forced on the patient is always the same: stay and pay out of pocket, or go home against medical advice.

Remember Audrey? She fell twice at home and a third time at the SNF. She felt she had no choice but to ignore the directions of her doctors. She was overwhelmed by the unrelenting appeals. If she did not have family advocating for her, would she have returned home and fallen a fourth time, this time causing serious injury or even death? Would she have spent her life savings on needed care and been forced to take Medicaid? Audrey was not uninsured. She was enrolled in a Medicare insurance plan that said it would cover up to 100 days in a SNF. Audrey's

doctors said she needed more time. A computer, not even at the Advantage plan, overruled Audrey's doctors.

Wisconsin is unique in the legal services it provides Medicare beneficiaries, which has allowed me to share the stories I know of with your investigative team. But what about the cases we do not hear? Our agency sees the same practices by all Advantage plans; there is no one culprit. And with Advantage plans sold nationally, this is not just a Wisconsin problem. In 2022, over 30 million individuals were enrolled in a Medicare Advantage plan.[13] One must wonder how many cases involving our most vulnerable citizens are never appealed due to illness, injury, stress, incapacity, death, and poverty. Our agency grapples with these realities on a daily basis, and I want to thank you for taking the time to investigate these practices.

Exhibits:

A. Notice of Medicare Non-coverage (July 18, 2022)
B. BFCC-QIO Determination Letter (July 20, 2022)
C. Detailed Explanation of Non-coverage (July 19, 2022)
D. BFCC-QIO Determination Letter (August 1, 2022)
E. Notice of Hearing (October 12, 2022)
F. naviHealth nH Predict Outcome tool (June 7, 2019)

[13] https://medicareadvocacy.org/medicare-enrollment-numbers/, (last visited May 15, 2023).

Health Services
, WI-544.
Phone No:715- Fax: 715

Notice of Medicare Non-Coverage

Patient name: Patient number:

The Effective Date Coverage of Your Current **Skilled Nursing Facility** Services Will End: **07/20/2022**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: LIVANTA 888-524-9900 or TTY 888-985-8775 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan Contact Information:
UnitedHealthcare
Appeals and Grievance
Mail Stop: CA124-0157
P.O.Box 6106
Cypress, CA 90630
Customer Service: 1-800-204-1002
TTY:711

Additional Information (Optional):

Once complete, please return this NOMNC to your naviHealth Care Coordinator on the same day it is issued (fax: 844-244-9482).

Telephone delivery does not require a signature and should only occur when the member is unable to understand the notice and the representative is not available to sign in a timely manner.

The following is to be completed by the provider delivering this notice by telephone (skip if in-person):

- Notice delivered by (print full name):_____ Title:_____
- Call date:_____Call time:_____ am / pm
- Spoke with:
  - Full name:_____
  - Telephone number:(_____)_____
  - Relation to member: ☐ POA ☐ AOR ☐ Other (specify):_____
  - Reason why member could not sign/understand:_____
- An explanation of this Notice of Medicare Non-coverage and the member's appeal rights were Provided as indicated above.
- Made aware of the effective date that skilled service(s) is ending is: _____and date financial liability to begin is: _____
- Last covered date:_____Service to end: Skilled Nursing Facility Services
- To file an immediate appeal, the QIO must be called by noon on (date):_____
- Your QIO name and telephone number is (as indicated above on page 1):
  LIVANTA: 888-524-9900, TTY: 888-985-8775
- If you miss this deadline, you may have other appeal rights and can contact your Health Plan.
- Your health plan name and telephone number is UnitedHealthcare 1-800-204-1002, or TTY: 711
- Provider's signature/title:_____Date:_____

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

daughter July 18, 2022
Signature of Patient or Representative Date

P.O.A.

Resident has activated POA and is unable to understand & sign. NOMNC. Daughter, POA signed 7/18/2022

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

The company does not treat members differently because of sex, age, race, color, disability, or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability, or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free: 1-800-368-1019 or Toll-free: 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español **(Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費您您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt **(Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

LIVANTA™
From practical innovations to results.™

BFCC-QIO DETERMINATION LETTER

July 20, 2022

Case:
Patient Name:
Patient Date of Birth:
Provider: Health Services
Service Date: May 11, 2022 **Medicare(HIC)#:**

Dear

Thank you for your patience while we completed a thorough review of your provider's decision to end services. We understand the appeal process can be stressful. We hope your experience with Livanta has been a positive one.

Livanta LLC is authorized by Medicare to review medical care and services to decide if medical services meet professionally recognized standards of health care, are medically necessary, and are delivered in the most appropriate setting. Livanta LLC is also mandated to conduct an expedited review when a beneficiary appeals a provider's decision to end Medicare covered services.

An independent, certified, licensed, practicing peer reviewer reviewed the provider's decision to end coverage for the medical services from Health Services. Based on a review of the available medical documentation, and the information you provided. the peer reviewer found that you no longer meet the Medicare coverage requirements for skilled nursing facility services. The peer reviewer offered the following comments:

A review of medical records received shows that the patient has had sufficient time in a Skilled Nursing Facility to achieve therapy goals. Based on the Physical and Occupational Therapy evaluations, the patient has achieved reasonable goals of care. The patient needs minimum assist for bed mobility, transfers and walking of 15 feet with a walker. Therapy can be safely transitioned to a different setting. Skilled services are no longer needed on a daily basis to maintain or prevent decline. There were no medical issues to support the need for ongoing skilled nursing care.

You or your representative were notified by telephone on July 20, 2022 at 4:15 PM Eastern time that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on July 21, 2022.

You will be responsible for the cost of all services continued at Health Services beginning on July 21, 2022, except for those that are covered (when applicable) by Medicare Part B. If medical services were stopped before July 21, 2022, you will be responsible only for applicable deductible or coinsurance amounts and convenience services and items not normally covered by Medicare.

Health Services and Medicare have been informed of this decision. We encourage you or your representative to discuss arrangements for further health care with your physician or case manager. Please be aware that this decision should not affect your Medicare coverage for medically necessary and appropriate services that you may require in the future.

If you disagree with our decision, you may request that Livanta LLC reconsider its decision to uphold Health Services's end of Medicare covered services. Your request must be made by telephone or in writing no later than **sixty (60) calendar days** from the date of this notice to:

Livanta LLC
Attention: Expedited Determinations
6830 W. Oquendo Rd Suite 202
Las Vegas, NV 89118
888-524-9900

If you or your representative have any questions regarding this action please call Livanta LLC at 888-524-9900.

Sincerely,

Matthew Stofferahn, MD
Medical Director

The Livanta Medical Director signs all letters to maintain physician reviewer anonymity.

cc: Health Services
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY

Health Services
, WI-544
Phone No: 715 Fax: 715
TTY users dial 711.

Detailed Explanation of Non-coverage

Date: 07/19/2022

Member name: Member number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current Skilled Nursing Facility services should end.

The facts used to make this decision:

Your case was carefully reviewed by our Medical Director to determine you are now at a level where you can transition from daily skilled services to services that are provided intermittently. When you admitted to the skilled nursing facility, you needed total help to move around, and you needed total help with most self-care skills. After receiving skilled services in the facility, you can move around with moderate help and perform most self-care skills with a lot of help.

Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

According to Chapter 8 of the Medicare Guidelines specifically related to Skilled Nursing Facilities (Section 30; 30.2.2; 30.3; 30.4.1.1; 30.6; 30.7), you must have a need for daily skilled nursing or daily skilled rehabilitation to receive coverage for skilled nursing facility services. Our Medical Director reviewed the documentation of your entire stay and determined you no longer need skilled services on a daily basis. More inpatient days at the skilled nursing facility are not medically necessary. A safe discharge plan has been recommended. You are now at a point where you can receive part-time skilled services.

Plan policy, provision, or rationale used in making the decision:

Your plan's policy requires our Medical Director to exclusively utilize Medicare Guidelines to determine the medical necessity for skilled services. The additional review of your plan's policy guidelines along with Medicare Guidelines confirm that you no longer meet criteria for daily skilled services.

If you would like a copy of the policy or coverage guidelines used to make this decision or a copy of the documents sent to the QIO, please call us at: 1-800-643-4845

EXHIBIT
tabbies
C

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

LIVANTA™
From practical innovations to results.™

BFCC-QIO DETERMINATION LETTER

August 1, 2022

Case:
Patient Name:
Patient Date of Birth:
Provider: Health Services
Service Date: May 11, 2022 **Medicare(HIC)#:**

Dear

Thank you for your patience while we completed a thorough review of your provider's decision to end services. We understand the appeal process can be stressful. We hope your experience with Livanta has been a positive one.

Livanta LLC is authorized by Medicare to review medical care and services to decide if medical services meet professionally recognized standards of health care, are medically necessary, and are delivered in the most appropriate setting. Livanta LLC is also mandated to conduct an expedited review when a beneficiary appeals a provider's decision to end Medicare covered services.

Based on a request for a reconsideration appeal, an independent, certified, licensed, practicing peer reviewer reviewed the provider's decision to end coverage for the medical services from Tomahawk Health Services. Based on a review of the available medical documentation, and the information you provided. the peer reviewer found that you no longer meet the Medicare coverage requirements for skilled nursing facility services. The peer reviewer offered the following comments:

A review of medical records received shows that the patient was admitted to the Skilled Nursing Facility (SNF). The patient is self feeding and requires minimal help for hygiene and grooming. The patient needs minimal help with dressing, bathing and toilet tasks. The patient can walk 15 feet with a walker. The patient needs minimal help for bed mobility and functional transfers. There are no acute medical issues. Daily supervised services are no longer required to maintain or prevent a decline in function. The patient is ready for a different level of care.

You or your representative were notified by telephone on August 1, 2022 at 2:07 PM Eastern time of the determination that the decision to end these services was upheld. These services will no longer be paid for by the Medicare program beginning on July 21, 2022

You will be responsible for the cost of all services continued at Health Services beginning on July 21, 2022, except for those that are covered (when applicable) by Medicare Part B. If medical services were stopped before July 21, 2022, you will be responsible only for applicable deductible or coinsurance amounts, and convenience services and items normally not covered by Medicare.

Health Services and Medicare have been informed of this decision. We encourage you to discuss other arrangements for further health care with your physician or case manager. Please be aware that this decision should not affect your Medicare coverage for all medically necessary and appropriate services that may be required in the future.

You may appeal the reconsideration decision to an administrative law judge. If you wish to appeal, please refer to the information provided in the attached document for more details.

Appeals must be made in writing within 60 days from receiving this letter. You may wish to consult with your primary physician or case manager before taking further action.

If you or your representative have any questions regarding this action please call Livanta LLC at 888-524-9900.

Sincerely,

Matthew Stofferahn, MD
Medical Director

The Livanta Medical Director signs all letters to maintain physician reviewer anonymity.

Information and questions about quality of care or appeals.
Contact Livanta at 888-524-9900

Complaints or concerns about Livanta's work?
Let CMS know at QIOCONCERNS@cms.hhs.gov.

cc: Health Services
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision

If you do not agree with this decision, you may appeal the decision to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA). You or your representative may present your case to the ALJ at a hearing. You may file an appeal on the following issues:

1. The reasonableness of the services;
2. The medical necessity of the services; or
3. The appropriateness of the setting in which the services were furnished.

You must have $200 in dispute to appeal to an ALJ. A claim can be combined ("aggregated") with others to reach this amount if: (1) the other claims have also been decided by a QIO; (2) all of the claims are listed on your request for hearing; (3) your request for hearing is filed within 60 days of receipt of all of the QIO reconsiderations being appealed; and (4) you explain why you believe the claims involve similar or related services.

You can find more information about your right to an ALJ hearing at **www.hhs.gov/omha** or by calling 1 855-556-8475. This is a toll free call.

How to Appeal

To exercise your right to appeal, you must file a written request for an ALJ hearing within **60 days** of receiving this letter. If your request for hearing is being filed late, you must explain why your request is being filed late. After you file an appeal, you may check your appeal's status via the OMHA website at **www.hhs.gov/omha** (click on Appeal Status Lookup).

When preparing your request for hearing, please use **Form OMHA-100**, available at: **www.hhs.gov/omha/forms/index.html**

Your request for hearing must include the following:

1. The Beneficiary's name, address, and Medicare health insurance claim number;
2. The name and address of the person appealing, if the person is not the beneficiary;
3. The representative's name and address, if any;
4. The case number listed on the front page of this reconsideration notice (or send a copy of the notice);
5. The dates of service for the claims at issue;
6. The reasons why you disagree with the QIO's reconsideration; and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

You must send a copy of your request for hearing to the other parties who received a copy of this decision (for example, the beneficiary or provider/supplier). Please **do not** send a copy of your hearing request to the QIO that issued this reconsideration.

Mail your request for hearing to (tracked mail is suggested):

OMHA Central Operations
1001 Lakeside Ave., Suite 930
Cleveland, OH 44114-1158

OMHA processes **Medicare Beneficiary** appeals on a priority basis. If you are a Beneficiary or you represent a Beneficiary, mail your hearing request to:

OMHA Central Operations
1001 Lakeside Ave., Suite 930
Cleveland, OH 44114-1158

If you are a Beneficiary or represent a Beneficiary, you can also call the OMHA Beneficiary help line at 1 844-419-3358 for assistance. This is a toll free call. For more information on the OMHA Beneficiary prioritization program, including limitations for Beneficiaries represented by a provider/supplier, or a shared representative, visit the OMHA website at **www.hhs.gov/omha** or call the Beneficiary help line.

Who May File an Appeal

You or someone you name to act for you (your **appointed representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor,or someone else to act for you.

If you want someone to act for you, you and your appointed representative must sign and date a statement naming that person to act for you and send it with your request for hearing. Call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

Help With Your Appeal

You can have a friend or someone else help you with your appeal. If you have any questions about payment denials or appeals, you can also contact your State Health Insurance Assistance Program (SHIP). For information on contacting your local SHIP, call 1-800-MEDICARE (1-800-633-4227).

Other Important Information

If you want copies of statutes, regulations, and/or policies we used to arrive at this decision, please write to us and attach a copy of this letter, at:

Livanta LLC
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105

If you have questions, please call us at:

1-855-878-1720

Other Resources To Help You

1-800-MEDICARE (1-800-633-4227)
TTY/TDD: 1-800-486-2048

If you need large print or assistance, please call 1-800-633-4227

Department of Health and Human Services
Office of the Secretary

OFFICE OF MEDICARE HEARINGS AND APPEALS

Kansas City Field Office
601 E. 12th Street
Suite 221
Kansas City, MO 64106-2817
(844) 566-6258
(816) 321-7292 (Direct)
(816) 527-0051 (Fax)
(844) 566-6258 (Toll Free)

10/12/2022

NOTICE OF HEARING

Appellant
Enrollee
Medicare No.
Date(s) of Service
OMHA Appeal Number
Administrative Law Judge Robert Clarke

A hearing in the above appeal is scheduled for:

Hearing Date: THURSDAY, 11/10/2022
Hearing Time: 09:30 AM Central Time

You are scheduled to appear by:

- ☑ Telephone
- ☐ Video-Teleconference (VTC)
- ☐ In-Person

You are instructed to call our office on the hearing date at the time indicated above. Please call

EXHIBIT tabbies E

(833) 419-1926 and enter 43353523 when asked for a passcode or collaboration code. Failure to call at the scheduled time will be considered a failure to appear for the hearing.

The following parties, participants, and/or witnesses are also scheduled to appear at the hearing:

Name	Role	Appearing by
CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY	Party	
Livanta		
LLC	Non-Party	

What do I do next?

You must respond to this notice within 5 calendar days of receipt. You are encouraged, but not required, to use the enclosed *Response to Notice of Hearing* (form OMHA-102) when responding. If you are a party to the appeal, your response must indicate whether you plan to attend the scheduled hearing, or whether you object to the proposed time and/or place of the hearing. If applicable, you must specify who else from your organization or entity plans to attend the hearing and in what capacity, and list any witnesses who will be providing testimony. If you are an employee of CMS or a CMS contractor and wish to attend the hearing as a participant, your response must indicate that you plan to attend the hearing and specify each individual who plans to attend.

What if I object to the type of hearing?

If you are a party to the appeal and you object to the type of hearing scheduled, please complete section 6 of the enclosed *Response to Notice of Hearing*, and indicate what type of hearing you would prefer (if you are also requesting to change the time of your scheduled hearing, see the section below titled "What if I can't attend my scheduled hearing?"). No explanation is required if you are an unrepresented beneficiary or enrollee requesting to appear by VTC. For all other requests for a VTC hearing, and any requests for an in-person hearing, you must explain why you object to the type of hearing scheduled. If the Administrative Law Judge changes the type of hearing, an amended notice of hearing will be sent to the parties and any potential participants who were sent a copy of this notice.

What if I can't attend my scheduled hearing?

If you are a party to the appeal and you cannot attend the hearing at the scheduled time and place, please call our office immediately at the direct dial phone number at the top of this notice. Please *also* complete section 4 of the enclosed *Response to Notice of Hearing* and explain why you are unable to attend the hearing at the scheduled time and place. If the Administrative Law Judge finds good cause to reschedule the hearing, an amended notice of hearing will be sent to the parties and any potential participants who were sent a copy of this notice.

What if I don't attend my scheduled hearing?

If you are the appellant and neither you nor your representative appears at the scheduled hearing, the Administrative Law Judge may dismiss your request for hearing unless good cause for the failure to appear is found. If you respond to this notice of hearing and fail to appear, you must contact the Administrative Law Judge within 10 calendar days after the hearing and provide a good cause reason for not appearing. If you do not respond to this notice of hearing and fail to appear, the Administrative Law Judge will send you a notice asking why you did not appear, and you will have 10 calendar days to respond. If you do not respond to the Administrative Law Judge's notice within 10 calendar days, or you do respond and the Administrative Law Judge determines you did not have good cause for failing to appear, your request for hearing will be dismissed. If the Administrative Law Judge determines that good cause exists, the hearing will be rescheduled and the time between the originally scheduled hearing date and new hearing date will not count toward the adjudication period.

What if I don't want a hearing?

If you are a party to the appeal, you have a right to appear at the hearing to present arguments in favor of your position, and offer testimony and evidence to the Administrative Law Judge. However, if you do not wish to present your case at a hearing, you may request a decision based on the written and other evidence in the record. To do so, please complete section 4 of the enclosed *Response to Notice of Hearing*. Please also complete and submit a *Waiver of Right to an Administrative Law Judge (ALJ) Hearing* (form OMHA-104). You can find a copy of this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. Please note that your waiver does not affect the right of other parties to participate in the hearing and even if all parties waive the hearing, the Administrative Law Judge may still decide to conduct a hearing if it is necessary to decide the case. If a hearing is conducted and you do not attend, you may still offer written evidence to the Administrative Law Judge. Please see below for additional information regarding the submission of evidence.

What if I no longer wish to pursue this appeal?

If you decide that you no longer wish to pursue this appeal, you may withdraw your request for hearing in writing. You may do this by letter or by completing and submitting a *Withdrawal of Request for an Administrative Law Judge Hearing* (form OMHA-119). You can find a copy of

this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. If you submit a written request for withdrawal and no other party has filed a valid request for hearing, your appeal will be dismissed. Your request to withdraw will not be honored if a decision, dismissal or remand has already been issued.

What issues will be addressed at the hearing?

The issues before the Administrative Law Judge include all of the issues brought out in the initial determination, coverage determination, or organization determination; redetermination; or reconsideration that were not decided entirely in a party's favor, for the claims or other appealed matters specified in the request for hearing.

What if I object to the issues listed above?

If you are a party and you object to the issues, you must notify the Administrative Law Judge in writing at the earliest possible opportunity before the time set for the hearing and explain your objections. You can either do this in section 6 of the enclosed *Response to Notice of Hearing* or at a later time, but no later than 5 calendar days before the date of your scheduled hearing. You must send a copy of your objections to all the parties who were sent a copy of this notice and to CMS or any CMS contractor that has elected to be a party to the hearing. The Administrative Law Judge will make a decision on your objections either in writing, at a prehearing conference, or at the hearing.

Can I have a representative?

Yes. You have the right to have a representative attend the hearing on your behalf or attend the hearing with you. You can be represented by an attorney or other person. If you have a representative and have not completed and submitted an *Appointment of Representative* (form CMS-1696), which can be found online at www.hhs.gov/omha, or other written statement authorizing your representative to act on your behalf, please call our office as soon as possible.

Can I request a copy of the case file?

Yes. If you would like a copy of all or part of your file before the date of the hearing, please contact our office for further instructions.

Can I submit additional evidence?

If you want to submit additional written or other evidence, please complete and submit a *Filing of New Evidence* (form OMHA-115). You can find a copy of this form online at www.hhs.gov/omha, or you may contact our office to receive a copy. Unless you are an unrepresented beneficiary or enrollee, you must submit all evidence by the date (if any) you have

specified in your request for hearing, or within 10 calendar days of receiving this notice. If evidence is submitted more than 10 calendar days after receiving this notice, any applicable adjudication period will be extended by the number of calendar days in the period between 10 calendar days after receipt of this notice and the day the evidence is received. Please note that although the 10-day submission time frame does not apply to unrepresented beneficiaries and enrollees, they may wish to submit any additional evidence as soon as possible to allow the Administrative Law Judge more time to consider the evidence before the hearing.

If you are a provider or supplier, or a beneficiary represented by a provider or supplier, and you are appealing a reconsideration issued by a Medicare Part A or Part B Qualified Independent Contractor (QIC), you must also submit a statement explaining why the evidence was not submitted prior to the issuance of the QIC's reconsideration. The Administrative Law Judge will determine whether you have good cause for submitting the evidence for the first time at the OMHA level of appeal.

Will any experts participate or testify at the hearing?

No experts are scheduled to testify at your hearing.

What happens at the hearing?

- The Administrative Law Judge will open the hearing and ask the parties, participants and any representatives to identify themselves and any witnesses they may be calling;
- The Administrative Law Judge will ask you and any other witnesses to take an oath or to affirm that the testimony is true;
- You will have the opportunity to present facts and arguments;
- If you are a party, you or your representative may present witnesses and may cross-examine the witnesses of the other parties;
- The Administrative Law Judge may question you and any other witnesses about the facts and issues;
- The Administrative Law Judge may allow you to submit additional written statements and affidavits about the matter in lieu of testimony or argument at the hearing. You must submit the additional statements and affidavits within the time frame designated by the Administrative Law Judge and provide a copy of them to the other parties to your hearing, if any, at the same time you submit them to the Administrative Law Judge;
- The Administrative Law Judge will review the issue(s) and entire record of your claim, independent of any determinations previously made on your claim; and
- The Administrative Law Judge will make an audio recording of the hearing.

How will I know the result of my case?

After the hearing, the Administrative Law Judge will issue a written decision, which will be mailed to all parties to the appeal, the relevant QIC or Independent Review Entity, and the Part D plan sponsor if you are appealing a Part D coverage determination. The decision will include findings of fact, conclusions of law, and the reasons for the decision. The Administrative Law Judge will base the decision on the evidence of record, including the testimony at the hearing.

Whom do I contact with other questions about my hearing?

If you have any questions about your hearing, please call or write our office. A direct dial phone number and mailing address are at the top of this notice. Please provide the Administrative Law Judge name and OMHA appeal number if you write to the office, or have the information available if you call the office.

cc:

CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY
PO BOX 6106
MS CA124-0157
CYPRESS, CA 90630

Livanta
6830 W. Oquendo Road
Suite 202
Las Vegas, NV 89118

; LLC

,

Enclosures:
OMHA-102 Response to NOH
OMHA-001 Notice of Nondiscrimination

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

NOTICE OF NONDISCRIMINATION

The Office of Medicare Hearings and Appeals (OMHA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. OMHA does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

OMHA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - TTY calls that are initiated by the caller through a public relay service
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact (844) 419-3358.

If you believe that OMHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 419-3358.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (844) 419-3358.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

RESPONSE TO NOTICE OF HEARING

Instructions: Complete sections 2 through 8 below, as applicable, and return this form to the assigned Administrative Law Judge (ALJ) **within 5 days of receiving the notice of hearing**. For expedited Part D hearings, contact the ALJ at the telephone number provided at the top of the notice of hearing **or** complete and return this form to the assigned ALJ **within 2 days of receiving the notice of hearing.** The return mailing address and fax number are at the top of the notice of hearing. You do not need to include the notice of hearing with your response.

Please note that only a party to the hearing may call witnesses; object to the time, place, or type of hearing; object to the statement of issues to be decided at the hearing; or object to the assigned ALJ (sections 4 through 6 below). Non-party participants are not permitted to call witnesses and may not file objections.

Section 1: Hearing information. [TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS]

OMHA Appeal Number	Appellant	
Type of Hearing ☒ Telephone ☐ Video-Teleconference (VTC) ☐ In-Person		Assigned ALJ Clarke
Hearing Day of Week THURSDAY	Hearing Date 11/10/2022	Hearing Time 09:30 AM
Telephone Hearing Call-in Number (*if applicable*) (833) 419-1026		Passcode or Collaboration Code (*for telephone hearing*) 43353523
VTC or In-Person Hearing Address (*if applicable*)	City	State / ZIP Code

Section 2: What is the responding party's or participant's information? (*Representative information in next section*)

Name (*First, Middle initial, Last*)	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

If the respondent is an entity or organization, please list all individuals who plan to attend the hearing and the capacity in which they are attending *(attach a continuation sheet if necessary)*:

Section 3 : What is the representative's information? (*Skip if you do not have a representative*)

Name	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

Section 4: Will you be present at the time and place shown above? (*Check one*)

☐ **I will be present at the time and place shown on the notice of hearing.** If an emergency arises after I submit this response and I cannot be present, I will notify the ALJ at the telephone number shown at the top of the notice of hearing as soon as possible.

☐ **I cannot be present at the time and place shown on the notice of hearing and would like to request that my hearing be rescheduled.** I understand that the ALJ has the discretion to change the time and place of the hearing as long as my explanation for my request to reschedule meets the good cause standard for changing the time and place of the hearing. (For example, good cause may be found due to an inability to attend the hearing because of a serious physical or mental condition, incapacitating injury, or death in the family or if severe weather conditions make it impossible to travel to the hearing. *See* 42 C.F.R. sections 405.1020(f) and (g), and 42 C.F.R. sections 423.2020(f) and (g) for additional circumstances that may establish good cause.) I understand that if I am the appellant and the hearing is postponed at my request, the time between the originally scheduled hearing date and the new hearing date is not counted toward any applicable adjudication period.

I would like to reschedule my hearing for the following date and time, and I have good cause to reschedule my hearing because:

☐ **I want to waive my right to appear at the ALJ hearing.** (*Please complete form OMHA-104 and attach it to this response.*)

PSC Publishing Services (301) 443-6740. EF

Section 5: Do you intend to call any witnesses to provide testimony at the hearing?

☐ No.

☐ Yes, I intend to call the following witnesses *(attach a continuation sheet if necessary)*:

Section 6: Do you object to any of the following conditions? (*Check all that apply*)

☐ **I object to the type of hearing scheduled.** If you are an unrepresented beneficiary or enrollee, and a telephone hearing is scheduled, you have the right to request that a VTC hearing be held instead if VTC technology is available. For all other parties, if a telephone hearing is scheduled, the ALJ may find good cause for an appearance by VTC if he or she determines that VTC is necessary to examine the facts or issues involved in the appeal.

If a telephone or VTC hearing is scheduled and the party, including an unrepresented beneficiary or enrollee, requests that an in-person hearing be held instead, the ALJ, with the agreement of the Chief ALJ or designee, may find good cause for an in-person hearing if VTC or telephone technology is not available, or if special or extraordinary circumstances exist.

I object to the type of hearing scheduled and request a (*check one*) ☐ VTC ***or*** ☐ in-person hearing because:

Note: No explanation is required if you are an unrepresented beneficiary or enrollee requesting a VTC hearing.

☐ **I object to the issues described in the notice of hearing.** I understand that I must send a copy of my objection to the issues to all the other parties who were sent a copy of the notice of hearing, and to CMS or a CMS contractor that elected to be a party to the hearing (if you do not have these addresses, please contact the ALJ's adjudication team at the telephone number shown in the letterhead of the notice of hearing). I understand that the ALJ will make a decision on my objection either in writing, at a prehearing conference, or at the hearing.

I object to the issues described in the notice of hearing because:

☐ **I object to the ALJ assigned to my appeal.** I understand that an ALJ cannot adjudicate an appeal if he or she is prejudiced or partial with respect to any party or has an interest in the matter pending for decision, and that I may object to the ALJ assigned to my appeal for these reasons. I understand that the ALJ will consider my objection and decide whether to proceed with the appeal or withdraw. I understand that if I object to the ALJ assigned to my appeal, and the ALJ subsequently withdraws from the appeal, another ALJ will be assigned, and any applicable adjudication time frame will be extended by 14 calendar days.

I object to the assigned ALJ because:

Section 7: If you are the appellant, do you want to waive or extend the time frame to decide your appeal? (*If yes, check one*)

☐ **I want to waive the time frame for the ALJ to decide my appeal.** I understand that by waiving this time frame, the ALJ does not have to decide my appeal within any applicable adjudication period that would otherwise apply.

☐ **I want to extend the time frame for the ALJ to decide my appeal.** I want the time frame to be extended _____ calendar days beyond any applicable adjudication period.

Section 8: Sign and date this form.

Party, Participant or Representative Signature	Date

Privacy Act Statement

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

If you need large print or assistance, please call 1-855-556-8475

Skilled Nursing Facility

nH Predict | Outcome

DOB:[_____, Gender: .
Admit Date: 06/03/2019

Likelihood of Hospital Admission from SNF in less than 30 days: 28% (High)

Patient Evaluation
Impairment Group: Orthopedic Conditions
Diagnostic Group: Upper Extremity Fracture
Primary Dx: S42.212A-UNSP DISP FX OF SURGICAL NECK OF LEFT HUMERUS, INIT
Usual Living Setting: Home Alone
Medical Complexity: 3 - Active, system disease limiting function
Grouper(s): None

	Basic Mobility	Daily Activity	Applied Cognition	Total Average Score
	E.g. Transfers, ambulation, stairs, wheelchair skills	E.g. Bathing, toileting, dressing, eating (ADL/IADL)	E.g. Memory, communication, problem solving	Average of Basic Mobility, Daily Activity, and Applied Cognition scores
Admission Function	32 (0–100) Max A to Mod A	33 (0–100) Mod A to Min A	65 (0–100) Close/Frequent Supervision	43 (0–100) Mod A to Min A
SNF Outcomes Prediction (+11 Avg. Gain)	44 Mod A to Min A	48 SU/Supervision/SBA to Mod I	69 Basic Decision/Problem Solving	54 Min A to SU/Supervision/SBA
Projected non-skilled caregiver needs post SNF	**3.75 Hours/Day**	**0.75 Hours/Day**	**None**	**4.5 Hours/Day**

Actual Discharge Setting After SNF of Similar Patients

Home Alone	9%
Home with Care	**52%**
Assisted Living	13%
Long Term Care	26%

Anticipated Length of Stay in Days*: 16.2 — **16.6 Avg.** — 17.0

Projected SNF Discharge: **6/20/2019**

Therapy:
Cycle: 15.3 Days on Average
561 Minutes per Week
5x/week: 112 minutes/day
6x/week: 93 minutes/day
7x/week: 79 minutes/day

Clinical Considerations: High (>25%) readmission alert. Home Alone unrealistic discharge plan.

naviHealth

This report was provided to your patient's health plan for conside
care and treatment. The information contained in this report is n
as or replace medical advice. All treating health care providers
responsible for their own medical judgment.

© 2019 naviHealth, Inc. All Rights Reserved. SNF: Skilled Nursing Facility *95% Confidence Interval (p<.05) Printed by KEiden on 6/7/2019 11:3

EXHIBIT
F

Skilled Nursing Facility

nH Predict | Outcome

DOB: [redacted] Gender: [redacted]
Admit Date: 06/03/2019

Admission Assistance Levels

Basic Mobility - e.g. Transfers, ambulation, stairs, wheelchair skills

May need a lot (mod/max) of assistance with:
- Advancing with his/her assistive device or wheelchair even short distances around the home
- Maneuvering the assistive device or wheelchair during transfers or walking
- Standing for even short time periods, for example, during transfers
- Transferring in/out of a car to attend any function outside the home
- Using his/her assistive device or wheelchair when transferring to chair, toilet or shower bench

May need total assistance with:
- Ascending or descending one step/curb with an assistive device or a wheelchair
- Going up/down ramps or steps with assistive device or wheelchair

Daily Activity - e.g. Bathing, toileting, dressing, eating (ADL/IADL)

May need a little (min/contact guard) assistance with:
- Basic activities of daily living (ADL) such as bathing and lower body dressing
- Completing simple housekeeping tasks around the home (simple dusting)
- Completing tasks that require fine motor coordination (snaps, buttons, sewing, slicing/dicing)

May need a lot (mod/max) of assistance with:
- Completing simple tasks around the home that require stamina, strength or balance (hanging curtains, simple above-the-head activities, etc.)
- Higher level activities of daily living such as medication administration and full meal preparation

Applied Cognition - e.g. Memory, communication, problem solving

May need partial to little assistance with:
- Figuring out a problem with a bill
- General household finances (managing checkbook)
- Navigating in the community
- Remembering calendar events/appointments

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

© 2019 naviHealth, Inc. All Rights Reserved.

Skilled Nursing Facility

nH Predict | Outcome

DOB: [redacted] Gender:
Admit Date: 06/03/2019

Applied Cognition - e.g. Memory, communication, problem solving (Continued)

May need total to partial assistance with communication, memory and social tasks including:

- Explaining/arranging household repairs
- Taxes, insurance and legal documents/transactions
- Understanding ingredients and portions

Predicted Assistance Levels upon Discharge from Skilled Nursing Facility

Basic Mobility - e.g. Transfers, ambulation, stairs, wheelchair skills

May need a lot (mod/max) of assistance with:

- Ascending or descending one step/curb with an assistive device or a wheelchair
- Going up/down ramps or steps with assistive device or wheelchair
- Standing from any chair or surface without an armrest, rail, or grab bar

May need a little (min/contact guard) assistance with mobility activities such as

- Advancing with his/her assistive device or wheelchair even short distances around the home
- Maneuvering the assistive device or wheelchair during transfers or walking
- Standing for even short time periods, for example during transfers
- Transferring in/out of a car to attend any function outside the home
- Using his/her assistive device or wheelchair when transferring to chair, sofa, toilet or shower bench

Daily Activity - e.g. Bathing, toileting, dressing, eating (ADL/IADL)

May need a little (min/contact guard) assistance with:

- Completing simple housekeeping tasks such as vacuming, cleaning sinks, etc.
- Completing tasks that require upper extremity strength (lifting boxes, moving light furniture, some gardening activities, etc.)

May need a lot (mod/max) of assistance with:

- Completing higher level activities such as running errands outside of the home
- Completing housekeeping tasks that require strength, stamina or balance (over-the-head activities of longer duration, moving heavy furniture, climbing step stool)

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

© 2019 naviHealth, Inc. All Rights Reserved.

Skilled Nursing Facility

nH Predict | Outcome

DOB: [redacted] Gender:
Admit Date: 06/03/2019

Applied Cognition - e.g. Memory, communication, problem solving

May need partial to no assistance with:

- Basic communication
- Following a recipe
- Remembering calendar events
- Remembering to do 4 to 5 errands

May need partial to little assistance with communication, memory and social tasks including:

- Getting household items repaired or installed
- Managing household finances
- Navigating in the community
- Shopping and doing price/budget calculations

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

© 2019 naviHealth, Inc. All Rights Reserved.

nH Predict | Outcome

DOB: [redacted] Gender:
Admit Date: 06/03/2019

The Report

Your goal is our goal – to return to the community as quickly and safely as possible. We have gathered your information and compared that against thousands of patients, similar to you, to understand what outcomes you may achieve with therapy. This report will give you an idea of what you may be able to do after therapy and how much assistance you may need.

Your Care Coordinator is: _____

Your Journey

Following therapy, patients like you have experienced the following:

Actual Discharge Setting After Skilled Nursing Facility of Similar Patients

Basic Mobility

You may need a little (less than 25%) physical assistance with such activities as walking, climbing stairs or transferring from a chair inside your home.

Caregiver Assistance Needs after Skilled Nursing Facility:
3.75 Hours/Day

Daily Activity

You may need a little (less than 25%) physical assistance with such activities as grooming, dressing or bathing.

Caregiver Assistance after Skilled Nursing Facility:
0.75 Hours/Day

Applied Cognition

You may be able to complete all complex tasks such as reading, counting money and conversing but you might have slight difficulty with such activities as completing a long insurance form or balancing a checkbook.

Caregiver Assistance Needs after Skilled Nursing Facility:
None

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

© 2019 naviHealth, Inc. All Rights Reserved.

nH Predict | Outcome

DOB: [redacted] Gender:
Admit Date: 06/03/2019

Your Care Skilled Nursing Facility

Your care will be based on your individual needs. Similar patients have experienced the following:

Target Discharge Date:	**6/20/2019**	Anticipated length of stay:	**16 - 17 Days**
Therapy:	**9.5 Hours/Week**	**High likelihood of hospital admission from the Skilled Nursing Facility within 30 days**	

Our Expertise

naviHealth works with your care team to help coordinate care and support clinical decision making. We draw upon the knowledge of experienced licensed clinicians. Using data from a patient database of over 3 million records, we help set realistic goals with you based upon what other patients like you have been able to achieve.

www.navihealth.com

naviHealth

The information contained in this report was provided for consideration by your health plan in authorizing services. naviHealth is not a health care provider and this report is not intended to serve as or replace medical advice issued by a health care provider. Your treating health care provider is responsible for making decisions and recommendations regarding your care.

© 2019 naviHealth, Inc. All Rights Reserved.

MARQUETTE UNIVERSITY
Be The Difference.

College of Nursing
Clark Hall
PO Box 1881
Milwaukee, WI 53201-1881
414-288-3803

Testimony

of

Visiting Research Professor

Lisa M. Grabert

for the

Committee on Homeland Security and Governmental Affairs

Permanent Subcommittee on Investigations

of the

U.S. Senate

"Examining Health Care Denials and Delays in Medicare Advantage"

May 17, 2023

Chairman Blumenthal, Ranking Member Johnson, and members of the subcommittee, I am Lisa Grabert, a Visiting Research Professor in the College of Nursing at Marquette University in Milwaukee, WI. I am a former Congressional staffer for the U.S. House of Representative Ways and Means Committee and I am honored to testify before the subcommittee today on the Medicare program, a policy area where I have worked for over twenty years. I applaud the subcommittee for addressing the important topic of prior authorization.

My testimony focuses on: 1) Medicare Advantage (MA) and contrasting it to what is offered by Fee-for-Service (FFS) or Traditional Medicare, 2) prior authorization—a managed care tool deployed in the MA program, and the 3) failure of FFS payment policies that are used to manage Traditional Medicare.

MEDICARE ADVANTAGE

Medicare Advantage ("MA") is an important part of the Medicare program. Just two weeks ago MA enrollment surpassed Fee-for-Service (FFS) enrollment, for the first time in the history of the program as the predominate coverage choice of Medicare beneficiaries (Biniek et al. 2023[b]). Medicare beneficiaries are voting with their feet and are increasingly revealing their preference for MA, which now represents 50.2 percent of the Medicare program's market share.

As part of selecting MA, beneficiaries receive traditional Part A and B benefits, supplemental coverage (aka so-called "Medigap" coverage), supplemental benefits (e.g. dental, hearing, vision), and typically Part D prescription drug coverage often at little or no additional cost above their existing Part B premium. Beneficiaries select MA for a variety of reasons, including improved financial protections, additional benefits (such as vision, hearing, and dental coverage), prior experience with managed care, and choice simplicity. As part of the tradeoff in receiving a

comprehensive benefits package, MA beneficiaries accept a provider network and some utilization review requirements (Grabert 2022).

In contrast, to construct the same comprehensive benefits package in FFS Medicare, beneficiaries must elect Part B, purchase a prescription drug plan, and a Medigap plan often at a greater total cost. Without Medigap coverage, FFS Medicare beneficiaries face unpredictable out-of-pocket expenses.

The financing structure between these two competing models for Medicare differ. The requirements for MA plans are articulated under section 1852 of the Social Security Act and are carried out by private health insurers who are directly paid by the Medicare program through risk-adjusted capitation (i.e. population-based payments) to construct a network and provide services. MA plans use a variety of financial tools to manage risk, including risk corridors, partial capitation, and bundles. Savings resulting from the implementation of a provider network and utilization review help fund MA's more comprehensive benefits package.

Unlike MA, FFS Medicare does not involve a managed care plan and all services consumed by the beneficiary are directly paid from the Medicare program to approved providers and suppliers through a litany of administrative fee schedules set annually. Any changes to the structure or nature of FFS payment require an act of Congress or an actuarially-certified model executed through the Centers for Medicare & Medicaid (CMS) Innovation Center.

As noted, there are a variety of highly detailed differences between MA and FFS. Given the focus of today's hearing, I limit my discussion to prior authorization and FFS payment rules.

PRIOR AUTHORIZATION

It is important to remember the context of the deployment of utilization review. Our country spends a significant portion of its economic power – nearly one-fifth of our Gross Dometic Product – on health care (NHE 2023). In health financing, policymakers have a variety of knobs to turn, be it the breadth of the provider network, coverage of innovative pharmaceuticals and medical devices, and the degree and depth of use of utilization review tools like prior authorization. Health financing involves a series of tradeoffs most important of all for the beneficiary, but also for policymakers and taxpayers. Appropriate and healthy debate over the use of these tools, especially prior authorization, is critical to the decision making process around health financing.

The term "prior authorization" appears in title XVIII of the Social Security Act, the title specifying the Medicare program, in several instances. There are four specific areas in which CMS applies prior authorization to FFS: hospital outpatient services, non-emergent repetitive ambulance transports, durable medical equipment supplies, and home health episodes of care (CMS[a] 2023). Beyond these narrow areas, prior authorization is not robustly used as a tool within FFS.

Unlike FFS, MA utilizes prior authorization with a much broader scope. While the statutory provisions for FFS prior authorization are permissive in nature, the statutory provisions for MA prior authorization are more restrictive and include prior authorization restrictions for COVID-19 testing, supplemental benefits, and emergency services.

The difference in statutory language pertains to the intent behind prior authorization. Prior authorization is intended to be a utilization tool for robust use by MA plans due to the underlying

incentives (such as capitated payments) within MA. As such, there is a not statutory definition limiting the scope of prior authorization in MA.

Further, until about a month ago, there was no regulatory definition of prior authorization.

On April 12, 2023, CMS finalized "regulatory changes" to MA prior authorization (CMS 2023):

> "First, we are finalizing that prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in this rule.
>
> "Second, we are finalizing that an approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation, and that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan.
>
> "Third, we are finalizing that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare laws.
>
> "We are finalizing that when coverage criteria are not fully established in Medicare statute, regulation, NCD, or LCD, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature.
>
> "We are also clarifying that coverage criteria are not fully established when additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD, or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.
>
> "When additional, unspecified criteria are needed to interpret or supplement general provisions, the MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.
>
> "Finally, to ensure prior authorization and other utilization managed policies are consistent with the rules we are adopting on coverage criteria and coverage policies and relevant current clinical guidelines, we are finalizing that all MA plans establish a Utilization Management Committee to review all utilization management, including prior authorization, policies annually and ensure they are consistent with the coverage requirements, including current, traditional Medicare's national and local coverage decisions and guidelines."

It is important to note that these changes will be effective on June 5, 2023. Prior to this date, there has not been any formal definition or process in place giving guidance to MA plans on how prior authorization can and cannot be applied.

Given this seismic change in policy, we would expect the landscape of MA prior authorization, after June 4, 2023, to shift. Now that the rules of engagement on prior authorization have been clearly articulated, it may be premature to pursue additional policy beyond what CMS has recently finalized. It is worthy to note that without considerable progress from Congress, CMS may not have been properly motivated to issue changes this year. As a separate attachment to my written testimony, I have included a detailed timeline of the major milestones to advance prior authorization policy, within the past five years.

Recent Efforts to Advance Prior Authorization Reform
In 2021 there were companion bills introduced in the both the Senate and House— *Improving Seniors' Timely Access to Care Act of 2021*. The House bill (H.R. 3713) had 326 cosponsors and the Senate bill (S. 3018) had 52 cosponsors. These bills primarily focus on many of the same changes CMS recently finalized, as well as changes included in a current proposal by CMS to establish an electronic prior authorization reporting system.

The House pursued regular order and did an official mark-up of the bill before the Ways & Means Committee. The House passed H.R. 3713 on September 14, 2022 by unanimous consent.

Prior to passage in the House, the Congressional Budget Office (CBO) released an official budgetary score for H.R. 3713. CBO estimated the cost of H.R. 3713 would be $16.2 billion over the 10-year budget window. CBO cited the following reasons for its score (CBO 2022):

> "Prior authorization is a utilization management tool that limits coverage to cases that meet the plan's standards of review.
>
> "By placing additional requirements on plans that use prior authorization, we expect H.R. 3173 would result in a greater use of services.
>
> "We expect Medicare Advantage plans would increase their bids to include the cost of these additional services, which would result in higher payments to plans."

From this explanation I assume CBO crafted its score using two key assumptions: 1) the requirements in H.R. 3173 will alter the status quo for application of prior authorization, which will result in an increase in service utilization; and 2) increased utilization will increase costs, which will cause MA plans to raise their annual bids, causing higher payments to MA plans in the future.

CBO's score represents a warning regarding spending in the Medicare program. CBO is clearly communicating that tinkering with underlying utilization review tools, such as MA prior authorization, can have significant fiscal down sides to the overall solvency of the Medicare program. To better illustrate why CBO issues this caution, we must examine a specific set of services. We need to better understand how MA prior authorization has impacted post-acute care.

Prior Authorization and Post-Acute Care
MA plans have been using prior authorization to manage post-acute care services for years. Hospital trade associations have been quick to place blame for the lack of growth in post-acute care on MA plans.

> "Insurers may save money as a result of delaying or denying discharge to the next appropriate setting to the extent the hospital continues providing services and the patient's

> condition improves to the point of no longer requiring the same next level of post-acute care" (AHA 2022).
>
> "MA plans' use of the prior authorization process to delay and deny patient transfers from acute hospitals to rehabilitation hospitals and units is a widespread and common problem that can harm patients" (AMRPA Survey).

Despite these anectodotal claims from hospitals, they provide little empirical evidence pointing toward inappropriate use of prior authorization of post-acute hospitalizations. However, a 2022 report on MA prior authorization included an audit of denials that met Medicare FFS coverage rules.

Among the 13 percent of services that were denied, 4 were for discharges from Inpatient Rehabilitation Facilities (IRF) (OIG 2022). 75 percent of the IRF denials were appealed, re-reviewed, and were not overturned (OIG 2022). The same report found the top three services targeted by prior authorization denials by Medicare Advantage plans were for advanced imaging services, injections, and post-acute care in IRFs (DiGiorgio A and Grabert L 2023).

In 2020, the Trump administration included a budget proposal that would allow use of prior authorization in FFS Medicare. Specifically, the budget called for new authority "toward items and services that are at high risk for fraud and abuse, such as inpatient rehabilitation facilities" (HHS 2020).

Given the evidence from the OIG report and policy support from the Trump budget, it is clear that IRFs are a service category that is worthy of the type of scrutiny afforded by prior authorization. The key to assessing why IRF discharges are so frequently targeted for prior authorization may lie within failures in FFS payment rules.

FFS PAYMENT RULES

On an annual basis, the FFS Medicare program spends nearly $60 billion on post-acute care (MedPAC 2023[a]). Four settings contribute to post-acute care, Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF), and Long-Term Care Hospitals (LTCHs). In the past decade, Congress and CMS have instituted comprehensive payment reform for HHA, SNF, and LTCH. However, **IRFs have yet to experience FFS payment reform.** Herein lies the reason IRFs may be subject to a disproportionate level of prior authorization by MA plans.

IRFs tend to be defined by a narrow definition within FFS Medicare that pertains to how these critical hospitals are reimbursed. On annual basis IRFs are required to maintain 60 percent of their census within the following 13 conditions: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, certain neurological conditions (e.g., multiple sclerosis, Parkinson's disease), burns, three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and hip or knee replacement when it is bilateral, when the patient's body mass index is greater than or equal to 50, or when the patient is age 85 or older (MedPAC[a] 2022).

If an IRF is not compliant with this "60-percent rule" it will no longer receive the IRF rate for services, the IRF will instead receive a lower acute care hospital rate. To illustrate the degree of

magnitude regarding this payment consequence one can compare the median IRF rate of $17,787 per discharge to the median acute care rate of $6,376 per discharge (MedPAC[a] 2022 and MedPAC[b] 2022). The nearly 3-fold difference in payment rates between these hospital classifications represents higher patient complexity and the need for comprehensive therapy.

Even though the majority of IRFs meet the 60-percent rule, policy makers have questioned the threshold and have recommended it be increased. In the past, administrations have recommended the IRF 60-percent rule be increased to a 75-percent rule. President Obama included this policy change in his annual budgets (HHS 2013 and HHS 2014).

Policymakers have also questioned the profitability of FFS IRF payment rates. The IRF Medicare margin (2019) is 13.5 percent (MedPAC[c] 2022). Contrary to IRFs, LTCHs had a Medicare margin (2019) of 2.9 percent (MedPAC[d] 2022). **The difference between these two hospital competitors is that one setting (LTCH) had comprehensive FFS payment reform and the other setting (IRF) did not.** The IRF Medicare margin has been excessive for several years, which is why **both the Bush and Obama administrations have previously recommended FFS payment cuts for IRFs** (HHS 2006, HHS 2007, HHS 2012, and HHS 2013).

Despite numerous bipartisan calls for reform of FFS IRF payment, IRFs continue to remain profitable. Where FFS has failed to pursue more efficient delivery of IRF services, MA has filled the gap with prior authorization.

On the FFS side, CMS empowers its Medicare Administrative Contractors (MACs) to audit all claims for a single IRF. The MACs are responsible for ensuring IRF compliance with the 60 percent rule. Unlike the MACs, MA plans do not have access to IRF data outside of the services an individual plan reimburses. For example, Aetna has access to all Aetna discharges for IRF ABC, but Aetna does not have access to the United or Cigna discharges for IRF ABC. Therefore MA plans are unable to audit against the standard of the 60-percent rule.

It would be helpful to know what the MA compliance rate is. **I strongly recommend this oversight committee compel CMS to publicly report the median compliance rate, per MA plan, with the 13 conditions listed above for IRFs.**

If the average MA rate is significantly different than the FFS 60-percent rule, Congress should consider altering the FFS compliance rate for IRFs. Such a policy change would ensure the statutorily mandated intent of parity between FFS and MA is upheld for IRF discharges.

Though I do not have empirical evidence, my assumption, based on over 20 years of studying IRF Medicare policy, is that the median MA rate of compliance with the 13 conditions is significantly higher than 60-percent. It is likely MA plans are using prior authorization to enforce this higher standard. **Simply put, for inpatient rehabilitation hospitals, MA is using its tools to enforce appropriate policy where FFS has failed.**

Thank you for the opportunity to share my perspective with the subcommittee. I look forward to continuing to work with you on these important issues.

Prior Authorization Policy Development—Timeline

- June 2018
  Consensus statement issued on management of prior authorization by national trade associations representing health insurance plans and providers (AHIP 2018).

- June 2019
  Introduction of H.R. 3107 (116th))—*Improving Seniors' Timely Access to Care Act of 2019* by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera (D-CA), and Roger Marshall (R-KS). The bill had a total of 280 cosponsors (H.R. 3107 2019).

- December 2020
  CMS publishes proposed rule (CMS 2020) for new prior authorizations requirements for Medicaid FFS, Children's Health Insurance Program (CHIP) FFS, Medicaid managed care, CHIP managed care and Qualified Health Plans (QHP). There were no requirements for MA.

- May 2021
  Introduction of H.R. 3173 (117th)—*Improving Seniors' Timely Access to Care Act of 2021* by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera (D-CA), and Larry Buchson (R-IN). The bill had a total of 326 cosponsors; 75% of members in the US House (H.R. 3173, 2021).

- October 2021
  Introduction of S. 3018 (117th)—*Improving Seniors' Timely Access to Care Act of 2021* by Senators Roger Marshall (R-KS), Krysten Sinema (I-AZ), John Thune (R-SD), and Sherrod Brown (D-OH). The bill had a total of 52 cosponsors (S. 3018 2021).

- April 2022
  Health & Human Services (HHS) Office of the Inspector General (OIG) releases report on MA Prior Authorization. Study found 13 percent of the prior authorization denials would have been paid under FFS Medicare (OIG 2022).

- June 2022
  House Committee on Energy & Commerce Subcommittee on Oversight and Investigations held a hearing on *Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans*

- July 2022
  H.R. 8487—*Improving Seniors' Timely Access to Care Act of 2021* is reintroduced by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera (D-CA), and Larry Buchson (R-IN) (H.R. 8487 2022). The bill was marked-up by the House Committee on Ways & Means (Report 117-696 2022).

- August 2022
  Kaiser Family Foundation report concludes 99 percent of MA plans utilize prior authorization (Freed et al. 2022).

- September 2022

  Congressional Budget Office releases score of H.R. 3173—*Improving Seniors' Timely Access to Care Act of 2021*. The bill costs $16.2 billion/10 years (CBO 2022).

  H.R. 3173 —*Improving Seniors' Timely Access to Care Act of 2021* passes U.S. House of Representatives by unanimous consent (Congressional Record 2022).

- December 2022

  CMS proposes new regulatory changes to MA prior authorization (CMS[a] 2022).

  CMS proposes new electronic prior authorization reporting requirements and reduces timeline for processing requests to 7 days (previously 14 days) for non-emergency and 24 hours (previously 72 hours) for emergency services (CMS[b] 2022).

- April 2023

  CMS finalizes new regulatory changes to MA prior authorization (CMS 2023).

References

America's Health Insurance Plans. (2018). "Prior Authorization Consensus Statement." Retrieved from (https://www.ahip.org/resources/2018-prior-authorization-consensus-statement?utm_source=Higher_Logic&utm_medium=email&utm_campaign=ahip&_zs=BiLtl&)

American Hospital Association. (2022). "Addressing Commerical Health Plan Challenges to Ensure Fair Coverage for Patients and Providers." Retrieved from (https://www.aha.org/system/files/media/file/2022/10/Addressing-Commercial-Health-Plan-Challenges-to-Ensure-Fair-Coverage-for-Patients-and-Providers.pdf)

American Medical Rehabilitation Providers Association. (2023). "eRehabData." Retrieved from (https://amrpa.org/eRehabData).

American Medical Rehabilitation Providers Association. "Medicare Advantage Prior Authorization Survey." Retrieved from (https://patient.amrpa.org/). Accessessed on May 15, 2023.

Biniek JF and Sroczynski N. (2023[a]). Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021. *Kaiser Family Foundation*. Retrieved from (https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/)

Biniek JF, Freed M, Damico A and Neuman T. (2023[b]). Half of All Eligible Medicare Beneficiaries are now Enrolled in Private Medicare Advantage Plans. Retrieved from (https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/)

Centers for Medicare & Medicaid Services. (2020). "Medicare Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges; Health Information Technology Standards and Implementation Specifications." Retrieved from: (https://www.govinfo.gov/content/pkg/FR-2020-12-18/pdf/2020-27593.pdf).

Centers for Medicare & Medicaid Services[a]. (2022). "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications. Retrieved from: (https://www.govinfo.gov/content/pkg/FR-2022-12-27/pdf/2022-26956.pdf)

Centers for Medicare & Medicaid Services[b]. (2022). "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 and Critical Access Hospitals in the Medicare Promoting Interoperability Program. Retrieved from (https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf)

Centers for Medicare & Medicaid Services. (2023[a]). "Prior Authorization and Pre-Claim Review Initiatives." Retrieved from (https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives)

Centers for Medicare & Medicaid Services. (2023[b]). "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Retrieved from (https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf)

Congressional Budget Office. (2022). "CBO's Estimate of the Statutory Pay-As-You-Go Effects of H.R. 3173—Improving Seniors' Timely Access to Care Act of 2021." Retrieved from (https://www.cbo.gov/system/files/2022-09/hr3173_0.pdf)

Congressional Record. (2022). "Improving Seniors' Timely Access to Care Act of 2021." Retrieved from (https://www.congress.gov/congressional-record/volume-168/issue-148/house-section/article/H7796-7)

DiGiorgio A and Grabert L. (2023). "Traumatic Brain Injury: A Case Study in Failed Incentives to Address the Needs of Medicaid Patients in California." *Mercatus Center*. Retrieved from (https://www.mercatus.org/research/policy-briefs/traumatic-brain-injury-case-study)

Freed M, Biniek JF, Damico A, and Neuman T. (2022). Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings. *Kaiser Family Foundation*. Retrieved from (https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/)

Grabert L. (2022). Medicare Must Provide Additional Cost and Access Information to Enhance Decisions Making Around Trade Offs Between Medicare Advantage and Medigap. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. 59.

Health & Human Services. (2006). "Fiscal Year 2007 Budget in Brief." Retrieved from (https://wayback.archive-it.org/3920/20130927190142/http://archive.hhs.gov/budget/07budget/centersformed.html#mlptabl).

Health & Human Services. (2007). "Fiscal Year 2008 Budget in Brief." Retrieved from (https://wayback.archive-it.org/3920/20130927185643/http://archive.hhs.gov/budget/08budget/2008budgetinbrief.pdf).

Health & Human Services. (2012). "Fiscal Year 2013 Budget in Brief." Retrieved from

(https://wayback.archive-it.org/3920/20140403203230/http://www.hhs.gov/budget/fy2013/budget-brief-fy2013.pdf).

Health & Human Services. (2013). "Fiscal Year 2014 Budget in Brief." Retrieved from (https://wayback.archive-it.org/3920/20150326110529/http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf).

Health & Human Services. (2020). "Fiscal Year 2021 Budget in Brief." Retrieved from (https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf)

H.R. 3107. (2019). "Improving Seniors' Timely Access to Care Act of 2021." Retrieved from (https://www.congress.gov/116/bills/hr3107/BILLS-116hr3107ih.pdf)

H.R. 3173. (2021). "Improving Seniors' Timely Access to Care Act of 2021." Retrieved from (https://www.congress.gov/bill/117th-congress/house-bill/3173)

H.R. 8487. (2022). "Improving Seniors' Timely Access to Care Act of 2022." Retrieved from (https://www.congress.gov/bill/117th-congress/house-bill/8487)

Medicare Payment Advisory Commission. (2022[a]). "Inpatient Rehabilitation Facilities Payment System." Retrieved from (https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_IRF_FINAL_SEC.pdf)

Medicare Payment Advisory Commission. (2022[b]). "Hospital Acute Inpatient Services Payment System." Retrieved from (https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_hospital_FINAL_SEC.pdf)

Medicare Payment Advisory Commission. (2022[c]). "Inpatient Rehabilitation Facility Services." Retrieved from (https://www.medpac.gov/wp-content/uploads/2023/03/Ch9_Mar23_MedPAC_Report_To_Congress_SEC.pdf)

Medicare Payment Advisory Commission. (2022[d]). "Long-Term Care Hospital Services." Retrieved from (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf)

National Association of Long Term Hospitals. (2022). "Legislation and Advocacy Support." Retrieved from (https://nalth.site-ym.com/page/LegislationAdvocacySupport?&hhsearchterms=%22prior+and+authorization%22)

National Health Expenditures. (2023). "NHE Fact Sheet." Retrieved from (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet)

Office of the Inspector Generals. (2022). "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." Retrieved from (https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp?hero=mao-report-04-28-2022)

Report 117-696. (2022). “Improving Seniors’ Timely Access to Care Act of 2022.” Retrieved from (https://www.congress.gov/117/crpt/hrpt696/CRPT-117hrpt696.pdf)

S. 3018. (2021). “Improving Seniors’ Timely Access to Care Act of 2021.” Retrieved from (https://www.congress.gov/bill/117th-congress/senate-bill/3018)

Uniform Data System. (2023). “IRF Documentation.” Retrieved from (https://www.udsmr.org/products/irf-documentation)

Testimony of Gloria S. Bent to the US. Senate Permanent Subcommittee on Investigations

May 17, 2023

Senators, thank you for the opportunity to tell my family's story of the impact of Medicare Advantage practices on our lives in the midst of my late husband's significant health crisis.

Please meet my husband of 56 years, Dr. Gary Dean Bent, father, teacher, research physicist, mentor. For six years he was in treatment for cancers at the University of Connecticut Health Center - first Hodgkin's Lymphoma treated with aggressive chemotherapy and then metastatic melanoma, treated with surgery, radiation therapy and two years of immunotherapy.

This time last year my family was celebrating with Gary that one year after the conclusion of his immunotherapy, MRIs and CAT scans continued to show no evidence of melanoma's return. We rejoiced! Then, the morning of Memorial Day 2022 Gary asked to be taken to the emergency room at the Health Center. "Something is not right in my head," was his diagnosis. "I'm bumping into walls, I can't remember how to tie my shoes." Within half an hour of our arrival at the emergency room a CAT scan confirmed his diagnosis; what was not right in his head was the presence of a lesion in his brain that was bleeding.

On June 1, 2022 the lesion and a hematoma were removed surgically and the ER suspicion that it was a melanoma was confirmed by pathology. Gary came out of surgery with significant cognitive and mobility impairments. He was confused, could not stand on his own or walk, and he had left neglect - meaning his brain no longer recognized that there was a left side to his body. His neurosurgeon, and the physical therapist and occupational therapist treating him post-op said he needed follow-up treatment in an acute rehabilitation and skilled nursing care center to regain some of the functions he had lost. We were given the names of three such highly specialized centers in our area and we applied to all three. Of the three, Gaylord Hospital for Specialty Care in Wallingford had a bed and accepted him as a patient. Gaylord has an outstanding reputation and we were pleased that he would be receiving their services.

Enter the Medicare Advantage " barriers accessing necessary care and treatment" your committee is asking about. We were told to expect his transfer to Gaylord on Wednesday, June 8. No approval from our Medicare Care Advantage provider had been received so the transfer was delayed. Finally, on a Friday afternoon, June 10, I received a call from our case manager at the hospital. United HealthCare, via something called naviHealth had just denied the request for acute rehab services claiming that Gary did not meet Medicare guidelines because he "wouldn't be able to withstand the intense therapy schedule." His surgeon and post-op physical therapist actually treating him, prescribed acute rehabilitation services, but someone, somewhere, in naviHealth, after reading his chart, decided he wouldn't be able to handle the therapy.

I asked if we could appeal the denial and was told the doctors had already appealed and lost. The next step was for our family to review local short term rehab and skilled nursing facilities in the area and submit three names to our case manager who would apply for services. Then the approval process would begin again. Never having had his treatments denied before I accepted this and spent the week-end in search of another facility.

Around June 13th his admission to Seabury Health Services in Bloomfield CT was approved by United Health Care/naviHealth for three days and he was transferred on June 14th. Shortly after his admission there we were told he would be assessed by physical therapy, occupational therapy and speech therapy. On June 27 I went to a plan of care meeting with Seabury staff to get the results of his assessments. Prior to this meeting I had already received a phone call from a naviHealth representative who was going to "help" me through the process. Before the Seabury assessments were even complete, she told me United HealthCare planned to discharge my husband on July 4th and that it was now my job to secure the safest possible housing situation for him to go to on discharge, based on the worst case scenario- that he would be a permanent wheelchair user. She strongly suggested I arrange for self-pay long term care and, failing that, since our home was not wheelchair accessible I should move - by July 4.

I was still processing that my spouse, holding a doctorate in physics could no longer tell time, didn't know the date, couldn't remember we had visited him each day and felt abandoned, might never regain mobility — I had neither the emotional nor financial wherewith all to pick myself up, dust myself off and in two weeks, create a new home for us all.

It was at the June 27 Seabury meeting that I learned all of us were going to have to fight - Gary by working hard at his therapies to regain functions and my daughter and me by withstanding the assault on services and coverage that naviHealth was going to launch. My telling the Seabury staff that I had been contacted by naviHealth filled the room with groans. They then outlined exactly what was coming our way in terms of attempts by naviHealth to deny payment by Medicare as soon as they possibly could. It unfolded exactly as they said it would, based on their past experience with other patients covered by Managed Medicare controlled by companies like United Health Care.

July 4th passed with no discharge demand. I heard from the naviHealth representative on a regular basis, usually to tell me of a coming discharge date - July 10th, July 15th, in two days. All of these calls filled me with anxiety. Meanwhile she called Seabury and reviewed Gary's health records regularly. Gary was receiving therapies six days a week and sooner than we

thought might be possible he was able to transfer from bed to wheelchair, wheelchair to walker, walker to toilet with the support of two people. He was a fighter!

Our first notice of nonpayment of medicare coverage arrived on July 23 with a discharge date of July 25. The denial process goes like this: a Notice Of Medicare Non Coverage (NOMNC) is received by the facility providing services to the patient. The facility is responsible for notifying the patient or their agent of the NOMNC. The patient or agent then has 24 hours to appeal the denial to Kepro - the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Kepro, according to Kepro "helps people who are on Medicare - and their families and caregivers - to file quality of care complaints and hospital discharge and skilled service termination appeals." A Kepro reviewer examines the reason for termination of services and the patient records and then deems the termination to be appropriate or inappropriate. Once the appeal is filed the discharge is on hold and coverage continues until the review is complete.

Seabury was ready for the July 23 denial, notified us promptly of the NOMNC and I filed an appeal with Kepro. On July 24 we were notified the reviewing physician for Kepro found the denial to be inappropriate, noting "You require minimal to maximum assistance with transfers. You appear to be making progress with skilled therapies. It is safe and appropriate to continue the present level of therapies and services. Based on this documentation, the independent physician has decided that you require skilled services."

We had won our first appeal. Gary's care continued, he and his therapists continued to work hard and he was able to move to one person assisted transfers and he was able to take some steps in the hallway using a walker. He wore a gait belt, got significant support from a therapist, and was followed by someone with a wheelchair so that when he needed to take a break he could. Those breaks came frequently, but he was up walking.

August 2 we received our second NOMNC - late on a Friday afternoon. Again, Seabury was ready, we were notified promptly and able to file our appeal in time. Again the reviewer for Kepro found the denial inappropriate; "With therapies, you require moderate assistance for bed, mobility, and toilet transfers. You require supervision for sit -to -stand and can walk 60 feet with a walker and contact guard assistance. You are dependent for stops. You require maximum assistance for upper body activities of daily living .... Given your functional status as well as discharge plans for home you would be at high risk for decline. It is safe and appropriate to continue present level of services. The independent physician has decided you require skilled services."

We had won another appeal and Gary's care continued. Therapists continued to work on use of the walker and, because we had made the decision to bring him home on discharge, the care plan now included instructing our daughter in assist techniques and assessing Gary's ability to transfer from wheelchair into our car. The plan was for him to return to oncology and immunotherapy to hold off further melanoma spread when he had regained some strength and he could safely transfer chair to car, car to chair.

While we were supporting him with frequent visits to Seabury we were also looking for wheelchair accessible three bedroom apartments, because we would have to combine two

households into one to provide the 2 to 1 care provider to patient ratio we were told we would have to meet to care for him at home and receive at home support.

We had been told that once a patient had won a couple of appeals, the naviHealth pattern was to speed up the denials - the more appeals the patient won, the faster the denials would begin to come afterward. True to pattern, we won appeal 2 on August 3 and the next denial came four days later. That appeal we lost. Four days after concluding he would be at risk of decline if denied services and with no remarkable changes in his status that I observed, the Kepro reviewer said, "Based upon a complete review of the medical record, the beneficiary may benefit from additional skilled services: however, continued daily skilled nursing and therapy services in a skilled nursing facility (SNF) are no longer reasonable and necessary. Additionally, continued stay in a SNF is not required to maintain the beneficiary's current condition or to prevent or slow a further decline."

He was discharged on August 7th. On discharge I was told Medicare Advantage would provide a hospital bed rental and I would be contacted in a few days by the approved rental company. Unfortunately I needed a bed for him the next day, so we had to rent at our expense. When I asked about a wheelchair I was told Medicare Advantage considered him mobile, so no chair.

The denial of coverage beginning August 5th meant our daughter did not receive the training in helping him transfer that we had been promised by staff. Nor did we get to learn how to facilitate his transfer from wheelchair to car. I asked that he come home via ambulance. We would have to make do in an inaccessible apartment until we could move into the accessible apartment we had found in Hartford.

Gary arrived home from Seabury at 7 pm. The EMT who brought him noted that Gary seemed very warm, was probably running a fever and had complained about headaches and neck pain whenever they crossed a bump in the road. Gary was unable to do any of the transferring he had done in Seabury and seemed to be disconnected and out of touch with us. He was running a low grade fever; we gave him Tylenol and monitored him through the night. We struggled to assist him with transfers from wheelchair into the hospital bed we had rented. Early the next morning his fever was elevated and it was very difficult to rouse him. When we did rouse him he did not know who he was, where he was or who we were. He was immobile. We called 911, EMTs

arrived, told us they thought he had an infection, and they transferred him to the UCONN Health Center emergency room. August 8th, after being home 11 hours, he was admitted to the hospital, underwent many tests and was ultimately diagnosed with meningitis. He had been discharged from the skilled nursing facility the aforementioned Medicare Advantage Plan determined he no longer needed with bacterial meningitis. He remained at Dempsey Hospital on IV antibiotics until early September.

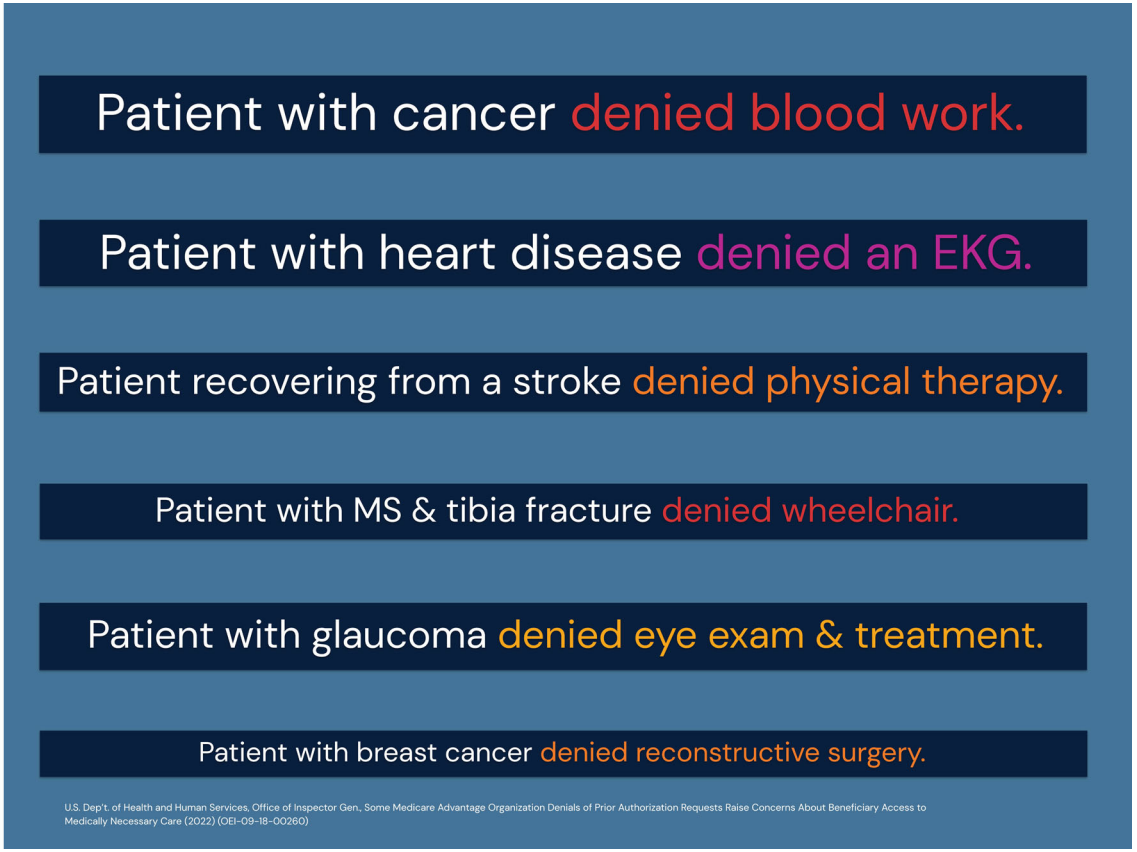
He was discharged home to our care, still on IV antibiotics in early September because he had developed COVID while in the hospital. The hospital wanted to send him to one of three short term care centers in the state that took covid positive patients. After reading the reviews of the facilities we opted, Covid or not, to bring him home with us.

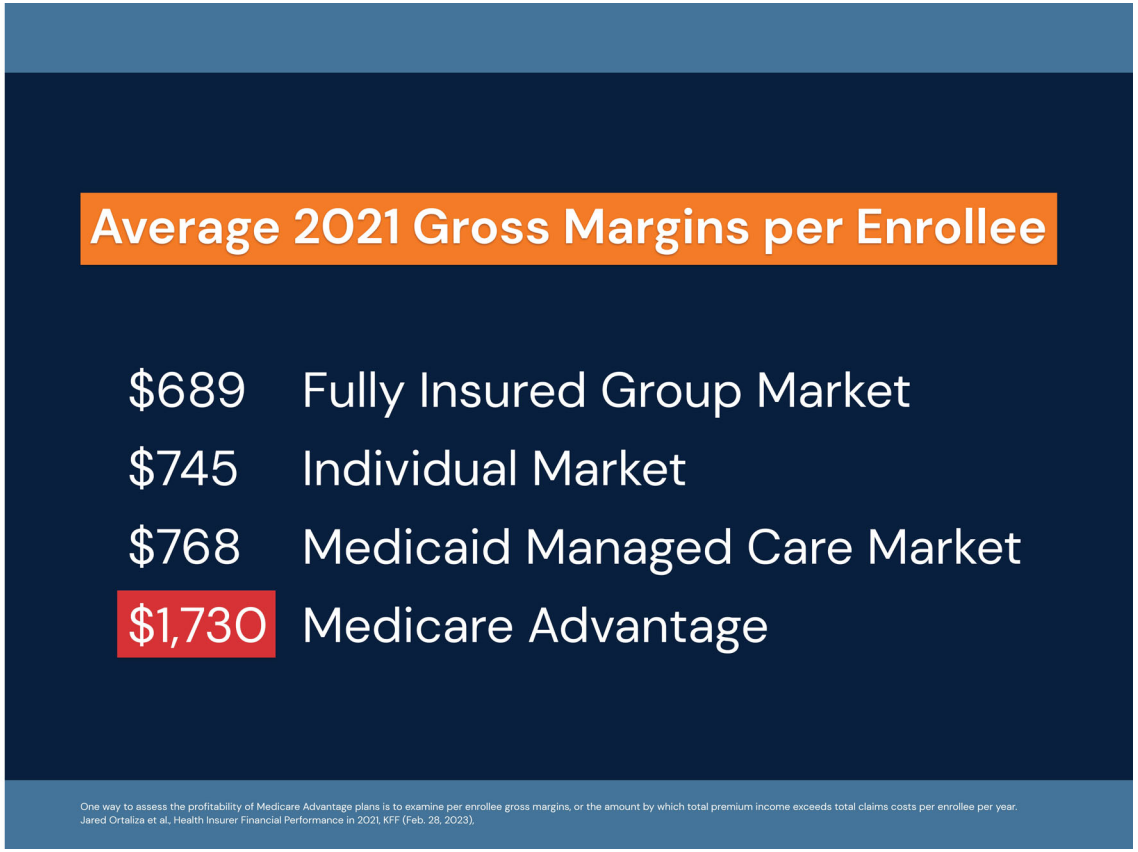
We cared for him 24/7 with support from Masonicare. While fighting meningitis he lost all of the abilities he had regained at Seabury. He received physical therapy and occupational therapy through Masonicare and was on his way to recovering some of those lost- yet- again skills - pulling himself into a standing position using a walker, beginning to take small steps with support and the walker in preparation for regaining the ability to transfer. He continued to plan via telehealth with his oncologist for a return to immunotherapy. In December, while fighting a urinary tract infection and the side effect of extreme fatigue caused by the antibiotic he was taking, Masonicare physical therapy was terminated because he was no longer making progress. The infection and fatigue, we were told, could not be considered in his recertification of services. He wasn't making progress. He seemed to lose hope when the therapists stopped coming. In mid January with the discovery of nodules in both lungs, his primary care physician told him it was time to move into home hospice care and Accent Hospice Care became our supporters. He died at home on March 3rd, 2023.

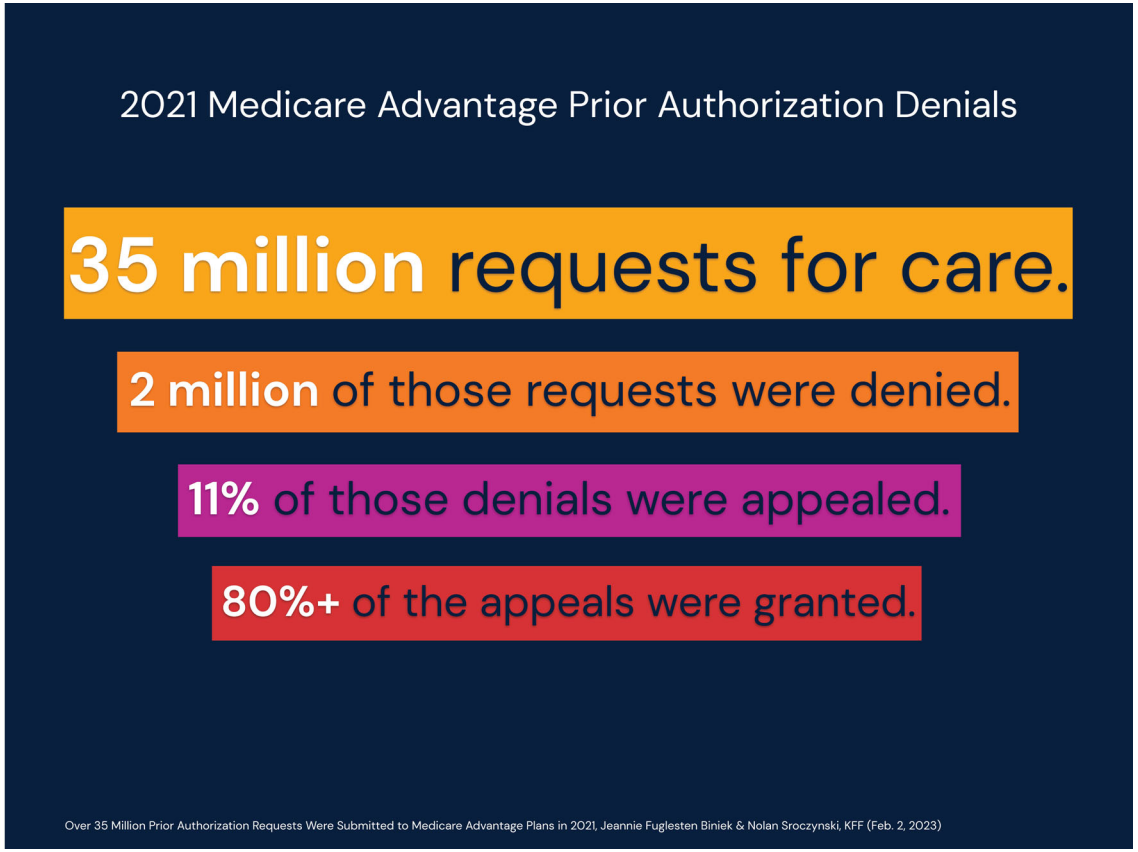
The last ten months of his life were devastating for all of us - physically and mentally exhausting, always overshadowed by the fear of what service would be denied next. With the reappearance of melanoma in May of 2022, a rug was pulled out from under us all, then came the added trauma of having to fight for the care he needed and was entitled to. This should not be happening to patients and their families. It is cruel.

Our family has come through this experience struggling with this question: Why are people who are looking at patients only on paper making decisions that override or deny the services that are judged necessary by health care providers who know their patients, are interacting with them in person and in some cases have been working with them for months or for years? We hope that the result of this hearing will be real change in the ways decisions are made about the services managed medicare patients receive, that providers will drive the decisions and that the primary goal will always be to provide the best possible care for the patient. We want no other family to have the heartbreaking experience we did.

Gloria S. Bent

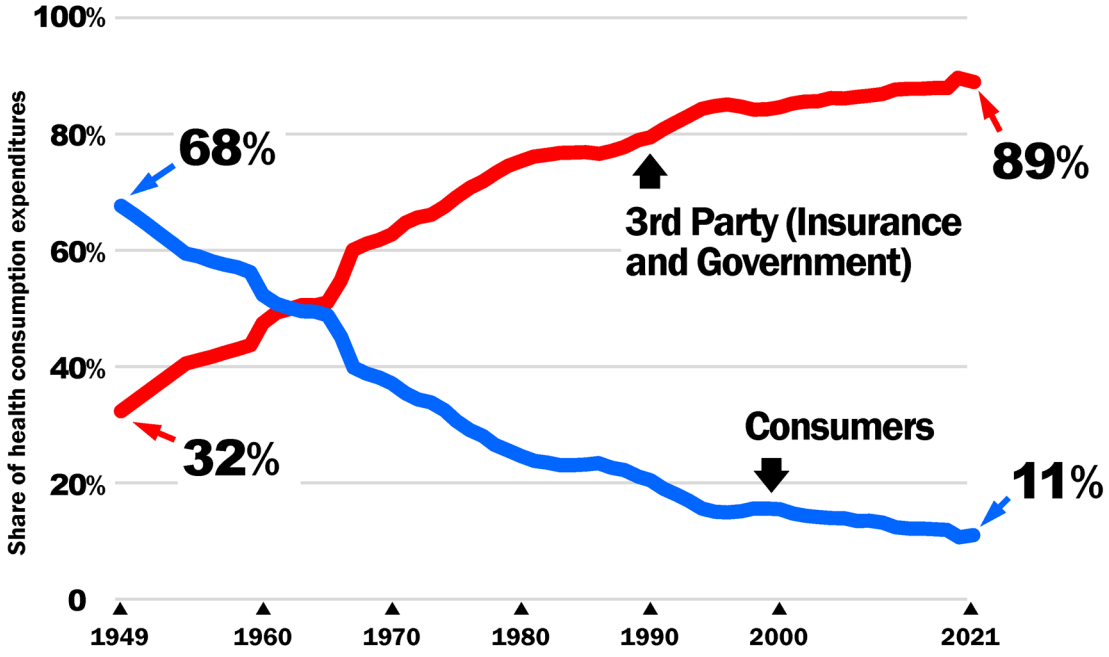

Patient with cancer denied blood work.
Patient with heart disease denied an EKG.
Patient recovering from a stroke denied physical therapy.
Patient with MS & tibia fracture denied wheelchair.
Patient with glaucoma denied eye exam & treatment.
Patient with breast cancer denied reconstructive surgery.
U.S. Dep't. of Health and Human Services, Office of Inspector Gen., Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (2022) (OEI-09-18-00260)


Average 2021 Gross Margins per Enrollee
$689 Fully Insured Group Market
$745 Individual Market
$768 Medicaid Managed Care Market
$1,730 Medicare Advantage
One way to assess the profitability of Medicare Advantage plans is to examine per enrollee gross margins, or the amount by which total premium income exceeds total claims costs per enrollee per year.
Jared Ortaliza et al., Health Insurer Financial Performance in 2021, KFF (Feb. 28, 2023).


2021 Medicare Advantage Prior Authorization Denials
35 million requests for care.
2 million of those requests were denied.
11% of those denials were appealed.
80%+ of the appeals were granted.
Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021, Jeannie Fuglesten Biniek & Nolan Sroczynski, KFF (Feb. 2, 2023)

HEALTH CARE: WHO PAYS

SHARE OF HEALTH CONSUMPTION EXPENDITURES



Centers for Medicare and Medicaid Services, percentages are approximate

RON JOHNSON U.S. SENATE

Case 1

- 85 year-old man with bladder cancer, completed radiation therapy and chemotherapy.
- Based on national guidelines (National Comprehensive Cancer Network/NCCN), patient needs a CT scan to monitor for recurrence every 3-6 months.
- Patient's CT scan at 6 months after treatment was denied by Aetna Medicare (EviCore). (this is the first unnecessary barrier to patient care)
- I called Evicore for a peer-to-peer review. The peer reviewer was a radiologist physician. I mentioned that this CT scan is recommended by national guidelines. The peer reviewer physician told me that he could not approve the CT scan because the Evicore guidelines do not indicate medical necessity for the scan (even while acknowledging that national NCCN guidelines recommend it). (this is the second unnecessary barrier to patient care)
- I wrote an appeal letter, again stating that the CT scan is recommended by national guidelines. With this appeal, the CT scan was approved.
- This example illustrates Aetna Medicare Advantage putting multiple unnecessary barriers to try to prevent Medicare Advantage cancer patients from receiving standard care. I have never received this type of denial from Medicare. Physicians simply do not have time to go through these unnecessary steps for every patient to get standard of care.

Case 2

- 69 year-old man with prostate cancer who wished to receive proton therapy.
- Medicare covers proton therapy for prostate cancer. However, this patient has BCBS Medicare (Evicore), which denied proton therapy. (this is the first unnecessary barrier to patient care)
- I wrote an appeal letter, stating that Medicare covers proton therapy for prostate cancer treatment, and Medicare Advantage plans need to provide the same coverage for patient care. Treatment was approved on appeal.
- Of note, Senator Marshall's office helped with this case (Nikki Meagher).

Case 3

- 71 year-old man with aggressive prostate cancer and is waiting to receive proton therapy.
- Medicare covers proton therapy for prostate cancer. However, this patient has Aetna Medicare (Evicore), which denied proton therapy. (this is the first unnecessary barrier to patient care)
- I called Evicore for a peer-to-peer review. I explained that this is a treatment that Medicare covers, and the patient should have the same access to treatment on a Medicare Advantage plan. The peer reviewer physician upheld the denial. (this is the second unnecessary barrier to patient care)
- I wrote an appeal letter, again stating that Medicare covers proton therapy for prostate cancer treatment. Treatment was again denied. (this is the third unnecessary barrier to patient care)
- A hearing has been scheduled with the Office of Medicare Hearings and Appeals. The patient continues to wait for his cancer treatment (now waiting 4+ months).
- Case 2 and Case 3 are two patients with the same diagnosis and wanting the same treatment. Case 2 was able to proceed with treatment after appeal, but Case 3 continues to wait 4+ months. The difference in process/wait time for Case 2 vs Case 3 shows an unreliable process for Medicare Advantage patients trying to get necessary cancer care.

Case 4A

- 79 year-old man with an aggressive prostate cancer.
- I ordered a PSMA PET scan to see if the cancer had spread beyond the prostate. This scan is recommended by national NCCN guidelines and is covered by Medicare.
- Unfortunately, patient had Aetna Medicare, which denied the PSMA PET scan. (this is the first unnecessary barrier to patient care)
- I called Aetna Medicare (Evicore) for peer-to-peer review. I spent time and talked to two different peer review physicians – both informed me that Medicare does not cover this scan; this is blatantly false information. (this is the second unnecessary barrier to patient care)
- The scan was delayed.
- I wrote an appeal letter again stating that a PSMA PET scan is recommended by national guidelines. The scan was approved on appeal.

Case 4B (same patient)

- In fact, the scan found that the cancer had spread to his spine.
- He needs radiation therapy to the spine, which is standard of care and recommended by national NCCCN guidelines.
- Medicare covers this treatment, but unfortunately Aetna Medicare (Evicore) denied the radiation treatment for this patient also. (this is the third unnecessary barrier to patient care)
- I wrote an appeal letter stating that radiation treatment is standard of care and recommended by national guidelines. The treatment was approved on appeal.
- Of note, Senator Marshall's office helped with this appeal for radiation treatment (Nikki Meagher).
- This Medicare Advantage patient faced two separate denials for standard of care that is covered by Medicare.

"Usual" process for pre-authorization denials

- Cancer patient needs treatment
- Hospital submits pre-authorization to insurance company for planned treatment
- If insurance company denies the pre-auth (e.g. treatment is deemed not medically necessary), the steps to appeal the decision are:
  - Peer-to-peer: cancer physician schedules a discussion with insurance company physician to discuss the denial.
    - This often takes several days to schedule. Insurance physician is often not a specialist (e.g. pediatrician deciding medical necessity of an appeal for cancer treatment)
  - Level 1 appeal: 3 days (expedited), 30 days (regular)
    - Performed by insurance company staff (concerns about conflict of interest)
  - Level 2 appeal: 3 days (expedited), 30 days (regular)
    - Usually performed by external, specialty-matched physician

Case 1 (total case time: 1 month 10 days)

- Metastatic kidney cancer causing pain. RT was denied by insurer.
- 6/16/21: initial auth request submitted
- 6/28/21: peer-to-peer – denial was upheld
- (multiple emails and hours on the phone with insurer, to try to get the formal denial letter and/or information on how to submit an appeal – essentially no response from insurer)
- (finally I had to go to Twitter to get insurer's attention)
- 7/14/21: denial letter received.
- 7/14/21 (same day): expedited appeal submitted. This should have a 72 hour window for response.
- 7/19/21 (longer than the allowed 72 hours): Insurer informs us that the appeal has been denied, and the case is now closed. Patient cannot get radiation treatment.
- 7/19/21 (same day): I contact insurer to ask why this patient was not offered the two levels of appeal. Usually after Level 1 appeal, there is a Level 2 appeal to an external specialty-matched reviewer. Why is the case closed prematurely without all levels of appeal for this patient?
- 7/21/21: I was offered another appeal review with a scheduled phone call at 10AM or 11AM. I waited by my phone and was afraid to leave, afraid of missing the appeal call. I was finally called at 12:50PM (almost 3 hours waiting by the phone).
- 7/22/21: The appeal was successful and patient was approved for treatment.

Case 2 (total case time 1 month 1 week)

- Kidney cancer with lung metastasis (RT to lung)
- 9/2/21: Initial authorization submitted
- 9/8/21: Expedited appeal submitted (3 day turnaround)
  - Appeal was changed by insurer to regular – because insurance staff decided this case did not warrant an expedited appeal (30 day turnaround)
- 9/29/21: first level appeal denied
- 10/4/21: second level expedited appeal submitted
- 10/11/21: decision overturned (patient able to have treatment)

Case 3 (not yet resolved)

- Breast cancer: needs lumpectomy and intraoperative radiation therapy
- Pre-authorization was denied for radiation therapy
- (Large national) insurer: there is no appeal option for this pre-auth denial
  - If medically necessary, the patient could go ahead with treatment and we will deny the charges, but you can try to appeal the denial afterwards
  - Patient has to decide between 1) Have the radiation treatment recommended by her doctors, but at risk for thousands of dollars out-of-pocket, or 2) forego the treatment recommended by her doctors

Case 4 (total case time 17 days)

- Breast cancer patient needs radiation treatment
- 9/17/21: initial auth submitted
- 9/21/21: peer to peer requested
  - Same day: KU physician called P2P, left a detailed message and call back number
  - No one called back
- 9/23/21: peer to peer denied (claimed no one called)
  - KU physician finally got ahold of P2P physician, who asked for the radiation plan to be uploaded for review
  - KU staff tried to upload radiation plan, but told by insurer that this is not allowed – P2P denied
- 9/27/21: expedited appeal submitted
  - 9/29/21: we find out that the appeal is being considered as a standard appeal
  - Lots of emails and phone calls – asking for clarification on why insurer staff can simply decide that cancer treatment is not urgent
- 10/4/21: decision was overturned (patient able to receive RT)

September 30

- (call for almost 90 minutes again)
- I called insurer at 888-397-8129 in appeals and initially spoke to Desha B. and she was not able to help me and transferred me to Luis G. who was in the Medicare department so he could not help me. He then transferred me to Austin V. and he only handles Chemo soooo/ he transferred me to Ivy J. and she stated she was not in appeals but would transfer me(at one point the automation said I was being sent for a survey) but luckily I was then transferred to Kendall (reference #4769) she said I needed to call 888-397-8129 and I explained that was the number I was speaking to her on and then she was suddenly able to start locating information
- She finally stated the reference #A134768268 now has a case #K2711146005 and that they have up until 10-12-21/I stated this is supposed to be a FAST appeal/she also inquired if I wanted to submit for authorization/I explained that had been done on 9-17-21 and then she said it could be peer to peer and I explained that had already happened to /then she said agreed that yes in is in FAST appeal and that it was escalated on 9-29-21 but that they have up until 10-12-21 to respond and I ask why since their guidelines state FAST appeal is 72 hour turn around? She said we needed to give them time/I stated this is a cancer patient who needs treatment and she doesn't have the luxury of extra time SHE HAS CANCER/
- s**he then let me know there is a new note today that nurse reviewer Linda Coon is currently reviewing the case.**

October 1

- I called insurer at 888-397-8129 and after going thru all the prompts the call disconnected. I called again and then got Johnnie who stated they could not hear the call and hung up. I called again and spoke to Lachandra F. and she then transferred me to June T. in peer to peer. She looked it up and stated we needed to allow more time and I explained the patient does not have the luxury of time to wait as she has cancer and needs treatment.
- She then transferred me to Joe(reference #6339 and he stated no nurse is assigned and to allow more time. I told him the patient has CANCER and needs treatment. He left the line and came back and stated that the patient could proceed if it was life threatening and we could then send in medical records and if insurer determined it was medically necessary they would pay/I explained that was why we were trying to get an authorization in place so that insurer could pay and the patient wouldn't get stuck with a huge bill/I explained that I had been told the case was assigned to nurse Linda Coons two days ago and that Dr Sun was reviewing it yesterday. Patient has cancer and I am not comfortable in telling her to allow more time. He then was transferring me to someone else who could help/I was utilizing my cell for the call and my desk phone started ringing and in hopes that it was insurer was calling with an approval I answered it while on transfer/when I answered the call SOME HOW Joe transferred the call to ME!
- OK so I called again and this time spoke to Carol reference #7542 (she actually was able to pull things up without transferring me)She stated that is was triaged for expedited appeal on 9-30-21 and the target due date is 10-6-21 (she stated "technically the appeal started 9-30-21" and I explained that NO it had started on 9-28-21 and that someone at insurer had changed it)I discussed with her about Nurse Linda Coons and she was able to locate that and that Linda had forwarded the case on for medical review. She then also emailed her and let her know I was calling and wanted a call on the status? (no note from Dr Sun per Carol)

Terrence A. Cronin Jr., MD, FAAD President
Seemal R. Desai, MD, FAAD President-elect
Robert S. Kirsner, MD, PhD, FAAD Vice President
Cyndi J. Yag-Howard, MD, FAAD Vice President-elect
Daniel D. Bennett, MD, FAAD Secretary-Treasurer
Keyvan Nouri, MD, MBA, FAAD Assistant Secretary-Treasurer
Elizabeth K. Usher, MBA Executive Director & CEO

U.S. Senate
Homeland Security & Government Affairs
Permanent Subcommittee on Investigations

Hearing:
Examining Health Care Denials and Delay in Medicare Advantage

May 17, 2023

Statement for the Record
American Academy of Dermatology Association

Chairman Blumenthal and Ranking Member Johnson, on behalf of the more than 17,000 U.S. members of the American Academy of Dermatology Association (Academy or AADA), thank you for the opportunity to submit a statement for the record regarding your hearing, *Examining Health care Denials and Delay in Medicare Advantage.* The Academy applauds Congress for its actions to recognize policies that limit patients' ability to receive innovative and timely treatments. In dermatology, drugs and other therapies are frequently delayed or denied due to unnecessary prior authorization and step therapy policies. While we recognize there has been bipartisan support for prior authorization and step therapy reforms and appreciate the Centers for Medicare and Medicaid Services (CMS) recent action to address these burdens, further steps are needed to ensure patients' access to medically necessary and innovative treatments.

The Academy believes:

- Congress must direct the CMS to provide increased oversight of Medicare Advantage (MA) plans to ensure that they are not unnecessarily delaying or denying patients access to therapies that range from basic fundamental patient care to innovative treatments, including denials solely by algorithm without oversight and final review by a physician of the same specialty of the condition being treated.

CORRESPONDENCE
PO Box 1968
Des Plaines, IL 60017-1968
EMAIL: mrc@aad.org
WEB: aad.org

ROSEMONT, IL OFFICE
9500 W Bryn Mawr Avenue, Suite 500
Rosemont, IL 60018-5216
MAIN: (847) 330-0230
FAX: (847) 240-1859

WASHINGTON, DC OFFICE
1201 Pennsylvania Avenue, NW, Suite 540
Washington, DC 20004-2401
MAIN: (202) 842-3555
FAX: (202) 842-4355

- Congress should direct CMS to extend its recent prior authorization policies as outlined in its proposed rule, "Advancing Interoperability and Improving Prior Authorization Processes," to include drugs to safeguard timely access to innovative treatments.

- Congress should require MA plans to develop a gold-carding policy for frequent treatments as it would alleviate administrative burdens placed on providers and, more importantly, protect beneficiaries' access to innovative care.

- Committee members should support bipartisan bill, the *Safe Step Act* (H.R. 2630), as it would ensure physicians remain the clinical authority over a patient's care.

Detailed recommendations can be found below.

Utilization Management Policies and the Impact on Patient Access to Innovative Therapies

Emerging therapies and technology to treat skin diseases continue to change the field of dermatology; however, patients face significant barriers to accessing these innovative treatments when MA and Part D plans implement unnecessary utilization management policies such as prior authorization and step therapy. The Academy has long advocated for solutions that remove prior authorization and step therapy policies that adversely impact patient care. For many skin diseases, new technologies for drugs and devices offer patients safer and more effective treatment options. These therapies, especially for chronic and complex skin conditions, are highly specialized and nuanced, and their efficacy is dependent on several patient factors. Prior authorization and step therapy policies that place a third party in a decision-making position, with no knowledge of the complexity or full history of a patient's condition, are not only inappropriate; they also impede a patient's access to the most effective treatment, and a delay can cause irreparable harm. The Academy has significant concerns about payers utilizing technology that enables a payer to reject a claim without thoroughly reviewing the supporting clinical documentation or being reviewed by the physician specialist with expertise on the disease for which the patient is being treated. Criteria and metrics used in automated review algorithms by payers must be completely transparent and available for review.

The Academy maintains that the clinically indicated choice of therapy should be respected and should rest on the patient-physician relationship where all critical factors—including efficacy and safety of all the treatment options, co-morbidities, and support system—are considered, fully discussed, vetted, and prescribed. Thus, prior authorization and step therapy policies must not be misused nor based solely on cost savings at the expense of clinical efficacy to ensure patient access to innovative treatments, especially those that offer less risk and better outcomes. We urge Congress to request that CMS increase its oversight of MA plans so that they do not unnecessarily delay or deny treatment with unwarranted utilization management policies.

Timely Access to Innovative Treatments Through Prior Authorization Reforms

Following strong bipartisan support in the previous Congress, especially from those on the Committee, for the *Improving Seniors Timely Access to Care Act*, CMS released proposed rules on prior authorization reforms to ensure timely access for patient care. While we recognize and appreciate recent CMS action, including its proposed rule, "Advancing Interoperability and Improving Prior Authorization Processes," CMS stopped short of increasing patient access to innovative treatments by excluding drugs from the proposed policies.

Dermatology is disproportionately impacted by prior authorizations for both generic and brand drugs. We appreciate Congress working to address prior authorizations in the *SUPPORT for Patients & Communities Act* (Public Law No: 115-271), which was enacted into law in October 2018. Congress included language, that the Academy advocated for, to create a standardized electronic prior authorization form for Medicare prescription drugs intended to streamline and reduce prior authorization delays. While these policies have increased traditional Medicare beneficiaries' timely access to drugs, problems continue in Medicare Advantage and Part D.

Prescription drugs account for the majority of prior authorization requests in dermatology. The Academy's 2020 Prior Authorization Survey found that approximately 25% of patients that come to a dermatology practice require prior authorization.[1] On average, dermatology offices have spent $40,000 on additional staff to help manage the prior authorization process, which takes 3.5 hours each day. In fact, dermatologists could see an additional 5 to 8 patients daily if no prior

[1] https://www.aad.org/dw/monthly/2020/october/facts-at-your-fingertips-prior-auth-practices

authorization was required. Needless to say, unwarranted prior authorization policies, especially those implemented for high-volume treatments, are a tactic used to exhaust providers, particularly those in small or solo practices who may not be able to devote the time and energy to the prior authorization process. Patients are ultimately deprived of access to medically necessary and innovative treatments due to unnecessary prior authorization policies.

To address timely access to innovative therapies, CMS needs to expand its electronic prior authorization and payer policies in its proposed rule to include drugs. AADA calls on Congress to direct CMS to extend its recent prior authorization and payer policies in its proposed rule, "Advancing Interoperability and Improving Prior Authorization Processes," to include drugs to safeguard patients timely access to innovative treatments.

Gold-Carding Could Increase Timely Access to Innovative Care

The Academy recommends that Congress direct CMS to implement a gold-carding policy similar to the *Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act of 2022* (H.R. 7995, 117th Congress) to increase timely access to innovative care for patients. "Gold-carding" is a type of program to improve efficiency and reduce burden on practices by exempting providers from prior authorization requirements if they have demonstrated a consistent pattern of approvals. AADA would be supportive of legislation that would exempt physicians from prior authorization requirements for the plan year if at least 90% of prior authorization requests were approved the preceding year.

In the CMS proposed rule, "Advancing Interoperability and Improving Prior Authorization Processes," CMS states that "gold-carding programs could help alleviate the burden associated with prior authorization and that such programs could facilitate more efficient and timely delivery of health care services to enrollees." In fact, CMS notes the success they have seen with similar programs they have implemented, such as the one they use in the Medicare Fee-for-Service Review Choice Demonstration for Home Health Services.

Gold-carding is a common-sense reform that will help reduce barriers to care, allow physicians to spend more time with patients, and put treatment decisions back where they belong – in the hands of physicians and patients. The AADA urges Congress to direct CMS to develop a gold-carding policy that would protect beneficiaries' access to receiving innovative services and medications in a punctual

manner.

Step Therapy Policies Delay Patient Access to Innovative Therapies

Step therapy or "fail first" policies have been shown to inhibit patient access to life-changing therapies and adversely impact patient outcomes. Step therapy is often used as a cost containment tool by health insurance plans, requiring patients to try one or more prescription drugs before coverage is provided for a drug selected by the patient's health care provider. Requiring patients to try and fail treatments jeopardizes the health of patients, potentially resulting in dangerous consequences. Step therapy incorrectly assumes that all patients start care at the same point in their disease process, and that the trajectory of their condition will be the same. It must also therefore make exceptions for stage and extent of disease, patient characteristics and current treatment, including if the provider believes the recommended course of action by the carrier could cause harm to the patient. In general, patients must be able to have access to alternative treatments if the first line option is not optimal or contraindicated.

While the Academy understands the need to contain health care costs, we are concerned that step therapy policies often do not take into account: a patient's medical history; whether or not the patient has already tried a certain drug and failed; if a patient has a medical condition that would interfere with the efficacy of the drug; if a drug's side effects would interfere with the patient's ability to perform their job, and; if the drug best for the patient is one with a different ingestion method or dosage form.

Due to this dangerous and burdensome practice, AADA urges members of the Committee to support bipartisan bill H.R. 2630, the *Safe Step Act*, which would ensure physicians remain the clinical authority over a patient's care, and to lessen the burden on patients required to go through step therapy protocols instituted by insurance companies. Modeled after state legislation, which the Academy is on record supporting through the State Access to Innovative Medicines (SAIM) Coalition, the bill provides a process for patients to easily access a request for an exception to step therapy protocol. The bill applies to insurance plans regulated by the federal Employee Retirement Income Security Act (ERISA). The bill would also require insurance companies to approve an exception request within three days, or 24 hours in the event of an emergency when the patient's life or health is in danger. To date, 35 states have enacted step therapy reform laws.

Conclusion

On behalf of the Academy and its member dermatologists, I thank you for holding this hearing, allowing the opportunity for stakeholders to submit a statement for the record, and for your commitment to ensuring patient access to innovative and life-changing treatments. The Academy looks forward to working with you and asks that you continue to consider including physician stakeholders' opinions in your ongoing hearings. As the Committee considers the challenges facing patient access to innovative therapies, we look forward to being a reference for this issue and others in the future.

The Academy appreciates your leadership on these issues and asks that the Subcommittee please consider the impact of these policies on the welfare of patients and unnecessary increased cost to the health care system.

Alliance of Specialty Medicine

Sound Policy. Quality Care.

May 23, 2023

The Honorable Richard Blumenthal
Chairman
Permanent Subcommittee on Investigations
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Ron Johnson
Ranking Member
Permanent Subcommittee on Investigations
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Gary Peters
Chair
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

The Honorable Rand Paul
Ranking Member
Senate Homeland Security & Governmental Affairs Committee
Washington, DC 20510

Subject: Delays and Denials in Medicare Advantage Plans

Dear Chairs Blumenthal and Peters and Ranking Members Johnson and Paul:

As the Alliance of Specialty Medicine (Alliance), a coalition of 16 medical specialty societies representing more than 100,000 physicians and surgeons, our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care. We write to thank you for examining Medicare Advantage plans during the hearing "**Examining Health Care Denials and Delays in Medicare Advantage**."

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining this approval is lengthy and typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. Patients are now experiencing significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved.

Specialty physicians and their patients are often subject to prior authorizations and other utilization management tactics in the Medicare Advantage program. Generally, utilization management processes delay enrollee access to medically necessary care and treatments and create considerable, unnecessary administrative burdens for specialty physicians. Equally concerning, these tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. While utilization management processes, such as prior authorization, may be appropriate in some situations, the Office of Inspector General has found that Medicare Advantage plans use prior authorizations to deny *medically*

necessary care, that is, care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records.

In the fall of 2022, the Alliance of Specialty Medicine surveyed over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care, as well as the increased administrative onus on medical practices. Respondents overwhelmingly indicated that the use of prior authorization has increased in the last five years across all categories of services and treatments:

- Over 93% of respondents answered that prior authorization has increased for procedures;
- More than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and
- Two-thirds (66%) responded that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.

Other key findings can be found in the attached survey results.

The Alliance supports opportunities to meaningfully improve utilization management in the Medicare Advantage program, reduce administrative burdens, and ensure safe, timely, and affordable access to care for patients. In the 117th Congress, we endorsed S. 3018, the *Improving Seniors' Timely Access to Care*, which garnered significant bipartisan support. The solutions included in this legislation, along with new regulations issued by the Centers for Medicare & Medicaid Services, will go a long way to ensuring that our nation's seniors get the care they need when they need it.

Thank you for holding this important hearing. If you have any questions or want to meet with the Alliance to discuss these issues further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
Society of Interventional Radiology

Alliance of Specialty Medicine

Sound Policy. Quality Care.

Nationwide Survey of Practicing Specialists:
Utilization Management Negatively Affects Clinical Care

Physicians Report Cases of Patients Blinded, Paralyzed Due to Care Delays by Insurers

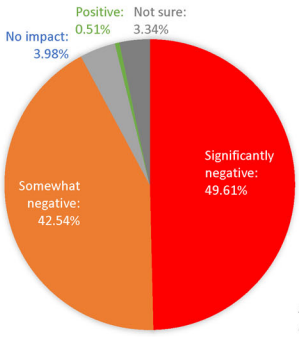
In the fall of 2022, the Alliance of Specialty Medicine conducted a survey of over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care, as well as the increased administrative onus on medical practices.

Respondents overwhelmingly indicated that the use of prior authorization (PA) has increased in the last five years across all categories of services and treatments: over 93% of respondents answered that PA has increased for procedures; over 83% answered that PA has increased for diagnostic tools, such as labs and even basic imaging; and over 66% answered that PA has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals. Other key findings are below.

For patients whose treatment requires prior authorization,
what is the impact of this process on patient clinical outcomes?

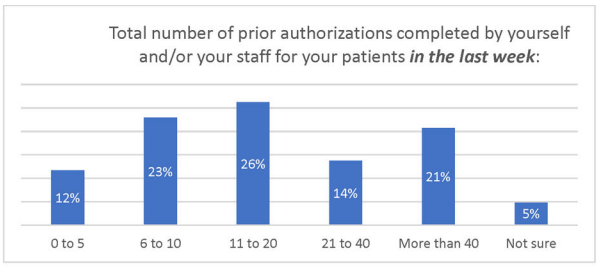
"It delays care and sometimes means that I have to use different medications or different procedures than what I think is most appropriate because the insurance company says so."

"I had a patient with an undiagnosed epidural abscess. I was suspicious of this diagnosis and ordered a stat MRI. The Hospitalist delayed it because her Blue Cross insurance doesn't recognize outpatient stat MRI orders. The patient is now paralyzed."



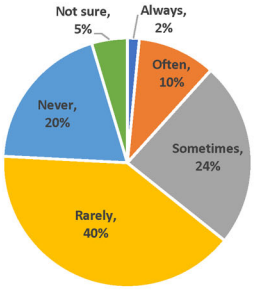
"Prior auth has resulted in some of my patients being blinded by various eye conditions over the years."

"Have seen permanent neurologic deficit, permanent pain syndromes secondary to delayed or denied care."



PA is leveraged to delay coverage of necessary care: over 87% of respondents reported that requests were eventually approved in the majority of cases.

When a peer-to-peer consultation is required, how often is the insurers' representative in the same/similar specialty or have experience with your specialty?



"Many can't even pronounce the words they are reading to me, let alone know what they mean or why they are significant."

"If we request a same specialty reviewer, it often will not happen prior to having to give up the scheduled surgical date."

"The Family Practice Physician [reviewer] will recommend [to the neurosurgeon] a lesser surgery that will not fix the problem, causing the patient to have a second surgery a few months later."

Have increased administrative burdens by insurers influenced your ability to practice medicine?

"I have seen this specifically contribute to physicians leaving the field and retiring earlier."

"Administrative burdens by insurers is the number one reason I consider leaving the field of medicine on a weekly basis. It's killing rheumatology!"

"I am at the mercy of prior auth in order to provide care for my patients."

A great source of frustration among respondents is the fact that insurers often deny payment after the fact for services they pre-authorized:

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement of

the

American Hospital Association

for the

Homeland Security and Governmental Affairs Committee Permanent

Subcommittee on Investigations

of the

U.S. Senate

"Examining Health Care Denials and Delays in Medicare Advantage"

May 17, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and 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) thanks the Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations for holding this important hearing on Medicare Advantage (MA) denials. We appreciate the opportunity to submit this statement for the record to highlight our concerns about some MA plans' inappropriate restrictions on beneficiary access to medically necessary care and urge Congress to increase its oversight of these plans.

Inappropriate denials for prior authorization and coverage of medically necessary services are a pervasive problem among certain plans in the 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. In addition, these practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with plan

requirements. They are also a major burden to the health care workforce and contribute to provider burnout. An advisory issued last year by Surgeon General Vivek Murthy, M.D., notes that burdensome documentation requirements, including the volume of and requirements for prior authorization, are drivers of health care worker burnout.[1]

Many of the harms associated with inappropriate delays and denials are evidenced by the striking report issued in April 2022 by the Department of Health and Human Services Office of Inspector General (HHS OIG). MA plans are denying medically necessary, covered services that met Medicare criteria at an alarming rate. These 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 protect sick and elderly patients, the providers who care for them and American taxpayers who pay MA plans more to administer Medicare benefits to MA enrollees than they do to the Traditional Medicare program.

Last year, in response to these developments, the AHA urged the Department of Justice to create a "Medicare Advantage Fraud Task Force" to conduct False Claims Act investigations into commercial health insurance companies that are found to routinely deny patients access to services and deny payments to health care providers. This would ensure that older Americans receive the care they need under MA and federal dollars are appropriately spent to provide, not deny, necessary services.

Additionally, addressing the disparities between Traditional Medicare and the MA program is a critical issue. The Traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MA plans. As of January 2023, the MA program includes more than 30 million enrollees, accounting for 50% of all Medicare beneficiaries.[2] Therefore, half of Medicare beneficiaries are not subject to the types of restrictions on access to care faced by beneficiaries enrolled in the MA program, which impedes progress towards equitable access to care and alignment between Traditional Medicare and MA. We believe all Medicare beneficiaries should have the same access to medically necessary care and consumer protections and that those enrolled in MA plans should not be unfairly subjected to more restrictive rules and requirements, which are unlawful and contrary to the intent of the MA program.

---

[1] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[2] https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicareadvantage-plans/

We appreciate recent rulemaking from the Centers for Medicare & Medicaid Services (CMS), which seeks to address a number of these concerns by better aligning MA coverage policies with Traditional Medicare. However, as CMS indicates, many of the regulatory provisions simply codify existing policies with which plans were previously

---

expected to adhere. Given this historic noncompliance with these requirements by certain MA plans, rigorous enforcement is critical to achieving meaningful gains in patient access, as the rules intend. With this in mind, we urge Congress to pass legislation with further oversight of the MA program, including greater data collection and reporting on plan performance and more streamlined pathways to report suspected violations of federal rules, to ensure timely patient access, consumer protection and meaningful enforcement of new CMS rules.

Office of Inspector General Raises Concerns about Beneficiary Access to Care under Medicare Advantage

The MA program is designed to cover the same services as Traditional Medicare, and by law, MA plans may not impose additional clinical criteria that are "more restrictive than Original Medicare's national and local coverage policies."[3] However, the recent HHS OIG report found that some of America's largest MA plans have been violating this basic legal obligation at a staggering rate.

The report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and therefore were inappropriate. In a program the size of MA, improper denials at this rate are unacceptable. Yet, as the report explained, because the government pays MA plans a per-beneficiary capitation rate, there is a perverse incentive to deny services to patients or payments to providers to boost profits. As a result, many insurers have found the MA program to be their most profitable line of business and have sought expansion into MA as part of their growth strategy.[4,5]

Certain Egregious Health Plan Policies Remain Unchecked

Hospitals and health systems have raised concerns for many years about certain MA plan tactics that restrict and delay access to care while adding burden and cost to the health care system. The types of issues that threaten access to medically appropriate care include:

- **More Restrictive "Internal" Medical Necessity and Coverage Criteria.** CMS rules preclude MA plans from utilizing clinical criteria that are more restrictive than

---

[3] CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16.
[4] https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-healthinsurance-markets-issue-brief/
[5] https://www.forbes.com/sites/brucejapsen/2021/10/01/parade-of-health-insurers-expand-medicare-advantage-intohundreds-of-new-counties/?sh=591ab1106b69

Traditional Medicare. However, the HHS-OIG report clearly details that MA plans are routinely doing exactly that. Additionally, MA plans often classify their medical

---

necessity criteria as proprietary and do not share its specifics with providers, resulting in a "black box" methodology for determining whether a service will be approved. This leaves providers and patients unable to anticipate what the plan may require as evidence of medical necessity, leading to unnecessary delays and denials and unequal coverage of medically necessary care for MA beneficiaries.

- **Inpatient Care Downgrades to Observation Status.** To give patients and providers a clear indication as to when a patient can be admitted to a hospital for inpatient care, CMS established that hospital inpatient admission is considered medically appropriate if the patient is expected to receive hospital care for at least two midnights. Many MA plans have applied more restrictive criteria for inpatient admissions that inappropriately limit patient access to medically necessary, covered hospital services. This is especially problematic in cases where a patient's care requires multiple days in the hospital (far exceeding the two-midnight threshold required for Traditional Medicare to cover the hospital say) and certain MA plans continue to downgrade those stays to outpatient or observation care. This practice can also have the effect of eliminating a patient's eligibility for certain post-acute care coverage and benefits that require a 3-day hospital stay prior to admission.

- **Post-acute Care (PAC) Admissions.** The HHS OIG report identified PAC as one of three services most frequently denied for prior authorization or payment when the requested service, in fact, met Medicare coverage rules and MA plan billing rules. Erroneous denials and delays such as these restrict access to care during both the PAC and prior hospital stages of care, for services that would otherwise be covered by Traditional Medicare. These delays and denials erode the overall quality of care provided to patients and undermine cross-setting clinical coordination efforts that are critical to high-quality, patient-centered care.

  It also appears that some Medicare Advantage Organizations (MAOs) may be motivated by financial reasons to keep a patient in the referring hospital for longer than is medically prescribed by the treating physician. In this case, the plan has already paid the hospital a flat rate for care and is either delaying or attempting to avoid discharging the patient to the next site of care, which would require a separate, additional reimbursement. AHA claims data analysis reflects that length of stay in the referring hospital is typically longer for MA beneficiaries than Traditional Medicare beneficiaries being discharged to a PAC setting.

  Additionally, stronger network adequacy requirements are needed for PAC sites of care. There are currently no network adequacy requirements for specific PAC provider types such as home health, inpatient rehabilitation facilities, and long-term acute care hospitals. To ensure MA beneficiaries have appropriate access to basic

benefits covered by Traditional Medicare, it is important that providers who deliver these basic benefits are appropriately represented in MAO networks.

- **Sepsis Coverage.** Several MA plans do not adhere to CMS clinical guidelines for sepsis, instead utilizing standards that are not supported by current clinical best practices, nor recognized by current coding or payment methodologies used by CMS. Such policies reduce patient access to care and undercut quality improvement efforts to prevent, detect, treat and improve sepsis care.

- **Emergency Services.** Several large insurers have been denying or downcoding coverage of emergency services after the care is delivered upon reviewing the outcome and patient records, and not based on what the clinician knew at the time the patient presented to the emergency department. These policies can deter patients from seeking critical and urgent care, while also resulting in significant financial losses to providers when payments are clawed back after the fact for care that was legitimately provided.

- **Specialty Pharmacy Coverage.** Large insurers are increasingly requiring health care providers to obtain physician-administered drugs from the insurer's owned or affiliated specialty pharmacy instead of allowing the health care facility to provide the drug on site from its own inventory. This practice is known as white bagging and raises serious patient safety concerns, creates the potential for significant delays in time-sensitive medical care, and adds tremendous burden and cost to the health care system. The white bagging practice will be part of the subject of a recently announced investigation by the Federal Trade Commission into the vertical integration of pharmacy benefit managers and large health insurance companies who wholly own mail order specialty pharmacies, which are being used to steer patients for profit.[6]

- **Mid-year Contract Changes.** MA plans are increasingly implementing unilateral mid-year contract policy changes that have a material financial impact on providers. After the contract has been negotiated and hospitals and health systems develop an annual operating budget based upon the terms of the contract, the plan unilaterally issues a policy change that materially changes the amount the hospital is paid for the services. In some cases, the changes are clinical in nature but still include a financial implication. In other cases, they are strictly financial restrictions.

  A common mid-year change is a site of service policy where a plan will stipulate in the middle of a contract year that they will now only cover certain services in a specific setting going forward, which can interrupt and fragment ongoing care. For example, requiring a patient receiving ongoing chemotherapy in a hospital setting to continue receiving cancer treatment in another setting or facility. Mid-contract year changes can subject patients to unexpected changes in coverage, as they selected

---

[6] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemenindustry

their plan at the beginning of the year understanding that care would be covered in certain settings, with certain providers, and then later finding out that these material rules can be changed without their knowledge or consent. These changes create an unpredictable environment for treating patients and are unfair to patients and providers.

Prior Authorization Processes

Not only is achieving alignment of medical necessity and coverage criteria related to MA prior authorization policies critical, but also alleviating the burdensome prior authorization process is vital to MA reforms. Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. The most common methods of prior authorization requests are fax machines and call centers. Additionally, 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. For each plan, providers and their staff must ensure they are following the correct rules and processes, which vary substantially between plans and by service, and are often unilaterally changed in the middle of a contact year.

This heavily burdensome process contributes to patient uncertainty regarding their care plan and can leave them in limbo, facing delays in care while the aforementioned steps are completed. According to a 2022 American Medical Association survey, 94% of physicians reported care delays associated with prior authorizations, while 80% indicated that prior authorization hassles led to patient abandonment of treatment.[7]

Greater Accountability Is Needed

The findings of the HHS OIG report, as well as the broader experience of MA beneficiaries, hospitals and health systems, clearly indicate that greater oversight of MA plans is needed to ensure appropriate beneficiary access to care. To address these concerns, the AHA specifically urges Congress to:

- **Establish Controls for MA Plan Usage of Prior Authorization.** The AHA supported legislation last Congress, The Improving Seniors' Timely Access to Care Act of 2021 (H.R.3173/S.3018), which would streamline prior authorization requirements under MA plans by making them simpler and uniform, and eliminating the wide variation in prior authorization methods that frustrate both patients and providers.

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

- **Improve Data and Reporting.** We strongly urge Congress to establish standardized reporting on health plan performance metrics related to coverage denials, appeals and grievances by plan and to require that these be made publicly available.

- **Conduct More Frequent and Targeted Plan Audits.** Pursuant to the HHS OIG recommendations, we urge additional CMS audits be conducted and targeted to specific service types of MA plans that have a history of inappropriate denials.

- **Establish Provider Complaint Process.** Health care providers, including hospitals and health systems, act on behalf of their patients when working with insurers to obtain approval and coverage for medically necessary care. We encourage Congress to establish a process for health care providers to submit complaints to CMS for suspected violation of federal rules by MA plans.

- **Enforce Penalties for Non-Compliance.** Congress should ensure that CMS exercise its authority to enforce penalties for MA plans that fail to comply with federal rules, including the 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 a number of the established regulations were already requirements under the health plan terms of participation in the MA program. Given MAOs historic lack of adherence to these rules, Congress should establish stronger programs to hold 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 responsibility of insurance oversight between the federal and state governments. To ensure that CMS and states exercise their authorities as needed, we encourage Congress to delineate and strengthen the specific oversight and enforcement responsibilities of state and federal authorities.

Conclusion

The AHA appreciates your recognition of these issues and the need to examine the quality of coverage offered by Medicare Advantage plans. We look forward to continuing working with you to address these concerns and to ensure all Medicare beneficiaries have access to timely and appropriate care.

Bristol Health

Kurt A. Barwis, FACHE
President and Chief Executive Officer

TESTIMONY OF
KURT A BARWIS, FACHE
PRESIDENT & CEO
BRISTOL HEALTH, INC.
SUBMITTED TO THE
PERMANET SUBCOMMITTEE ON INVESTIGATIONS
EXAMINING HEALTH CARE DENIALS
AND DELAYS IN MEDICARE ADVANTAGE
MAY 17, 2023

My name is Kurt A. Barwis, and I am President & CEO of Bristol Health, Inc. 41 Brewster Road, Bristol CT, 06010. Honorable Members of the Permanent Subcommittee on Investigations "Examining Health Care Denials and Delays in Medicare Advantage," please accept this written testimony and data concerning Medicare Advantage payment abuse and delays.

Bristol Health, Inc. is an independent integrated health system, providing innovative, integrated and individualized care for the community of Bristol, CT and its surrounding areas. Bristol Heath sits within miles of three large teaching tertiary care centers and an additional community hospital, creating a highly competitive landscape. Despite the geographic pressures and an approximately 72% government payers mix, Bristol Health has combined net revenues of $200.8 million. Bristol Health consists of Bristol Hospital (CMS 4 Star Facility), a 154-bed private, not-for-profit community hospital; Bristol Home Care and Hospice Agency (CMS 4 Star Organization); Bristol Hospital Multispecialty Group, a physician governed not-for-profit medical foundation comprised of 150+ physicians/advance practice professionals delivering 152,242 office visits; Ingraham Manor (CMS 4 Star Facility), a 128-bed, short-term rehabilitation and long-term care facility; Bristol Hospital EMS and the Bristol Hospital Development Foundation.

In FY 2022 Bristol Hospital discharged almost 6,000 patients, provided care to 31,711 emergency patients and system wide employed approximately 1,700 people in the greater Bristol area.

My testimony is focused on the Prior Authorization "PA" practices of insurance companies that are severely impacting timely access to care; blocking patients who require care from access; increasing the cost of care; causing physician burnout; causing moral injury to physicians and physician extenders and finally, causing independent physicians and hospitals to seek employment/acquisition/consolidation. These practices often utilize internal-unpublished non-generally accepted clinical criteria. Access to insurance company PA staff is not available to meet patient needs on "**nights, weekends and holidays"** exacerbating needed care transitions. These plans who generally advertise "we are here for you" are not.

The U.S. Department of Health and Human Services Office of the Inspector General ("OIG") issued a report on PA findings titled "Some Medicare Advantage Organization Denials of Prior Authorizations Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" April 2022. The following are excerpts from the audit report:

1) "A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits.
2) We found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules – in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service).
3) First, MSOs used clinical criteria that are not contained in the Medicare Coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that our physician reviewers determined were medically necessary.
4) Second, MAOs indicated that some prior authorization request did not have enough documentation to support approval, yet our reviewers found the beneficiary medical records already in the case file were sufficient to support the medical necessity of the services.
5) We found that among the payment requests that MAOs denied, 18 percent met Medicare coverage rules and MAO billing rules."

This independent authoritative audit found major issues that are consistent with testimony about MAO PA practices presented to the Connecticut General Assembly Insurance and Real Estate Committee in 2021 and 2023, as well as the testimony presented to its Public Health Committee in 2023. Moreover, the compelling audit findings validate the OIG's "central concern" about the potential incentive for MAOs "to deny beneficiary access to services and deny payments to providers in an attempt to increase profits." All one has to do is look at the profits these companies are publishing and for example the fact that one of the largest, Humana, is getting out of all other lines of health insurance to singularly focus on Medicare Advantage - to know that profits are bountiful at the expense of enrollees and providers.

It is important to note that what you get in response from the insurance industry concerning the use of PAs is not current and often subjective. For example they will selectively point to surveys, such as "physicians say that "X" percentage of the care they provide is unnecessary", while the full context and critical causation is completely omitted. Defensive medicine in this case being a primary cause - simply stated physicians are required to meet a standard of care and professional judgment or potentially be exposed to a career ending malpractice suit. The PA process is overriding physician professional judgment without the MAO ever seeing or evaluating

the patient. The real question to be asked is, will we implement or modify the Patient Bill of Rights to protect patients from harm that results from an insurance company denying necessary care? Will we enact legislation to ensure that patients who are harmed have the absolute right to sue their insurance company mirroring what exists for health care providers? As outlined in the OIG report (see number 3 above), PA denials often do not utilize or conform to widely accepted standards of care and professional judgment, so how is it equitable and fair that enrollees don't have a clear pathway and right to hold insurance companies that use PAs accountable for harm they cause? Unfortunately when patients engage and challenge denied PAs the answer they most often get is the denial was because the provider didn't provide enough documentation or appropriate documentation to support that the service or procedure was medically necessary. Moreover, this pushes all of the blame and liability back on the provider when that is most often not the case. Giving enrollees/patients a Bill of Rights that gives them a clearly defined and absolute right to sue an insurance company for harm as they can all providers will serve to hold insurance companies accountable for their actions, increase transparency and improve the reliability of the PA process. Surprisingly, in 2023 we exist in a Wild West world when it comes to the use of PAs – accordingly law and order is indicated – the insurance companies that use PAs inappropriately need to face real consequences for the patient harm they cause. Congress should strongly consider giving its citizens such rights and protections.

Example of MAO PA Abuse at Bristol Hospital

Efficient emergency department flow is critical to ensuring that the arriving patient's immediate access to needed care is available. Emergency departments assess, diagnose, stabilize, treat and/or appropriately discharge the patient to home or admit the patient within their organization or to a post-acute care facility such as a skilled nursing facility. Emergency department flow is dependent on system capacities such as the intensive care, medical surgical, behavioral health or a specialty unit's ability to receive and care for patients. It is important to note that all of these departments need to be able to timely discharge patients to receive patients from the Emergency Department. More often, timely discharge is impacted by insurance company prior authorization requirements.

With respect to ED MAO patients that are deemed most appropriately transferred to a post-acute facility, the availability of beds is typically not the limiting factor; rather, the limiting factor is the need for an insurance prior authorization to move the patient successfully.

Factually, any delay in the system can and often does back up an emergency department causing crowding, long holds on stretchers and incoming access issues including but not limited to diversions to other emergency departments.

While the causes are multifactorial I would like to focus on one of the most significant, persistent and damaging ones, timely insurance prior authorizations "PAs".

Bristol Health, Inc. frequently encounters challenges in working with MAOs and securing timely authorization and payment for care we provide to our patients, which can result in unnecessary delays and increased administrative burdens. These challenges often include misuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year, among others.

One of most significant delays in PA occurs when we are seeking a Skilled Nursing Facility "SNF" authorization when a patient is ready for discharge from an acute episode. The delay in authorization ranges from 2-3 days with an overall average of 1.6 for our fiscal year ending 9/30/2021 as detailed below.

Bristol Hospital Medicare Advantage Organization Patient Delays related to insurance prior authorizations - (specifically acute discharge waiting for prior authorization to SNF)						
	MEDICARE ADVANTAGE ORGANIZATION					
	MAO 1.	MAO 2.	MAO 3.	MAO 4.	MA5.	Totals
Total SNF discharges for FY 2021 (10-1-20 through 09-30-21)	47	241	93	14	70	465
# of Cases sent on Insurance waiver / No authorization requirement	17	22	36	0	8	83
# of Cases needing SNF level authorization	30	219	57	14	62	382
# of Cases delayed due to authorization process	22	136	28	13	56	255
# of days lost awaiting authorization (Avoidable NON-PAID Days)	**28**	**218**	**37**	**18**	**105**	**406**
Average Days Delay per case	1.3	1.6	1.3	1.4	1.9	1.6
Percent of total cases sent with no authorization requirement	36%	9%	39%	0%	11%	18%
Percent of total cases needing insurance authorization requirement	64%	91%	61%	100%	89%	82%
Percent of cases needing insurance authorization with delay	73%	62%	49%	93%	90%	67%

During FY 2021 some MAOs waived prior authorizations requirements due to the pandemic, for short durations. It should be noted that Bristol Hospital received only the DRG payment for each MAO patient. Accordingly, for those situations where we experienced discharge delays due to PA review, which totalled 406 days, we were paid **"nothing at all"** for those 406 days of care we provided while waiting for the PAs. Further, 100% of the authorization requests for these patients were approved with the exception of ones where we needed the denial for commercial or Husky. There were 21 initial denials, 7 of those were overturned by peer-to-peer review and the other 14 were transferred to a SNF under a secondary payer (either Husky or private pay).

The FY 2021 cost for the 406 days that Bristol Hospital, a nonprofit charitable organization, provided to MAO organizations based on our last filed Medicare cost report would be $525,676.62. Using our observation rate that cost would be $1,001,991. However, neither of these approaches captures the true incremental cost of providing care to patients that didn't need to be in our hospital. For example: the fact that we were and are in a severe national staffing crisis paying upwards of $190 per hour for a travel nurse.

From a patient perspective these PA delays:

1) Presented added risks.
2) Lengthened the time that it took the patient to fully stabilize, improve and resolve their condition.
3) Forced patients to suffer through periods of ineffective treatment (in an acute care bed versus skilled) before permitting access to the most appropriate therapy.
4) Limited access to new arriving patients and for patients in our emergency department who urgently required an acute care bed. Factually, in December/January of 2022 when we were being overrun by very sick Covid patients we had as many as 10 patients in our acute care beds waiting for a PA while there were an equal number of patients in our emergency department waiting for an acute care bed.

Why are these specific acute to post-acute PA delays occurring?

1) MAOs know that a hospital cannot discharge a patient without a safe discharge plan.
2) Post-acute facilities will not take an MAO patient without a PA – they will not get paid if they do.
3) MAOs get paid a PMPM and are 100% at risk for the care a MAO patient receives.
4) Hospitals cannot bill a patient who is delayed by an MAO in a hospital bed unnecessarily. Further, to discharge and readmit the patient to an observation status is not appropriate or practical.

5) MAOs refuse to negotiate or renegotiate our contracts to agree to a reasonable per diem for delayed inpatient discharges due to delayed PAs. Our small system has zero leverage and the MAOs use this deceptive practice to improve profitability.
6) Given the significance of Medicare Advantage in the community served by Bristol Health, we cannot go non-par without causing confusion and access issues. Accordingly, what would likely meet the definition of a "deceptive practice in an insurance contract" does not because we are participating with all MAOs and the contract language we are forced to accept prevents us from asserting it.

Federal Preemption Issues and Concerns

Ninety ("90") percent of the PA abuse at Bristol Health, Inc. is by MAO plans. MAO business represents 30% of the Hospital's total book of business and MAO penetration in the communities served by Bristol Health is greater than 70% of the Medicare eligible population. The remaining portion is related to fully insured and employer sponsored plans. MAO plans enjoy a broad federal preemption with respect to states legislating laws, rules and regulations. The Centers for Medicare & Medicaid Services ("CMS") regulations state that the federal standards established for MAOs "supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency)." See 42 CFR 422.402. The Medicare Managed Care Manual Chapter 10 – MA Organizations Compliance with State Law and Preemption by Federal Law clearly further establishes these boundaries.

States' early attempts in this area by and large were focused on consumer protections from MAO false or deceptive marketing - which remains a consistent theme across the U.S. In fact the U.S. Senate Committee on Finance launched an inquiry in in August of 2022 and published a report on the issue "Deceptive Marketing Practices Flourish in Medicare Advantage." In every state that attempted to protect seniors from MAO deceptive marketing, federal preemption was asserted by CMS, and states were instructed to file complaints as opposed to enacting laws. However, states can require certification/licensure requirements for marketing representatives and MAOs must limit their employment of marketing representatives to only those who meet such requirements. Interestingly and somewhat related, CT does have licensure requirements for "Medical Management" companies. Similarly, MAOs must only use CT licensed Medical Management companies.

More recently as many as forty-one ("41") State legislative bodies proposed and many have passed PA legislation. Given the broad federal preemption related to MAOs, states are left waiting for Congress and/or CMS to address the abuse. State laws, rules and regulations cannot adjust or impact the existing federal/CMS PA rules for MAOs. Specifically, states cannot for example limit what procedure, diagnostic test or treatment can be gated by a PA. However, states may be able to address the delays

related to patient access to care as outlined in the data from Bristol Hospital above. This might be accomplished through state legislation establishing administrative fees to compensate for delayed hospital discharges and for the extreme burden and associated cost born by physician staff in navigating MAO PA procedures, which pulls physicians away from treating patients and thus limiting access to care.

The theory behind this approach being that these are not fees/costs that are related to a "covered service" and they are not modifying the rules related the use of PAs, they are simply a fee to cover administrative costs in a physician medical office and the cost of providing care for patients that are delayed by an insurance company, that are waiting for an insurance company to make a determination. On the hospital side in CT, we already have the ability to bill State Medicaid a per diem for certain behavioral health patients waiting for an appropriate level of care transfer.

Additional Points:

1) In terms of the cost of care in CT, implementing PA and avoidable day/PA delayed discharge daily fees actually "decreases the cost of care." The vast majority of PAs are currently required by MAOs. MAOs are paid per member per month by Medicare, not seniors living in CT.
2) The cost of PAs and PA delays are currently being shifted unchecked onto medical providers. Establishing a fee to cover the costs and administrative burden of the PA process will lead to improvements in PA efficacy.
3) It should be noted that larger systems are providing PA services to their affiliated and non-affiliated community based physicians when they send their patients for diagnostic tests, treatments and procedures at their facilities. Bristol Health, Inc. as a standalone, low cost provider does not have the resources to do this.

Thank you for the opportunity to submit this written testimony.

Sincerely,

Kurt A. Barwis, FACHE
President and Chief Executive Officer
Bristol Health, Inc.

AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Statement for the Record
from the

American Medical Rehabilitation Providers Association (AMRPA)

Homeland Security & Governmental Affairs Committee
Permanent Subcommittee on Investigations
United States Senate

Hearing on:

Examining Health Care Denials and Delays in Medicare Advantage

May 17, 2023

Contact: Kate Beller, Executive Vice President for Policy Development and Government Relations

(202) 207-1132 | KBeller@amrpa.org

www.amrpa.org

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

On behalf of the members of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to provide a written statement for the record of the Subcommittee's recent hearing, "Examining Health Care Denials and Delays in Medicare Advantage." We thank the Subcommittee for its time and attention to these important issues and encourage the Subcommittee to continue this focus on ensuring that Medicare Advantage (MA) beneficiaries can access medically necessary care without delays and other barriers.

AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and units, referred to in the Medicare program as "inpatient rehabilitation facilities" (IRFs). Our hospitals and units focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, and spinal cord injury patients. The vast majority of our members are Medicare participating providers and according to the Medicare Payment Advisory Commission (MedPAC), IRFs served 335,000 Medicare beneficiaries with more than 379,000 IRF stays in 2021.[1]

Reform of prior authorization practices and other utilization management techniques employed by MA plans has long been at the top of AMRPA's advocacy agenda because of the direct and adverse impact these practices often have on some of Medicare's most severely ill and injured beneficiaries, including those living with disabilities. Prior authorization reform is particularly important in the rehabilitation medicine context when timely and appropriate care transitions from the acute care hospital can dramatically improve a patient's functional recovery and quality of life. While there has been significant growth in the MA program in recent years – with more than half of all beneficiaries now enrolled in MA plans[2] – there has also been increasing scrutiny of plan behavior by federal oversight entities.[3] The confluence of program growth and problematic plan behavior makes timely and effective policy changes to MA plans' prior authorization and denial practices all the more critical to correct serious and concerning care access and equity issues. Reforming MA plans' practices is particularly imperative in advancing health equity, as research shows that minority and low-income beneficiaries enroll in MA plans at a significantly higher rate, and these beneficiaries face larger knowledge gaps and disenrollment rates.

Our statement focuses on four key issues:

(1) the impact of prior authorization and other MA plan practices on beneficiary access to care in the inpatient rehabilitation facility benefit,
(2) AMRPA's support for recent and pending policy reforms to MA plan practices,

---

[1] Medicare Payment Advisory Commission (MedPAC), *MedPac March 2023 Report to the Congress: Medicare Payment Policy* (March 15, 2023) (https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf)
[2] Centers for Medicare and Medicaid Services (CMS), *Medicare Monthly Enrollment* (May 2023) (https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment)
[3] See, e.g., Department of Health and Human Services (HHS) Office of Inspector General (OIG), *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.asp).

(3) further areas for Congressional and regulatory engagement, and
(4) additional detail and context regarding the discussion of the IRF benefit during the Subcommittee's recent hearing.

I. Impact of Prior Authorization and MA Plan Practices on IRF Beneficiary Access

AMRPA members across the country report that MA plans routinely and consistently divert beneficiaries away from IRFs to less intensive settings of care through the misuse or abuse of prior authorization and other utilization management practices. Some of these specific tactics include using flawed or unsupported proprietary guidelines that conflict with Medicare coverage rules, reliance on unqualified reviewers to overturn the clinical judgment of treating physicians and specialized rehabilitation providers who make up the rehabilitation team, using delay tactics to pressure hospitals and patients into using inappropriate substitutes for IRF care, and not providing real-time and responsive recourse to appeal adverse decisions. As the Subcommittee heard from the hearing witnesses, the impact of inappropriate delays and denials of IRF admissions that result from the misuse and abuse of prior authorization have a direct negative impact on beneficiaries' long-term health, function, and ability to maximize their recovery.

AMRPA recently embarked on an effort to collect data on the outcomes of MA plan prior authorization requests for IRF admissions nationwide in August 2021. A total of 475 IRFs from 47 states, as well as the District of Columbia and Puerto Rico, submitted data on the outcomes of 12,157 requests for the survey month. Overall, the data confirmed the observations of AMRPA members regarding prior authorization practices. More than 53% of all initial requests for an IRF admission were denied, resulting in nearly 6,500 patients being diverted to less-intensive settings of care during just one month. The high rate of denial was very consistent across providers, with 87% of all hospitals having at least 30% of their requests denied during the month. Each of these denials represents the overruling of a practicing physician treating a severely and acutely ill recovering patient.

In addition to the high rate of denial, the survey data confirmed that MA beneficiaries spend an astounding number of unnecessary days in the acute care hospital waiting for prior authorization determinations, with a 2.5+ day average wait time for all determinations. MA plans often claim that prior authorization is used as a utilization management tool to mitigate unnecessary costs; however, this fails to account for the expense of prolonged inpatient stays that may create greater costs to patients and the Medicare program. Even among patients for whom MA plans approved their initial request for IRF admission, the survey data represents more than 14,000 days in the aggregate spent waiting for a determination during a single month. These unnecessary delays result in additional acute care hospitalization expenses while restricting acute care hospitals from filling their beds with other patients with pressing care needs. We once again note that for patients in need of the intensive, medically managed course of rehabilitation provided in IRFs, every day spent waiting in an acute care bed without receiving rehabilitation care can limit their ability to recover and achieve their maximum level of health and function. The findings of AMRPA's survey are summarized in Appendix 1 and detailed in full in Appendix 2.

We also appreciate the Subcommittee's attention to the results of the Department of Health and Human Services (HHS) Office of Inspector General's (OIG) 2018 and 2022 report confirming the inappropriate practices used by some MA plans. As the Subcommittee heard, the OIG found that MA plans overturned 75% of their own denials, but only about 1% of denials were ever appealed by beneficiaries and providers.[4] More recently, the OIG found that IRF services were among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules.[5] These findings, and similar findings raised by other provider and stakeholder organizations, highlight another concerning issue that AMRPA has raised with CMS and others multiple times. While some beneficiaries may eventually be able to garner a victory on appeal in cases where their services had been inappropriately denied by MA plans, this path is by no means assured, even when the plans are denying claims that meet the Medicare coverage criteria. As the Subcommittee heard in Ms. Bent's all-too-familiar testimony, the appeals process is lengthy, costly, and comes at a time when patients are at their most vulnerable; many, if not most, patients simply do not have the resources to be able to pursue an appeal even when their physician and other providers can confidently assert that their care *should* be covered. Stricter oversight by both Congress and the Administration, in concert with rehabilitation stakeholders, is the only way to ensure that MA beneficiaries are not blocked from accessing the care they need.

AMRPA is pleased to learn of the Subcommittee's outreach to the largest MA plans to learn more about how decisions are made to deny access to care, and we look forward to additional information being released by the Subcommittee regarding its findings.

II. Recent Regulatory Reforms Show Promise, but Enforcement is Critical to Ensure Compliance

As noted throughout the recent hearing, the Centers for Medicare & Medicaid Services (CMS) recently finalized one rule focused on restricting certain MA plan practices regarding prior authorization and other barriers to care (the "2024 MA rule")[6], and is reviewing a second proposed rule focused on streamlining and standardizing the use of prior authorization by MA plans and other payers (the "electronic prior authorization rule").[7] AMRPA has strongly supported both of these rules and advocated for additional refinements to ensure that they

[4] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Medicare Advantage Appeal Outcomes and Findings Raise Concerns About Service and Payment Denials* (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf).

[5] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *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).

[6] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023).

[7] 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 and Critical Access Hospitals in the Medicare Promoting Interoperability Program, 87 Fed. Reg. 76,238 (Dec. 13, 2022).

meaningfully address problematic payer behavior. In particular, we continue to seek an expansion of the electronic prior authorization proposed rule to require MA plans return decisions for expedited and urgent requests (such as post-acute care authorizations) within 24 hours (instead of the proposed 72-hour timeframe), and a commitment from CMS to publicly report data on prior authorization practices on a service-specific basis and in a way that is easily accessible to and understood by enrollees.

We are pleased to see that a number of Subcommittee members have signed a pending letter to CMS calling for these specific reforms to be included in the final rule. Our detailed comments on the 2024 MA rule can be found here and our comments on the electronic prior authorization rule can be found here.

However, as Chairman Blumenthal stated during the hearing, these regulations (both those that are finalized for MA Contract Year 2024 and those that are pending in the electronic prior authorization final rule) will only have the desired impact if they are appropriately enforced. While we are heartened that CMS has heard the calls from patients and providers to rein in these types of plan behavior, we will be monitoring closely to understand how plans are complying with these new and newly codified requirements and work to ensure that CMS is appropriately overseeing the implementation of these rules when they go into effect. This is particularly important because AMRPA members continue to report that MA plans are currently using these tactics that will presumably be barred beginning in Contract Year 2024.

Given the Subcommittee's investigatory and oversight functions, we believe that it may be relevant to follow up with CMS after implementation of the rules to ensure plans are complying with the letter and intent of the regulatory reforms. We would be happy to provide the Subcommittee with any additional information and data from our members as well as to highlight how CMS is working to ensure better oversight. AMRPA has recommended that CMS develop a robust enforcement plan, including auditing processes, transparent reporting processes, and penalties for non-compliance, to ensure that MA plans comply with the new and important reforms outlined in these rules. MA plans should be publicly accountable for their policies and practices, and key metrics should be able to be easily measured across plans so beneficiaries have a better understanding of their access to post-acute care under the plan's policies when making enrollment decisions. At a minimum, such reporting should include the number or percentage of denials, the reason(s) for each denial, and the turnaround time to respond to requests for care approval. Such public reporting will also allow Congress to fulfill its oversight role of CMS' management of the MA program, and better understand whether and how additional action may be necessary to ensure that MA patients can access medically necessary care to which they are legally entitled.

III. Discussion of IRF Coverage Requirements and IRF Payment System

AMRPA appreciates the Subcommittee's focus on the IRF benefit, given the previously cited findings that IRF services are among the most prominent service types denied by MA plans despite meeting Medicare coverage rules. We would like to offer additional details and context on some of the IRF-specific payment and coverage rules referenced during the hearing; though

these issues are largely *not* directly related to the MA policies within the Subcommittee's focus, we want to ensure that Members of the Subcommittee fully understand how these issues interact with the field's concerns about unnecessary delays and denials of medically necessary IRF care.

We recognize the Subcommittee's attention to the costs incurred by the Medicare program, and the need to ensure that Medicare dollars are spent on high-value care. We share the concern from several witnesses that some of the MA plan practices discussed during the hearing may be incentivized by the cost structure of the MA program, which offers higher profit per patient when care is denied or patients are diverted to lower-cost settings. This is because MA plans are paid a capitated monthly amount for each patient, thereby creating a financial incentive to care for the patient most efficiently. We also note that some analyses have suggested that reining in the use of prior authorization and other utilization management techniques by MA plans could result in higher expenditures by the Medicare program in the short term. However, as noted in the OIG report (detailed further below), a significant portion of MA denials are for care that met the Medicare Fee-for-Service criteria, i.e., should have been covered by the MA plans (which must provide, at minimum, the same level of coverage offered in Fee-for-Service or "Traditional" Medicare). Therefore, AMRPA firmly believes that such inappropriate denials are not reasonable cost-cutting measures but instead are limitations on medically necessary care to which MA beneficiaries are entitled.

Further, the care provided in IRFs is critical to the long-term health and function of beneficiaries who have sustained severe injuries and illnesses that necessitate intensive inpatient hospital rehabilitation. By receiving a full course of medically necessary, intensive therapy in an IRF, patients are able to maximize their recovery, often reducing or eliminating the need for longer-term (and costly) medical care after discharge. For example, a study on the long-term clinical outcomes of clinically similar patients treated in IRFs and SNFs found that patients treated in the IRF setting were able to return to the home setting earlier while experiencing fewer emergency room visits and hospital readmissions over the two-year study period.[8] In contrast, when patients who need IRF care are instead diverted to lower-intensity settings, or face significant delays in beginning IRF care while languishing in an acute care hospital, they may achieve lesser outcomes, face a greater threat of readmissions, and/or need ongoing medical care and support – all of which result in excess costs to the Medicare bottom line over the long term. AMRPA firmly believes that ensuring patient access to the right medically necessary care, at the right time, in the right setting, as determined by the patient's specific care needs, is the best way to achieve better patient outcomes and protect the fiscal health of the Medicare program.

IRF Services in OIG Report

AMRPA continues to strongly back the findings and recommendations in the OIG's recent report regarding delays and denials that some patients face in their MA plans. As referenced previously, the OIG specifically identified inpatient rehabilitation as a service that its reviewers believe is inappropriately restricted by MA plans. The OIG found that 13 percent (1,631 denials) of the

[8] Dobson DaVanzo & Associates, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge* (June 2014).

more than 12,000 denials in the week-long sample met Medicare coverage rules, and thus likely would have been approved in the Fee-for-Service program. Within these more than 1,500 instances of inappropriate denials, the OIG report highlighted approximately 30 specific examples: four of these involved denials of IRF admissions.

In each of these examples, the OIG found that MA plans determined the request for IRF admission did not meet the Medicare coverage criteria, though the OIG's physician panel found otherwise. These cases follow common patterns that frequently inhibit patient access to IRF care. In one example, the MA plan determined that a lower level of care (such as a skilled nursing facility or home health care) was sufficient and thus denied the IRF admission, while the OIG reviewers found that the patient's condition was in fact severe enough to necessitate the medical supervision and management that occurs in an IRF. This trend was specifically referenced in the 2024 MA proposed rule preamble, which clarified that MA plans cannot deny a request for otherwise covered post-acute care services in a particular setting just because the patient might be able to also receive care in a less-intensive setting.[9] Other denials included inappropriate determinations that patients did not meet the Medicare medical necessity criteria for IRF admission.

The report also noted that at the time of the OIG's data request, three out of four of these inappropriate denials had not been reversed, though the report does not confirm whether or not those three cases had been appealed. We again emphasize that no matter how egregious any given denial of care may seem to both patient and provider, the appeals process is difficult and burdensome for even the most well-resourced patients. Ms. Bent also noted that even successfully reversing a denial does not mean that a given beneficiary can stop worrying about their coverage and does not protect the patient from receiving subsequent denials. A robust appeals process allows some beneficiaries the ability to challenge care denials but cannot substitute for further action to rein in these practices.

CMS Rules for Classification of IRFs

As referenced in the written testimony from the Subcommittee's witnesses, IRFs must comply with specific criteria to maintain their classification as IRFs and receive Medicare payment under the IRF Prospective Payment System (PPS), as opposed to the traditional acute care hospital payment system (IPPS). IRFs must meet all criteria to be classified as an inpatient hospital under Medicare regulations and meet the so-called "60 Percent Rule." This requires that at least 60% of all patients admitted to an IRF for treatment must have a diagnosis of one or more of 13 specified conditions listed in 42 C.F.R. § 412.29(b)(2). These conditions include stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, certain neurological conditions, burns, certain severe arthritis conditions, and bilateral hip or knee replacements when the patient has a body mass index equal to or greater than 50 or is age 85 or older. The other 40% (or less) of an IRF's patients may qualify for coverage with a wide variety

[9] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications, 87 Fed. Reg. 79,452, 79,501 (Dec. 27, 2022).

of other debilitating conditions. IRFs are evaluated on an annual basis to determine whether they have met or exceeded the 60 Percent Rule in order to maintain their exclusion from the IPPS.

It is important to note that the 60 Percent Rule is purely used to determine, in the aggregate, whether a freestanding rehabilitation hospital or unit can maintain its designation and payment under the IRF PPS and is *not* used to determine whether individual patients qualify for admission to IRFs. IRF admission decisions are driven on an individual basis by a detailed set of Medicare coverage rules, laid out separately in 42 C.F.R. § 412.622. These extensive coverage requirements involve an individualized assessment of each potential IRF patient, not based on their single diagnosis code, but on a comprehensive evaluation of the patient's needs and prospective outlook in response to treatment. Patients who are appropriate for IRF care have conditions that are serious enough to require intensive, interdisciplinary treatment, in a hospital setting, with significant medical management and oversight. If a patient does not meet the full slate of coverage criteria in the clinical judgment of the rehabilitation physician, they will not be approved for an IRF admission. In fact, our members consistently report that a high percentage of patients referred to IRFs are determined *by the IRF clinical team* to not meet these very stringent criteria.

There are a number of highly complex patient populations that benefit from receiving IRF care that fall outside the conditions covered in the 60 Percent Rule. These conditions, including cardiac, oncology, and pulmonology (among others), are clearly suitable for intensive rehabilitation, as these patients require multi-disciplinary medical teams and close medical supervision by a full-time physician. Any insinuation that these patient populations should not be treated in an IRF due to the fact that they fall outside of those conditions listed in the 60% rule is a misunderstanding of the highly complex and diverse IRF patient population and fails to recognize changes in care delivery since the 60% rule was first implemented in 1984 (then referred to as the 75% rule). AMRPA would therefore strongly counter any suggestion that MA plans should use the conditions cited in the 60 Percent Rule to enforce a higher standard of access to IRF admissions, as such policy would impede access for patients who clearly benefit from IRF services and violate the existing coverage rules.

We share the Subcommittee's particular concern about MA plans' reliance on algorithms, proprietary guidelines, and other strict criteria that are not found in the Medicare coverage regulations, to restrict access to care against the decisions of treating doctors and other clinicians. Along similar lines, allowing MA plans to utilize the 60 Percent Rule as a de facto coverage restriction would not only go beyond the scope of MA plans' authority but would serve as exactly the type of "checkbox" restrictions that eliminate the role of physician judgment in an IRF admission. Such policy would also fail to reflect advances in medicine and technology that have made intensive rehabilitation an integral part of the recovery for an increasingly broad range of patients[10] – which in turn demonstrates the ongoing need for patient-centered and physician-led admission decision-making.

***

[10] As an example, due to treatment advances and improved outcomes, the American College of Surgeon's Commission on Cancer now requires that rehabilitation services be included in order to certify a cancer program.

We appreciate the Subcommittee's time and attention to these critical issues and look forward to working with you and your colleagues to advance health care policy reforms that ensure patients are able to access the care they need. If you have any questions, please contact Kate Beller, AMRPA Executive Vice President for Policy Development and Government Relations, at kbeller@amrpa.org.

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute
Hackensack MeridianHealth

AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Appendix 1: Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices (Executive Summary)

Background: AMRPA has long demonstrated the impact of PA through patient experiences and examples of provider burden. In 2021, CMS asked whether AMRPA could work to "quantify" the impacts of these practices with hard data on delays and other adverse outcomes. As a result, AMRPA embarked on an effort to collect data on the outcomes of MA plan PA requests for IRF admissions nationwide in August 2021. As part of this effort, a total of 475 IRFs from 47 states, plus the District of Columbia and Puerto Rico – approximately 40% of all IRFs nationwide – submitted data on the outcomes for 12,157 requests for the survey month. The results demonstrate numerous failures in the current PA process used by MA plans.

Results: Overall, the data confirmed the observations of AMRPA members regarding PA practices. First, the data showed that MA plans overrule the judgment of treating, specialized rehabilitation physicians at a very high rate. Overall, *more than 53% of all initial requests for an IRF admission were denied*, resulting in 6,482 patients being diverted to less-intensive settings during the course of just one month. The high rate of denial was very consistent across providers, with 87% of all hospitals having at least 30% of their requests denied during the month. Given the rigorous screening performed by IRFs prior to making a request for admission, these results are driven in large part by the use of unqualified reviewers and reliance on inappropriate guidelines, as well as the lack of practical appeal options.

PA Requests for Admission to IRFs (August 2021)	
Percent of Initial Requests Denied	**53.32%**
Average Wait Time for Denied Requests	**2.59 Days**
Average Wait Time for Approved Requests	**2.49 Days**
Total Wait Days	**30,926**

In addition to the high rate of denial, the survey data confirmed that MA beneficiaries spend an astounding number of unnecessary days in the acute-care hospital waiting for PA determinations. The average wait time for all determinations was more than two and a half days. This experience was also consistent among providers across the country, with 84% of IRFs reporting that the average response time was two days or greater. Even among patients that MA plans approved upon the initial request, there was *a total of more than 14,000 days spent waiting for PA determinations during the month*. Therefore, even when appropriate determinations are made, the process is still harmful to beneficiaries due to delays in receiving needed interventions, and the process is still costly to Medicare and providers.

In addition to the continued restrictions on IRF access due to PA, AMRPA has also been able to collect data on the outcomes of waiver of PA requirements. AMRPA did this by analyzing data from the early months of the COVID-19 PHE, when MA plans voluntarily waived their PA policies. The findings statistically affirm the inappropriate denial of IRF access for MA beneficiaries.

Comparison of Medicare and MA Patients' Use of IRF Services						
	Q4 2019		Q2 2020		Q3 2020	
	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients	Part A Medicare Patients	MA Patients
FFS vs. MA Admissions	79.93%	20.07%	69.54%	30.46%	76.45%	23.55%
Case Mix Index	1.42	1.54	1.50	1.53	1.49	1.57
Discharge to Community	78.58%	74.92%	77.29%	77.29%	74.15%	71.83%

Source: eRehabData®

In 2019, and consistent with historical figures, MA beneficiaries represented only 20% of Medicare IRF admissions despite representing approximately 36% of Medicare beneficiaries in total. When MA plans temporarily suspended PA in response to the early stages of the COVID-19 PHE (Q2 2020), MA beneficiary admissions to IRFs increased to more proportionate volumes. Despite the increased admissions, the medical and functional profiles of patients remained remarkably similar. In other words, IRFs were treating more of the same types of patients, dispelling any notion that the PA process was properly screening out inappropriate referrals. Unfortunately, despite CMS' own recommendations, MA plans largely re-implemented and maintained their PA policies in Q3 2020, and IRF admission for MA beneficiaries dropped to levels consistent with historical levels.

Beyond data from the field, independent audits of MA plan practices have confirmed the inappropriate use of PA. In 2018, the HHS OIG reviewed MA determinations and appeals data.[11] It found that MA plans overturned 75% of their own denials. However, it also found that only about 1% of denials were ever appealed by beneficiaries or providers. This data is consistent with AMRPA's assertion that the current structure and timeline of MA determinations and appeals render little meaningful recourse for beneficiaries, especially those most in need of timely care. Building on its prior findings, the HHS OIG issued a second report this year that

[11] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denial*s (September 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.)

examined the PA determinations of MA plans.[12] In this report, the OIG found that IRF services were among the "most prominent" of the service types that MA plans denied despite meeting Medicare coverage rules. In this report, the OIG provided several specific examples of MA beneficiaries being denied IRF care inappropriately, all of which are typical of denials occurring on an everyday basis at IRFs throughout the country.

The data available from the Independent Review Entity (IRE), which is the second level of appeal for MA determinations, supports the finding that there is inadequate opportunity for appeal of plan decisions. In the most recent available IRE data, only 2,799 IRF appeals were submitted during the first quarter of 2022.[13] A rough extrapolation points to this being approximately 5% of the total initially *denied* IRF requests in a calendar quarter. Since denied reconsiderations are automatically forwarded to the IRE, this means that very few initial IRF denials are ever appealed due to the impractical timeline, MA plans reverse themselves at a very high rate on Reconsideration (thereby avoiding the claim being forwarded to the IRE), or some combination thereof. Under either or both scenarios, there is again little-to-no accountability or oversight as to the accuracy or timeliness of MA determinations since so few initial denials are ever independently reviewed, and there is no data available on these initial determinations.

***

[12] Department of Health and Human Services (HHS) Office of Inspector General (OIG), *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).
[13] Part C Reconsideration Appeals Data – Q2 2022 (http://www.medicareappeal.com/researchersdata).

Appendix 2: Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices (Full Survey Results)

Access to Inpatient Rehabilitation for Medicare Advantage Beneficiaries: An Examination of Prior Authorization Practices

Abstract

The use of prior authorization (PA) by Medicare Advantage (MA) plans is a pressing concern among rehabilitation providers. A nationwide survey of rehabilitation hospitals and units (RHUs) was conducted to determine how frequently PA was used to deny admission to an RHU, how timely those decisions were rendered, and the resulting consequences for patients. The survey, which tracked data for one month (August 2021), found that MA plans overrule rehabilitation physician judgement at a rate of 53%. In addition, patients wait on average more than two and half days for a determination. This resulted in more than 30,000 days waiting for determinations during the single survey month. Since the vast majority of patients being referred to an RHU are hospitalized in an acute hospital, enormous cost and burden results from the use of PA. In addition, seriously impaired MA beneficiaries may be harmed by denials and delays in access to care.

Introduction and Background

Medicare Advantage (MA) plans offer various premium and cost-sharing arrangements that differ from traditional Medicare (TM), as well as health and wellness benefits not offered to beneficiaries enrolled in TM. In addition to financial flexibilities, MA plans are permitted to employ various utilization management strategies not regularly used in TM, including requiring prior authorization (PA) of an item or service as a condition of payment. When PA is required by MA plans, the plan must pre-approve the service, or payment will not be made to the provider. While the use of PA to manage benefits is permitted, MA plans are nonetheless obligated by law to provide all of the benefits offered in TM.[i]

The number of beneficiaries who have chosen to enroll in MA plans has grown at an accelerated pace in recent years. Of the approximately 64 million Medicare beneficiaries, an estimated 28 million now receive their Medicare benefits through private insurers that have contracted with CMS to offer MA plans.[ii]

As enrollment in MA has grown, providers have reported that PA determinations and subsequent denials have increased and often do not follow appropriate evidence-based guidelines.[iii] In addition, physicians report the PA process often delays care and has a negative impact on clinical outcomes.[iv] Concerns have also been raised about the lack

of accountability for the use of PA by MA plans. These concerns are due to high overturn rates of denials and due to insufficient publicly reported data. [v]

In the context of rehabilitation hospitals and units (RHUs), PA delays the discharge of patients from an acute hospital and denies or delays access to needed therapeutic interventions. RHUs (referred to by Medicare as Inpatient Rehabilitation Facilities or IRFs) provide specialized physician-directed care that includes close medical management and an intensive program of rehabilitation. The goals of care in an RHU include continuing medical management of the patient's underlying health problems and improving the patient's functional capacity so that the patient can return to the community. The vast majority of patients referred for admission to an RHU are in an acute hospital due to serious illness or injury.

The Medicare coverage criteria stipulate that an RHU stay is eligible for payment if the patient would practically benefit from and tolerate intensive, multi-disciplinary therapy and requires ongoing supervision by a rehabilitation physician.[vi] The Medicare rules also require that a rehabilitation physician approve each patient for admission. Due to the stringent Medicare rules and the intensity of services offered, RHUs treat more seriously ill and functionally impaired patients than lower intensity post-acute care settings.

Medicare does not have regulatory requirements for PA response times that are specific to hospitalized patients. This has increasingly become a concern since many providers have reported exacerbation of the process burden and high rates of denials for PA requests for admissions. In addition, there is essentially no publicly available data to determine the consequences of PA requirements at the initial determination level or at the initial appeal level. Medicare and its contractors do report the outcomes of the second level of appeal (formally referred to as "Reconsideration by an Independent Review Entity"). However, this level of appeal is rarely utilized for patients seeking admission to an RHU given the lengthy and time-consuming process, which is impractical for patients in need of immediate care decisions.

Given the lack of available data on PA practices and outcomes, the American Medical Rehabilitation Providers Association (AMRPA) conducted a survey of RHUs across the nation to gain more quantitative and qualitative information, including the pervasiveness of PA use as a benefits management practice, frequency of denials, and associated delays in care.

Survey Objectives

The goals of this survey were to determine how common denials of authorization for RHU care are, how timely those determinations are made, and what the consequences of those determinations may be.

Design

RHUs were solicited to participate prospectively in a data collection effort for the month of August 2021. The survey was publicized through trade association and professional channels to the RHU community, including disclosure of the specific questions that would be included on the survey and a spreadsheet form that could be used to capture the PA activity as it occurred. Participants submitted their data via an online portal.

The survey consisted of nine questions, shown below in Table 1.

Table 1: Survey Questions
S1. How many Medicare Advantage patients did you request prior authorization to admit for rehabilitation hospital care?
S2. How many of those requests were ultimately approved?
S3. For those cases that were approved, how long did it take on average for the MA plan to grant authorization from the time of initial request (in days and including weekends)?
S4. How many of your requests were ultimately denied?
S5. In those denied cases from question #4, how long did it take on average for the MA plan to issue its *initial* formal denial from the time of the initial request (in days and including weekends)?
S6. In how many cases, whether ultimately approved or denied, did the hospital, physician, patient (or family) need to engage in extra effort to try to obtain authorization for admission? This could include requests from the plan for additional documentation, needing to conduct a peer-to-peer discussion, filing a formal appeal, or any other steps that were taken beyond the initial request for authorization.
S7. Of those requests requiring additional engagement from hospital, patient, or family (per question #6), how many were ultimately granted authorization?
S8. In your experience, what do you think has most common reason Medicare Advantage plans use to deny an authorization request? Please only select one answer. a. Patient does not meet Medicare criteria for IRF admission. b. Patient could be treated at lower level of care/intensity. c. Patient does not meet medical necessity criteria (generally). d. Patient does not require physician supervision. e. Patient does not require multiple therapy disciplines and/or intensive therapy. f. Patient cannot tolerate multiple therapy disciplines and/or intensive therapy.
S9. Was prior authorization waived during the month of August by plans or your state due to COVID-19 or for any other reasons? Note: Any patients admitted under these circumstances without a prior authorization request being made should not be included in your survey results. a. Yes b. No

AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

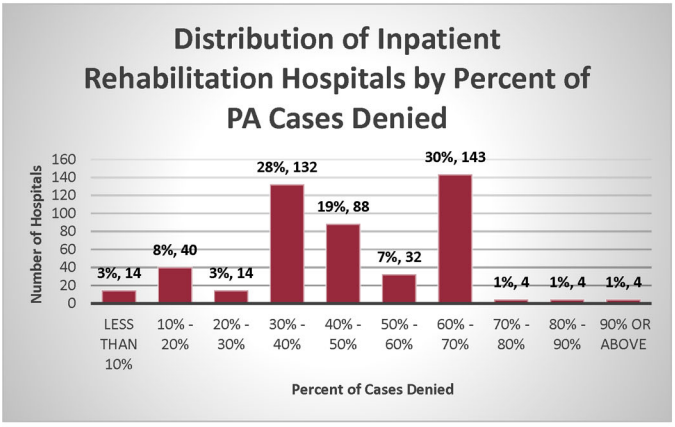
Participants

Data were submitted by 102 respondents who provided information about a total of 475 RHUs, representing approximately 40% of the RHUs nationwide. [vii] The responses included RHUs from 47 states and Puerto Rico. Data on 12,157 PA requests for the month of August 2021 were included in the survey.

Results

Of the 12,157 PA requests reported for the month, 6,482 of those requests were initially denied by the MA plan (53.32% of all requests). 84% of respondents reported that 30-70% of initial requests were denied during the survey month. **Figure 1** shows the distribution of denial frequency cited by RHUs.

Figure 1. Distribution of Hospitals by denials



Wait times of greater than 2 days for requests were typical for the vast majority of respondents, with 84% of respondents waiting more than 2 days on average for all requests. The average wait time for the initially approved requests was 2.49 days. The average wait time for the initially denied requests was 2.59 days.

The wait times were very consistent across all IRFs. 84% of RHUs also reported an average wait time of 2.1 days or greater for denied requests. For approved requests, the majority (56%) had wait periods over two days. **Figure 2** shows the distribution of wait time for a negative response. **Figure 3** shows delays experienced when an initial favorable response was received.

Figure 2. Distribution of Hospitals by wait time for negative response

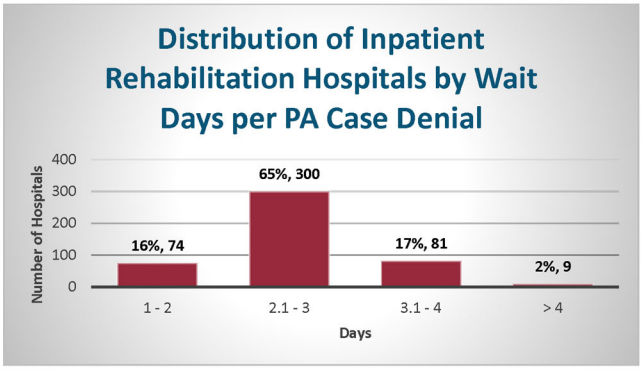
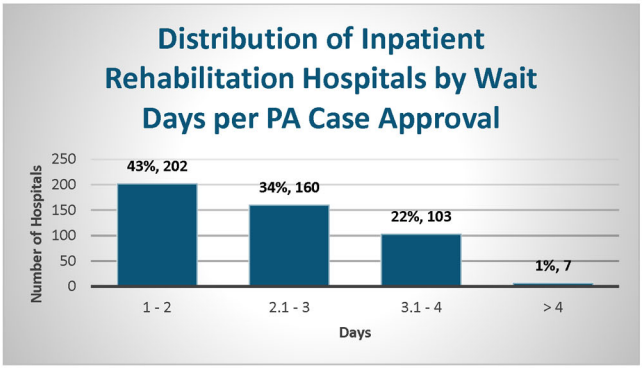


Figure 3. Distribution of Hospitals by wait time for favorable response



A total of 14,152 acute hospital days were spent waiting for requests that were ultimately approved, and 16,774 acute hospital days were spent waiting for denied requests, totaling 30,926 total acute hospital days spent waiting for a determination.

Respondents provided information regarding any additional effort required to seek authorization for 4,823 requests. 35.39% of these requests required additional effort on behalf of the hospital, physician, patient, or family. For requests that required this additional effort, 28.94% were approved for admission as part of the initial request.

The most commonly provided reason for a denial cited by RHUs was that the patient "could be treated at a lower level of care/intensity." The next most common reason was that the patient "does not meet medical necessity criteria." Some respondents indicated multiple rationales for denying payment, so the total of reasons reported exceeds 100%. Finally, 29% (136) of respondents indicated that PA was waived at some point during the survey month by plans or regulators due to the COVID-19 pandemic.

Discussion

PA is being commonly used to deny patient access to RHU care. These determinations are difficult to challenge, since subsequent appeals take additional days, and the patient typically must be transferred more promptly than that. The data presented here shows that even when a MA plan agrees with the request, there are substantial delays in communicating that decision. With these delays and denials, there is an associated risk that patients may be harmed.[viii]

The high frequency of denials suggests that there is a striking disagreement between the medical decisions of practicing rehabilitation physicians and the judgments being rendered by MA plans. Since rehabilitation physicians determined that each of these referred patients required RHU admission, the widespread denials by MA plans calls into question what criteria and expertise plans utilized to render decisions.

Although MA plans are not required to disclose the specific expertise and guidelines they use to reach determinations, respondents reported the primary reason cited for a denied request was that the patient "could be treated at a lower intensity setting of care." This is disconcerting because Medicare has stated that this shall not be a basis for denying RHU coverage, yet denials for this reason appears to be a common practice by MA plans.[ix] Whether a patient could be treated elsewhere is *not* one of the Medicare criteria used by physicians to determine whether the patient is appropriate for inpatient rehabilitation admission. Instead, that determination is made based on whether the patient meets the enumerated Medicare standards, referenced above. This finding is consistent with other surveys that have found that plans utilize improper medical guidelines for PA requests.[x]

If any of the denied patients been enrolled in TM, they likely would have been admitted to the RHU without delay. Instead, because the beneficiary chose to enroll in MA, and due to the opaque review process and criteria utilized by MA plans, the patients were denied access to the RHU.

Medicare regulations require MA plans to issue determinations "as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request."[xi] This survey shows that MA plans consistently *do not* issue determinations as expeditiously as the beneficiary's condition requires, since such a response would be made within minutes to hours, not days. It is likely that in many cases, PA unduly delays the initiation of needed therapeutic interventions and hampers patients' recovery. This

finding is again consistent with other surveys that indicate PA detrimentally impacts clinical outcomes for patients.[xii]

The data presented here represent only one month of activity during the COVID-19 Pandemic and National Public Health Emergency. Since the vast majority of patients seeking admission to an RHU are hospitalized in an acute hospital, each day of delay in transfer represents increased risk and cost. Since MA plans typically pay for hospital admissions on a prospective basis, the immediate additional cost is borne by the hospital.[xiii] As these additional lengths of stay are captured through Medicare's tracking of resource utilization, payments may be increased due to extended length of stay for these patients, costing Medicare additional unnecessary dollars.

Conclusions

MA plans' use of the PA process to delay and deny patient transfers of from acute hospitals to RHUs is a widespread and common problem that can harm patients. PA processes increase administrative burden, delay necessary care, and increase waste and cost to the health care system.

There is an urgent need to eliminate these unnecessary delays in providing care to patients and mitigate denials based on opaque and inconsistent criteria. These needs can be addressed by regulatory and contractual changes to the MA plan operational requirements, and by ensuring that qualified clinicians are making proper and timely determinations about RHU referrals.

References

[i] 42 C.F.R. § 422.101.
[ii] Bob Herman, *Medicare Advantage enrollment soars almost 9%, Axios* (Jan. 18, 2022), https://www.axios.com/medicare-advantage-enrollment-2022-soars-055b6d7d-d2c7-4e69-9eba-420c0ee4ef6e.html.
[iii] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April, 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[iv] American Medical Association, 2021 AMA Prior Authorization (PA) Physician Survey, (February 2022) https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[v] HHS Office of Inspector General (OIG), Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (Sept. 25, 2018) (https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp).
[vi] 42 C.F.R. 412.622.
[vii] CMS Inpatient Rehabilitation Facility Data, General Information Data Set (December 2021), https://data.cms.gov/provider-data/topics/inpatient-rehabilitation-facilities.

[viii] Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge; Dobson & Davanzo (July 2014) (https://amrpa.org/Portals/0/Dobson%20DaVanzo%20Final%20Report%20-%20Patient%20Outcomes%20of%20IRF%20v_%20SNF%20-%207_10_14%20redated.pdf)
[ix] CMS IRF PPS Coverage Requirements Nov. 12, 2009 National Provider Conference Call ("Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.") (Available for download: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage).
[x] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[xi] 42 C.F.R. § 422.572(a).
[xii] American Medical Association, 2020 AMA Prior Authorization (PA) Physician Survey, (April 2021) https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf & https://www.ama-assn.org/system/files/2021-05/prior-authorization-reform-progress-update.pdf.
[xiii] Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices, Robert A. Berenson, Jonathan H. Sunshine, David Helms, and Emily Lawton, Health Affairs 2015 34:8, 1289-1295 (https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1427).

May 17, 2023

The Honorable Richard Blumenthal
Chairman
Senate Homeland Security and Governmental Affairs Committee
Permanent Subcommittee on Investigations
340 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Johnson
Ranking Member
Senate Homeland Security and Governmental Affairs Committee
Permanent Subcommittee on Investigations
340 Dirksen Senate Office Building
Washington, D.C. 20510

Re: MGMA Testimony — "Examining Health Care Denials and Delays in Medicare Advantage" Hearing

Dear Chairman Blumenthal and Ranking Member Johnson:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this important hearing on "Examining Health Care Denials and Delays in Medicare Advantage" and appreciate the opportunity to provide feedback on this critical topic. Challenges associated with obtaining prior authorizations and the myriad of arbitrary requirements associated with them are routinely identified by medical groups as the most challenging and burdensome obstacle to running their practices and delivering high-quality care to patients.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following feedback.

In March 2023, MGMA surveyed over 600 medical groups to better assess the impact that prior authorization in Medicare Advantage (MA) has on the ability to deliver high-quality care. The findings overwhelmingly show that prior authorization in MA is increasingly burdensome for medical group practices and contributes to delays and denials of necessary medical care, increased practice administration costs, and disrupted practice workflows. Specifically, our survey found:

- **When asked to rank payers from most burdensome to least burdensome as it pertains to obtaining prior authorizations, medical groups identified MA plans as the most burdensome, followed by commercial plans, Medicaid, and traditional Medicare.**

- **84% of practices surveyed reported prior authorization requirements for MA had increased in the last 12 months, while less than 1% reported that they had decreased.**
- **58% of practices saw 15% or more of their patients either switch from traditional Medicare to MA or between MA plans.**
- **84% of practices reported having to reauthorize existing Medicare-covered services for those Medicare beneficiaries who've switched plans.**

MGMA has long advocated for prior authorization reform. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*. Our organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the consensus statement was released, medical groups report little progress in any of these areas. Ninety-five percent of group practices report treating patients that are covered by MA plans. This, paired with the recent finding that half of all eligible Medicare beneficiaries are currently enrolled in private MA plans, is why Congress needs to address dangerous prior authorization practices in MA now. Arbitrary and ever-changing prior authorization requirements lead to delays in care and negative health outcomes.

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your colleagues to craft sustainable and commonsense solutions to protect vulnerable patients and allow medical groups to deliver high-quality care. If you have any questions, please contact Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs