

Testimony
of
Visiting Research Professor
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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”
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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 (Biniak 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 Domestic 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 anecdotal 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 authorization 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).

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