Health Care Plan Accountability Update

March 28, 2024-July 1, 2024

TOP NEWS

AHA responds to CMS request for information on Medicare Advantage data

The AHA May 29 submitted a letter to the Centers for Medicare & Medicaid Services responding to a request for information regarding Medicare Advantage data, urging CMS to increase oversight of the program. The AHA raised concerns about certain prior authorization practices, access to post-acute care services, vertical integration of large, national insurers, and the timeliness of insurer payment for services, among other issues, suggesting additional data collection, reporting and policy changes that could help to improve oversight and transparency in these areas. Finally, the association discussed implications for the continued rapid growth in MA enrollment and how it may affect Traditional Medicare, as well as special considerations for rural and critical access hospitals that may be uniquely affected by growing MA penetration.

MEDICARE ADVANTAGE

CMS finalizes Medicare Advantage, Part D payment changes for CY 2025

The Centers for Medicare & Medicaid Services April 1 finalized proposed changes to Medicare Advantage plan capitation rates and Part C and Part D payment policies for calendar year 2025, which the agency estimates will increase MA plan revenues by an average 3.7% from 2024 to 2025. The notice implements expected changes to the Part C risk adjustment model that were finalized in the CY 2024 final rule and are being phased-in over three years, such as transitioning the model to reflect ICD-10 condition categories and using more recent data available for fee-for-service diagnoses and expenditures, in addition to providing technical updates to the methodology for CY 2025. It also finalizes technical updates to the Part C and D star ratings; includes certain adjustments to provide stability for the MA program in Puerto Rico; and implements changes to the standard Part D drug benefit required by the Inflation Reduction Act of 2022, including capping annual out-of-pocket costs for people with Medicare Part D at $2,000 in 2025. CMS also reminds stakeholders to consider submitting comments to the Medicare Advantage Data Request for Information announced in January; comments are due May 29.

For more on the rule, see the CMS fact sheet. AHA members received a Special Bulletin with further details from the final rule.

CMS finalizes rule for 2025 Medicare Advantage, prescription drug plans

The Centers for Medicare & Medicaid Services April 4 finalized changes to the Medicare Advantage and prescription drug programs for contract year 2025 intended to improve access to behavioral health care; cap and standardize MA plan compensation to brokers, including prohibiting volume-based bonuses for enrollment into certain plans; limit the distribution of personal beneficiary data by third-party marketing organizations; ensure that MA plans offer appropriate supplemental benefits; streamline enrollment for

individuals dually eligible for Medicare and Medicaid; and annually review MA utilization management policies for health equity considerations.

Among other changes, the final rule streamlines the appeals process for enrollees if their MA plan terminates coverage for certain post-acute care services; standardizes the appeals process for MA Risk Adjustment Data Validation audit findings; limits out-of-network patient cost-sharing for certain plans serving dually eligible enrollees; and gives Part D plans more flexibility to substitute biosimilars for reference drug products.

CMS releases report on Medicare Advantage coverage disparities based on race, ethnicity and sex

A report from the Centers for Medicare & Medicaid Services examining disparities in care based on race, ethnicity and sex shows that in 2023, clinical care disparities were most common for Native American and African American enrollees. Native American and African American enrollees scored below average on measures in diabetes care, while African Americans additionally scored below average measures in behavioral health, cardiovascular care and care coordination. Results for Asian American, Hispanic, Native Hawaiian or Pacific Islander enrollees were mixed, while scores for male and female MA enrollees on patient experience and clinical care measures were similar.

AHA urges Senate Budget Committee to streamline prior authorization process in hearing on reducing administrative burden in health care

In a statement submitted May 8 for a Senate Budget Committee hearing on reducing administrative burden in health care, AHA urged Congress to streamline the prior authorization process in Medicare Advantage.

AHA urged legislators to make prior authorization requirements simpler and more uniform; conduct more frequent audits to specific MA plans with a history of inappropriate denials or delayed prior authorization response timeframes; establish a provider complaint process for suspected federal violations by MA plans; enforce penalties for MA plans failing to comply with federal rules; and provide clarity on states' role in MA oversight.

Additionally, AHA urged Congress to add prompt payment requirements for MA plans when services are furnished by in-network providers to enrollees and to subject those plans to interest penalties if they fail to make timely payments. AHA also expressed support for legislation supporting gold carding programs, and CMS's proposed rule to standardize claims attachments under HIPAA.

GAO report finds lack of oversight on Medicaid managed care plans' prior authorization requirements for children

A report released May 29 by the Government Accountability Office found a lack of state oversight on Medicaid managed care plans' use of prior authorization for children's health care services. It found that none of the states sampled reviewed a representative sample of commercial Medicaid plans' claim denials or used data to assess "the appropriateness of the full scope of plans' prior authorization decisions." The study underscores concerns that Medicaid managed care plans may implement policies that deny medically necessary care to children enrolled in Medicaid.

HHS announces investigation of MA prior authorization use for post-acute care

The Department of Health and Human Services' Office of Inspector General the week of June 24 announced its intent to investigate Medicare Advantage Organizations' prior authorization denials for post-acute care after a qualifying hospital stay.

"Medicare Advantage plans must cover at least the same services as original Medicare, but Medicare Advantage Organizations (MAOs) may impose additional administrative requirements, such as requiring prior authorization before certain services can be provided," OIG said on its website. "We will examine selected MAOs' processes for reviewing prior authorization requests for post-acute care in long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities. We will also review the extent to which the selected MAOs denied requests for post-acute care and examine the care settings to which patients were discharged from the hospital." OIG expects to issue findings in 2026.

PRIOR AUTHORIZATION

AMA survey shows physicians, patients heavily burdened by prior authorization

A majority of physicians say the prior authorization process continues to have a negative impact on patient outcomes and employee productivity, according to a survey by the American Medical Association. Nearly a quarter of physicians (24%) reported that prior authorization led to an adverse event for a patient, and more than nine in 10 reported prior authorization has a negative impact on patient outcomes (93%) and delays access to care (94%). More than a quarter of physicians (27%) reported prior authorization requests are often or always denied, and more than four in five (87%) reported prior authorization requirements lead to higher overall use of resources that result in unnecessary waste.

Perspective: Continuing the Push for Medicare Coverage that Protects Patient Access

"Slightly more than half of America's eligible Medicare population — more than 33 million people — are enrolled in Medicare Advantage (MA) plans, and they are more likely than those in traditional Medicare to report delays in care due to needed insurance approvals" wrote AHA President and CEO Rick Pollack June 21 in his Perspective column. "The misuse or misapplication of prior authorization requirements has led to dangerous delays in treatment, clinician burnout and waste in the health care system."

NEW RESOURCES

Costs of Caring: New AHA report highlights mounting financial challenges for hospitals

The AHA May 2 released a new report highlighting how hospitals and health systems continue to experience significant financial pressures that challenge their ability to provide 24/7 care for patients and communities.

Podcast: The Impact of Prior Authorization on Clinicians and Patients

Andrea Preisler, AHA senior associate director of administrative simplification policy, Jennifer Cameron, executive director of patient access at Children's National Health System, and David Jacobson, M.D.,

division chief of blood and marrow transplantation at Children's National Hospital, discuss what the new prior authorization rule means for ensuring clinicians can do what they do best: take care of their patients. LISTEN NOW

WORTH A LOOK

'What's My Life Worth?' The Big Business of Denying Medical Care, Alexander Stockton, The New York Times, March 14

When 'Prior Authorization' Becomes a Medical Roadblock, Paula Span, The New York Times, May 25

Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care, Department of Health and Human Services Office of Inspector General

Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill. Chris Hamby, The New York Times, April 7

Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated, Christopher Weaver, Tom McGinty, Anna Wilde Mathews, Mark Maremont, The Wall Street Journal, July 8

LETTERS/ADVISORIES/STATEMENTS

Following NYT Investigation, AHA Urges DOL to Investigate Actions of MultiPlan and Commercial Insurers, April 9

CMS Issues Final Rule for CY 2025 Medicare Advantage, Prescription Drug Plans, April 12

AHA Statement to Senate Budget Committee on Alleviating Administrative Burden in Health Care, May 8

AHA RFI Response to CMS on Medicare Advantage Data and Oversight, May 29