



Statement for the Record

Nicole O. Fallon
Vice President, Integrated Services & Managed Care
LeadingAge

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“Examining Health Care Denials & Delays in Medicare Advantage”

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We are grateful for the opportunity to submit this statement from LeadingAge regarding our nonprofit, mission-driven members' observations, and experiences around the current state of affairs related to Medicare Advantage (MA) plans' inappropriate care denials and delays, as well as other practices that threaten access to care for MA enrollees and others who need health care. We are also pleased to see the subcommittee investigate these critical, access to care issues.

LeadingAge represents more than 5,000 non-profit aging services providers, and other mission-minded aging services organizations. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age.

Through comments to the Centers for Medicare & Medicaid Services (CMS), letters to members of Congress, and other advocacy efforts, LeadingAge and our members have for several years been sounding the alarm on these and other issues that threaten Medicare beneficiaries' access to Medicare services. Unfortunately, our Skilled Nursing Facility (SNF) and Home Health (HH) providers report that inappropriate denials, delays, reduced services, and incomplete care not only continue but are on the rise among some MA plans.

In addition, as MA plans' market share and clout continues to grow, an additional threat to access is looming in the form of inadequate rates for services performed. MA plan contracts increasingly, pay SNFs and HH providers 60-80% of Medicare Fee for Service (FFS) rates while also reducing the number of days of services. Simultaneously, MA plans processes impose significant the administrative burden on providers through laborious and frequent prior authorizations.

Given MA plans' market dominance, providers have no choice but to accept MA plans financially inadequate contracts and terms. Failure to contract could put the provider out of business – yet being in-network threatens their financial viability. These MA plan actions have a direct impact on Medicare beneficiaries and their families as well as consequences for the entire health care system, such as patients backing up in hospital beds.

Failure to address these issues will lead to additional access issues for beneficiaries, as providers close or refuse to contract with these plans because their contract terms and policies are not financially viable.

The following situations threaten beneficiary access to Medicare services when enrolled in an MA plan:

- 1. Inappropriate Care Denials/Service Discontinuations**
 - a. MA Plans Lack Understanding of or Flout Medicare Coverage Requirements
 - b. MA Plans Use Generalized Algorithms Instead of Individualized Assessed Need
 - c. MA Plans Reduce Care Duration
 - d. Lack of Plan Accountability for Safe Transitions and Discharges
- 2. Burdensome and Lengthy Prior Authorization and Appeals Processes Deter Challenges**
- 3. Inadequate Provider Reimbursement Threatens Access Across Health Care System**

Below we provide additional detail and examples of each of these circumstances.

Inappropriate Care/Service Denials and Discontinuations

According to a JAMA article in October 2022,^[1] 99% of MA enrollees are in plans that require prior authorization for some services. While assuring that services provided are effective and needed is a worthy goal, the prior authorization process is often riddled with problems. An April 2022 Office of

Inspector General (OIG) report^[2] found that Medicare Advantage Organizations (MAOs) sometimes delayed or denied MA enrollees access to services, even though the requests met Medicare coverage rules. Most were the result of human error (misplacing submitted documentation or system software programmed incorrectly). OIG also reports that MAOs overturned about 75% of their own prior authorization denials on appeal.

MA plans require prior authorizations for many services, especially post-acute care (PAC) services from SNFs and Home Health providers. CMS has said for basic Medicare A & B services, MA plans must follow the same coverage criteria as traditional Medicare and plans cannot add their own internal criteria to determine coverage. In other words, if a service would be approved by traditional fee-for-service (FFS) Medicare, it should also be approved by the plan. However, as the OIG reports, MA prior authorization requirements often result in care delays or denials for MA enrollees in need of essential care – which would have been covered under Medicare FFS.

Based upon MA plan determinations our providers have experienced, it is fair to conclude that some MA plans either do not understand Medicare coverage requirements or choose to flout these requirements. This is concerning, but sadly, not surprising; MA plan prior authorization reviewers have not been required to have expertise in post-acute care, which has changed in a recent MA final rule. Instead, LeadingAge providers see a trend of plans focusing on the enrollee's need for therapy vs. other daily skilled services. For example, a plan might indicate an enrollee no longer needs skilled care because they no longer need therapy or are no longer making progress^[3], but fail to acknowledge other skilled needs such as the person is still being tube fed for a significant portion of their daily calorie requirements, or is being treated for decubitus ulcers that are stage 3 or higher. Plans also seem to not be evaluating whether as a practical matter, is it more cost effective and efficient to deliver these services in a SNF. In addition, some MA plans do not appear to consider whether the individual has adequate family caregiver support to safely return home.

LeadingAge providers have observed increasing denials or discontinuation of services for patients in the following circumstances:

Denials or discontinuation based on ability to ambulate: Plans are denying skilled care when an individual can ambulate just a few feet (50-150). This is not enough to get them to the grocery store or be able to care for themselves. They may be able to walk up a few steps, but not enough to get into their home. Plans do not consider these limitations in determining continued need for coverage.

- **Examples from LeadingAge members:** “Transfers from the acute care setting are most certain to be denied if the patient is walking more than 100 feet, even with the existence of several rest breaks. If the patient lives in an assisted living facility (ALF), we can expect the authorization to be denied if the patient is walking more than 50 feet. These decisions are made without consideration of the patient’s baseline, their medical challenges or their current support system (or care hours provided in an ALF).” It should be noted that the definition of assisted living varies greatly across states, as it is regulated on the state level.”
- “One SNF had a 68-year-old with a subdural head bleed, cognitive challenges but because she could ambulate 100 feet, NaviHealth (a third-party contractor for the plan that makes coverage determinations) denied skilled care. The person appealed the decision. It took 3 days to win the appeal and an additional 4 days for the plan to tell

NaviHealth it was approved. The woman had to stay in the hospital an additional week as this process played out. “

- “A resident with a new feeding tube may find his/her coverage terminated when he/she is able to walk 150 feet while he/she is attempting to transition to 25% PO intake [to take medications by mouth] and bolus feedings (use of a catheter syringe to distribute nutrition through a feeding tube) with the assistance of speech therapy. Speech therapy does not appear to be a respected discipline in the review process.”
- “All Medicare Advantage plans are inclined to terminate services for residents with a new colostomy, new feeding tube or indwelling Foley catheter when they are capable of walking 50 feet and have a “teachable party” at home. Quite often the “teachable party” is the resident’s elderly spouse.”

Discontinuation of services for “lack of progress”: Skilled care encompasses a breadth of services, including – not limited to – physical therapy. In fact, CMS’ reimbursement systems for SNFs and HH were updated in recent years to ensure they adequately paid for the resources to deliver therapy services and other care that medically complex individuals require. Our providers are seeing MA plans make determinations based exclusively on a patient’s therapy notes without consideration of their need for medical management; and deny or discontinue care due to lack of progress in therapy, which is in direct violation of the [Jimmo v. Sebelius settlement/CMS policy](#)

- Cancer patients receiving treatment find their skilled service coverage terminated when they cannot participate to an expected level of therapy due to the adverse effects of the treatment. These residents must choose between therapy and treatment.
- “Under traditional Medicare, we are able to continue to provide skilled care to residents under Part A coverage as per the discretion of the professional therapists due to advancement of skills. Under a Managed Care situation, residents are more often than not, cut from coverage due to ‘progress’ not occurring quickly enough. This, in turn, often places the residents, families, and caregivers in tough situations financially, as they are required to enter a private pay status. Appeals are initiated fairly frequently, but not often with success.”

CMS, in its latest final MA rule (CMS-4021-F), reinforces that the expectation is that MA plans follow Medicare coverage criteria, including abiding by the Medicare laws, regulations, and national and local coverage determinations. The Jimmo v. Sebelius legal settlement is such a requirement. The Jimmo v. Sebelius settlement agreement states that a beneficiary’s lack of potential for improvement or restoration cannot be the sole reason for denying skilled care. This is also supported in 42 CFR Part 409.32 “The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.” Regrettably, SNFs and HHAs have witnessed plans increasingly denying care for this cited reason.

Discontinuation or only partial coverage of a full course of IV medications or nutrition. Intravenous medications must be inserted by a nurse. Some IV medications are antibiotics given to fight an infection and others manage a person’s pain. Some individuals are unable to eat on their own so require IV nutrition in addition to daily nursing care and/or rehabilitation. LeadingAge members around the country report that MA plans increasingly deny coverage for a full course of IV treatment.

- “Aetna Medicare Advantage case managers may terminate skilled services for residents receiving IV medications daily when they are able to walk 50 feet and transfer to a car for outpatient infusions.”
- MA plan denied person who can’t eat on their own and requires IV nutrition, plus other nursing, and rehabilitation care. These are all skilled care services under Medicare.

Denials or discontinuations based upon an algorithm not an individual’s needs. MA plans are increasingly using third parties (PAC management companies) to manage post-acute services. While there is nothing inherently wrong with contracting out for specialized expertise, MA plans structure contractors’ incentives to maximize cost savings and reduce the use of post-acute care, often to beneficiaries’ detriment. Some of these contractors use generalized data or algorithms to determine the need for and duration of care with no consideration of the MA enrollee’s specific circumstances. Plans increasingly use algorithms to challenge providers’ in-person patient assessments and require them, under the threat of not being paid, to downgrade the patients’ level of care. Medicare Advantage Organizations (MAOs) have other tools to reduce costs, such as use of their three-day stay waiver or encouraging more community admissions to HH to stabilize individuals with chronic conditions and avoid unnecessary hospitalizations. However, rather than take advantage of these resources, MA plans often opt to just eliminate SNF or HH use and shift the care burden to the individual or family members.

Lack Of Transparency In Coverage Determinations: Transparency in how plans make coverage determinations is essential to ensure plans meet Medicare coverage requirements and deliver equitable access to Medicare services. These algorithms, described above, are a black box. In one example provided by a member, the NaviHealth nH Predict document, which is derived from an algorithm, noted that the average length of stay in SNF for a person similar to the enrollee is 13.2 days. The plan or its third-party contractor (in this case NaviHealth) use this report to determine the individual’s discharge date based upon the data which is generalized experience. In this case, the algorithm indicated, the individual should be discharged after 13.2 days even though the patient still required IV medication regimen for a prescribed additional 16 days. Under traditional Medicare FFS, the patient would have received coverage for all the days that they required IV medication. But the plan did not cover it.

Members also tell us that it is not clear where the third-party contractors obtain some of their data on the patients especially related to cognition because the provider does not submit, nor is asked for, BIMS (Brief Interview for Mental Status) scores, which would tie to this metric. Our position is supported by the home health regulation at 42 CFR Section 409.44, which explicitly states, *“A coverage denial is not made solely on the basis of the reviewer’s general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regard the beneficiary’s individual need for care.”*

As one provider member noted, “The thing missing from their tool is the true impact that the resident’s other comorbidities have on the resident’s functional status. They also do not factor in acute medical changes that the resident may be experiencing (while in the SNF) as an extension of the primary medical diagnosis resulting in resident instability. Instead, they tend to stick to the last covered day identified in their model. They may approve another 1-2 days but what is going to change in 1-2 days???”

Other common denials or early terminations of services:

- **Unrealistic documentation submission timelines not met.** A prior authorization was submitted on a Friday. The plan told hospital at 1 p.m. to fax updates same day (with a 4 p.m. deadline). Updates were not received by 4 p.m., so plan denied the care and said it wouldn't reconsider. The denial came through on a Monday. Person remained in hospital while the denial was appealed through Wednesday at \$700-900 per day private pay rate. This was just a documentation issue. Plan did nothing with authorization over the weekend but expected provider to submit data same day as denial.
- "Residents who have been prescribed non-weight bearing status find their skilled service coverage terminated after 1 -2 weeks, which requires them to pay privately for skilled services if they remain non-weight-bearing for more than 1-2 weeks."
- "The most affected and unfortunate group are the SNF residents who are recovering from a stroke. Their average length of stay is approximately sixteen (16) days. Skilled services are most often terminated when their progress slows down as opposed to when they reach a well-defined plateau."

Lack of Plan Accountability for Safe Transitions and Discharges Another concern related to access to care is early terminations of care and/or poor care transitions. SNFs are required to ensure safe discharges for all in their care. The difference between discharge practice in traditional Medicare and MA is striking. In traditional Medicare, the SNF determines the appropriate discharge timing based upon Medicare coverage requirements, taking into account the individual's care plan and in consultation with the patient and their family. For MA beneficiaries, plans – not the SNFs – make the determination to terminate SNF coverage. Beneficiaries are issued a Notice of Medicare Non-Coverage (NOMNC); these determinations often fail to consider all of the challenges the individual will face returning home (e.g. five steps must be taken to enter the house but person can manage only one step) including the availability of family caregiver support (e.g. frail spouse unable to assist, children live far away and can't help purchase groceries or pick up medications).

Our members say it is not uncommon for an enrollee to receive a NOMNC, for example, late on a Friday afternoon, requiring a Sunday morning discharge. For several reasons, discharging on a weekend or holiday may not be practical or safe for a beneficiary/enrollee. Many residents will need services, such as HH or other personal care, to be delivered at home. Therefore, upon receiving notice of discharge, an individual and their family needs time to evaluate their care-at-home options (e.g. choose a HH provider, order equipment), confirm that a preferred provider has capacity to help, and complete the intake process necessary for services to begin. In addition to arranging services, soon-to-discharge Medicare Advantage enrollees may need prior authorization for durable medical equipment, such as a hospital bed or oxygen concentrator, but many plans don't conduct prior authorizations over a weekend. The result: delay in obtaining often critical items, which can impede recovery or possibly lead to a setback.

In many cases, it may not be possible to complete all the necessary arrangements on a weekend, even with the facility's support of the resident through discharge planning, referrals, and development of the discharge summary that supports coordination of post-discharge care. Therefore, in some cases, the SNF will disagree with the MA plan determination to end coverage, and yet, the SNF is still obligated to ensure a safe discharge often with limited notice. In cases such as this, the financial burden falls to the family, if they can afford to pay. If they cannot, the SNF assumes financial responsibility.

Beneficiary Example: To illustrate these challenges, consider this example shared by a family member in Minnesota whose wife received 6 weeks of care in a LeadingAge member SNF. While they were pleased with the SNF care they received, the couple were surprised by the short notice they received regarding a discharge date for the wife, especially given the fact that it was a holiday weekend when few services were accessible. They received the NOMNC on a Wednesday afternoon indicating her discharge would be Friday morning (less than 48 hours). They had no way to arrange HH services on such short notice especially because it was the week between Christmas and New Year's, and the couple and the SNF staff also didn't believe the SNF resident was ready to go home. The husband caregiver, who is 83 years old, felt the 2-calendar day notice was inadequate and should have been at least 3 days. Due to their concerns, the couple paid out of pocket privately for two additional days of SNF care (e.g. roughly \$1000) after their appeal was denied. The wife then returned home on Jan. 2 with the 83-year-old husband serving as her home health aide. She fell that night and he was unable to pick her up off the floor requiring him to call the fire department for help. He was told by SNF social work staff that "premature discharges" are common among MA plans. He asked us if we could advocate for more notice to ensure others don't encounter similar situations.

This is an important area where MA plans and providers need to better communicate, and plans should share accountability for safe discharges for their MA enrollees. Plans should be required to provide beneficiaries with ample notice prior to a discharge to preclude beneficiaries having to immediately appeal, pay out of pocket or endure an unexpected discharge without proper services in place for their care transition. It is unclear why some plans are not using their care coordinators to assist enrollees with establishing services and pursuing necessary authorizations to secure needed equipment and ensure safe transitions and discharges.

Burdensome and Lengthy Prior Authorization and Appeals Processes Deter Challenges

LeadingAge providers witness daily MA plan denials for care that would be covered under traditional Medicare. Beneficiaries and their families are often reluctant to appeal and there are no assurances that these appeals will be successful. Most PAC services require prior authorization.

Too much process, more paperwork than needed. To obtain prior authorization for initial or continued PAC services, providers must submit reams of documentation (often 40-50 pages per request), in different formats, composition, and methods to comply with each MA plan's submission requirements. The timeframes for receiving the necessary prior authorization from the MAO can vary from one to as many as 30 days. This timeline extends further when requests are made over weekends and holidays because many plans don't staff their prior authorization processes seven days a week – even though care is still needed. If coverage is denied, the appeals process adds additional waiting time. The impact is that the MA enrollee is hospitalized for a longer time before initiating skilled care, rehabilitation services, or home health care. If a PAC provider accepts the patient while authorization is pending, the provider must issue a Notice of Medicare Non-Coverage to the beneficiary because it is unknown whether the service will be covered by the plan. This puts both the provider and the beneficiary in financial jeopardy if service isn't ultimately authorized by the plan.

When approvals are granted, they are often for only a short duration (e.g., 2 HH visits or 5 to 7 SNF days) and the provider must again submit reams of documentation to receive authorization to continue needed services. When these are approved, it is often for only a few days at a time or an additional 1-2 HH visits. Prior authorization processes place significant ethical and administrative burdens on providers, and stresses and costs on beneficiaries.

In addition, when services are denied, many MA plans are using what appear to be form letters offering little to no detail about the cause for denial. One LeadingAge member reports that the most frequent denial notice received states, “Based on Medicare guidelines and the information we have about your condition, you don’t meet all the requirements. The requirements are: (1) you need skilled nursing care or rehabilitation services every day AND (2) the services are reasonable and necessary for the treatment of your illness. You can receive the care you need in another setting, such as home, a long-term care facility, or other outpatient setting.” We know that some plans are wrongfully denying care and yet based upon the above language from a denial notice, believe they are complying with Medicare coverage criteria. For this reason, we are not confident that plan behavior will change without further education and/or consequence.

The path to resolving inappropriate denials is for the individual to appeal, but this is not a simple matter. The current compliance system requires beneficiary/provider/family to go through potentially multiple layers of appeals which are time consuming, can disrupt care, and require providers to dedicate additional staffing resources to these efforts.

Issues of equity and access: As we consider ways to ensure health care equity, the current appeals process demands further scrutiny. It places undue burden on families with limited means because if they appeal a decision that is further denied by the plan, they are then on the hook financially to pay for the uncovered services received while awaiting an appeal decision. Many cannot afford to take that chance. One SNF social worker noted about 20% of families/enrollees decide not to appeal for this reason; others opt out because they are daunted by the complexity of the process and lack of knowledge “how all this works.” How can we simplify the process and provide more real-time decision making to ensure access to care occurs close to the time the care is needed, not months or years later?

In some cases, even providers are deterred from making an appeal. In one case, a frail, hospitalized 92-year-old woman was ready for discharge but still required help getting out of bed. Her doctor believed she could benefit from PAC SNF rehabilitation to improve her function. However, he decided to abandon his referral because “plan prior authorization determinations take too long”—extending the hospital stay—and he believed the plan would ultimately deny coverage for the service even when warranted. The doctor concluded the delay would be bad for the patient leading to further deterioration and gave up on the prior authorization request. Prior authorization delays prevent timely access to medically necessary care often resulting in MA enrollees receiving less care.

One Wisconsin provider describes their experience and that of beneficiaries/family members with the lengthy MA appeals process: “The standard Medicare SNF appeal process is ineffective and may be construed to favor the decision of the Medicare Advantage plan as functional data is utilized for decision-making. Most of our residents with Medicare Advantage plans appeal their discharge, but few of our residents covered under Medicare Part A appeal our decision as they are able to participate in the decision to terminate skilled services.

- Appeals for transfers denied from the acute care setting to the SNF are reviewed within a verbal peer-to-peer (physician-to-physician) interaction whereas the treating physician has the ability to challenge the medical director representing the Medicare Advantage plan. A large percentage of these denials are overturned through this process.
- The initial denial of continued SNF care, from our observation, is based solely upon the functional data provided by the skilled nursing facility. The resident or family member provides

their justification for appealing the decision to terminate services to a customer service representative who transcribes their statement and refers it to the review team staffed by a third-party consultant (Livanta). There is no opportunity for a peer-to-peer advocacy for the resident. A response is generated within 48 hours of the appeal. It is rare to find that decision has been overturned. The second level (reconsideration) appeal basically follows the same process. Again, there is no opportunity for a peer-to-peer advocacy for the resident. This level of appeal is stated to generate a response within sixty (60) days, of which time the resident is responsible for paying for services if he/she chooses to remain in the facility. Chances to have a decision overturned at this level are more likely, but rare. The appeal process moves on to a third level which finally affords the resident an opportunity to include medical advocates in the presence of an administrative law judge. Few residents take advantage of this level of appeal.”

The appeals process needs to be simplified, shortened and permit engagement from provider advocates to ensure more real-time access to medically necessary care.

Inadequate Provider Reimbursement Threatens Access Across Health Care System

Another threat to Medicare beneficiaries’ access to care and services is inadequate provider reimbursement from MA plans. MA plans contract with healthcare providers outlining how they will be paid for services and the policies providers must follow. Across the country, MA plans via contracts are reducing providers’ overall revenue in three key ways: 1) pay providers less for each unit of service (e.g., days, visits); 2) authorize fewer units of services; and 3) categorize an enrollee at a lower level of care than the enrollee’s assessment indicates, resulting in a lower provider unit payment even when it takes more resources to care for the individual. These are not value-based contracting terms that drive quality care, but merely mechanisms to pay providers less, generating profits for the MA plan. If they continue, they will place further strain on MA enrollees ability to timely access needed care and services.

The plans largely control who is in their networks and the nature of the contracts. There is little, if any “negotiation” with the MA plans. They will tell providers to “take it or leave it”. In this area CMS’s hands are tied. Section 1854 (6)(B)(iii) of the Social Security Act states that, “In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary’s authority under this part.” The intent of this provision is to promote competition. However, it was drafted in a time when MA comprised only a small fraction of the marketplace. It is out of step with current market realities and enrollment patterns and needs to be amended to ensure adequate provider payments and beneficiary access to high quality providers. It is this provision in law that prevents CMS from intervening in provider-plan contractual arrangements, from setting a provider rate floor to ensure adequacy and continued care access, and even requiring plans to meet quality criteria for provider networks.

In addition, MA enrollees seeking PAC services face a number of financing, access, and quality challenges that are rooted in contracting policies and procedures.

Payments don’t always cover costs but providers in some markets have no meaningful choice about whether to participate. Low provider payment is the number one concern of LeadingAge members including skilled nursing facilities (SNF), home health agencies (HHAs), and hospice organizations.^[4] They

have watched their payments from MA plans diminish in the past 5-10 years at the same time enrollment in MA has grown 21% over the past 10 years. In general, SNF and HH providers report that MA plan contracts only reimburse them at 60-80% of Medicare FFS rates – while expecting more from providers.

MedPAC assumes that providers accept these contracts because payments from MA plans are adequate^[5]. This does not reflect the reality providers face in many markets where they have no choice but to contract because the MA plan enrollment represents 50% or more of all beneficiaries. In some cases, a single plan controls more than 50% of the market. Choosing not to contract would result in insufficient service volume, so they sign contracts with inadequate payment terms, creating a financial death spiral.

Examples: one LeadingAge member SNF reports that they are paid a flat rate (75% of typical Medicare FFS payment) by the plan regardless of the patient's acuity providing a financial disincentive for the provider to accept a referral of one of the plans' enrollees. Another SNF indicated that they are expected to accept MA rates equal to the state Medicaid rates which, experts agree, don't begin to cover the costs of that custodial care – let alone the more intense skilled care provided through SNFs and HHAs. This SNF is a preferred referral partner for the large hospital system in its area because it is a high-quality, 24/7 responsive provider and helps patients return home safely and quickly. The plan refused to consider increasing the provider's proposed rate and instead pursued contracting with less sophisticated SNF providers. We have reports that HH agencies in certain markets refuse to accept referrals for MA enrollees due to the low payments offered by the MA plans. It is resulting in MA enrollees backing up within hospitals and health systems in markets around the country where MA enrollment is high.

Even when contract terms appear more reasonable, plans sometimes find ways to skirt contract provisions. For example, though a contract may offer tiered rates based on acuity, the plan never approves payment beyond the lowest tier. Another contract indicates it will pay when an individual's IV antibiotic cost exceeds \$100/day. However, the patient is prescribed two medications for this purpose totaling \$150/day and because each medication is less than \$100, the provider isn't reimbursed to cover their actual costs. Medicare FFS will pay \$140-160 for these meds. Under MA, the provider loses up to \$60 per day when they care for an individual who needs IV medication.

HHAs are regularly paid per home health (HH) visit by MA plans rather than for a 30-day episode of care, as is the case in Medicare FFS, where the HHA determines the number of visits necessary to achieve the enrollee's goals within the episodic payment.

Plans use additional tools to deny provider payments for services previously approved and delivered.

Once services have been authorized and provided, the next challenge for providers is getting the claims processed and paid. MA plans will deny claims for services previously authorized, audit claims years after the fact and claw back funds often claiming lack of documentation and some plans don't pay timely.

- **Inconsistency:** Providers report that they can bill a claim one month and have it paid, but next month submit a claim the same way and it is denied. Often, denials seem random. Denied claims require repeated calls to the plan to resolve and hours on hold.
- **Not Paid Timely:** Some PAC providers note that clean claims are not paid in a timely way. Unlike Medicare FFS claims which must pay within 14 days of a clean claim, one provider indicated that MA plans are taking six to eight weeks to pay a clean claim submission. MA regulations require

MA plans to pay clean claims from in-network providers within 30 days of receipt or pay interest on the claim to the provider; and pay non-contracted providers within 60 days. Unfortunately, there is no recourse or process for providers when MAOs fail to meet this requirement.

- **Excessive audits and clawbacks:** PAC providers report that plans refuse to pay for some pre-authorized services or in other cases, pay but then, upon audit, require the provider to return payment for services appropriately authorized. Sometimes these recoupments of payment occur years after the service was delivered. One LeadingAge provider had a plan take back a payment five years after the service was authorized and the claim paid. In contrast, Medicare auditors reviewing FFS claims are limited to three calendar years. Providers can appeal, and often win, but this significantly delays final receipt of payment and uses costly staff time— yet another huge administrative burden. The OIG report noted in its April 2022 report that 18% of provider payments denied by MAOs met Medicare coverage rules and the MAO’s billing rules. Further, the OIG notes that in 2018 MAOs denied 56.2 million payment requests overall (9.5%) in the MA program. Most of these denials were the result of an error during processing (e.g. overlooking a document) and system processing errors. But these practices continue with impunity. One provider reports a four-foot stack of full or partial payment denials, following audit, that staff must go through and prove (for a second time) that the claim should be paid for a service rendered. Providers have little recourse and often give up because they don’t have the resources to repeatedly pursue claims.

OIG has recommended that CMS take steps to clarify MA plans’ responsibility related to appropriate clinical criteria, update its audit protocols to address denials and appeals and direct MAOs to take steps to correct their payment processing errors. Medicare beneficiaries should receive the care they need, and providers should be paid to provide it in predictable, fair, and straightforward ways.

The Bottom Line

As a result of these contracting, access, quality, and payment shortcomings, MA enrollees are not able to obtain the benefits they think they signed up for, especially troublesome when they are in crisis and need post-acute care.

The cumulative consequences of these concerns are that MA enrollees are often denied needed services unless they pay out of pocket (which isn’t an option for many families), have limited choices of providers that may best fit their needs, and often don’t realize this until they have an immediate need for post-acute care. These enrollees are often denied basic Medicare post-acute services, resulting in unnecessary or extended hospitalizations. The net effect for PAC providers is that low payment rates, extreme administrative burdens, increased costs, and frequent denials of needed care jeopardizes their continued existence and quality of care, which impacts the entire health care system. With limited provider networks, access to high-quality care— particularly in rural areas— is shrinking. Providers aren’t being greedy, but like any business, expect and deserve to be paid for services rendered so they can pay their staff and other bills. If they continue to be underpaid or have payments clawed back by MA plans, they will have no choice but to decline MA contracts and/or close their doors.

While MA plans were held harmless for quality ratings during the pandemic, quality ratings have now been reinstated. In 2023, the number of plans with at least four stars has dropped by 16%. Only 51% of plans are now at or above four stars, down from 67%. Overall, plan performance declined slightly on

several measures, but the biggest performance changes showed more members choosing to leave the plan, having challenges getting appointments and care quickly, or getting needed care.^[6]

Recommendations: What needs to change

In this section, we offer actions HHS/CMS or Congress could take to address the barriers described above to ensure and improve access to post-acute care for MA beneficiaries and better value for the taxpayers who foot the bill for the Medicare program. For more details, LeadingAge provided [detailed recommendations](#) to CMS with specific examples of problems and potential solutions.

1. MAKE PAYMENT RATES ADEQUATE AND PREDICTABLE.

- **Establish a rate floor:** Congress must authorize CMS to ensure provider rate adequacy and access to Medicare services. At present, the non-interference clause prevents CMS from taking such actions. Congress should amend this clause to permit the HHS Secretary to establish a rate floor that plans must pay unless the plan can negotiate a pay-for-performance or other value-based arrangement (VBA) with the provider. CMS could ensure rate adequacy by establishing Medicare FFS rates as the floor for payment. Plans would either pay that rate or negotiate a VBA that is advantageous for the plan and the provider.
- **Limit number of audits plans can initiate and the lookback period.** Medicare FFS allows for a sample of claims to be audited and limits the lookback period for these audits.^[7] CMS should establish similar guardrails for MA plans to follow regarding provider payments to ensure greater predictability and reduce administrative burden on providers. Auditors – whether in the FFS program or in the MA program – should also be held to the same timeliness standards that providers are held to.
- **Prohibit plans from requiring providers to downgrade to a lower level of care than indicated by assessment as a condition of payment.** Providers conduct required, standardized assessments for all Medicare beneficiaries to determine the level of their PAC needs and the corresponding payment. Some plans instruct PAC providers to submit a claim for a lower level of care than the assessment indicates and tell the provider they will not be paid if they submit a claim at the assessed level.

2. ADDRESS CHALLENGES WITH PRIOR AUTHORIZATION AND SIMPLIFY APPEALS PROCESS TO ENSURE BENEFICIARIES RECEIVE THE CARE THEY NEED.

- **Standardize the prior authorization process for traditional Medicare A & B benefits that all MA plans must use to achieve uniformity, consistency and simplicity.** A standardized form or single portal offers three key benefits: 1) it ensures plans are complying with traditional Medicare coverage determination requirements; 2) it reduces administrative burden on providers by eliminating a multitude of forms and processes; and 3) it could expedite the review process at the plan level as critical information would be provided in a uniform format making it easier for a plan reviewer to confirm coverage criteria are met. This standardization could be achieved by creating a single portal, which in turn could standardize other common plan processes, such as provider credentialing/re-credentialing, claims processing, and appeals, etc. The portal data could offer CMS a better view into care delivery patterns in MA plans and

across geographies and identify ways to guide improvement to ensure MA enrollees do not experience poorer outcomes than their Medicare FFS counterparts.

- **Require plans to conduct prior authorization reviews 365 days per year or authorize service automatically during weekends and holidays.** Requiring prior authorizations is a choice MA plans make for certain services and equipment. Beneficiaries, in contrast, often do not have a choice when they are going to need medically necessary care. Therefore, if plans require a pre-authorization of services, then they must ensure those decisions can be made without delay. If MA organizations (MAOs) aren't willing to staff these processes over weekends/holidays, then medically necessary services, at these times, should be subject to automatic approval and payment for all services provided until a coverage determination is made by the plan. Delayed care is denied care.
- **Establish penalties for plans that fail to meet the established prior authorization timeliness standards.** CMS should establish shorter turnaround times for prior authorizations and plans should be subject to penalties when they fail to meet these timeframes. MA enrollees should not linger in a hospital awaiting a determination for PAC services already ordered by a licensed provider. The rule of thumb is for every day in a hospital, it takes 3 to 4 days for the patient to return to their pre-hospitalization function. Therefore, all prior authorizations for PAC should be expedited with decisions made within no more than 24-48 hours after request. But MA plans aren't motivated for quick discharges from the hospital because the hospital is paid a flat rate regardless of the number of days a patient remains in the hospital, whereas PAC services are a new cost to MAOs. No beneficiary should sit in a hospital because a timely determination of coverage has not been made by the MAO. We support CMS's "Advancing Interoperability and Improving Prior Authorization Processes" proposed rule (CMS-0057-P) proposal to reduce standard prior authorizations timeframes to no more than seven calendar days but encourage CMS to reduce expedited reviews to no more than 24-48 hours.
- **Simplify the appeals process for beneficiaries including requiring plans to issue Detailed Explanation of Non-Coverage (DENC) instead of Notice of Medicare Non-Coverage.** Beneficiaries and their families indicate they are intimidated by the appeal process, don't feel they know enough or can't take the financial risk that their appeal won't be successful. The appeals process must be demystified and simplified. This begins with the information the plan provides when denying or discontinuing services. When plans deny or discontinue coverage for services, the notice should include the person-specific reason (e.g. diagnoses was missing from documentation) for the denial, not a generic notice (e.g., insufficient information to support approval). CMS should provide guidance on the required specificity to ensure the information is actionable and not a form letter. This approach could expedite a successful readmission or help a patient determine if the decision warrants appeal.

In addition, we encourage CMS to look at other ways to simplify the appeal process for beneficiaries and providers who support their efforts. CMS might also consider amending the DENC or Notice of Medicare Non-Coverage notices to include a check box for the provider and/or enrollee to indicate if they do not agree with the determination but perhaps feel they are unable to appeal due to financial risk. This approach would

require the document to then be submitted to CMS for tracking purposes. It might help in identifying plans who are struggling with access to care issues. Or who need additional oversight or training on traditional Medicare coverage requirements.

- **Require plans to be responsible for safe discharges home when coverage is denied.** Given that the MA plans make the determinations for when services are denied or discontinued for their enrollees, CMS should clarify that MA plans are accountable for ensuring safe discharges and transitions of care for their enrollees, and that MAO care coordinators are expected to assist enrollees with establishing any needed service(s) or equipment, and obtaining any required prior authorizations for the next stage of their recovery.
- **Require plans to report data on prior authorizations.** MA plans should report annual plan-level information on certain prior authorization metrics to CMS including: the services for which it requires prior authorizations (PAs); the percentage of PAs approved by category of service (e.g., post-acute care, hospital, physician); the percentage of PAs denied, approved following appeal; and average time from PA request to determination for both standard and expedited requests. A link to a plan's annual report should be included in the Medicare plan finder tool to assist beneficiaries in making better informed enrollment decisions. CMS could also publish annual plan complaint data, including total number of complaints a plan received and group the complaints by type (e.g., marketing, access to care/denials, availability and access to network providers, etc.). This information could be helpful to consumers as they make choices and it rewards plans who don't use deceptive marketing practices, egregiously deny access to care and maintain up-to-date network information.
- **Enhance current CMS oversight activities by establishing a channel for providers to confidentially submit non-compliance issues.** Providers offer an on-the-ground set of eyes and ears and know in real time when a plan is not complying with standard Medicare coverage practices. Establishing a channel for providers to confidentially notify CMS of these non-compliance issues could serve as a check and balance in the system, as so few appeals are pursued due to beneficiary/family reluctance. It might be as simple as allowing providers to submit identified issues via current channels such as 1-800-Medicare (e.g. press 2 if you are a provider reporting on a compliance issue) or online (with or without documentation) by creating a provider reporting intake form. The current system lacks a clear mechanism for providers to report issues. Beneficiaries need real-time accuracy and access, not delayed compliance via audits. Ensuring providers' ability to submit feedback would bring another, valuable set of eyes and ears on the ground to ensure compliance and identify patterns of non-compliance earlier. Such a complaint resolution process would be most effective, if complaints were researched and responded to within prescribed time frames depending upon the reason for the complaint. For example, issues that directly impact a beneficiary's access to medically necessary care whether because of an inappropriate coverage denial or network inadequacy issue should have a short response time (e.g., few days to a week). Delayed care has consequences for all Medicare beneficiaries. Marketing complaints may warrant a longer time to research and address.

We appreciate the opportunity to share our concerns and our providers' examples of MA plan practices related to coverage determination delays and denials and its effects on MA enrollee access to care. We encourage Congress to take swift action to address these issues so MA enrollees can reap the benefits of MA plans without the harm. Please let us know how we can further support your endeavors to address the current issues and inequities.

^[1] "Improving Prior Authorization in Medicare Advantage", Journal of the American Medical Association, October 2022 as accessed at: <https://jamanetwork.com/journals/jama/article-abstract/2797197>

^[2] Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care", Office of the Inspector General, April 27, 2022, as accessed at: <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>

^[3] No longer making progress is not a valid reason for a denial as found in *Jimmo v. Sebelius*; many beneficiaries in home health remain eligible for ongoing maintenance therapy and are not provided this care by MA plans. SNF patients with certain diagnoses may be unable to improve but still benefit from maintenance therapy or assistance that reduces further deterioration.

^[4] Hospice organizations currently only participate in the Medicare Advantage program through the Value-Based Insurance Design (VBID) demonstration at the Center for Medicare and Medicaid Innovation (CMMI). They are already experiencing issues with contracting for payment in this demonstration and are concerned that their future will resemble what our SNF and HHA members are currently experiencing.

^[5] Skilled nursing facility services: Assessing payment adequacy and updating payments, MedPAC, March 2022 https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch7_SEC.pdf

^[6] <https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings>

^[7] Medicare Fee-For-Service Recovery Audit Program, 1/29/2018 : <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/ADR-Limits-Institutional-Provider-Facilities-January-29-2018.pdf>