Federation of American Hospitals®

Enhancing Transparency and Accountability in Medicare Advantage: FAH Proposes New Performance Measure

THE PROBLEM

Medicare Advantage (MA) plans market to seniors with promises of lower or no medigap premiums or cost sharing and extra benefits, like meal delivery and gym memberships. However, the gap between expectations of blanket coverage and the reality when beneficiaries require care often leaves beneficiaries disappointed.

The problem of benefit transparency extends beyond marketing practices, as beneficiaries frequently do not know up front whether a medically necessary treatment will or won't be covered by insurers. While MA plans often overturn their own initial prior authorization denials, the process to appeal and seek reversal is complex and time consuming for both beneficiaries and those providing care.

Furthermore, there's no accountability for insurers when they arbitrarily delay or deny access to treatment that a doctor and patient agree is most appropriate. Given the extent to which denials are overturned, it is evident that insurers are intentionally using practices that slow the system down or enable them to avoid payment for necessary care. Unfortunately, there is no reporting or measurement of the initial delay or denial of care, so there is no transparency on the effects of these insurance practices.

This pattern of delayed or denied care has been singled out by the Medicare Payment Advisory Commission (MedPAC), members of Congress, CMS, and the Department of Health and Human Services' Office of the Inspector General (OIG).

MedPAC's analysis of CMS-published MA data showed that MA plans overturned their initial denials 80 percent of the time in 2021.

A 2022 OIG report revealed that 13 percent of prior authorization denials by MA plans would have been covered by traditional fee-for-service Medicare, affecting 26.4 million beneficiaries in MA in 2021.

In another 2018 report on prior authorization abuses, the OIG found that MA plans often overturned 75 percent of their own initial denials during 2014-2016.

THE REMEDY

To expose these problematic insurance practices, and hold health plans accountable, FAH recommends CMS include in the Medicare Part C & D Star Ratings Program, a performance measure specifically focusing on the percentage of initial MA plan denials that are upheld and overturned. The addition of this measure will enhance CMS's oversight of MA plans' delay and denial of prior authorization and payments and provide beneficiaries with needed insight to inform their decision-making.

Performance measures are a cornerstone of value-based healthcare, and the Medicare Part C & D Star Ratings Program provides a robust mechanism for CMS oversight of MA plans and improvement.

FAH has developed a new measure that CMS can use to address transparency and access to care issues in Medicare Advantage – as well as impact their future payment by affecting their Stars rating.

It is titled "Level 1 Upheld Denial Rate Measure" and it will reveal the percent of level 1 appeals where a plan's determination was "upheld" by the plan out of all the reconsiderations made by the plan (upheld, overturned, and partially overturned determinations).

After assessing the measure's suitability for inclusion in the Medicare Part C & D Star Ratings Program, the experts who make up the Battelle-convened Clinician Recommendation Group, overwhelmingly supported including it in the CMS Measures Under Consideration Final Report.