Inappropriate Reimbursement Patterns of Medicare Advantage Plans

KEY POINTS

1. Medicare Advantage Plans cover 20.4 million Medicare beneficiaries or 34%, an increase from 6.9 million beneficiaries or 18% in 1999 with an increase of 196% and an increase of 84% since the enactment of the Affordable Care Act (ACA), or 7% since 2017 to 2018.
2. CMS data shows significant overpayments to Medicare Advantage plans ranging up to $16 billion each year.
3. Medicare Advantage Plans must offer a "benefit package" that is at least equal to Medicare's and cover everything Medicare covers.
4. The out-of-pocket and premium costs for Medicare Advantage Plans have been skyrocketing ($976 in 1999 to $6,800 in 2019), up 600% from 1999 and 94% from 2011, since the enactment of ACA.
5. Some significant out-of-pocket expenses, of as high as $300 per visit, exceeds the total reimbursement costs for some services provided by interventional pain physicians and ambulatory surgery centers.
6. Medicare Advantage Plans have been denying access to multiple interventional techniques, specifically percutaneous adhesiolysis (CPT 62264), and interspinous prosthesis (CPT22869), despite the fact that they are covered by Medicare in all states except those covered by Noridian and Palmetto GBA, both of which have issued a noncoverage policy for adhesiolysis beyond their authority.

REQUESTED ACTIONS

To provide appropriate patient access for all services in Medicare and Medicare Advantage Plans, Congress should:

- **Please support H.R. 3107 – Improving Seniors' Timely Access to Care Act of 2019** *(see back page).*
- Medicare Advantage Plans, as enacted by law, must cover all services covered by Medicare .
- All Medicare carriers must issue appropriate LCDs for all procedures, when requested.
- Medicare carriers must be banned from issuing noncoverage policies, which should only be issued by CMS through MCAC.

Introduction

The rapid growth of policies for Medicare Advantage Plans is causing denial of patient access and inappropriate reimbursement practices when patients have to seek alternative forms of relief, thus contributing to the opioid epidemic (**Fig. 1**)

Medicare Advantage or Disadvantage

The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program "Medicare+Choice." It was later renamed "Medicare Advantage" through the Medicare Modernization Act (MMA) of 2003. The enrollment growth trend is continuing in 2019,

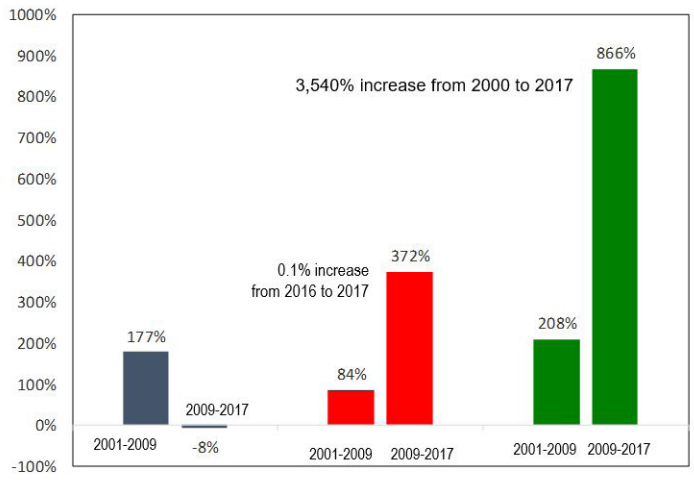

Fig. 1. Quantification of Opioid Deaths

Inappropriate Reimbursement Patterns of Medicare Advantage Plans *(continued)*

and has occurred despite reductions in payments to plans enacted by the Affordable Care Act of 2010 (ACA), (**Fig. 2**). However, the plans have been given the opportunity to increase out-of-pocket limits for Medicare Advantage Plan enrollees. Thus, the 1999 out-of-pocket limit of $976 is now over $6,800 in 2019, an increase of 600% (**Fig. 3**). These expenditures are on top of the increases in cost-sharing for Part B drug benefits.

Since the ACA was passed in 2010, Medicare Advantage enrollment has grown 71%. As of 2018, one in 3 people with Medicare (34% or 20.4 million beneficiaries) is enrolled in a Medicare Advantage Plan (**Fig. 2**). Medicare Advantage has increased from an 18% proportion of Medicare beneficiaries in 1991 (6.9 million beneficiaries) to 34% in 2018 (20.4 million beneficiaries).

The share of Medicare beneficiaries in Medicare Advantage Plans ranges across states from 1% to over 40% and across counties from less than 1% to more than 60%.

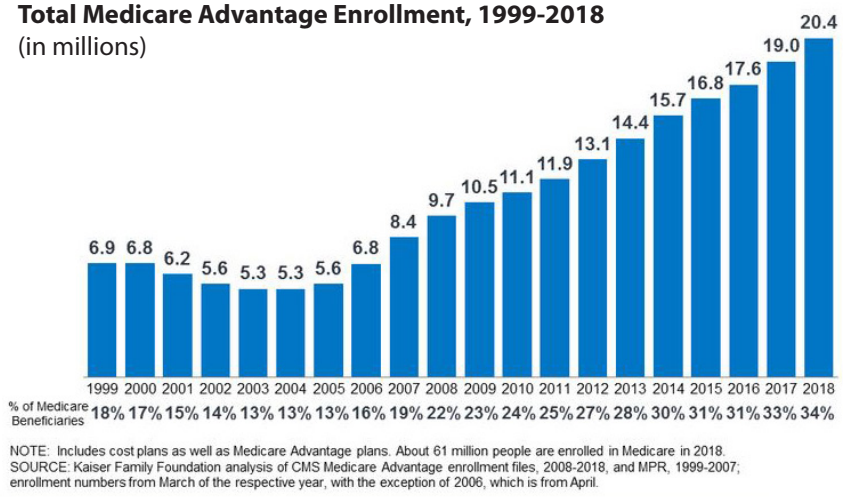

Fig. 2. Enrollment in Medicare Advantage Plans has steadily increased since 2004.

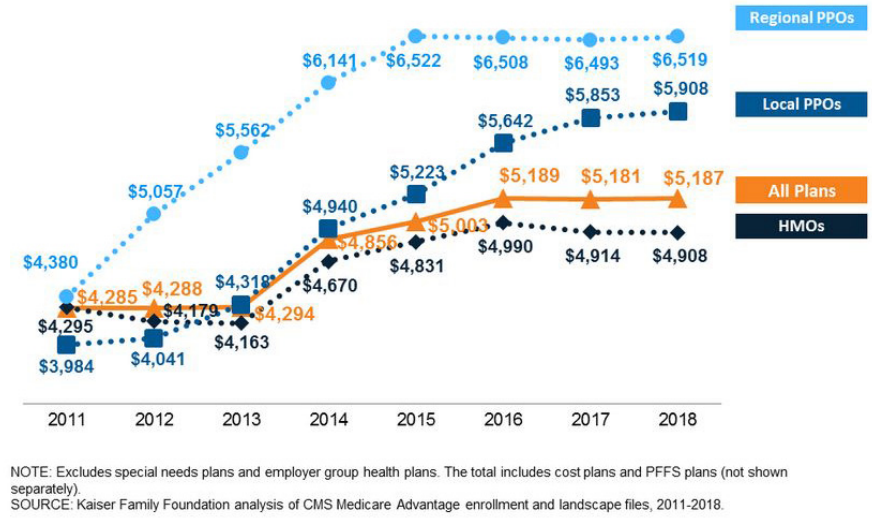

Fig. 3. Average annual out-of-pocket limit for enrollees in Medicare Advantage Plans.

Overpayment Saga

In the past three years, health insurers overcharged Medicare by almost $30 billion.

Medicare Advantage Benefit Package

- Medicare Advantage Plans must offer a "benefit package" that is at least equal to Medicare's and cover everything Medicare covers.
- All Medicare Advantage Plans are required to limit out-of-pocket costs for Parts A and B to approximately $6800 per year as of 2019.

Present Issues for IPM: Denial of Access

Medicare Advantage is denying multiple procedures with unreasonable explanations. We request Congress take action for Medicare Advantage Plans to cover all the services covered by Medicare as dictated by law, and all carriers to issue Local Coverage Determinations (LCDs).

We also request that Congress should take action against MACs issuing National Coverage Determinations (NCDs) beyond their authority, such as Noridian and Palmetto GBA, which have issued NCD for percutaneous adhesiolysis despite significant evidence for the effectiveness and safety of the procedure.

Interventional Pain Management Techniques

Interventional pain management techniques are minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain.

Quoted Reasons for Denying Access and Inappropriate Reimbursement

Medicare Advantage Plans claim these treatments are:

- Experimental and investigational
- They do not have LCDs
- Deny all appeals and ask to follow the Web site
- Refuse to follow the terms of the contracts and push physicians out of network

Medicare Advantage Plans: Integrity Manual

The basic rule as shown in Chapter 4 of the Medicare Managed Care Manual describing benefits and beneficiary protections, Section 10 (Introduction) and Section 10.2 (Basic Rule) shows:

Failure to provide these services may be considered as discrimination under Section 10.5.2 (Anti-Discrimination) based on race, color, national origin, medical history, claims experience, and disabilities. The Centers for Medicare and Medicaid Services (CMS) is also obligated to review for discrimination and steering. Thus, the procedure is covered.

Lack of Medicare Local Coverage Policies

Local coverage determination (LCD) policies are policies used to make coverage and coding decisions in the absence of specific statutes, regulations, national coverage policy, national coding policy, or as an adjunct to a national coverage policy.

Identification of a need for an LCD is based on a validated widespread problem identified for potentially high-dollar or high-volume services, to assure beneficiary access to care, or when frequent denials are issued or anticipated.

Thus, LCDs are not essential for each and every procedure. Consequently, there are no LCDs in any state in the United States or Puerto Rico for some procedures. All Medicare fee-for-service programs reimburse these procedures without an LCD, despite a multitude of requests from the providers to issue LCDs. The refusal by Medicare carriers is based on the fact that it does not meet the criteria for an LCD with any widespread problem, high-dollar amount, or billing issues.

H.R. 3107 Improving Seniors' Timely Access to Care Act of 2019

(information on following page)

H.R. 3107 – Improving Seniors' Timely Access to Care Act of 2019

KEY POINTS

1. Medicare recipients continue to face delays in care due to the lengthy prior authorization process.
2. There continues to be a lack of transparency for beneficiaries and providers alike on how Medicare Advantage plans use prior authorizations.
3. This bi-partisan legislation would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorizations under the Medicare Advantage Program, providing much-needed oversight and transparency of health insurance plans.

REQUESTED ACTIONS

We ask that you join Representatives DelBene, Kelly, Marshall, and Bera in co-sponsoring **H.R. 3107** and securing its enactment.

BACKGROUND

The Improving Seniors' Timely Access to Care Act of 2019 would facilitate electronic prior authorization, improve transparency for beneficiaries and providers alike, and increase Centers for Medicare & Medicaid Services (CMS) oversight on how Medicare Advantage plans use prior authorization.

Specifically, the bill would:

- create an electronic prior authorization program including the electronic transmission of prior authorization requests and responses and a real-time process for items and services that are routinely approved;
- improve transparency by requiring plans to report to CMS on the extent of their use of prior authorization and the rate of approvals or denials;
- require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care;
- hold plans accountable for making timely prior authorization determinations and to provide rationales for denials; and
- prohibit additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization.

The demand and need for such reforms is growing, particularly as more seniors choose Medicare Advantage for their health insurance needs. According to a recently released Kaiser Family Foundation report, A Dozen Facts About Medicare Advantage in 2019, Medicare Advantage enrollment has nearly doubled in a decade. One-third of all Medicare beneficiaries, or 22 million people, are enrolled in Medicare Advantage plans, and nearly four out of five enrollees are in plans that require prior authorization for some services. In addition, the Congressional Budget Office projects that beneficiaries enrolled in Medicare Advantage plans will rise to nearly half of all Medicare beneficiaries by 2029.

ABOUT ASIPP, NANS, AND SIPMS

The American Society of Interventional Pain Physicians (ASIPP) is a not-for-profit professional organization founded in 1998 which now comprises over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain.

The North American Neuromodulation Society (NANS) is a 1600-member multidisciplinary medical specialty society founded in 1994 and dedicated to the field of neuromodulation.

The Society of Interventional Pain Management Surgery Centers (SIPMS) is a national organization devoted exclusively to the issues of providing Interventional Pain Management procedures in the Ambulatory Surgery Center (ASC) setting.

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS (ASIPP)
NORTH AMERICAN NEUROMODULATION SOCIETY (NANS)
SOCIETY OF INTERVENTIONAL PAIN MANAGEMENT SURGERY CENTERS(SIPMS)

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