

Testimony for the United States Senate Permanent Subcommittee on Investigations

**At a Hearing Entitled
“Examining Health Care Denials and Delays in Medicare Advantage”**

May 17, 2023

Statement by Christine J. Huberty, Attorney

Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR)

Dear Mr. Chairman and Members of the Subcommittee:

My name is Christine J. Huberty. I have served as an attorney at the Greater Wisconsin Agency on Aging Resources (GWAAR) since 2015. The Elder Law and Advocacy Center at GWAAR provides free legal services to adults over age 60 under Title IIIB of the Older Americans Act. As an advocate for senior residents of Wisconsin, part of my job is to provide legal assistance to residents experiencing Medicare coverage denials.

The purpose of my testimony is to share my experiences with Medicare Advantage plans routinely denying coverage of skilled nursing facility (SNF) stays, which endangers the health and safety of beneficiaries, causes unnecessary stress and financial hardship, and many times shifts expenses to the state’s Medicaid program.

Imagine you receive a call that your mother has fallen and has been admitted to the hospital for treatment. After four days in the hospital, your mother’s doctors determine that it is unsafe for her to return home. Instead, they recommend transferring her to a skilled nursing facility (SNF) for rehabilitation. Her doctors order physical and occupational therapies for six to eight weeks to regain strength, balance, and mobility. However, on the seventh day of her stay, your mother’s Medicare Advantage plan issues a notice that it will no longer provide coverage.

Your family is blindsided because although your mother is making progress, she is nowhere near ready to go home.¹ No doctor or therapist has even suggested this.

Neither the hospital nor the SNF is surprised because they rarely see patients with Advantage plans get more than two weeks of coverage, regardless of medical orders and diagnoses. Your mother is given appeal instructions and your family scrambles to do them on time. The appeals are denied. Your mother returns home against her doctors' orders out of fear of paying out of pocket.

After just four days at home, your mother falls a second time, and is hospitalized yet again. Her doctor's advice is the same: she needs physical and occupational therapies in a SNF until it is safe for her to return home. This time, her Advantage plan issues a denial while she is still hospitalized.² Your family again starts the appeal process. This time it is successful, but not for long. Your mother is able to transfer to the SNF with Medicare coverage but receives yet another denial after just nine days, even though she has fallen a third time at the SNF. Again, against doctors' orders, she returns home rather than furthering an appeal or paying out of pocket.

This is not just a client story – this is Audrey's³ story – a family member of mine. Despite my continued advice and free legal services, Audrey's family decided that continuing to appeal was too stressful. Fortunately, Audrey's family had enough money to pay for the denied charges and lived close enough to help locate safe housing options and home care.

¹ Medicare coverage in a skilled nursing facility does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition. *Jimmo v. Sebelius* settlement agreement approved by the U.S. District Court for the District of Vermont (January 24, 2013).

² This is called a Prior Authorization denial, which differs only slightly from Post-Admission denials.

³ Name has been changed to protect anonymity.

For beneficiaries who do continue to appeal, it is up to them to collect hundreds of pages of medical records from the hospitals, SNFs, and treating physicians to plead their cases – all while trying to recover from an illness or injury. If settlements are reached, the Advantage plans often admit they lacked these records when issuing their original denials. It can take anywhere from months to over a year to get through an Administrative Law Judge (ALJ) hearing and receive a decision, and even longer to get a reimbursement if the ALJ decision is favorable.⁴

Beneficiaries are expected to navigate several levels of appeal all while trying to recover from the incident that caused them to enter the SNF in the first place.⁵ Patients first learn of a denial when they are issued a Notice of Medicare Non-coverage (NOMNC) from the SNF. (Ex. A). This notice has no information or reasoning provided for the denial. Most patients will call to request an appeal immediately because a NOMNC gives only two days' notice before coverage ends. When beneficiaries request an immediate appeal, it is automatically sent to a Quality Improvement Organization (QIO),⁶ which issues a Determination Letter. (Ex. B). This first Determination Letter provides scant information regarding the specific reasons for a denial.

At the same time, beneficiaries receive a Detailed Explanation of Non-coverage letter from the Advantage plan. (Ex. C). However, contrary to its name, the “Detailed” Explanation of Non-coverage contains no more than a few sentences particular to the beneficiary. After

⁴ Unfavorable ALJ decisions can be appealed at a fourth level (Medicare Appeals Council), however, to date our agency has not received decisions – favorable or unfavorable – for any MAC appeals.

⁵ See <https://www.hhs.gov/about/agencies/omha/the-appeals-process/level-1/part-c/index.html> (last visited May 10, 2023).

⁶ According to the Centers of Medicare and Medicaid Services (CMS), “Beneficiary and Family Centered Care (BFCC)-QIOs help Medicare beneficiaries exercise their right to high-quality health care. They manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider’s decision to discharge them from the hospital or discontinue other types of services. Two designated BFCC-QIOs serve all 50 states and three territories, which are grouped into ten regions.” Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs> (last visited May 11, 2023).

receiving the first Determination Letter, the patient can appeal again with the QIO.

Unfortunately, the QIO generally performs a cursory review and upholds the denial in a second Determination Letter. (Ex. D). Even in the cases where the QIO overturns the Advantage plan's denial, another denial is usually issued just a few days later, forcing the beneficiary to appeal again and again.⁷

At this point, the patient must decide whether to further the appeal by formally requesting a hearing before an ALJ. This is a critical stage where most people either find an advocacy resource or give up. Requesting a federal ALJ hearing not only sounds intimidating, but many individuals believe they are required to find an attorney to proceed. The hearing request must be in writing, and when the patient receives a Notice of Hearing, they must respond within five days, provide all documents (medical records), and prepare a list of witnesses. (Ex. E). Prior to the hearing, the patient will not know who will be attending the hearing. It is not unusual for the 'other side' to have upwards of six individuals on the telephone hearing ranging from legal counsel, other representatives, medical professionals not associated with the patient's care, and "observers." If the patient is still in the facility, they must also find a way to attend this telephone hearing from their bedside. Many hearings need to be rescheduled or postponed due to the patient's inability to obtain medical records. The burden to provide such records is on the beneficiary, not the Advantage plan. To say the appeals process is unbalanced in favor of the Advantage plans is an understatement.

Continuing an appeal is daunting, if not insurmountable, and even more so when you learn that patients are fighting an uphill battle before they even start rehab. In most cases,

⁷ This practice has become so prevalent that advocacy groups have developed a grievance procedure. <https://medicareadvocacy.org/new-from-the-center-form-to-contest-multiple-medicare-denials-issued-by-medicare-advantage-plans/> (last visited May 15, 2023).

Advantage plans utilize third-party contractors that apply algorithms in order to predict when a patient will be ready to go home - before they even begin to receive care in a SNF. (Ex. F). This prediction is based on millions of past beneficiary data points.⁸ The Advantage plan itself rarely, if ever, speaks with a patient's doctors or reviews records. Instead, the Advantage plan defers decision-making to these third-party contractors. A handful of medical records may be reviewed by the contractors, but a full review does not take place unless the beneficiary advances through the appeals process, and sometimes not even then. Despite its claims, the results of the algorithm's predictions are not shared with the beneficiaries themselves.

Consider what this situation looks like for an individual with no family, friends, or legal representatives. How does this story unfold for an individual with dementia, a stroke victim, or a person who has lost a limb? In Wisconsin, the average cost of just one day in a SNF is over \$300.⁹ The individuals who can't afford to stay in the SNF will likely be advised to deplete their funds – forcing poverty – to qualify for the State's Medicaid program.

Our agency rarely encounters Original Medicare denials of SNF stays, despite the requirement that Advantage plans offer the same benefits and apply the same coverage criteria and standards.¹⁰ Original Medicare covers up to 100 days in a SNF.¹¹ Our clients with Advantage Plans are lucky to receive 14. This discrepancy is largely due to Advantage plans' overwhelming reliance on, and often incorrect application of, the "custodial care" exclusion.¹² The Medicare Benefit Policy Manual defines "custodial care" as those services that:

⁸ nH Predict Video, available at <https://navihealth.com/nh-predict-video/>, (last visited May 10, 2023).

⁹ Wisconsin Medicaid Eligibility Handbook § 39.4.6.

¹⁰ 42 C.F.R. § 422.100.

¹¹ 42 C.F.R. § 409.61(b) Posthospital SNF care furnished by a SNF, or by a hospital or a CAH with a swing-bed approval. Up to 100 days are available in each benefit period after discharge from a hospital or CAH. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility.

¹² Medicare Benefit Policy Manual, Chapter 16, § 110.

“assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the A/B MAC (A) or (B) considers the level of care and medical supervision required and furnished. It does not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.”

Some examples of denials based on the custodial care exclusion include:

1. A 79-year-old brain cancer patient experiencing weakness, inability to walk, and multiple falls had surgery to drain fluid on his brain. His doctors recommended six to eight weeks in a SNF for therapies, incision care, and medication monitoring. He was denied on day 28 despite falling numerous times in the SNF. He was ultimately able to return home on day 57.
2. A 71-year-old patient had a seizure, pneumonia, and a broken hip. Her doctors recommended at least four weeks in a SNF for therapies. She was denied on day seven. One of the reasons she was denied was due to her “inability to think clearly and reason.” She was ultimately able to return home on day 50.
3. An 82-year-old patient with two broken ankles entered a SNF for rehab after an accident. His doctors recommended at least four weeks in the SNF. He was denied on day 15. He was able to return home on day 30.
4. A 75-year-old patient suffered a stroke and was admitted to a SNF for rehab. As a result of the stroke, he was paralyzed on one side, and had difficulty swallowing, understanding, speaking, reading, and writing. His doctors ordered at least nine weeks in the SNF. He was denied on day 33. He was ultimately able to return home after 134 days. However, his doctors attested that had he not had a gap in therapies while he was dealing with his appeal, he would have likely been able to return home weeks earlier.
5. A 78-year-old patient broke his shoulder and needed both rehab and daily nursing care because he could not properly care for his colostomy bag one-handed. His doctors recommended at least six to eight weeks at the SNF. He was denied on day 17. It ultimately took until day 41 before he could care for his colostomy bag himself and return home.
6. An 80-year-old patient had hip surgery and was admitted to a SNF for rehab. His doctors recommended eight weeks in the SNF. He was denied on day 24 despite experiencing multiple falls. He was only discharged from the SNF on day 70 because he suffered a stroke.

7. An 86-year-old patient in a wheelchair fell and broke her upper arm. Her doctors recommended eight weeks at a SNF for rehab. She was denied on day 17. She was able to return home safely after day 78.
8. An 81-year-old patient using a wheeled walker received treatment at a hospital for COVID-19 and was transferred to a SNF for rehab. At the first SNF, he developed a stage IV (volleyball-sized) bed sore and was re-hospitalized. His doctors ordered a second SNF stay for rehab and wound care. He received a denial on day 67. His wound still had not healed.
9. An 89-year-old patient who lived independently at home fell and broke her leg. After hospitalization, she was admitted to a SNF for rehab. Her Advantage plan issued a denial after three weeks stating that she would need custodial care for the rest of her life. After two more months of rehab, she was able to return home and continue an active lifestyle.

For these examples, the Advantage plans determined the patients were ready for a “lower level of care” using the custodial care exclusion. Note, however, that in nearly all cases, the patient’s medical need for their SNF stay ended when their doctors’ had predicted, and sometimes earlier. Furthermore, in these instances, the patients experienced no difference in care; they stayed in their same beds, their same rooms, and received the same therapies. The only thing that changed for the patient is the Advantage plan no longer covered room and board – the most expensive portion of their stay. In these cases, the choice forced on the patient is always the same: stay and pay out of pocket, or go home against medical advice.

Remember Audrey? She fell twice at home and a third time at the SNF. She felt she had no choice but to ignore the directions of her doctors. She was overwhelmed by the unrelenting appeals. If she did not have family advocating for her, would she have returned home and fallen a fourth time, this time causing serious injury or even death? Would she have spent her life savings on needed care and been forced to take Medicaid? Audrey was not uninsured. She was enrolled in a Medicare insurance plan that said it would cover up to 100 days in a SNF. Audrey’s

doctors said she needed more time. A computer, not even at the Advantage plan, overruled Audrey's doctors.

Wisconsin is unique in the legal services it provides Medicare beneficiaries, which has allowed me to share the stories I know of with your investigative team. But what about the cases we do not hear? Our agency sees the same practices by all Advantage plans; there is no one culprit. And with Advantage plans sold nationally, this is not just a Wisconsin problem. In 2022, over 30 million individuals were enrolled in a Medicare Advantage plan.¹³ One must wonder how many cases involving our most vulnerable citizens are never appealed due to illness, injury, stress, incapacity, death, and poverty. Our agency grapples with these realities on a daily basis, and I want to thank you for taking the time to investigate these practices.

Exhibits:

- A. Notice of Medicare Non-coverage (July 18, 2022)
- B. BFCC-QIO Determination Letter (July 20, 2022)
- C. Detailed Explanation of Non-coverage (July 19, 2022)
- D. BFCC-QIO Determination Letter (August 1, 2022)
- E. Notice of Hearing (October 12, 2022)
- F. naviHealth nH Predict Outcome tool (June 7, 2019)

¹³ <https://medicareadvocacy.org/medicare-enrollment-numbers/>, (last visited May 15, 2023).