California Hospital Association

December 15, 2023

Mark Ghaly, MD, MPH
Secretary, California Health & Human Services Agency
1215 O St.
Sacramento, CA 95814

RE: Unlawful Health Plan Practices Placing Hospital Services at Risk

Dear Secretary Ghaly:

Californians are facing a grave and growing threat to their ability to access critical health care services due to the detrimental — and illegal — business practices of many health plans. Access to care for patients is choked due to clear systemic failures among many health plans stemming from inadequate operational systems, self-serving processes, and staffing shortfalls.

Patient care is further constricted as many health plans compel providers to terminate contracts due to unsustainable financial losses created by improper denials and delays (including imposing frivolous procedural requirements that result in non-payment for legitimate, "clean" claims), as well as arbitrary reductions in reimbursement for care rendered. This is particularly concerning as Medi-Cal reimbursement is already less than the cost of care and managed Medi-Cal plans have hundreds of millions in surplus funds that should immediately be directed to patient care and provider reimbursement.

State regulatory agencies — the Department of Managed Health Care and the Department of Health Care Services — have already found ample evidence to cite and fine health plans for these behaviors. Tens of millions in fines for LA Care is one recent example, but similar violations are rampant across all managed care plans and have created crippling challenges that jeopardize care and access to critical services for the most vulnerable.

We would like to invite you to a series of meetings with hospital leaders to hear firsthand how these practices are a growing impediment to patient care and discuss potential metrics to track performance improvement. In the meantime, state regulators can take immediate action to protect patients' right to receive the care and access they deserve by implementing remedies, detailed below, that create mechanisms for required reporting, transparency, and enforcement of detrimental health plan practices.

A 2023 survey of California hospitals sheds more light onto how these practices create direct, negative impacts on patient care, especially when it comes to discharge to more appropriate levels of care:

- An estimated 9% of all hospital patients in the state face discharge delays of at least three days after medical clearance, adding 14 days to their hospital stays on average.
- Insurers typically do not pay any of the costs associated with boarding patients who have been medically cleared for discharge.

- On any given day, some 4,500 patients occupy inpatient or emergency department hospital beds despite being medically ready for discharge. This affects those in managed care plans at higher rates than those in fee-for-service plans.
- Seventy-eight percent of California hospitals identify delays or denials of authorization as one of the top insurance policies that delay discharges.
- California hospitals annually provide 1 million days of excess inpatient care and 7.5 million hours of excess emergency department care due to unnecessary barriers imposed by insurers.

In addition to these issues, health plan payment practices violate requirements for prompt and fair payments, further constraining providers' ability to deliver the care Californians deserve. The **share of claims left unpaid for more than 90 days has increased by an estimated 34 percent since before the pandemic**, with **the six largest plans in the state failing to pay bills within 90 days between 52% and 76% of the time, according to recent A/R survey information**. These unnecessary delays create resource gaps for hospitals — especially the more than 50% currently operating with negative margins. And as we all work toward reducing the growth of health care costs, the hours needed to "chase" reimbursement for services already provided are a major barrier to efficient care delivery.

For patients needing emergency care who require hospital admission, these practices create significant barriers. Many plans do not have the staff or processes to issue authorizations for hospital admission following emergency treatment and subsequently **deny payment entirely for the duration of the admission**, **citing the absence of an authorization.** This is an abject failure of these plans' staffing models that at once prevents hospitals from obtaining the needed authorization to deliver care and also directly benefits health plans financially as they do not have to pay for the care their members received.

Hospital leaders have tried to address these issues directly with health plans and collectively through state and federal hospital associations to no avail. Despite these efforts, the situation is getting worse, and patients are paying the price. It is time for regulators, including the Department of Managed Health Care and the Department of Health Care Services, to ensure that laws are being enforced and patients are being protected. To address these problems, the state should act promptly in three ways.

1. **Address Current and Longstanding Violations of California's Prompt Payment Laws**
    - Direct health plans to immediately pay all claims that have not been reimbursed, contested, or denied beyond statutory deadlines, including interest owed. Ensure that health plans include reimbursement for any uncontested portions of claims in these payments.
    - Require plans to specify all reasons for contesting or denying a claim, and for "downcoding" services to a less intense/lower paying service within statutory deadlines.
    - To the extent additional information is required to complete a claim, direct health plans to specify — in writing — all the information that is needed, within statutory deadlines.
    - Require plans to process claims using information made available to them via electronic medical records and health information exchanges, and during the utilization management process.
    - Protect against irrelevant and unnecessary requests by requiring plans to specify, in writing and within statutory deadlines, why requested information is necessary to complete a claim.

2. **Ensure Compliance with Current Laws on Payments for Services Rendered**

- Direct health plans to pay in full for hospital care while patients await transfer to post-hospitalization services when a health plan has failed to arrange for a timely care transition.
- Require plans to pay for all care that has been authorized or does not require prior authorization.
- Require health plans to pay for the entire course of hospital care in instances where services have been authorized or do not require authorization (e.g., emergency care), unless or until the health plans have fulfilled their legal obligations to notify both the hospital and physician of the decision to discontinue care and a care plan has been agreed upon by the three parties.
- In support of existing law, create a new requirement that health plans deem all care as authorized if the plan fails to authorize care within statutory deadlines for arranging care in a timely manner.

3. **Enhance Oversight Beyond Current Laws to Create Greater Accountability**
    - Create a dashboard to track performance against state rules on prompt and fair payment and timely arrangement of care. Individual metrics should include unpaid claim amounts beyond statutory time frames, claim denial and contestation rates, patients awaiting care transitions while hospitalized, and prior and concurrent authorization speed.
    - Regularly review a representative sample of prior authorization denials for timeliness and consistency with medical necessity criteria.
    - Initiate non-routine audits of health plan practices and performance against the state's rules on prompt and fair payment and arrangement of care. Prioritize investigations of health plans with the worst record on metrics captured in the performance dashboard.

Making sure that health plans meet their obligations to provide care to patients, ensure adequate networks, and promptly arrange and pay for that care must be part of the state's strategy to protect access to care, avoid further hospital closures or reductions in services, and protect the state's health care safety net. We welcome the opportunity to work together to maintain access to health care for all Californians.

Sincerely,

Carmela Coyle
President & CEO