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U.S. Senator Pete Ricketts
139 Russell Senate Office Building
Washington, DC 20510

Hearing: United States Senate Special Committee on Aging
Friday, February 23rd, 2024, at 10:00 AM CT
Douglas County Health Center, Omaha, Nebraska

Thank you for the opportunity to speak regarding the challenges associated with Medicare and Medicare Advantage (MA). My testimony today will focus on challenges faced by healthcare providers who are committed to caring for our Medicare and Medicare Advantage population.

Nebraska Medicine provides health care services to a significant number of patients who are covered by Medicare and Medicare Advantage. These patients represented 43.5% of health care services provided in FY23. The Medicare-eligible population has been trending upward over the last several years, and we anticipate that trend will continue as our state's population ages. Of total Medicare-eligible patients, Medicare Advantage enrollees make up approximately 35% of the total of Medicare-eligible population, and this proportion of patients enrolled in MA plans versus traditional Medicare continues to grow.

Medicare Advantage plans, offered as an alternative to traditional Medicare, are intended to provide the same benefits as traditional Medicare as a minimum standard. Unfortunately, healthcare providers routinely face challenges securing medically necessary care when Medicare Advantage coverage has been chosen by a Medicare beneficiary. **The greatest challenges include prior authorization requirements, reimbursement challenges and inconsistent Medicare Advantage plan interpretations of Medicare rules.**

The most recent "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F" is a good start to address concerns related to delayed or denied care for Medicare Advantage beneficiaries resulting from prior authorization requirements. However, opportunities remain to ensure timely access to appropriate care for Medicare Advantage beneficiaries while reducing administrative burden for providers.

Application Programming Interfaces (APIs) and timeframes for payer responses do not address or standardize payer reasons for denial which can vary across MA plans and are often of sync with Medicare coverage guidelines. The Contract Year (CY) 2024 Medicare Advantage Final Rule continues to allow MA plans to apply their own coverage criteria when Medicare coverage criteria is not fully established. **This results in variability among various MA plans and a requirement for providers to navigate multiple payer policies creating additional burden.**

As an example, Nebraska Medicine routinely experiences authorization denials for medically necessary care with requirements from the MA plan to complete a peer-to-peer discussion or a letter of medical necessity - even though the care plan is considered the best course of treatment by our providers, it meets standard of care guidelines, and a Medicare coverage policy (local or national coverage decision, LCD or NCD) does not exist. To further complicate matters, the appeal process for every MA plan is

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different. Some allow a peer-to-peer; some require a letter of medical necessity, while others may require a letter of medical necessity first with a peer-to-peer as a next step. **Providers must navigate numerous different payer policies, as one MA plan is simply one MA plan.**

Imagine a patient recently diagnosed with cancer waiting for approval to begin cancer treatment and having a payer question the treatment plan of a highly respected provider with excellent outcomes that the patient trusts. The patient wants to act quickly; they want their payer and provider to act quickly. **Yet, delays occur due to prior authorization requirements that are simply administrative in nature. In most cases, final approval is received with no change to the original treatment plan, making all of the administrative work ultimately unnecessary.**

Imagine the provider who is caring for the same patient and many others, who is focused on quick, appropriate, medically necessary care for all patients. They see their patients face to face, talk to them, examine them; they are aware of the most up to date research and best courses of treatment; yet they are required to spend countless hours talking to payers (*during payer business hours*) or writing letters to substantiate their treatment plan. **This additional burden placed on providers takes time away from caring for patients which is their top priority.**

Now consider this same patient may require hospital care followed by post-acute care needs. Hospital stays with Medicare Advantage plans present another set of challenges. In an acute hospital, there is a difference in reimbursement for stays classified as "observation" and those classified as "inpatient." Inpatient stays require a higher, more resource-intensive level of care, and thus, are reimbursed at a higher rate. To simplify the classification, Medicare implemented a 2-midnight rule in 2013, which means that inpatient services are considered appropriate if the physician expects the patient to require medically necessary hospital care spanning at least 2 midnights. The Contract Year 2024 Medicare Advantage Final Rule clarified that Medicare Advantage plans must comply with general coverage and benefit conditions included in Traditional Medicare regulations. Yet, Nebraska Medicine is experiencing medical necessity denials for inpatient stays on cases with length of stays 4 days and greater – double the Traditional Medicare requirement. **Medicare Advantage plans continue to deny medical necessity for patients that would have been approved for inpatient status based on the Traditional Medicare 2-midnight rule.**

Not only does the classification of care as observation or inpatient affect hospital reimbursement, patient out-of-pocket costs may increase due to the difference in deductible, coinsurance and coverage guidelines associated with observation versus inpatient stays. The denials are often received within the first 24-36 hours of care and place additional administrative burden on the hospital to work with the payer to overturn the denial while the patient is being treated. The administrative burden in this case includes both nurse and physician time. The hospital has been forced to contract with outside physicians to simply battle payer's physicians to allow inpatient status. **Holding the MA plans accountable to traditional Medicare 2-midnight rules would protect our patients and reduce administrative burden and cost for the provider and the payer.**

Imagine this same patient is now ready for discharge, and the care team agrees that an Acute Rehab Facility is necessary, for example. Nebraska Medicine contacts the Medicare Advantage plan, who

denies Acute Rehab authorization. A peer-to-peer is completed by the attending physician, and the MA plan confirms acute rehab denial but approves patient discharge to a Skilled Nursing Facility (SNF). The family and care team identify a SNF for discharge purposes. After a week of waiting for approval, the MA plan denies the SNF level of care. At the same time that many MA plans are denying ongoing hospital care for lack of medical necessity, their process for approval of post-acute care creates barriers to accessing a lower level of care for these patients, which leads to longer lengths of stay in the hospital. When this occurs, the cost and burden of care falls to the hospital to supply services that go uncompensated while awaiting approval and acceptance to a SNF, acute rehab unit (ARU) or long-term acute care hospital (LTACH). And the patient waits.

After discharge, this same patient may require readmission back to the acute hospital setting. The MA plans do not follow CMS readmission guidelines. Readmission denials have been escalating, and the only path to appeal is a written letter. At this time, some MA plans deny ALL readmissions without consideration for diagnosis or expected readmission rates.

Related to Traditional Medicare I would like to address 2 items:

First, the 3-day inpatient requirement for a SNF stay. For traditional Medicare patients, the requirement for a 3-day inpatient stay prior to coverage for skilled nursing services is often viewed as an antiquated measurement of severity of illness and does not reflect recovery timeframes in today's healthcare world. Nebraska Medicine would advocate for dissolution of the 3-day SNF requirement.

Second, proposed Medicare HOPD Cuts or "site neutral" policies. The concept of "site neutral" policies on the surface makes sense to address the goal of eliminating cost disparities between hospital outpatient departments and independent physician offices. Going beyond the surface, hospitals bear costs that physician practices or Ambulatory Surgery Centers do not, including 24 hours day availability, the ability to treat complex medical conditions, requirements to provide emergency care and to participate in emergency preparedness activities. Continued cuts have the potential to impact hospital's ability to provide essential care for the communities they serve.

In conclusion, administrative costs to comply with rules, monitor for denials, appeal for proper patient care, and pursuit of proper and fair reimbursement continues to escalate in cost and time and is unsustainable. Thank you for the opportunity to share my perspective.

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