Nov. 1, 2019

The Honorable Lloyd Doggett
United States House of Representatives
Chairman, Health Subcommittee, Ways and Means
2307 Rayburn House Office Building
Washington, DC 20515

Re: The Negative Impact of Medicare Advantage on Hospitals and Patients in Texas

Dear Chairman Doggett,

In September, hospital leaders from Texas met with you to discuss several issues of concern impacting health care delivery and the patients they serve. In that meeting, you requested additional information about the impact of Medicare Advantage on rural hospitals and patients across the state. The rapid growth of Medicare Advantage enrollees threatens Texas' health care safety net. For rural hospitals, Medicare Advantage causes financial instability on an already fragile provider community. Since 2013, Texas has seen more rural hospital closures than any other state in the nation—23.

In addition to rural hospitals, it has become clear that challenges with Medicare Advantage impact a wide range of hospitals. While Medicare Advantage aims to curtail costs of the program broadly, in some cases it can impede patients' access to medically necessary care and threatens the stability of the hospital safety net. Ongoing concerns voiced by patients, providers and policymakers about the harmful impact of Medicare Advantage warrant Congressional review and action. On behalf of the hospitals and health systems represented by the Texas Hospital Association and the Texas Organization of Rural & Community Hospitals, thank you for the opportunity to provide comments on this issue.

The following summarizes hospitals' challenges with Medicare Advantage and includes direct feedback from more than a dozen THA and TORCH member hospitals.

Low Reimbursement

Medicare Advantage plans reimburse hospitals at a lower rate and offer benefits and cost-sharing arrangements for beneficiaries that are significantly different from traditional Medicare. The rapid growth in enrollment exacerbates reimbursement issues. In some areas of rural Texas, the rate of older adults choosing Medicare Advantage reaches almost 50%,

according to the Centers for Medicare & Medicaid Services. For several counties, the penetration rate more than doubled over the last three years.

Medicare Advantage plans' payment rates are based on a negotiated contract and do not consider federal payment policies designed to help vulnerable hospitals ensure access to care. These plans do not provide cost-based reimbursement, nor are they recognized as Medicare for federal cost report purposes. This is determinantal to Texas' 85 critical access hospitals that receive cost-based reimbursement in traditional Medicare. The low Medicare Advantages rates undermine the federal payment policies designed to ensure adequate reimbursement for rural hospitals.

For some rural hospitals, the difference in reimbursement between traditional Medicare and Medicare Advantage has resulted in an annual loss of several hundred thousand dollars. For hospitals with very thin operating margins, a shift of this magnitude can negatively impact patient care and a hospital's ability to stay open for business.

In addition, some hospitals lack the leverage and expertise to negotiate fair contracts and rates with Medicare Advantage plans. Medicare Advantage plan administrators negotiate contracts as a core function of their daily business and, by way of contracting with many providers, have access to information and resources that advantage them in the negotiation process. Small, stand-alone facilities are unable and/or find it cost prohibitive to maintain contract negotiation specialists on staff.

Limited Access to Necessary Medical Care

Medicare Advantage limits beneficiaries' access to necessary medical care in a number of ways that traditional Medicare does not. For instance, some patients must travel outside their community to receive care from providers in the plan's network and incur added costs for necessary treatments. These problems are increasingly common among lab services because some Medicare Advantage plans require patients to use "preferred lab providers." If the preferred lab provider is outside a patient's community, the patient will incur additional costs to travel to the preferred lab provider. If a patient receives services from an out-of-network hospital's lab, the patient may be responsible for meeting their deductible and a large out-of-pocket cost for those lab services. When patients do not cover this cost, hospitals incur more bad debt.

Some Medicare Advantage beneficiaries also lack access to durable medical equipment, health care specialists, chronic care programs, geriatric psychiatry programs and long-term care facilities.

Prior Authorization

Prior authorization challenges hinder hospitals' ability to provide timely, medically necessary patient care. Medicare Advantage plans can require enrollees to receive prior authorization before certain services will be covered, including some inpatient hospital and skilled nursing facility stays, Medicare Part B drugs and other specialized services. The Kaiser Family

Foundation reported in June 2019 that nearly four out of five Medicare Advantage beneficiaries are enrolled in plans that require prior authorization for some services.

Prior authorizations often are overly stringent and require frequent recertification and additional administrative resources, delaying medically necessary treatment. Texas hospitals large and small in rural, urban and suburban communities experience these challenges.

Hospital staff may wait on hold for an hour or more for approval from a Medicare Advantage plan. Recertifications also are an issue, especially related to critical access hospitals' "swing beds" which can typically be used to provide acute care or skilled-nursing facility services. A patient in traditional Medicare qualifies for a swing bed for 100 days, yet Medicare Advantage does not recognize them. Medicare Advantage plans frequently require hospitals to recertify care every seven days. These recertifications often are denied, forcing hospitals to discharge patients that may otherwise continue to improve with treatment if they were enrolled in traditional Medicare.

Medicare Advantage plans also deny claims at a higher rate than traditional Medicare. A September 2018 report from the Office of Inspector General for the U.S. Department of Health and Human Services raised concerns about inappropriately denied claims and payments by Medicare Advantage. Payments for approved care can take approximately 15 days longer than traditional Medicare, and hospitals face the threat of a retrospective review, denial and recoupment of payment at some point in the future. In some cases, this occurred almost a year after the patient was discharged. Medicare Advantage plans also frequently change inpatient claims to observation, even in cases where patients clearly meet criteria for an inpatient stay.

Deceptive Marketing and Confused Patients

Aggressive and deceptive marketing campaigns create confusion among older adults. Many Medicare beneficiaries unknowingly sign up for a Medicare Advantage plan. Some do not realize they are switching from traditional Medicare to a Medicare Advantage plan until they seek care. Others inadvertently choose Medicare Advantage instead of the supplemental coverage they seek. To protect patients and ensure clarity, one hospital created education materials to help patients understand the potential implications of opting into Medicare Advantage, such as limited choice of providers, limited access to care and hidden costs.

Policy Solutions

Some argue that over the years disjointed legislative reforms to Medicare Advantage and traditional Medicare have led to broad differences between the programs, resulting in unintended negative consequences for patients and providers. To support the needed discussion among policymakers and stakeholders about policy solutions to address these problems, THA offers the following ideas for review.

- Ensure adequate reimbursement for hospitals by:
    - Requiring CMS to cost settle with hospitals to address the payment shortfall created by Medicare Advantage.

    - Protecting cost-based reimbursement for critical access hospitals or allowing them to count Medicare Advantage patient days as traditional Medicare days for the purposes of the Medicare cost report.
- Safeguard patients' access to timely, medically necessary care by:
    - Increasing oversight of Medicare Advantage plans to ensure beneficiaries receive the same access to and level of benefits as those in traditional Medicare.
    - Studying the utilization management practices of Medicare Advantage plans and their impact on access to care and health outcomes.
    - Reforming the prior authorization and appeals process to ensure patient care is not rationed or unnecessarily delayed.

These challenges undermine hospitals' ability to provide essential care services for older adults. THA, TORCH and its member hospitals are eager to assist you and the subcommittee on reform efforts that will better protect and ensure access to care for Medicare Advantage enrollees.

Thank you for the opportunity to provide comments on this issue. Please contact Cameron Krier Massey, THA's federal affairs representative, at cameron@scoutGR.com or 512/656-1716 with any follow up questions.

Sincerely,

Ted Shaw
President/CEO
Texas Hospital Association

John Henderson
CEO/President
Texas Organization of Rural & Community Hospitals

The concerns and details in this letter reflect direct feedback from THA and TORCH member hospitals. A list of those hospitals is available upon request.