Ongoing Medicare Advantage Challenges

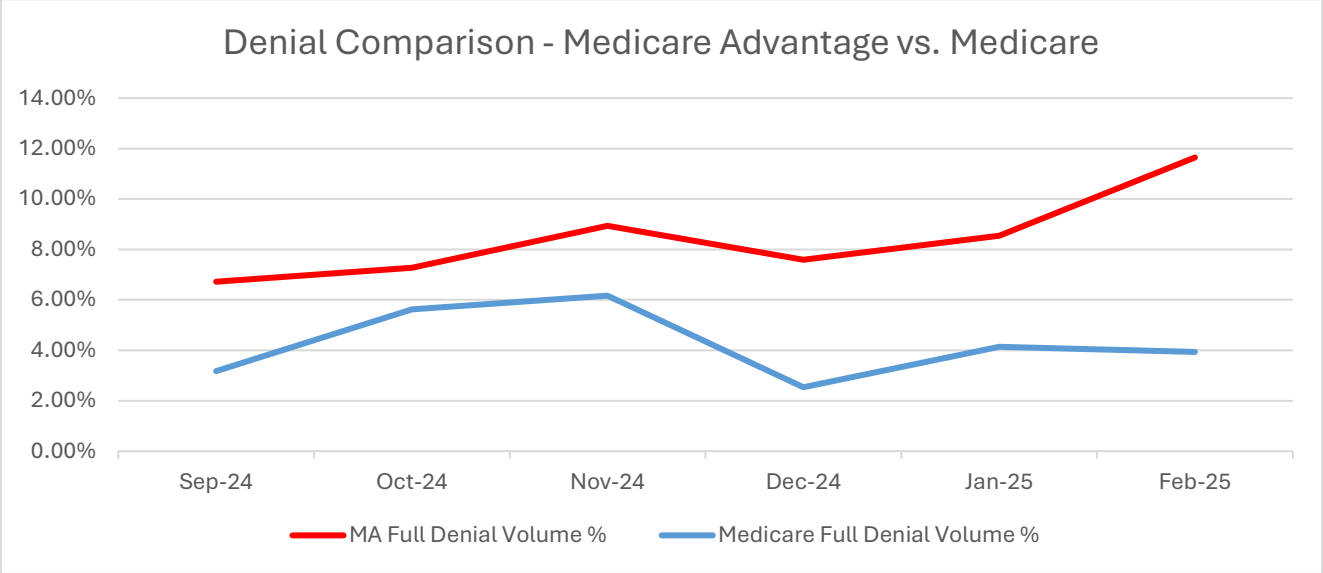
Tennessee hospitals face recurring and ongoing challenges with Medicare Advantage (MA) plans, including increased administrative burden, patient discharge delays, prior authorizations, as well as significantly higher denial rates and audits compared to fee-for-service Medicare.

MA patients also suffer from a lack of access to the same care afforded to Traditional Medicare patients.

Prior Authorization/Denials

Prior authorization is intended to ensure that healthcare services are medically necessary by requiring providers to obtain approval before a service or other benefit will be covered by a patient's insurance. However, current prior authorization requirements and processes may create barriers and delays to receiving necessary care, as well as exacerbate complexity for patients and their providers.

Denials not only occur in prior authorizations but also in claims. Over the past six months for a representative sample of TN hospitals, MA plans denied, on average, 8.5% of claims, while Fee for Service Medicare's denial rate was 4.3%. The higher denial rate by MA plans translates to millions in lost reimbursement to TN hospitals, all the while, according to MEDPAC, **the MA program costs the federal government 20% more than Traditional Medicare.**[1]



[1] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

Payment Parity for Critical Access Hospitals

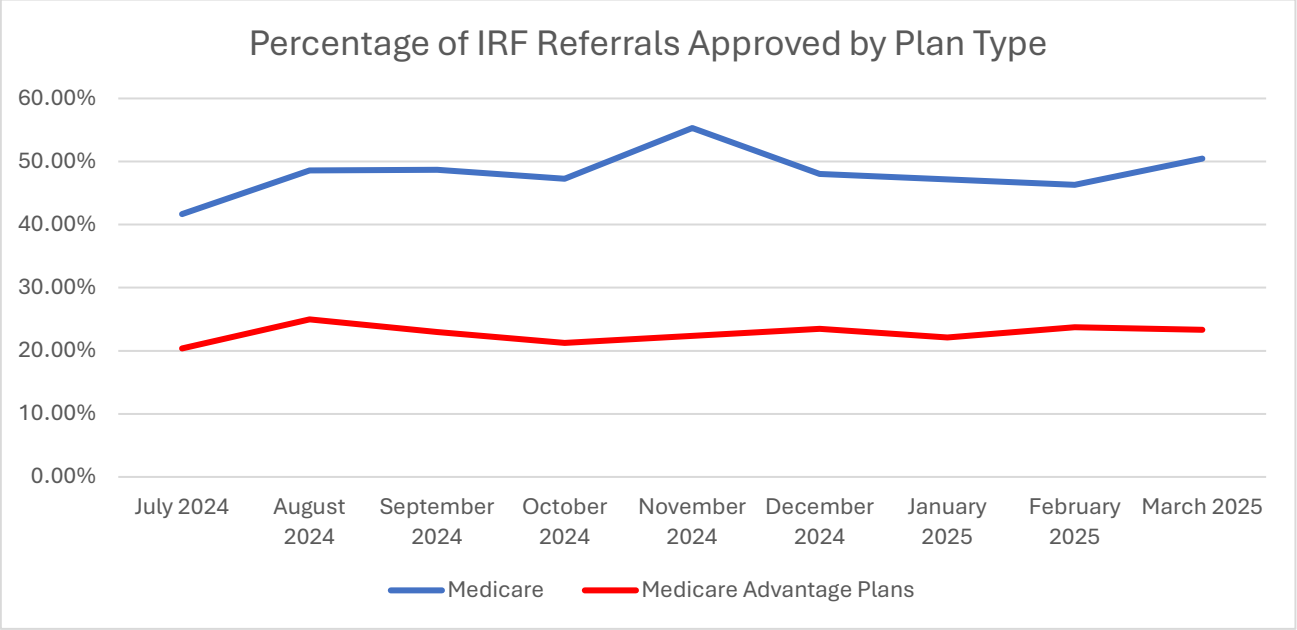
The Critical Access Hospital (CAH) designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services.

- Traditional Medicare pays CAHs at 101% of eligible costs. **However, MA plans are not required to compensate CAHs in the same way.** In a recent survey, 100% of Tennessee CAHs reported the shift of patients from Traditional Medicare to MA has negatively impacted their hospitals' finances, a strong indication the MA program has adverse effects on rural healthcare.
- **TN now has 54% market penetration for MA, which further exacerbates the issue for our CAHs**

Access to Post-Acute Services

Many patients need care once they are discharged from an acute care facility. Post-acute care includes home health, skilled nursing care, inpatient rehabilitation, or long-term acute care.

MA plans have **implemented barriers to discharging patients** to post-acute care providers, including arduous prior authorization processes and delays that leave patients without the services they need and without the services Traditional Medicare would cover. As noted below, MA plans approve only half of the admission referrals to inpatient rehabilitation facilities (IRF) when compared to Traditional Medicare.



The Need for Stronger Oversight

We believe there is a need for increased oversight of MA plans, including collecting data regarding approval percentages for services that require prior authorization and using that data to compare MA plan performance to other MA plans as well as to Traditional Medicare. This data would clearly highlight the issues providers and patients are having with MA plans and should be used to inform CMS' oversight and enforcement actions.

Tennessee hospitals urge Congress to evaluate and improve oversight in the MA program and work with CMS to implement penalties for plans failing to comply with CMS rules and regulations.

As noted in the graph below, despite the 2024 CMS final rule which outlined that MA plans must follow the two-midnight rule, MA plans' rate of observation patients continues to be double, or more, that of Traditional Medicare. Essentially MA plans try to drive reimbursement down by paying lower observation rates, even when patients meet Medicare's inpatient criteria.