MEDICARE ADVANTAGE

NHA | NEBRASKA HOSPITALS

Failing patients and jeopardizing Nebraska hospitals.

Report prepared by the Nebraska Hospital Association

The Issues

Nebraska seniors need to fully understand their Medicare enrollment choices this fall.

Medicare Advantage plans are aggressively sold as being a lower cost option, but the reality for patients and healthcare providers can be very different.

Medicare Advantage plans deny care more often than traditional Medicare and can delay treatment when it is needed most. Medicare Advantage plans often require prior approval for most prescription drugs, inpatient hospital stays, therapy, dialysis, and diagnostic services such as laboratory tests. The care is not covered if the plan denies approval for these services.

Prior authorization requirements mean nurses and doctors are forced to spend hours on the phone with insurers justifying their care decisions instead of treating patients. Medicare Advantage plans can undermine physician expertise and disregard a patient's individual medical needs.

Medicare Advantage can switch health care providers to be out of network at any time and come with out-of-pocket costs. Unlike traditional Medicare, which has essentially no out-of-pocket costs, MA plans in 2024 have an average of $9,000 in-network, out-of-pocket costs and more than $13,000 out-of-network costs.

Nebraskans deserve timely and efficient care. Twice as many Medicare Advantage patients were stuck in hospitals after being medically discharged as were traditional Medicare patients. This delays patients from receiving appropriate care, keeps them separated from family and community, and increases overall health care costs.

> "The extra costs that Medicare Advantage plans force us to incur to fight denials and for preauthorization takes away from our ability to improve patient outcomes."

Contents:

Negative Patient Experiences with Medicare Advantage

"A patient had a type of prostate cancer that has a higher risk of spreading beyond the prostate gland. Our local radiation oncologist wanted to treat him with the standard fractionation dose of 45 treatments in accordance with the National Comprehensive Cancer Network (NCCN) guidelines. The patient's MA plan went against the physician's medical advice and authorized only 28 treatments.

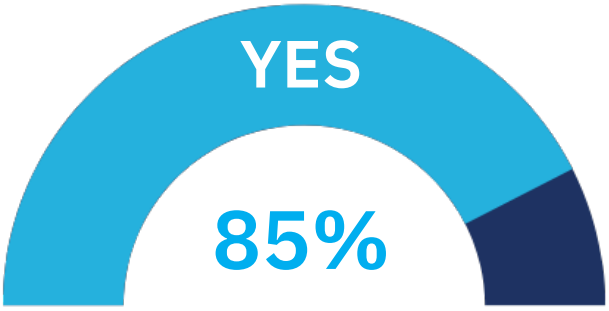
Our physician ordered a test which indicated a malignancy, confirming their desire for 45 treatments. The MA plan would not cover this treatment plan and again only authorized 28 treatments. The physician was concerned the patient would not receive a complete response to the shorter course of treatment."

"We had a patient needing a CT scan due to a history of lymphoma and new symptoms. Medicare Advantage prior authorization denied the scan as not medically necessary. Our physician called the insurance plan the day after denial of prior authorization to do a peer-to-peer review and was told that the case was already closed."

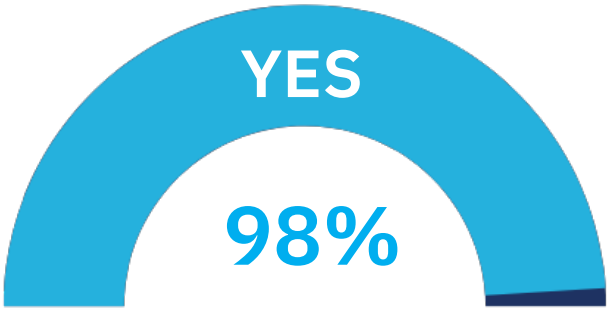
"We had a patient that suffered from a heart attack and was receiving cardiac rehabilitation after he was released from the hospital. His MA plan imposed a copay for each visit he had with our Cardiac team - costing him over $1,000 out of pocket. He ultimately decided to not continue with the Cardiac Rehab because he could not afford it."

MA Prior Authorization Restricts Necessary Care

85% of NE hospitals report that Medicare Advantage plans negatively impact the care their hospital is able to provide to patients.

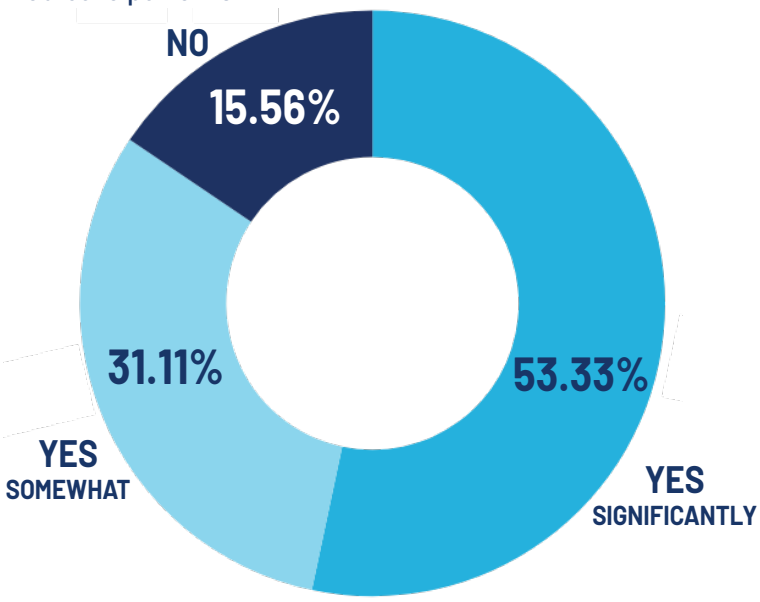


Almost 98% of NE hospitals report that prior authorization requirements by Medicare Advantage plans negatively impact clinical care and DELAY necessary care.



Post-Acute Placement Delays

Over 84% of NE hospitals report it is more difficult to get post-acute placements approved for Medicare Advantage patients than traditional Medicare patients.



"A patient was in a Nebraska hospital with a broken pelvis, waiting to be discharged to skilled care. We spent more than a week trying to find a placement for her. When we finally found placement with the 4th facility on our list, the MA plan only approved her for a stay of less than two weeks even though the facility was advocating heavily that she needed to stay longer."

"Delays in obtaining authorization is the main barrier for post-acute placement. Delays can take several days. This is especially true over the weekend when MA plans don't respond."

"Many post-acute facilities do not like to see patients with MA plans and they shy away from accepting them because of payment issues."

Biggest Challenges with MA Plans

PRIOR AUTHORIZATION REQUIREMENTS **PAYMENT DENIALS** **LOWER REIMBURSEMENT**

Financial Impact on Nebraska Hospitals

HAS THE SHIFT IN MEDICARE/MEDICARE ADVANTAGE PAYER MIX NEGATIVELY IMPACTED THE FINANCES OF YOUR HOSPITAL?

Administrative Burdens on Nebraska Hospitals

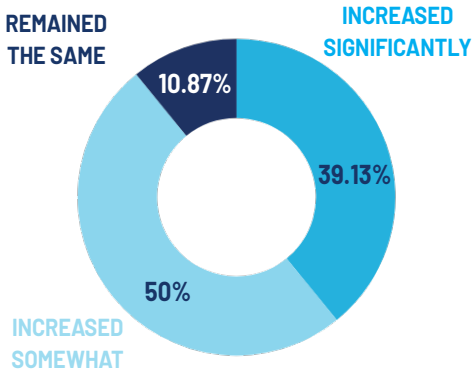
"Staffing required for prior authorization is the main increase to our overall costs. Front line staff, nurses and physicians are all involved in this process. Case managers and billing staff are also labored with ensuring the patient received an authorization, otherwise payment denials will follow."

"Our care teams are spending time on hold justifying their care decisions instead of treating patients."

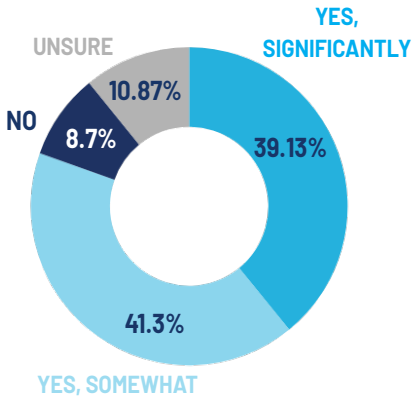
"The lower payments and higher administrative burden is a significant negative impact which limits our ability to expand services or add needed resources to existing services."

"We have seen increased denials and have had to allocate more resources to fighting these denials."

Over 89% of NE hospitals report that the cost to comply with MA plans has increased.



80% of NE hospitals tell us the increased administrative barriers in MA plans to provide care contribute to physician burnout.



Policy Changes for Medicare Advantage

Aggressive prior authorization practices add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with MA plan requirements. They are also a major burden to the health care workforce and contribute to provider burnout.

The NHA recommends streamlining prior authorization requirements under Medicare Advantage plans. This includes increasing transparency on services that require prior authorization, standardizing the format and process to transmit requests and responses, improving the timeliness of responses, requiring more detailed and complete denial notices, and streamlining appeals processes.

The NHA recommends that CMS include Medicare Advantage plan data in the Medicare Cost Report, which would ensure that Critical Access Hospitals can be adequately reimbursed for services provided to MA patients. This would preserve healthcare services in rural communities.

The NHA recommends Congress pass legislation with further oversight of the MA program, including greater data collection and reporting on plan performance and more streamlined pathways to report suspected violations of federal rules, to ensure timely patient access, consumer protection and meaningful enforcement of new CMS rules.

The NHA recommends:

STREAMLINING PRIOR AUTHORIZATION REQUIREMENTS FOR MA PLANS.

PAYING RURAL HOSPITALS ADEQUATELY TO PRESERVE HEALTH CARE SERVICES.

FEDERAL LEGISLATION WITH ADDITIONAL OVERSIGHT OF THE MA PROGRAM.

Source: NHA member survey September 2024