Testimony for the Record

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For the Hearing

"Medicare Advantage: Past Lessons, Present Insights, Future Opportunities."
July 22, 2025
LeadingAge

House Committee on Ways & Means Chairman Jason Smith, Health Subcommittee Chairman Vern Buchanan, Oversight Committee Chairman David Schweikert, and members of the committee, LeadingAge appreciates the opportunity to submit this written testimony in response to your July 22 hearing, "Medicare Advantage: Past Lessons, Present Insights, Future Opportunities." We appreciate your expressed interest in improving the Medicare Advantage (MA) program by identifying and addressing challenges that are becoming more pronounced due to the rapid enrollment growth in MA.

LeadingAge represents more than 5,400 nonprofit aging services providers and other mission-driven organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information visit leadingage.org. In addition, some of our providers also lead MA and/or Special Needs Plans (SNPs).

We were encouraged to hear many members of the committee acknowledge that while MA and SNPs offer older adults and other Medicare beneficiaries many desirable benefits that the program itself warrants some improvements to not only preserve the Medicare trust funds that support Medicare Part A and B services but also ensure that MA is delivering on its promises to ensure access to medically necessary Medicare services and support older adults in managing their chronic conditions and maintain their best possible health. At the same time, providers are needed to deliver these services and supports. Therefore, it is equally important that in the quest for innovating care delivery and reducing costs that we also preserve the financial viability of the care providers across the continuum. For this reason, we must balance the flexibility we currently give the plans with protections for beneficiaries and providers to prevent greed from overshadowing the needs of the people those plans are there to serve.

Committee members highlighted some key areas for improvement and corresponding legislation to accomplish some of these goals. Below we would like to supplement those arguments for improvement with the experiences and concerns our skilled nursing facilities (SNFs) and home health agencies (HHAs) face daily as they strive to support the older adults they care for who are enrolled in MA and special needs plans (SNPs). We seek to ensure that the solutions under consideration will not only help

physicians and hospitals but also are extended to post-acute care (PAC) providers who are subject to the same administrative burden and inadequate payment concerns. Most importantly, any solutions must not lose sight of the individuals being serve. Yes, Medicare beneficiaries are opting to enroll in MA/SNP plans in record numbers but much of that is a financial consideration as the MA program caps out-of-pocket costs and is required to use rebate dollars to offer supplemental benefits above and beyond those of traditional Medicare.

Beneficiary access to PAC services is jeopardized when provider payments don't cover their costs, Medicare Advantage (MA) plans do not process prior authorizations timely or in compliance with Medicare regulations, and well-intentioned or outdated regulations create unnecessary roadblocks to care. Our comments reflect the challenges faced by our skilled nursing facilities (SNFs) and home health agencies (HHAs) over the past decade as payment sources and levels have evolved and administrative burden has increased, both directly impacting current and future access.

We share many of the committee members' remarks and concerns. Here are some areas we believe deserve further attention and reforms.

Provider Payment and Access to Post-Acute Care Services

Access to post-acute care (PAC) services is directly tied to the financial viability of providers. SNFs and HHAs are facing mounting financial pressures due to declining all-payer margins, rising operational costs, and the increasing administrative burden of participating in multiple Medicare Advantage (MA) plans, which now cover over 50% of Medicare beneficiaries. These challenges threaten not only PAC access but also the broader range of services these providers offer in their communities including long-stay nursing home care.

Providers rely on a mix of payment sources—Medicare, MA, Medicaid, and Veterans Affairs—to sustain operations. However, when any one payer under-reimburses, it jeopardizes the provider's ability to cover costs. Medicaid, for example, has historically underpaid; a 2024 ASPE report found that Medicaid covered only 82% of the actual cost of care for nursing home residents. Traditionally, Medicare helped offset these shortfalls, but as MA enrollment has grown, MA payments have dropped to just 50–80% of traditional Medicare rates, exacerbating the financial strain on SNFs and HHAs.

MA plans often offer SNFs flat-rate contracts that fail to account for patient acuity, with some providers reporting rates as low as 75% of Medicare FFS regardless of the patient's needs. In some cases, MA plans offer rates even lower than Medicaid for the more complex and resource-intensive skilled nursing care. Similarly, HHAs report being denied payment for essential tools like wound care supplies, making it difficult to deliver necessary care to MA enrollees.

The administrative burden compounds the problem. MA plans frequently require prior authorizations, conduct concurrent reviews, and delay or deny payments—even for services that were authorized and delivered. An April 2022 OIG report (OEI-09-18-00260) found that 18% of denied MA provider payment requests met both Medicare coverage and the MA plan's own billing rules. Providers often must resubmit documentation, and many lack the resources to persist through lengthy appeals. Premier Inc.

reported that claims adjudication cost providers over $25.7 billion in 2023, with 70% of denials ultimately overturned—highlighting the inefficiency and burden of the current system.

Despite these challenges, CMS is limited in its ability to intervene. Section 1854 of the Social Security Act prohibits CMS from setting provider rate floors or requiring MA plans to meet minimum quality or payment standards. This regulatory gap allows MA plans to continue reducing payments and increasing administrative demands unchecked.

For these reasons, LeadingAge supports the **Prompt and Fair Pay Act (H.R. 4559)**—sponsored by Reps. Doggett and Murphy—which seeks to ensure timely and adequate payment from MA plans. It would provide much-needed financial stability for providers and help preserve access to care for Medicare beneficiaries.

Medicare Advantage Prior Authorizations: A Barrier to Post-Acute Care Access

Medicare Advantage (MA) prior authorization (PA) requirements are increasingly obstructing access to medically necessary post-acute care (PAC) services and imposing significant administrative and financial burdens on SNFs and HHAs. Most PAC services now require prior authorization. Our SNFs and HHAs report denials, delays, reduced services and incomplete care are on the rise among some MA plans and don't comply with Medicare coverage regulations. We've included links to two key reports that underscore how MA prior authorizations continue to increase each year and alarmingly show how plans are denying prior authorizations for PAC services at 3x the rate of all other services.

As Dr. Basel noted in his testimony, SNFs are an integral part of the health care ecosystem especially in rural communities. Hospitals don't have beds for other patients if can't discharge to SNFs. Similarly to Dr. Basel, our PAC providers also have not seen any improvements in more timely or more accurate prior authorization (PA) decisions since the implementation of updated MA rules governing PAs. While the 2024 MA audit report suggests MAOs are trying to comply with these regulations, it also highlights that the MAOs continue to have internal system errors that can be a key cause of inaccuracies.

MA plans are denying post-acute care (PAC) services at much higher rates than all other services according to the 2024 Senate "Refusal of Recovery" report and a January 2025 KFF report notes 81.7% of appealed denials are overturned suggesting many denials are unjustified or due to documentation issues. An April 2022 OIG report on MA examining 2019 data from the largest 15 MAOs supports this conclusion. Delays leave patients without medically necessary care and burden hospitals who are unable to discharge patients because the next site of service has not been authorized and burden PAC providers who are required to resubmit repeat requests or appeals for services to be covered for a beneficiary when the initial request should have been approved. Some SNF providers have reported that some MA termination of coverage notices for a single patient have been appealed as many as 9 or 10 times because they are overturned upon appeal only to have the MA plan reissue the notice almost immediately. **In addition, the most recent CMS audit report of the MA plans including compliance with the 2024 regulations, continues to show that plans' internal processes fail to provide timely notification of coverage decisions, "overlook pertinent clinical information" that would support approval of service requests, and deny coverage due to a "system logic error."**

Providers must navigate a fragmented and inconsistent PA landscape. Each MA plan has its own unique processes, codes, portals, and documentation requirements. Requests often require 40–50 pages of documentation**,** and review times range from 1 to 30 days, with further delays over weekends and holidays due to limited staffing. When care is denied or delayed, hospitals are unable to discharge patients, and PAC providers must issue Notices of Medicare Non-Coverage, placing both the provider and beneficiary at financial risk.

Even when services are approved, authorizations are often limited to short durations—such as **two home health visits or five SNF days**—requiring repeated submissions for continued care. This "concurrent review" process is burdensome and lacks standardization across plans.

The lack of consistency and transparency in PA decisions is a major concern. Providers report that similar cases yield different outcomes depending on the plan or reviewer. MA plans often fail to understand or follow Medicare rules regarding medical necessity for PAC services. Internal system errors, such as misfiled documentation or "system logic errors," frequently result in unjust denials. The 2024 CMS audit report confirms that MA plans continue to "overlook pertinent clinical information" and deny coverage due to "system logic errors," despite updated regulations.

These practices not only delay recovery but also strain the entire healthcare system. Hospitals face longer lengths of stay for MA patients, which reduces bed availability and increases costs. SNFs and HHAs must hire additional staff to manage the administrative load, diverting resources from direct patient care.

LeadingAge has been actively advocating for reform. The organization supports the bipartisan **Improving Seniors' Timely Access to Care Act (S.1816/H.R.3514)**, which aims to standardize and modernize prior authorization processes, track outcomes, and ensure MA plans do not use PA as a barrier to care. LeadingAge has submitted extensive comments to CMS and Congress, including recommendations for data collection, appeals tracking, and concurrent review oversight.

Given the page limitation requirements for this testimony, please see our other comments to other policymakers on current prior authorization issues and recommendations for improvements.

- LeadingAge Statement for the Record to the Senate Homeland Security & Government Affairs Permanent Subcommittee on Investigations on MA prior authorization denials and delays.
- LeadingAge Response to CMS RFI on MA
- LeadingAge comments to the 2024 CMS MA Data RFI.
- LeadingAge suggestions to CMS on their data collection initiative related to Service Level Data Collection for Initial Determinations and Appeals (CMS-10905) including tracking concurrent review requests (re-authorization or requests to continue care).

Additional reports:

- "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-acute Care" report (October 17, 2024)

- "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023"

Medicare Advantage Program Needs More Data and Accountability. Strides are being made to collect additional MA data including on supplemental benefits, prior authorizations, concurrent reviews and claims payments. It is still early days as CMS has just recently started or soon will start collecting this data. In the meantime, issues with inappropriate prior authorizations and payment denials and timely decisions persist. The Office of the Inspector General can document issues back to at least 2019 that continue to show up in the 2024 CMS audit of Part C and D plans with no clear direction for when these issues will be corrected. We agree with witnesses that MA supplemental benefits deserve a closer look given how much money MA plans are paid in rebate dollars to deliver these services. CMS began collecting data on supplemental benefits in 2024 and we would encourage Congress to ask for a report looking at the rebate dollars received in comparison to the supplemental benefits accessed by MA enrollees so improvements can be made to this process if necessary.

LeadingAge Perspective on Key MA Legislation
We were pleased to hear so many members of the committee aligned with our concerns about prior authorizations, overpayments to MA plans, administrative burden and inadequate payment of providers by the MA plans, and the need for greater transparency and accountability. We couldn't agree more.

Throughout the hearing, a number of bills were mentioned that are designed to reform aspects of the MA program, which members said they seek to correct or reform. These include H.R. 4559, the *Prompt and Fair Pay Act;* H.R. 3514/ S.1816 Improving *Seniors' Timely to Care Act; H.R. 4093 – "Apples to Apples Comparison Act of 2025" and* H.R. 3467 Rep. Schweikert's broad MA reform bill.

LeadingAge urges Congress to pass H.R 4559 and H.R. 3514 this year to begin to ensure the financial viability of providers and begin to take steps to modernize prior authorizations in order to reduce the administrative burden and speed up plan decisions to improve beneficiaries' access to medically necessary services.

We look forward to working with Rep. Schweikert on his work to reform the MA program, but we have some concerns about how H.R. 3467 is currently drafted to achieve his desired reforms.

We support efforts to correct overpayments to Medicare Advantage plans that are unnecessarily syphoning off funds from the Medicare Hospital Insurance Trust Fund accelerating its insolvency. We are unclear how all aspects of the adjustments to the MA plan benchmark would impact the payments MAOs receive and in turn, what impact that could have on the rates MAOs ultimately pay to providers, which are already grossly inadequate to cover the costs of delivering care to MA enrollees. As for the proposal related to eliminating the quality bonus, LeadingAge has long questioned why MAOs get a quality bonus payment over and above the base per member per month payment for meeting defined quality metrics. Provider quality or value-based programs withhold a portion of provider funds that they must earn back. MedPAC recommended in 2020 that the MAO quality bonus program should be replaced with a Value Incentive Program, that would use a portion of plan payments to fund the incentives for demonstrating quality among other changes worth considering.

The bill's automatic enrollment is cause for concern, as written. We would argue that the MA program is not ready for an automatic enrollment approach for all the reasons we outline above: inappropriate and untimely prior authorizations and wrongful payment denials persist; inadequate reimbursement rates

paid to providers; and insufficient MA data and accountability. As Dr. Brian Miller mentioned, there is currently no way to truly compare the value delivered by MA vs. traditional Medicare to beneficiaries or taxpayers.

Logistically, we have concerns with how the automatic enrollment would be implemented. It seeks to implement the provision on January 1, 2028, for all Medicare beneficiaries entitled to Medicare Part A and enrolled in Part B. The first question is would this apply to individuals already enrolled in an MA or SNP plan? What would happen to individuals currently assigned to an Accountable Care Organization, those who have employer retiree benefits or those who have been in Medicare fee-for-service (FFS) for a number of years? According to the legislation, individuals would be enrolled in the "lowest premium cost" MA plan in their area. While Medicare beneficiaries are price sensitive, this approach gives no consideration to overall out-of-pocket costs (premium may be low but cost sharing might be higher). In addition, this approach doesn't consider whether the individual's current providers are in the plan's network or if their prescription drugs are covered and affordable under the plan, which are also critical selection criteria. An individual would have "an opportunity to decline such enrollment" but it is not clear if this would happen before or after they were enrolled in a plan not of their choosing, and how long a period of time they would have to opt out or how easy that process would be. All of this could lead to a lot of confusion and churn.

Next, once enrolled, the legislation would lock these individuals into the selected or auto-assigned plan for 3 years. They would be prohibited from returning to traditional Medicare or enrolling in a different MA plan. The language does mention an exception for "hardship events" but gives no instructions to the HHS Secretary on what things might be considered beyond "serious illness." Plans bid every year and can change their provider network, how much they charge for premiums, co-payments and deductibles, and what supplemental benefits they offer. Without additional changes in regulation, individuals would be locked into a plan, but the plan could change the rules. In addition, by locking in a beneficiary for 3 years, they have no recourse if a plan is wrongfully denying them access to core Medicare services. The person would just have to accept it. This provision may also constrain competition in the MA marketplace. If individuals are locked in for 3 years, then it makes it more difficult for new plans to enter the market as it shrinks the available pool of potential enrollees as many of them are prohibited from changing plans.

Another provision in the bill seeks to incorporate hospice care into the standard MA plan benefit package for all enrollees**.** The provision would change the current process (when a MA beneficiary elects hospice care, their coverage changes to Fee for Service (FFS) Medicare) to require Medicare Advantage (MA) plans to pay for hospice care. Congress has made decisions over the course of the benefit's history that deliberately keep hospice separate from Medicare Advantage. Doing so ensures hospice remains a managed, holistic benefit outside of MA. Efforts, such as a demonstration program through the Center for Medicare and Medicaid Innovation (CMMI) that tested the coverage of hospice by MA plans was unsuccessful for a variety of reasons, including challenging operational issues between plans, the Centers for Medicare and Medicaid Services (CMS), and hospice providers that do not seem to have easy fixes. For these reasons, we would urge Congress to not pursue this policy.

Finally, we have long-supported and advocated for opportunities for PAC providers to be able to contract with MA/SNP plans through a variety of value-based arrangements. However, we also recognize that some SNFs and HHAs providers have little experience with risk-based arrangements such as capitation and therefore would benefit from opportunities to learn by being phased in to greater risk overtime. This could be achieved by starting with a pay for performance (P4P) or similar value-based

arrangement. Additionally, in our experience, value-based or other risk arrangements are not widely used by MAOs in contracting with SNFs and HHAs in any type of P4P, episodic payment or other similar capitation. We speculate that it is difficult for plans to set up these models for PAC settings and might benefit from CMS providing some guidance in the form of templates for different alternative payment arrangements. We offer specific ideas for how to approach this in our Fulfilling the Promise: Medicare Advantage white paper.

We hope these comments will help spur ideas for additional ways to improve the reforms ideas in Rep. Schweikert's legislation.

The Bottom Line

Provider payment pressures jeopardize beneficiaries access to quality services. Health plan cost containment measures such as prior authorization and claims adjudication add to providers' and taxpayer costs and administrative burden. Regulations that present barriers to beneficiaries accessing care or may result in a retraction of PAC services should be reconsidered or eliminated.

We commend the Joint Subcommittees for more closely examining the lessons learned, witness insights and future opportunities to improve the program to ensure access to quality, timely and necessary care for beneficiaries. Additionally, we urge Congress to ensure adequate payments from all payer sources so providers can invest in innovation and continue serving vulnerable adults. We ask the committee to not delay in ensuring MA plans pay their fair share for SNF and HHA services, as is envisioned by Reps. Doggett and Murphy's Prompt and Fair Pay Act, by joining these sponsors and passing this bill.

We support the 200+ bipartisan representatives and senators who are fighting to modernize and standardize the prior authorization process to reduce the administrative burden on providers and speed decisions so MA enrollees can have timely access to needed care, through the *Seniors' Timely Access to Care Act (H.R.3514).* Congress and the Administration lack data on prior authorization costs, claims adjudication, and MA plan encounter data, hindering effective oversight. Standardizing processes like prior authorizations, claims payments, and codes in MA could reduce costs and administrative burdens and expedite care for beneficiaries.

Again, we appreciate the opportunity to share our concerns and look forward to working with you in crafting solutions to these issues that currently jeopardize older adult access to care and services. Please let us know how we can further support your endeavors to improve post-acute and long-term services for older adults. Please contact Nicole Fallon with any questions or follow up at nfallon@leadingage.org.