United States Senate

WASHINGTON, DC 20510

December 21, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Brooks-LaSure:

We thank the Centers for Medicare & Medicaid Services (CMS) for taking steps to ensure that Medicare Advantage beneficiaries receive the same services they would under traditional Medicare, as required by law. With the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Final Rule (CMS-4201-F) (the Final Rule) taking effect January 1, 2024, we are writing to ensure that critically and chronically ill Medicare Advantage beneficiaries will have the same access to Long-Term Care Hospital services as traditional Medicare beneficiaries.

Long-Term Care Hospitals (LTCHs) are hospitals that provide specialized care for high-acuity patients who require an extended hospital stay. These facilities are designed to care for severely ill patients who require complex medical treatment, such as mechanical ventilation and wound care. To be recognized as an LTCH, CMS requires hospitals to satisfy the conditions of participation of a short-term acute care hospital (STACH) but have an average Medicare length of stay greater than 25 days. In contrast, the average Medicare length of stay in a STACH is about 5 days.

Unfortunately, Medicare Advantage plan prior authorization practices are creating significant barriers to LTCH care for critically and chronically ill patients. A 2022 report by the Department of Health and Human Services' Office of Inspector General concluded that Medicare Advantage Organizations "sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules" and that these denials sometimes delayed beneficiaries from receiving medically necessary care or prevented them from receiving the care altogether. Sadly, LTCHs are also subject to this trend. Medicare Advantage beneficiaries are less than half as likely to receive LTCH care compared to traditional Medicare beneficiaries. Recent research suggests that these practices may be worsening the outcomes of Medicare Advantage beneficiaries; a 2021 peer-reviewed study found that delays in the transfer of mechanically ventilated patients to an LTCH decreased a patient's likelihood of being successfully weaned from the ventilator and breathing on his or her own.

We were pleased to see CMS respond to these practices by including language in the April 2023 Final Rule that specifies that Medicare Advantage plans must comply with general coverage and benefit conditions included in traditional Medicare coverage policies. The Final Rule also

codifies previously released CMS guidance that Medicare Advantage plans must: (1) make medical necessity determinations based on traditional Medicare coverage criteria; 2) consider if a service is reasonable and necessary; 3) consider the patient's medical history when making medical necessity determinations; and 4) where appropriate, plans' medical directors must be involved in ensuring the clinical accuracy of medical necessity determinations.

The statute allows Medicare Advantage plans to create contracted networks, but the Final Rule specifies that Medicare Advantage plans must align with traditional Medicare in terms of covering different provider types and settings. This means that if care can be delivered in more than one way or in more than one setting, and a practitioner has ordered a covered item or service for a Medicare Advantage enrollee, then the Medicare Advantage plan cannot deny coverage. CMS provides the following example in the Final Rule:

> *"[I]f an MA patient is being discharged from an acute care hospital and the attending physician orders post-acute care at a SNF because the patient requires skilled nursing care on a daily basis in an institutional setting, the MA organization cannot deny coverage for the SNF care and redirect the patient to home health care services unless the patient does not meet the coverage criteria required for SNF care…."* See 88 Fed. Reg. at 22190 (April 12, 2023).

We have heard concerns from LTCHs in our states, as well as patients, that LTCHs regularly receive denial letters from Medicare Advantage plans stating that an LTCH transfer was not required because the patient could receive all necessary services in the short-term acute care hospital, even though the provider referred the patient to an LTCH, and the patient met all the medical necessity requirements for LTCH care.

Based on the specifications included in the Final Rule and given that 42 CFR §412.3 covers admissions to an LTCH, we write to ensure that the Final Rule requires Medicare Advantage plans to apply traditional Medicare standards and requirements in assessing prior authorization requests for LTCH admissions. That is, a Medicare Advantage plan – like a traditional Medicare plan – cannot deny admission to an LTCH if the patient is being discharged from an acute care hospital, the patient's attending physician orders post-acute care in an LTCH, and the patient meets the coverage criteria for inpatient admissions under 42 CFR §412.3.

We write to ask CMS to confirm this interpretation is correct and to request such information be publicly clarified to eliminate confusion for Medicare Advantage plans and ensure that LTCHs are treated the same as any other post-acute care provider under the Medicare Advantage regulations.

We appreciate CMS's commitment to improving Medicare Advantage enrollees' access to Medicare-covered benefits and we look forward to working with you to ensure that Medicare Advantage beneficiaries have access to the services they are entitled to by law.

Sincerely,

United States Senate

WASHINGTON, DC 20510

Christopher S. Murphy
United States Senator

Thom Tillis
United States Senator