



August 31, 2022

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013
Submitted electronically

Dear Administrator Brooks-LaSure,

LeadingAge appreciates the opportunity to comment on CMS's request for information on various aspects of Medicare Advantage (MA) Program ("RFI").

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports, and home and community-based services who contract with Medicare Advantage and Special Needs Plans to provide services. In addition, we also have providers who lead the operations of their own MA plans, Special Needs Plans (SNP) and PACE programs.

As of June 2022, MA enrollment represents roughly 46% of beneficiaries on average nationally but within regions around the country the growth is even higher (According to recent Better Medicare Alliance report, 724 counties and 123 Congressional Districts have MA enrollment levels of 50+%). Therefore, we believe we are at a critical juncture and now is an appropriate time to re-examine the law and rules we put in place for these plans as we see the effects they have had on the marketplace.

MA plan practices and policies impact the entire health care system. Their delays in approving care requests can back up patients in hospital beds, which impacts the entire population not just seniors. Failure to address the issues highlighted below, we believe, will lead to access issues for beneficiaries, as providers close or refuse to contract with these plans because their contract terms and policies are not financially viable and require significantly more staff resources that they just don't have in this current environment.

Instead of addressing each individual question within the RFI, our comments will address thematic issues that our aging service providers face related to participation with MA and Special Needs Plans (SNPs). Where appropriate we will respond directly to some of the specific questions posed by the RFI.

Our feedback on how to address some of the current dilemmas follows:

Provider Payments, Networks and Contracting Terms

As we noted above, our association consists of more than 5,000 aging service providers, which includes skilled nursing facilities (SNFs), long-stay nursing homes, life plan communities, home health agencies, hospice providers, and Home and Community Based Service providers. Each of which have opportunities to contract with MA plans. Provider payment is the number one concern of these providers. They have watched their payments from MA plans diminish in the past 5-10 years at the same time that enrollment in MA has grown. One SNF reports they are paid a flat rate by the plan regardless of the patient's acuity and that rate is 75% of what they are typically paid by Medicare FFS. Another provider in Oklahoma reported being offered a contract for SNF services that was equal to a Medicaid per diem rate. They are a preferred referral partner for the large hospital system in their area because of quality and offer 7-days per week admissions and therapy for residents. They help residents return home sooner. The plan refused to consider increasing its proposed rate and instead pursued contracting with smaller, less sophisticated SNF providers who didn't understand the rate they were being offered would not cover their costs. Another provider notes that they are paid \$300 less per day by a major national plan than they would be paid under Medicare FFS for the same resident with really high care needs. Some plan contracts offer to pay providers based off tiers/level of care needs but then never approve a payment above the lowest tier. Another contract indicates it will pay the SNF when IV antibiotics exceed \$100/day, however, often the patient is prescribed two medications for a total of \$150/day but because each medication is less than the prescribed limit the plan doesn't reimburse the provider because it was two medications not one that exceeded the limit. Home health agencies are regularly paid per visit rather than the Patient-Driven Groupings Model (PDGM) rate and the per visit rates are far below the cost of care. These are not value-based contracting terms that drive quality care but merely mechanisms to pay providers less.

Providers are now reaching a tipping point where they can no longer receive a lower payment for more beneficiaries while being expected to do more work. The numbers just don't add up. MedPAC assumes that providers accept contracts because payments from MA plans are adequate. This does not reflect the reality providers face in many markets where they have no choice but to contract because the MA plan enrollment represents 50% or more of all beneficiaries. In some cases, a single plan or Medicare Advantage Organization (MAO) controls more than 50% of a market. Choosing not to contract would result in insufficient service volume making it difficult to impossible for the provider to keep their doors open. Therefore, they sign the contracts, creating their own financial death spiral, as plans pay significantly less than Medicare fee-for-service (FFS). In fact, plans are often paying closer to Medicaid rates, which all agree don't cover the costs for less intensive Medicaid services let alone Medicare skilled care. Thus, the pattern we are seeing is lower rates with increased administrative burden.

In addition, some provider/plan contracts have remained unchanged for a decade or more, which translates into no rate increases while costs have continued to rise. Just during COVID-19, costs have increased dramatically for food, staffing, and infection control supplies. On staffing, SNFs have seen an 8.1% increase in nursing average hourly wages, and 9.2% for agency staff in 2021 – [CLA report](#)); home health agencies have seen an overall 11.5% increase in two year quarterly compounded wage growth. MA plans that are not regularly conducting contract renewals and renegotiations are causing providers to fall further and further into the hole to serve MA beneficiaries. On top of that, MA plans regularly require providers to do even more including processing more paperwork, more frequently, with shorter lengths of stay and fewer visits per MA enrollee. This means that these providers are conducting labor and time intensive admission evaluations (e.g., MDS, OASIS, etc.) more frequently. The costs are highest at the beginning of an episode of care, but the rates don't reflect that churn nor the plan expectations

for updates every few days. Unlike Medicare FFS, where there are no prior authorization requirements for our providers, MA plans often require a prior approval before skilled services can be initiated, even when the services are ordered by the discharging physician. One SNF noted that they have 3 FTEs in their billing office just to deal with MA billing, prior authorizations, audits and claims and that does not account for the time of their clinical staff. Other SNF and home health members report proportionally similar levels of FTE time needed to deal with the administrative burden.

Contracts are also capping daily outpatient therapy reimbursement regardless of the units of therapy provided according to the resident's plan of care. Often SNFs contract out these services and so end up paying the therapy provider more than they are reimbursed for the service.

Finally, PAC provider payments are further reduced due to an inability to collect co-payments and co-insurance that the plans charge their enrollees. One provider notes they end up receiving less than \$300 per day to provide skilled care, medications, therapy, supplies and other ancillaries (which is one-third to one-half the payment they receive from Medicare FFS for comparable consumers). PAC providers are getting stuck writing off bad debt due to co-pays and co-insurance that MA enrollees don't pay. These co-pays vary by plan and service provided so it is difficult to pre-collect these amounts based upon expected co-pay or co-insurance. PAC providers are typically notified of the amounts after the patient has discharged making it more challenging to collect. Many patients enroll in the MA plan for the low premiums and then cannot afford the co-pays or co-insurance, and the PAC provider must pursue the individual for payment, often unsuccessfully. In original Medicare, there is no copayment for home health, so having to determine which beneficiaries have Medicare Advantage and then pursue them for payment is additional burden that is payer specific.

Due to the high rate of MA penetration around the country, providers have little leverage in the negotiation process. Plans know this and use this especially when they have the majority of MA enrollees in a market. Plans will give a provider a contract and refuse to negotiate stating they can get another provider. Rates being offered range from being equivalent to what Medicaid will pay to no more than 80% of Medicare FFS in most cases. Value-Based Arrangements (VBAs) that allow providers to earn more are rare for PAC providers, unless they own and lead an MA/SNP plan or are part of a larger provider network.

Medicare Advantage plan payments from CMS will have grown more than 13% between 2021 -2023. However, no similar rate increases have been passed along to the providers who deliver the care to the beneficiaries enrolled in these plans. MedPAC has noted, "Total Medicare payments to MA plans (including rebates that finance extra benefits) average an estimated 104 percent of FFS spending," (MedPAC March 2021 Report to Congress, Chapter 12) This situation is reaffirmed in MedPAC's 2022 report and yet, provider rates are paid at less than Medicare FFS. While plans post profits, PAC providers have experienced negative operating margins. This is unsustainable.

We understand that the non-interference clause - Sec. 1854 (6)(b)(iii) of the Social Security Act - limits actions that can be taken by CMS regarding payment rates, "The Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract..." However, like previous limits on Medicare prescription drug price negotiations, the time has come to change this statute. It was established in a time where MA represented a small fraction of the

marketplace. It is now being used by plans to bully providers into financially unsustainable contracts that can only jeopardize future access to post-acute care services for MA and Original Medicare beneficiaries. It is in CMS's and beneficiaries' best interest that CMS is able to ensure providers are adequately paid to preserve care access and quality care delivery. Insufficient rates paid through MA contracts can ultimately jeopardize care access throughout the health care system, as MA becomes the dominant payer.

When MA enrollees select an out-of-network provider, the providers report plans are extremely slow to pay, subject them to numerous prior authorizations, and other paperwork, and apply high co-pays for which they are rarely reimbursed (especially for dual eligible). Some of these providers are not out of network by choice and not because of quality but simply because the plan "has enough providers."

Recommendations:

- The HHS Secretary should establish a rate floor that plans must pay unless the plan can negotiate a pay-for-performance or other value-based arrangement (VBA) with the provider. CMS could ensure rate adequacy by establishing Medicare FFS rates as the floor for payment. Plans wishing to not pay these rates would be incentivized to negotiate a VBA that is advantageous for the plan and the provider. The reality is if we want high quality care, ratcheting down provider rates is merely a recipe cutting corners and ensuing poor quality care. If MA payments make up or may make up a significant percentage of skilled nursing facility, home health agency, and someday hospice revenues, we must make sure these rates are adequate to ensure quality care or the whole system of care for older adults is placed in jeopardy.
- Require plans to pass along a certain percentage of any rate increase to the providers.
- Require plans to regularly review their contracts and update rates in accordance with inflation and other factors similar to the Medicare FFS payment rule process.
- Eliminate the non-interference clause that constrains CMS from ensuring provider rate adequacy and setting expectations for plans to enter into VBAs with all provider types not just physicians and hospitals.

Network Adequacy

Plans are required to ensure adequate numbers of providers by type in their network. CMS establishes time and distance standards that a plan must meet to ensure that 85-90% of enrollees have access to certain providers. Our non-profit, mission-driven post-acute care providers have encountered three key situations that should raise concern about the networks: 1) smaller providers are increasingly being excluded or dropped from plan networks because the plan says it is "too much work to contract with them"; 2) high quality providers who refuse financially unsustainable MA contract terms are replaced by lower quality providers leaving MA beneficiaries with access to fewer or no high quality providers; and 3) regulatory changes made in CY2021 make it okay for plans to have less provider access in rural areas. Beginning with CY2021 plans, three changes to MA rules on network adequacy were adopted that could potentially negatively impact rural areas: 1) Lowers the threshold to meet network adequacy to 85% of beneficiaries have access to a provider within time and distance standards; 2) Provides a 10% credit to plans against the 85% network adequacy standard when plan is available in a Certificate of Need (CON) area; and 3) Provides a 10% credit when plan has one or more telehealth providers of a particular type.

These changes can be cumulative. For example, a plan could meet network adequacy standards in a rural area in a CON state where the plan has at least one telehealth provider by ensuring that at least 65% of enrollees have access to certain providers within time and distance standards. What does that mean for the other 35% of MA enrollees in that area? Beneficiaries living in rural America deserve equal access to care. These changes potentially set up an inequitable standard.

Recommendations

- Network adequacy requirements should include a third factor requiring plans to contract with providers of all quality levels to ensure true choice for beneficiaries. Amend section 422.204 or 422.205 to require plans to ensure access to 1 or more providers with 3 stars or higher for nursing homes and home health. In addition to and as part of other network adequacy requirements, such as time and distance standards. MA networks should not be made up of lower quality providers. MA enrollees deserve access to high quality post-acute care providers. CMS could publish a list like it does for ACOs, identifying providers who are three stars or higher. This proposal would not prohibit 1- and 2-star providers but must ensure plans are not contracting only with low rated providers. It is important that plan networks reflect the provider quality available in the marketplace. Alternatively, CMS could require plans to annually report their network providers by type and star rating or include the star rating of their network providers in their provider directory to provide beneficiaries with important decision-making tools. Network quality information should be made public.
- Limit plans from removing or excluding providers just because of size. Consider an any willing provider clause to ensure access to small providers who can offer beneficiaries a more person-centered experience (e.g., Green house models) or that are limited by virtue of their provider type (e.g., Adult Day Service providers). Some providers may never get the opportunity to be in-network because they are too small to get the attention of the plan, or it may be perceived the provider's participation would be too costly and yet the provider may be high quality. This practice of excluding high-quality providers due to size may ultimately lead to these providers closing their doors or consolidating, which in health care does not always prove more cost effective. It also can hamper equity by eliminating providers who serve targeted ethnic, religious populations such as nursing homes that are faith-based and whose meals are appropriate to the person's religious beliefs (e.g., a Jewish nursing home that may serve kosher meals), or those dedicated to serving low-income individuals or hospice programs designed for Latinx cultures.
- Repeal or prohibit lower standard in rural areas (e.g., 85% of beneficiaries have access to providers within given time and distance standard adopted in rule) and limit Certificate of Need (CON) and telehealth credits in rural areas.

All payer contracts

Some providers are entering into the Institutional Special Needs Plan market (own their own ISNP) so can more easily meet residents' needs and then share gains with the providers in their networks, which in turn, offers financial sustainability for these providers and allows the providers to pay direct care staff better wages. However, some plans require "all payer contracts", which means if you contract with the plan for their plan business you must compete with their ISNP in your building. If you cancel the ISNP contract, then you are no longer eligible for any other business/referrals from a large national plan. For one provider, losing that rehab contract would cost \$1.5M dollars in revenue. Their attorneys tell them this practice violates antitrust- law, but providers are afraid to pursue such a claim for fear of

retribution. There are cases where other providers have won their case but then received no referrals from the plan after the case was won. Another provider notes that they would opt not to contract with one major national plan because the rates are so low, they lose money on every person they serve. However, they have no choice but to contract because they must contract for Medicaid managed care with the plan and then they are automatically contracted for all their plans (e.g., MA, commercial, etc.).

MA Plan Claims

Our PAC providers all share stories of the inconsistent, varied claims processes that leads to inappropriate denials and enormous administrative burden just to get paid for services provided to MA enrollees. Examples provided include:

If no prior authorization (PA) is obtained, the entire claim is denied even if other services on the claim weren't tied to the PA.

The entire claim is often denied for the smallest human error in documentation.

Some companies will deny the entire claim if a SNF staff member does not write a progress note that indicates section GG of the MDS was agreed upon and completed by the Interdisciplinary Team.

Providers report that they jump through so many hoops to get paid. Providers can bill a claim one month and have it denied but next month submit a claim exactly the same way and it is paid. There is no sense to it. Denied claims require repeated calls to the plan to resolve. Consistently, we hear that smaller, regional plans tend to pay better and prioritize provider relations more than larger national plans but still pay below the cost of care. As the size of the plan grows, the rates and the level of provider support and communication tends to go down.

In addition, several PAC providers note that clean claims are not paid timely. Unlike Original Medicare FFS claims which pay within 14 days of a clean claim, one provider indicated that MA plans are taking 6 to 8 weeks to pay from a clean claim submission. This provider says they don't have enough volume to use a clearinghouse for submissions. The MA regulations (422.520) requires MA plans to pay clean claims within 30 days of receipt for network providers or pay interest on the claim to the provider and within 60 days for non-contracted providers. Clearly in this example the law is not being followed. The question is what recourse do providers have? Who do they call to remedy this?

Recommendation: CMS should establish a dedicated provider support line to accept complaints, and address plan compliance issues such as prompt payment of clean claims including coordinating with State Departments of Insurance who might own or share jurisdiction over this issue.

Value-Based Arrangements

As we have established, current MA contracts with post-acute care providers offer rates that are below Medicare FFS. Value-based arrangements (VBAs) offer an opportunity for these providers to be rewarded financially for the quality and value they deliver to Medicare/MA beneficiaries. MA plans will note that they contract with some providers in VBAs. This is true for physicians and hospitals but, at present, few post-acute providers have the option to contract with MA plans in a VBA. Those PAC providers who are fortunate to have a VBA typically are receiving a bonus payment for achieving certain metrics (e.g., discharging patient within 2 weeks, or reducing hospitalizations) and are less likely to be

single site providers but instead either a larger PAC organization or part of a provider network.

We have also heard that the plans' systems often don't accommodate these alternative rates. In cases where PAC providers are able to enter into a VBA, it usually requires them to escalate the contract negotiation to the C-suite level to obtain such an arrangement, not the contract manager level, because it is considered a one-off situation. We believe that a combination of incentives and tools could help create greater opportunities for providers to enter into VBAs with plans, which we hope will create greater financial sustainability for them, while also benefiting plans through more standardization and incentives. In addition, by encouraging VBAs in MA plan contracts, it can create a tipping point for providers who are in similar arrangements through accountable care organizations or other CMMI models. This incentive alignment across programs makes it easier for providers to make the necessary care delivery changes to transform care for beneficiaries. CMS has set a goal for how many beneficiaries in FFS Medicare will be in an accountable arrangement by 2030 but are acting on the assumption that beneficiaries in MA are already in a version of accountable care. This isn't the case and CMS needs to enforce their vision of quality based, value-based care across its whole range of payers.

3a. What steps could CMS take to support more value-based contracting in the MA market?

Recommendations:

- **Develop guidance or templates that establish a roadmap with VBA parameters.** Develop VBA templates specific to post-acute provider services that plans can use as a foundation for payment terms. Plans could use these templates voluntarily but by having standardization and incentives, it may encourage the upgrading of plan systems that can support these alternative payment methodologies. Ideally, these templates would allow for providers to take steps towards assuming greater risk over time, so providers have time to learn and adapt. In addition, a phased-in approach would allow plans to build their systems. For example, pay-for-performance arrangements could be an important first step, while also providing guidance on establishing sub-capitated arrangements for more experienced providers. This proposal has the added value that these templates could be better aligned with CMMI models and used within CMMI models, too, to expand the number of providers in VBAs or alternative payment models.
- **Establish goals for the percentage of contracts that should be VBA by provider types.** Some state Medicaid managed care programs establish expectations for the percentage of VBA contracts a plan must have with providers each year of a contract. CMS could establish a similar expectation for MA plans based upon the number of years the plan has been participating in the MA program. This may create the incentive for plans to upgrade their systems knowing this is the expectation. Again, this proposal may be currently prohibited by the non-interference clause and as such, be another reason for its elimination.
- **Encourage VBAs between providers and MA plans serving specific or high-need populations.** To improve quality and advance health equity, CMS could encourage plans and providers to specifically enter into VBAs to better serve members and from agreed-upon communities of need with identified SDOH needs and facing health disparities. This should be informed by and through contractual arrangements with providers and community-based organizations serving these beneficiaries, with outcomes that improve key metrics – including potentially avoidable hospitalizations and readmissions.
- **Invest in health information exchange.** Our members can capture important data from in-home and other assessments, and patient monitoring that can assist MA plans in improving on key HEDIS measures (e.g., medication reconciliation). But we did not benefit from the financial investments for meaningful use like the hospitals and physicians did. Therefore, for providers

like SNFs and HHAs as well as hospices, IT infrastructure has been lacking, preventing the efficient and timely exchange of critical health information between these providers and plans. Providers like adult day and other Medicaid HCBS services likely have even less infrastructure. Plans should provide providers with ready access to their HIE systems and incentivize them through “pay for reporting” of health information. CMS should also encourage Congress to invest in health IT infrastructure for those providers that never received meaningful use dollars.

Prior Authorizations

No one wants services delivered that are unnecessary. However, the prior authorization (PA) process plans use is riddled with problems, including denials for services that should have been approved. According to Kaiser Family Foundation in 2018, 80% of MA enrollees were in plans that required prior authorization for some services; 71% of enrollees’ plans required PAs for SNF stays and 62% for home health services. In the [April 2022 OIG report](#) on MA plans and prior authorization, OIG found MAOs sometimes delayed or denied MA beneficiaries’ access to services, even though the requests met Medicare coverage rules. (18% of the denied PA requests). Most were the result of human error by the plan missing a document that had been submitted or MA organization’s (MAOs) system was not programmed correctly. OIG also notes that, “MAOs approve the vast majority of prior authorization requests and provider payment requests...” Further, OIG cites in its 2018 report that Medicare Advantage Organizations (MAOs) overturned about 75% of their own prior authorization denials and in 2015, CMS cited 56 percent of audited MA plan contracts for making inappropriate denials. “CMS took enforcement actions against MAOs, including issuing penalties and imposing sanctions. Because CMS continues to see the same types of violations in its audits of different MAOs every year, however, more action is needed to address these critical issues.” This should call into question the benefit of conducting these reviews and placing the additional administrative burden on providers. One SNF provider shared that while a PA typically takes 1-3 days for the plan decision, appeals of those decisions can take an additional 4-7 days, and then if approved, it takes additional days for the plan to enter the approval into its system so its PAC management provider (e.g. NaviHealth) will permit the service to be delivered. The impact is the MA enrollee sits in the hospital for an additional week before they can initiate skilled care and rehabilitation services. We hear about similar issues from our home health members, also resulting in delayed care.

In other cases, providers reported PAs taking as many as 30 days, requiring a SNF or HHA needing to issue a Notice of Medicare Non-Coverage (NOMNCs) to the beneficiary because it is unknown whether the service will be covered by the plan. More timely decision-making on PAs and transparency about plan practices can help shape appropriate policies related to PAs in the future.

In some locations around the U.S., prior authorizations for SNF services can take as long as 20-30 days. By the time the decision is made, the SNF services have started and ended. In the meantime, the SNF was required to inform the enrollee that if they choose to access the SNF care recommended by their discharging physician at the hospital, the MA plan may not pay, and the enrollee would be financially responsible for the full cost of services received. This is not the type of stress beneficiaries need when they have recently been discharged from a hospital and require additional skilled care services.

We believe that if MA plans opt to use utilization management tools such as prior authorization, then they should staff those divisions adequately to meet the caseload that they themselves create.

In addition to the timeliness of prior authorization decisions, PAs pose the following additional challenges for providers and beneficiaries:

- **Administrative Burden:** PAs place significant administrative burden on providers for two reasons. First, each plan has its own process, deadlines, and criteria. Second, the plans require the PAC provider to produce up to 30-50 pages per request consisting of: hospital discharge summaries, therapy evaluation notes, nursing notes, discharge planning, social service notes and complete required plan forms for these approvals often with short (e.g., less than 24 hour) turnaround times or be denied payment. Initial services may be approved but the duration of service approved is shorter than Medicare FFS and requires submission of additional data for PA renewals. SNFs report needing to seek PA renewals every 3 days. Each plan is different how they want the data/documentation submitted: fax, email, voice mail, online portal, or U.S. mail. Sometimes the plans' systems can't receive the volume of data requested, leading to the need to resubmit or having PAs or claims denied for missing documentation.
- **Plans audit claims and prior authorizations after the fact and take back payments, sometimes years later.** PAC providers report that plans approve prior authorizations, then later either refuse to pay or pay then require repayment upon audit for a service they approved. This is a particular pain point for providers, which often discourages them from wanting to accept MA enrollees for service. Each plan has its own policies, reimbursement methodologies, and separate claims forms and processes. This leads to additional administrative burden for providers who must navigate these disparate procedures and often requires them to hire additional staff just to be able to bill plans and pursue prior authorizations, etc. What is most galling though is when the plan retroactively denies a claim that was originally paid. This often occurs when the MAOs audit providers. These audits are frequent and can include all claims submitted.

Sometimes this "take back" of payment occurs years after the service was delivered. One provider had a plan take back a payment 8 months after it was paid, another had a payment recouped 5 years after the service was delivered. It requires providers to appeal, where they often win but can delay final receipt of the payment for 2-3 years after the service was delivered.

While this take-back practice is reported across plans, one national plan, in particular, is known for constant recoupment behavior. The recoupment practice by this plan is so frequent that eventually providers can no longer dedicate any more time to fighting for the payment they deserve for the service already delivered. In the end, providers are increasingly refusing to contract with this MAO because the rates are insufficient to cover costs of care and the additional administrative burden plus audits make it impossible to justify working with this plan. Unfortunately, this plan holds a huge beneficiary market share; their business practices with provider partners are likely having or will have a detrimental impact on the care of many patients. No one argues that plans should be able to recoup funds inappropriately paid, but they should not be able to recoup funds when the appropriate documentation was provided, the prior authorization was approved prior to service delivery, and the service was delivered. This requires appeals to the plan, which

evidenced by the OIG report often reverses their own decision. This is wasted time and effort. Often it is the plan's own system that is wrongly programmed and kicking out claims even though sufficient and appropriate documentation is provided. Outside of appealing the decisions, providers have little recourse and often give up because they don't have the resources to constantly resubmit documentation and claims that should have been paid the first time.

OIG recommended back in 2018 that CMS should "enhance its oversight of MAO appeals data and provided beneficiaries with clear, easily accessible information about serious violations by MAOs. As of March 2022, CMS had not yet implemented these recommendations." In the April 2022 OIG report, it found MAOs denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied services included advanced imaging services such as MRIs and PAC facility stays. (e.g., SNF, IRF, etc.). MAOs claimed insufficient documentation for prior authorization requests, yet OIG reviewers found sufficient information in the beneficiary medical records in the case files to support medical necessity of the services. *"Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers."* (OIG report, April 2022) The OIG report notes that in 2018, MAOs denied 56.2 million payment requests overall (9.5%) in the MA program. This practice has to stop, and this behavior can no longer go unchecked. It is administrative waste in a time where providers are already significantly short staffed.

- **Care is Increasingly Being Denied or Duration Reduced.** Providers are reporting increased denials for skilled post-acute services and/or approvals for fewer days and visits than is the standard of care based upon the patients' identified needs. One SNF provider notes that in recent weeks, PAs have been denied for any individual who can ambulate more than 100 feet. In one case, the patient had a subdural head bleed and cognitive impairments but could walk 100 feet and was denied admission for skilled services. The person appealed and won but sat in the hospital for a week while the appeal was considered, and the approval communicated to NaviHealth (the PAC care management company the plan contracts with). Other patients are sent home from the hospital to recover even in cases where they live alone and are unable to get to the grocery store, or where they are a primary caregiver to their spouse.

The question is why are basic Medicare services being denied to MA enrollees? Our SNF and home health providers are increasingly seeing denials for skilled care. Post-acute skilled care is a Medicare benefit, and yet almost every plan requires prior authorization for these services even though they are ordered by the discharging physician.

We support the Improving Seniors' Timely Access to Care Act legislation. Which if passed, we believe will begin to bring about some needed change to plan prior authorization processes. We especially like the requirement that plans report in on the number of prior authorization (PA) requests made, number approved, and number appealed – we are hopeful more transparency will help with oversight and behavior change.

Recommendations:

- Create a clearinghouse/single portal for all MA plan PA processes to create standardization or uniformity, consistency and ease of use. The burden should be on the plans to adjust their system and processes to link to the clearinghouse.
- **Establish limits on the number of claims and prior authorizations that plans can audit each year** (e.g., a representative sample or percentage of files) and the look-back timeframe that can be audited (e.g., 1 year from clean claim or prior authorization). If a provider is found to be largely in compliance, they should not be audited again for another 2 years. The Secretary might consider aligning the MA plan look-back periods for audits to the [timelines for Medicare FFS on the look-back period](#). Medicare FFS has a policy of placing providers “under review” if not meeting clean claims, when this happens, education must be provided to ensure clean claims until provider gets to 97%. Could a similar requirement for plans to assist providers who have a low clean claim rate be required of plans?
- **Establish timely prior authorization timelines for plans or require plans to staff their PA process 24/7/365 with qualified personnel** (e.g., nurses at a minimum) who can make a PA decision in 24-48 hours, if required before accessing a service. Without this level of service, care is delayed to beneficiaries who are often discharged over weekends. Current practices place an undue burden on families and does not ensure the same access to care as is afforded Original Medicare beneficiaries.
- **Establish penalties for plans that fail to meet the established PA timeline requirements.** These penalties could include services would be automatically approved for a minimum number of days or visits if the PA decision isn’t made timely; or plans could be required to pre-pay provider for similar services offered in the future for the next 6 months or pay the provider 110% of the contracted rate or all untimely PA decisions.
- **Require CMS to establish a dedicated provider complaints line** to report instances where an MAO is wrongly and consistently denying claims or missing prompt payment or PA decisions.
- **Add measures to the MA star rating system** that track payment/claim denials, appeals and rate of overturned. MAOs could receive higher ratings for improving their denial to overturned rate, which might require them to ensure their systems are adjudicating claims properly. This would elevate the importance of getting this right as it can ultimately affect the MAOs rebates used to fund supplemental benefits.
- Timely payment and payment denial data must be tracked, and penalties imposed when MA plans repeatedly and wrongly deny claims even though they follow the Medicare coverage rules.

Beneficiary Access to Care and Understanding of Coverage

When asking members for input for this RFI response, we heard from numerous providers that MA enrollees don’t really understand what they have signed up for or how the coverage works. We hear often from providers that their beneficiaries do not even know they are on Medicare Advantage. Some think they have signed up for Medicare Supplemental Insurance and don’t understand that they have to pay co-pays and co-insurance or that the plan must approve certain services. For this reason, hospitals, SNFs, and home health agencies end up the “educators” on benefits and coverage. This responsibility seems misplaced.

Recommendation: MA plans must explain post-acute care coverage all enrollees 65 years and older. Plans would be required to communicate upfront and directly with the member or Power of Attorney about the plan's coverage and ramifications before the member transitions to post-acute care.

Providers also note that they spend their days advocating to get the MA enrollees the care they need when the plans want to limit that care and discharge individuals earlier before they can be independent at home.

Inappropriate prior authorization (PA) denials delay care and cause undue stress on beneficiary and their families.

Please also see our notes above on prior authorization denials, appeals, overturns and the corresponding negative consequences that these requirements inflict. One member notes that every single MA plan they work with requires a prior authorization before a resident can be treated. "Residents are often discharged from the hospital on Friday evenings, Saturdays, and Sundays; days and times insurance companies do not work. There is no one "on call" to provide PA so we often treat residents for "free" until we can get a PA on Monday. Once received, the prior authorization is not consistently retroactive to the admission date." This is a frequent story across our continuum.

Providers report that MA enrollees that they care for are not permitted sufficient days/time in a SNF to recover fully, regardless of how sick they were in the hospital. This contributes to frequent re-hospitalizations because they are discharged from SNF to home too soon for safe transitions. Examples have been noted where an individual was discharged home and they lived alone so family had to scramble to take time off of work to care for them because they still had limitations. Families who opt to continue care provided by a SNF or home health agency are then subject to paying privately out of pocket or the provider organization absorbs the cost. It is not clear if these costs are being captured in studies that tout the successes of MA.

Recommendation:

- Establish a provider-dedicated line to assist with these anti-trust practices and other fair practice issues. Not all providers are able to afford the legal fees to fight these issues. The ability to report bad practices to a central authority who can track these practices and take action would offer a more even playing field.
- Plans should be surveyed annually to assure compliance with MA standards and regulations comparable to the regulations for SNFs.

10c. What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

Provide greater oversight of post-acute care utilization management. MA plans are increasingly using third parties called post-acute care management companies to "manage" post-acute care services. There is nothing inherently inappropriate with an MA plan contracting out for expertise in certain areas, including post-acute care. However, incentives for these PAC management companies should align with beneficiaries' best interests not just cost savings to the plan. MA plans incentivize vendors and conveners to reduce post-acute utilization without consideration for the impact on overall cost and care outcomes (particularly in hospital readmissions). Thus, there is a devaluation of these post-acute care services and a missed opportunity to improve outcomes and reduce overall costs. For example, MAOs

could opt to use their 3-day stay waiver or encourage more community admissions to home health to stabilize individuals with chronic conditions in lieu of unnecessary hospitalizations. Instead, the typical result is to just shorten SNF lengths of stay and limit or not use home health and shift the care burden to the family when an individual is not yet able to care for themselves independently.

Administrative Burden

Unlike Original Medicare FFS, every contract and process for submitting payment, seeking prior authorization of services, credentialing, etc. is different for every MA plan. At the same time there has been a growth in the number of plans offered in markets, resulting in providers having many more contracts to manage and keep track of their variations. This is not time well spent. This is a particular area where efforts to standardize and streamline processes can benefit both providers and plans.

Providers find themselves in an unwinnable situation when they contract with MA plans. They are paid less than Medicare FFS, but they have more administrative costs to comply with health plan contracts. Providers have gone from a single Medicare claim submission form, minimal prior authorization requirements, one auditor (their MAC) to needing to navigate multiple contracts each who have their own claims forms, online entry, credentialing process, audit approach, appeals and grievances, etc. One home health agency reports they hired a full-time person just to submit the eligibility and benefit checks for the MA plans. A SNF member has 5 positions or 3 FTEs in their finance department to meet the demands these MA contracts necessitate.

Several SNF providers note that MA plans require documentation updates to be provided every 3 to 5 days to justify renewing a prior authorization and then the provider hears nothing from the plan for days afterward. Once notified the plan will say they are ending coverage in 2 days, which does not allow for an optimal transition leaving little time for family and providers to prepare. Often these MA enrollees are not well enough to return home alone, so families are left scrambling to set up care or take time off work to provide the care themselves.

Credentialing and recredentialing is a process every plan must undertake with each provider in its network. Much of this information is already available as providers must be a Medicare certified provider or supplier so this credentialing process seems redundant as providers are listed with CMS and licensed or registered with CMS. Why is a plan collecting the same data points? Ohio is in process of testing a credentialing portal for Medicaid managed care that might provide some insights about how to streamline this process across plans reducing the time commitment by plans and providers.

Recommendations:

- **Establish a clearinghouse or single portal for collecting/uploading data and standardize the data/documentation collected.** Key to plan decision making for claims approvals and prior authorizations is data. This underscores the need for improvements in health information exchange and establishing a single clearinghouse or portal for all of this data. Providers report that most plans ask for the same information for prior authorizations and similar information for credentialing, but each has their own process and timing for submitting this data. Some like it faxed, others emailed, and others via a plan-specific portal. A single portal or clearinghouse would allow all documents to be uploaded or accessed through a single platform by plans and providers eliminating the need to repeatedly upload “missing” documentation. The “clearinghouse” could be used for prior authorizations, claims processing, credentialing, etc.

Forms and submissions could be standardized for each of these processes eliminating the wasted time re-enter documentation that gets lost by the plan.

For credentialing, providers could enter data once that is then used by all plans reducing administrative burden. A single platform would allow beneficiaries to be matched to their plan and possibly certain forms could be pre-populated (e.g., with co-payments and co-insurance details) or the appropriate data attached to the beneficiary in the system. By standardizing these processes, IT companies would likely be incentivized to upgrade systems for health plans due to the standardized processes creating economies of scale for the system investments. If all data is in a single database, CMS might have a better view into care delivery patterns in MA plans, across geographies, identify best practices and produce reports to help guide improvement and ensure MA enrollees are not given inadequate care or experiencing poorer outcomes compared to their Original Medicare counterparts.

- Establish a single audits and appeals process with standardized documentation requirements and denial codes.

The reality is if there were common practices, then it would be easier for not only providers to submit the right information the first time and within the prescribed time, but it would also be easier for plans to update their systems for these standardized systems. Technology companies could build systems that reflect the new requirements. The status quo which is a system in which plans' inability to correctly process claims, find prior authorization documentation that is submitted, and pay according to contract or accommodate value-based arrangements cannot continue.

Data collection

As our comments have noted so far, data is critical in the MA program from claims to prior authorizations to assessing beneficiary risks and tracking outcomes of care. However, at present, CMS has limited access to the data being collected by MA plans. Some states have adopted all-payer databases that give them a more robust view of utilization, outcomes and care delivery patterns across payers. We would encourage CMS to establish its own all-payer database. This would provide additional insight into the care being received by MA vs. Original Medicare beneficiaries and whether the outcomes are indeed better. The MA experience should not be a black box if we are to ensure health equity among plan enrollees and those in Original Medicare.

In addition, we have already noted the importance of tracking MA plan outcomes related to prior authorizations, denials, appeals and the results of the appeals. We believe this data should be tracked and used for future policy forms.

We also need data on not only the supplemental benefits plans are offering but an understanding of the frequency with which they are accessed and ultimately, the associated outcomes in order to determine if the new supplemental benefits are a good investment and whether they should be incorporated more broadly into the Original Medicare benefit.

We think an annual survey of provider satisfaction or experiences with MA plans would provide insights into issues that could be addressed and may pose threats to the stability of the broader Medicare program or health care system.

A few of our PAC providers would like CMS to track information on the number of MA enrollees who pay privately to access certain services that their MA plan won't cover and the number who have incurred debt due to an end of coverage imposed by the plan.

In addition, we would like to see a plan hospital readmission measure added to the Quality rating system. We also would like to see CMS track length of stay in SNF, and home health visits for MA enrollees. When these three items are considered together, it provides a better picture of the appropriateness of care being delivered. In addition, if the outcomes are better for MA enrollees, it could offer best practices that might be able to be adopted more broadly by the Medicare program.

Future Models for Testing

We heard from one of our provider network leaders that they think CMS should look at testing the idea that MA enrollee care plans are co-created by a team made up of providers and members of the plan's care management team similar to the concept of the Patient-Centered Medical Home model. As this person put it, payers need to be more engaged than just approving or denying payment for services. This would address other member concerns that MA plans' care managers make service determinations based upon paper records only and don't see the MA enrollee.

Recommendation: CMS asks if there are other benefit design flexibilities or eligibility criteria that should be considered. A number of years ago, Erickson Communities obtained legislation that allowed them to exclusively serve residents of their communities in their life plan communities. It appears that ISNP growth is being driven by provider-led plans. As with any SNP or MA plan, enrollment numbers are key to spread risk within a plan. For provider-led ISNPs, CMS could test provider-led/residential-based ISNPs ability to auto-enroll their residents into their plans if they are currently in Medicare FFS? It could be structured in such a way to allow residents to opt out or choose another MA or SNP plan.

9. What payment or service delivery models could CMMI test to further support MA benefit design and care delivery innovations to achieve higher quality, equitable, and more person-centered care? Are there specific innovations CMMI should consider testing to address the medical and non-medical needs of enrollees with serious illness through the full spectrum of the care continuum?

Consider a Home Health VBID. The CMMI Home Health Value-Based Purchasing (HHVBP) model clearly demonstrated the value that home health agencies can provide on patient care and reducing overall Medicare spending (particularly on readmissions). HHVBP is being rolled out nationwide in 2023 and CMS is projecting \$3.4B in savings from its implementation over the next five years. While home health agencies may be involved as ancillary providers in current VBID models, CMMI could explore a demonstration specifically designed to test and incentivize appropriate use of home health to improve outcomes on key quality measures and reduce overall spending. Models should enable maximum flexibility and include, at a minimum, an upside/downside risk component. Advanced arrangements may involve delegating responsibility for total cost of care. This model should also look at how to balance the needs of home health beneficiaries who need ongoing skilled support vs those that have an acute rehabilitative need. Some home health beneficiaries, like those with Parkinson's Disease or other

degenerative condition, benefit from ongoing home health care to keep their condition stable or prevent decline.

10. Are there additional eligibility criteria or benefit design flexibilities that CMS could test through the MA VBID model that would test how to address SDOH and health equity?

Expanded Healthy Food and Produce: Though food and produce are available as home-delivered meals through SSBCI, the MA population more broadly in certain areas and those from certain communities may also require health food options. For example, seniors facing food insecurity or individuals with physical impairments that impact food preparation, as well as members from areas with limited healthy food options and grocery stores (i.e., food deserts), could benefit from home-delivered meals. Moreover, members may be impacted by food that is prepared by caregivers or other members of the household. Expanding the benefit to address the needs of caregivers and family living with the member would support the health of members as well.¹

We recommend that CMS further expand the definition of primarily health-related to include healthy food and produce as supplemental benefits to address SDOH needs for MA members more broadly and consider flexibility to expand the benefit to cover food for the member's household.

¹Geisinger Health's Fresh Food Farmacy program (FFF) prescribes enough fresh food for two meals per day, five days per week, for *everyone* in the patient's household. The program improved outcomes (average 2-point drop in HbA1c levels and lower weight, blood pressure, triglycerides, and cholesterol), and led to a collective \$1.5 million in health care savings for patients who participated in the program. Moreover, the intervention has the potential to change the trajectory of disease burden and future costs. More information found here:

<https://wwfw.geisinger.org/freshfoodfarmacy>

Expanded Caregiver Support: Additional flexibility to specifically address the needs of caregivers – both in the VBID model at large and in the hospice track --with expanded benefits would be welcome. For example, respite care, call-in support line, caregiver training and resources greatly support caregivers and prevent unnecessary hospitalizations of members. However, though benefit flexibility is already available to provider caregiver support, benefits like respite care are limited to 5 days. Limitations on these benefits negatively impact those who are already facing health disparities.

Other caregiver supports to test that would benefit caregivers, and ultimately beneficiaries, include care management social services (e.g., virtual administration/finance/legal support, live navigator); and free caregiver videos with best practices on delivering culturally competent care in home-settings for different demographics and cultural communities (e.g., dementia patients, African American, Puerto Rican, etc.).

Lastly, standardized caregiver burden assessments could be developed and used by the caregiver's physician to assess stress-levels of family caregivers and ensure caregivers are then connected to appropriate caregiver support services. The assessments could also give insight into the family's system of care more broadly.

Payment for In-Home Support Services. Though in-home support services have increasingly been offered as MA supplemental benefits under the expanded definition of "primarily health related", certain markets may not see the same uptake due to existing Medicaid coverage for members, robust state Medicaid benefits, and a greater concentration of smaller regional plans that may not have the resources to offer supplemental benefits beyond standards supplemental benefits (e.g., dental, vision). These same regional plans typically serve members who are at-risk of becoming Medicaid eligible and

could benefit from in-home support services. CMS could test payment for in-home support services within VBID.

Payment for Adult Day Services: Similarly, adult day services are available for plans to offer as a supplemental benefit. CMMI should test what it would take for plans to offer broader coverage for adult day services and the parameters of how adult day could fit into the Medicare program more broadly than as a supplemental benefit. This could include looking at it as a service for specific populations (such as the dementia population). Adult day services are critical component of expanding equitable, community-based care and are massively underfunded and CMS should invest in figuring out what it takes for them to remain vital parts of their communities.

11a. What additional innovations could be included to further support care delivery and quality of care in the Hospice Benefit Component of the MA VBID model? 11b. What are the advantages and disadvantages of receiving the hospice capitation payment as a standalone payment rather than as part of the bid for covering Parts A and B benefits?

We wanted to add a note on hospice generally. While hospice care is currently only incorporated into MA through hospice benefit component of the MA VBID model, we have major concerns about the trends we see with our other providers entering hospice. For example, the demonstration does not allow prior authorizations. In the current state of play. If hospice were to be “carved in” to MA outside of the confines of a demonstration, there would be prior authorization. Hospices are already experiencing very short lengths of stay (about 50% of beneficiaries in 2019 were in hospice for 18 days or less; 25% for a week or less). A delay in prior authorization could easily mean the patient never receives service. Hospice referral is often hard fought for; it is hard to accept hospice care. Delays in service due to PAs will likely result in people opting not to go with hospice.

The administrative burden of this demonstration is already substantial, and most hospices are only working with one plan partner. One hospice reported biweekly 4-hour meetings with the MA plan, and this is for a patient load of about 12. The submission of claims is already going awry in a demonstration environment. It simply seems like the problems that SNF and home health already face are being repeated in the demonstration and would be compounded if hospice officially became part of MA. The stakes are also very high – it is the most vulnerable time in a patient and family’s journey, and we hope that administrative process and cost savings do not interfere with high quality end of life care.

We support receiving the hospice capitation payment as a standalone payment, rather than as part of the bid for covering Parts A and B benefits. If the hospice capitation payment was folded in as part of the bid, we would expect that MA plans would be constrained by the bid, competing needs, and conduct utilization management through reductions in hospice utilization.

We are committed to maintaining the integrity of the hospice benefit. We feel it is imperative that the comprehensive hospice benefit remains intact to ensure hospice-related outcomes. By moving to the bid, MA plans may “unbundle” the hospice benefit, which would not serve hospice patients well, and also put hospice providers in an untenable position given financial instability. In fact, the prohibition on unbundling the benefit should remain regardless of whether the payment remains standalone or becomes part of the bid. Moreover, during this demonstration period, it is imperative that the payment be separate from the bid to fully evaluate the impact of the model.

VBID should encourage MA plans to increase hospice access for their patients to improve end-of-life care. As hospice access increases, the VBID hospice-specific payments to MA plans will increase per capita. With any evaluation of program success, the whole picture needs to be evaluated to include Parts A/B payments as well as the VBID hospice payment to evaluate the potential for total cost of care reductions.

Ensuring palliative care flexibility, though definition needed in the long run. In the current state, the definitions and use of palliative care is set up to be flexible for MA plans to explore different models. We believe it is important to maintain that flexibility during the demonstration period to foster innovation. However, though VBID-participants may add palliative care as a supplemental benefit, palliative care services are undefined and beneficiaries may not receive the full array of palliative care services, depending on the MA plan's specific definition. MAOs also vary in their willingness to contract with providers for palliative care; many look to vendors or their own care management teams. While not inherently problematic, it speaks again to the variation in services that will be received by beneficiaries in the VBID demonstration. In the long-term, without the delineation of "core" palliative services, beneficiaries may face discrepancies in interpretations of comprehensive palliative care services. This definition is of particular importance given that CMS recently expanded MA supplemental benefits to include non-health related benefits, including palliative care for beneficiaries with more than 6 months to live.

Moreover, CMS could also work with VBID model participants and hospice providers to more clearly define when and how patients are or should be transitioned from palliative care to hospice.

Continue Transitional Concurrent Care (TCC). We are supportive of TCC as an important innovation but note that is difficult to test TCC in the current demonstration given limited understanding and awareness from providers of the benefit. With more physicians aware of TCC, we would expect that beneficiaries have increased access to continued curative treatments, increased satisfaction, and earlier election of hospice. However, as TCC utilization increases, it may increase hospice revocation risk in the short-term for those patients receiving TCC as that model continues to be refined by MA plans and hospice providers. CMMI could do more work on education on TCC. It would also be helpful to have data on which treatments are being utilized or requested to guide the provision of TCC in the community.

Transparency, Enforcement, and Stakeholder Collaboration

At present, our members' perception is MA plans can act with impunity. They witness inappropriate marketing efforts, delayed and inappropriately denied care, and contract and regulatory non-compliance. This is particularly frustrating for SNFs who are under what seems like constant compliance scrutiny and penalties. We need more transparency, accountability and enforcement.

There is no current process for trade and professional associations, CMS, and plans to raise concerns and make recommendations to improve the MA benefit, coverage and processes. We, need a forum for providers, plans, consumers, and the agency to identify and address issues. The MA program cannot be sustained for the beneficiaries that have chosen it if it doesn't continue to evolve with the input of all relevant stakeholders. Currently, there is no neutral venue for plans and providers to identify issues, discuss solutions and/or understand each other's role and financial needs.

Given our providers' experience to date and our list of recommendations above, it is clear that the MA program would benefit from a cross-stakeholder collaboration group where issues could be identified, solutions discussed and recommended, innovations shared and possibly bridges built eliminating the us vs. them situation we currently face.

Recommendation: CMS should establish a forum or stakeholder advisory group where issues can be raised, solutions identified, successful innovations and collaborations shared, and policy and regulatory changes recommended that will help sustain the program and ensure it operates to maximum efficiency.

In addition, we need a better system for reporting issues where MA plans are not in compliance, are engaged in anti-trust behavior, are inappropriately denying care, sending misleading marketing to consumers, etc. It is not clear that the Medicare Complaint Line can be used or is useful to providers or what is done with the information received.

Recommendation: CMS might consider conducting annual provider experience surveys on their experience with MA plans – these surveys should also impact a plan's star rating like the beneficiary rating of health plan and quality impact their star ratings. The information could be sorted by provider type and could provide insights into trouble areas as well as adoption of Value-Based Arrangements.

Improve the Medicare Advantage complaints: We request more transparency on how many complaints are received, and how they are adjudicated. Are plans held accountable? Should beneficiaries be aware of the number of complaints a plan has before they decide about enrolling? To date, only state licensing agencies-- usually the Dept of Insurance— can revoke a license or opt not to renew. We have not seen any such action taken, in practice, but if there was a way to track complaints that was more publicly reported, we might see these practices change. Or we could establish standards or thresholds at which disciplinary actions or penalties are enforced.

Recommendation:

Establish a provide support line related to MA that provides a neutral arbiter, where contract terms are not being enforced or Medicare policy not followed. Perhaps the Medicare Administrative Contractors could serve as the neutral party to review for fair and accurate contract compliance. Not all smaller providers can afford pursuing legal action nor subsequent retaliation that could follow for taking such action.

- Establish a dedicated line for MA complaints that can be submitted by the public, an individual enrollee, providers about issues with plans. Individuals should be able to submit complaints about plan marketing practices including when they are not enrolled in a plan. Allow for complaints to be submitted via a 1-800 number but also via email or online form to make it easy for individuals to submit. Currently, this information is taken in via 1-800 MEDICARE. However, it is not clear whether complaints ever lead to punitive action taken against the plan. Consider requiring the Secretary to report annually on the number of complaints received by plan/MAO and punitive actions, if any, taken against the plan. This could be included as a disclosure in plan materials to beneficiaries.
- Consider adding a component to Medicare Plan Finder that notes the number of complaints CMS received for a rolling 3-year period and identify any punitive actions taken. Complaints

could be identified by categories: service denials, illegal marketing practices, provider complaints, et al. This would provide beneficiaries with another tool when deciding to enroll in an MA plan beyond looking just at premium cost. This approach could also incentivize plans to minimize and address these issues.

- Add new measures to the Star Rating System requiring MA plans to report on prior authorizations requested, granted, denied, and overturned; and number of payments submitted, denied, and overturned on appeal.

Other Questions

Health Equity

Recent updates to the MA regulations included a requirement that all SNPs conduct health risk assessments that include one or more social determinants of health (SDOH) questions. We are supportive of this new requirement but believe to truly address MA enrollees' needs in the best possible way that this requirement should be extended to MA plans as well.

We believe their inclusion will help these core issues to be identified sooner and addressed within an individual's care plan. There are benefits to collecting this information including trending data. However, we suggest CMS consider further revisions to the MA/SNP regulations to allow plans to use this SDOH data for determining eligibility for special supplemental benefits for the chronically ill (SSBCI) in their plans' offerings.

We look forward to the information that these questions will yield and how it can be used to shape the future of MA plan benefits and develop strong individualized care and service plans for the enrollee. However, we also believe it is important that plans do more than just obtain answers to questions. They should also have a responsibility to share this information with providers and use this information to assist their enrollees in identifying resources to address these unmet SDOH needs. We are not suggesting that the plan itself must directly deliver the needed service but should help in connecting their enrollees with resources to help address identified needs. It is not clear if the current regulations imply that this should occur, but we would suggest CMS clearly describe the plan's role and responsibility related to information obtained through these questions. We encourage CMS to track this standardized data to identify trends and perhaps compare to supplemental benefits offered and utilized. Are enrollees accessing available plan benefits that would address their SDOH needs?

The Bigger Picture - Improving MA Requires Thought About How It Interplays with Medicare as a Whole.

Finally, to ensure the sustainability of the MA program, which nearly 50% of Medicare beneficiaries have turned to for their Medicare benefits, we must not only make changes and improvements to MA plan requirements but also step back and consider the interplay of the MA program and policies with the broader Medicare program to ensure the viability of providers and necessary protections and choices for beneficiaries. We have noted above the impacts MA plans have on the financial viability of providers, and how their prior authorization policies and care management can sometimes result in beneficiaries backing up in hospitals or being returned to their home early. For these reasons CMS must consider the potential ramifications of its policies to permit MA organizations (MAOs) to also participate in Center for Medicare and Medicaid Innovation models such as ACO REACH. This creates the opportunity for one or

more MAOs to potentially monopolize a market. The result would be that Medicare beneficiaries no longer have a real choice about how they receive their Medicare benefits in cases where one MAO makes all the decisions in a market. Today, if an MA enrollee is dissatisfied with their MA plan, they can return to Medicare FFS. Providers in these circumstances would have no choice but to contract with the MAO or close their doors. The health care system in those markets and non-Medicare populations could also see their access to care and providers impacted by the MAO policies and payments. For these reasons, CMS should carefully consider whether they should place some limits on MAO participation in CMMI models and/or limit plan dominance in a given market to preserve beneficiary choice and access to care. One way CMS could preserve choice is to only permit provider groups to lead CMMI models and keep MAOs in the MA space.

Alternatively, CMS might also consider that another way to approach the issues is to level the playing field between Original Medicare and Medicare Advantage. For example, what would happen to beneficiary selection if:

- Original Medicare amended its standard benefit package to include vision, hearing, and dental benefits? Or other types of supplemental benefits like in-home support services?
- Original Medicare capped a beneficiary's out of pocket costs on an annual basis like MA?
- Brokers had to offer all available plans, options in a beneficiary's market.
- MA plans weren't paid more than Original Medicare?
- MA plans had to pay providers at least Medicare FFS?

Also, we urge CMS to consider how current MA policies impact dual eligible and others on Medicaid. Because of disparities in payment, Medicare unfortunately often helps to subsidize a provider's ability to take Medicaid patients. Policy decisions like FFS rate cuts, a lack of oversight over MA payment rates, and low Medicaid rates lead to an environment where providers simply cannot take Medicaid patients. CMS wants to promote equity but without providers that can survive financially, we are going to have a major access to care crisis that will likely continue to disproportionately impact those most at risk. Medicare Advantage is playing a role in that dynamic by underpaying or denying care.

We can wait no longer to make important changes to the Medicare Advantage program to ensure continued access to care for beneficiaries and provider viability.

Thank you again for the opportunity to share our thoughts with you regarding the future direction of the Medicare Advantage program. We are happy to discuss or answer any questions you may have.

Sincerely,



Nicole O. Fallon
Vice President, Health Policy & Integrated Services
Director, Center for Managed Care Solutions & Innovations
LeadingAge
nfallon@leadingage.org