February 13, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically

Dear Administrator Brooks-LaSure,

LeadingAge appreciates the opportunity to comment on the "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly (PACE); Health Information Technology Standards and Implementation Specifications" ("proposed rule"). While current MA rules often contemplate MA plan interactions with acute care providers and physicians, less attention has been given in the rules to post-acute care (PAC) services. Our provider members have observed that in the intervening years, this has resulted in some plans limiting access PAC care for their enrollees. Every time an MA plan refuses to pay a PAC provider for a pre-authorized set of services rendered or audits every claim, it threatens access to these services because the administrative burden and financial cost is too high for providers to continue to participate in MA. The proposed rules take important initial steps to remedying some the current inequities and barriers our providers have observed.

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 and experiences of providers of post-acute care, long-term services and supports, and home and community-based services who contract with Medicare Advantage (MA) and Special Needs Plans (SNP) to provide services. In addition, we also have providers who lead the operations of their own MA plans, SNP and PACE programs. Our comments will focus on issues that impact their ability to effectively deliver services and be paid for those services.

This proposed rule appears to acknowledge that we are at a critical juncture as Medicare Advantage enrollment is nearing 50% of all enrollees. If we don't ensure proper beneficiary protections and program improvements now, it may become too late. In particular, we applaud CMS's attention to putting a stop to deceptive marketing practices and making sure prospective enrollees receive accurate, clear and complete information about their choices between traditional Medicare and MA. We also are pleased to see efforts to clarify and ensure equitable access to traditional Medicare Parts A & B benefits to the roughly 30 million enrollees in Medicare Advantage. LeadingAge members have long had concerns about some plans' practices to limit access to these benefits for their enrollees and those we

serve in our skilled nursing facilities (SNFs) and home health agencies (HHAs). Our hospice members who are participating in the Value Based Insurance Design (VBID) model are also concerned about these trends. In preparation for our comments, we solicited feedback from these PAC providers on how these care determinations are made today in traditional Medicare compared to how MA plans make them related to PAC services.

Our intent is to only comment on those items that directly impact post-acute care (PAC) providers and the services they deliver to MA enrollees. We offer our support to these proposed rules and offer our perspective on refinements to certain areas that we believe will ensure that the intent is achieved. We also offer some related suggestions for future consideration for how to continue to bolster the MA regulations to enhance beneficiary protections and ensure access to services by incentivizing continued provider engagement by reducing administrative burden and ensuring reimbursement adequacy.

Clarifying Medicare Advantage (MA) plans' obligation to cover traditional Medicare Part A & B benefits

LeadingAge applauds CMS's efforts to clarify MA plan obligations related to ensuring MA enrollees have equitable access to medically necessary Medicare A & B benefits like those in traditional Medicare including abiding by the same coverage criteria. However, we believe that without further clarification and enhanced enforcement efforts that improper denials will continue. PAC providers are observing that plan coverage determinations do not demonstrate an understanding of Medicare regulations related to PAC services. Instead, plans focus on the enrollee's need for therapy vs. other daily skilled services. For this reason, a plan might indicate an enrollee no longer needs skilled care because they no longer need therapy or are no longer making progress[1], but fail to note the person is still being tube fed for a significant portion of their daily calorie requirements, or is being treated for decubitus ulcers that are stage 3 or higher. Plans also seem to not be evaluating whether as a practical matter, is it more cost effective and efficient to deliver these services in a SNF.

In addition, currently, one provider reports that the most frequent denial notice received states, "Based on Medicare guidelines and the information we have about your condition, you don't meet all the requirements. The requirements are: (1) you need skilled nursing care or rehabilitation services every day AND (2) the services are reasonable and necessary for the treatment of your illness. You can receive the care you need in another setting, such as home, a long-term care facility, or other outpatient setting." We know that some plans are wrongfully denying care and yet based upon the above language from a denial notice, believe they are complying with Medicare coverage criteria. For this reason, we are not confident that codifying current expectations will change behavior without further education of the plans. To ensure that this equitable access is achieved, LeadingAge encourages CMS to add some additional language to this section.

Recommendations:

[1]No longer making progress is not a valid reason for a denial as found in *Jimmo v. Sebelius;* many beneficiaries in home health remain eligible for ongoing maintenance therapy and are not provided this care by MA plans. SNF patients with certain diagnoses may be unable to improve but still benefit from maintenance therapy.

- **Further clarify the breadth and scope of post-acute care (PAC) services to be covered.** The new proposed clauses added to section 422.101 cite 42 CFR part 409 to refer to Skilled Nursing Facility (SNF) care and Home Health (HH) Services. While this citation notes the services to be provided, it does not also explicitly state the duration of these available benefits. We want to ensure MA enrollees access includes up to 100 days of skilled nursing care (when medically necessary) and coverage for all medically necessary, 30-day home health episodes, as is permitted under traditional Medicare. We also ask CMS to highlight that in addition to MA plans abiding by the Medicare laws, regulations, and national and local coverage determinations, they also are prohibited from denying coverage for lack of progress. This is specified in 42 CFR Part 409.32 "The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities." This is consistent with the Jimmo v. Sebelius settlement agreement that states that a beneficiary's lack of potential for improvement or restoration cannot be the sole reason for denying skilled care. Regrettably, SNFs and HHAs have witnessed plans increasingly denying care for this cited reason. Therefore, we believe it warrants highlighting.
- **Ensure third party care management companies or contractors are also required to follow traditional Medicare coverage criteria.** Third-party care management companies and similar contractors are often employed by the MA plans to make coverage decisions on behalf of the MA plans. To ensure equity and consistency in access to these services, we ask CMS to reinforce that both MA plans themselves as well as any of their third-party contractors are subject to these same expectations related to coverage criteria and as such, are prohibited from applying algorithms that indicate expected utilization based upon the experience of other individuals with a similar diagnosis versus an individual's specific set of circumstances. Algorithms should be limited in all cases to those that are based upon current evidence that is widely used treatment guidelines or clinical literature, as is proposed in 422.101(b)(6) for plan internal coverage criteria. Additionally, it is essential that plans and their representatives are transparent about how coverage determinations are made to ensure they meet Medicare standards. To date, these algorithms are a black box. In one example provided by a member, the nH Predict document from NaviHealth noted that the average length of stay in SNF for a person similar to the enrollee is 13.2 days. They noted a discharge date based upon this generalized experience. The projected date of discharge was 16 days before the person would complete their IV medication regimen, which is a skilled service and therefore, should have been covered. Providers also note that it is not clear where the third-party obtains some of their data on the patients especially related to cognition because the provider does not submit nor is asked for BIMs scores, which would tie to this metric. Our position is also supported by 42 CFR Section 409.44 related to home health which explicitly states, *"A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regard the beneficiary's individual need for care.*"
- **Enhance enforcement efforts to ensure compliance.** Without any new enforcement provisions, we are concerned current denial practices will continue especially since, as CMS notes, much of this section of the proposed rule merely codifies current expectations of plans. LeadingAge provider members witness daily MA plan denials for care that would be covered under traditional Medicare. Individuals receiving IV medications who are told they can go home even though it qualifies as a

skilled nursing service under 42 CFR 409 and cannot be obtained in the community. We've also heard numerous examples of individuals denied: continued skilled care because they are not making progress in their therapies even though they may require other skilled care or the therapy prevents further deterioration or preserve current capabilities; or initial skilled benefits are denied because the individual can ambulate 50 feet even though they have other skilled needs. The path to resolving these inappropriate denials is for the individual to appeal, but this is not a simple matter. The current compliance system requires beneficiary/provider/family to go through potentially multiple layers of appeals which are time consuming, can disrupt care, and require providers to dedicate additional staffing resources to these efforts. As we consider ways to ensure health care equity, the current appeals process bears further scrutiny. It places undue burden on families with limited means because if they appeal a decision that is further denied by the plan, they are then on the hook financially to pay for the uncovered services received while awaiting an appeal decision. Many cannot afford to take that chance. One social worker noted only about 20% of families/enrollees decide to appeal for this reason. Others are daunted by the complexity of the process and lack of knowledge "how all this works." We recommend the following ways to enhance enforcement in this area:

- **Establish a confidential provider complaint line:** Providers can play an important role in helping CMS identify patterns of inappropriate care denials. It might be as simple as allowing providers to submit identified issues via current channels such as 1-800-Medicare (e.g. press 2 if you are a provider reporting on a compliance issue) or online (with or without documentation) by creating a provider reporting intake form. The current system lacks a clear mechanism for providers to report issues (e.g. plans denying care when patient can ambulate 50 ft or for lack of improvement). Beneficiaries need real-time accuracy and access not delayed compliance via audits. Providers could bring another set of eyes and ears on the ground to ensure compliance and identify patterns of non-compliance earlier. Such a complaint resolution process would be most effective, if complaints were researched and responded to within prescribed timeframes depending upon the reason for the complaint. For example, issues that directly impact a beneficiary's access to medically necessary care whether because of an inappropriate coverage denial or network inadequacy issue should have a short response time (e.g., few days to a week). Delayed care has consequences for all Medicare beneficiaries. Marketing complaints may warrant a longer time to research and address. As CMS considers a new provider compliance reporting channel, we believe these important compliance tools will be most effective if they afford confidentiality and non-retaliation protections for providers. Providers have expressed concern about some MA plans retaliating in such circumstances.
- **Greater plan complaint transparency for consumers:** One way to hold plans accountable is to publish data in the plan finder tool on medicare.gov annually reporting total number of complaints a plan received and group the complaints by type (e.g., marketing, access to care/denials, availability and access to network providers, etc.) This step is particularly important given that CMS is proposing to reduce the weight of complaints in the Star Rating system as part of this proposed rule, which we believe is premature and should be delayed. This information could be helpful to consumers as they make choices and it rewards plans who don't use deceptive marketing practices, egregiously deny access to care and maintain

up-to-date network information.

Circumstances upon which plans can employ their own internal coverage criteria

In Section III.E.2, CMS asks (p. 141 of proposed rule PDF version) whether it should consider, and under what circumstances, allowing MA organizations (MAOs) to have internal coverage criteria in addition to requirements in current regulations, noting that some traditional Medicare A & B benefits don't have applicable national coverage determinations (NCDs), local coverage determinations (LCDs) or traditional Medicare coverage criteria. Without knowing which A & B benefits do not have coverage criteria it is difficult to know how to respond to this request. In general, we think plan-specific coverage criteria should be limited to supplemental benefits not traditional Medicare benefits. In cases where plans are permitted to have internal coverage criteria, they must be transparent to providers and beneficiaries.

We support CMS's position that any internal coverage criteria developed by a plan be based upon "evidence that is widely used" and would ask CMS to clarify that proprietary algorithms that generalize care needs of a population by diagnosis would not fit this definition and should not be used by the MA plan or its third-party care management or other contractors.

Support change to require pans to honor the PAC setting identified by the discharging physician.

We support the revocation of the current policy outlined in the June 2000 final rule that permitted plans to choose how a service was delivered in cases where a service could be delivered in more than one way. We think honoring the physician's orders related to services needed and appropriate site of service is important and should not be able to be overturned by an MA plan. However, we believe that a beneficiary/enrollee should retain their choice of service if more than one option exists.

Improvements to prior authorization processes to limit purpose and frequency

The prior authorization process is flawed and CMS's proposals seek to address it. Some MA plans' additional coverage criteria have posed a barrier to enrollees accessing basic Medicare benefits. When they do approve prior authorizations, it is for short increments, requiring a cycle of re-authorization requests to be made every few days to continue needed care. This proposed rule starts with the foundation that plans need to provide access to the same type of care to their enrollees that is available to enrollees under traditional Medicare. They are being paid to do so. LeadingAge supports CMS's goals of limiting the purposes for which prior authorizations can be required – medical necessity and diagnoses confirmation – and its efforts to reduce the number of authorization requests that must be made. We also agree that a prior authorization should cover a "course of treatment" to limit the number of requests that need to be made and to provide enrollees with a clear picture of the care and services that will be covered so they can focus on their health and recovery. In order to achieve these objectives, we ask CMS to further refine its definition of "course of treatment" to ensure its application to post-acute care (PAC) services and propose the following recommendations to simplify and speed the process.

Recommendations:

- **Develop a standardized form for prior authorization requests for traditional Medicare benefits.** If all plans must follow the same coverage criteria for traditional Medicare benefits and are not permitted to have additional internal criteria for these services, then it would follow that it would be most efficient for all providers to submit the same information to every plan. Therefore, this is a

case where CMS could create a standardized form to ensure that all coverage criteria are followed for traditional Medicare and MA benefits. A standardized form would reduce the administrative burden on providers seeking approvals by eliminating multiple different forms and processes to obtain the needed prior authorizations. A standardized form could also streamline the approval process at the plan level as reviewers would know where to look for the critical information needed to decide whether the request complies with traditional Medicare criteria and eliminate the need to comb through volumes of data. This could reduce the time to make these decisions and speed beneficiary access to needed services. In addition, it increases the likelihood that decisions are made correctly the first time, because the necessary information is easier to be found by the reviewer. Correct initial decisions are good for the beneficiary as it expedites their access to needed care and could minimize their need to appeal.

- **Change of process when coverage is reinstated based on a quality improvement organization (QIO) decision**. Plans should be prohibited from issuing another 2-day termination of services notice in these cases. Instead, the enrollee record should be reviewed, and CMS should require a plan to conduct its own in-person assessment to determine the appropriate duration of service, as well as considering any medical necessity determinations made by the QIO.
- **Require MA plans ending or denying coverage to provide the enrollee with a Detailed Explanation of Non-Coverage (DENC).** Another way to be more transparent and accountable is for CMS to require plans to notify the enrollee of the detailed reason care is being terminated or denied and the support for that position. Non-coverage notices should be detailed and specific to the individual's set of circumstances not a form letter, which is often received today. A Detailed Explanation of Non-Coverage would be more informative and help the enrollee and their family better assess if an appeal is appropriate and what information they would need to initiate such an appeal. DENCs also help the provider know if a plan needs more information or just missed relevant information already provided in the voluminous documentation to support service continuation. This also holds plans accountable by requiring them to explain the rationale for the termination and demonstrate that they have appropriately considered all the factors necessary before making their determination.
- **Examine additional ways to simplify and expedite appeals process.** In addition, we encourage CMS to look at other ways to simplify the appeal process for beneficiaries and providers who support their efforts. Perhaps something as simple as adding a check box to the DENC or Notice of Medicare Non-Coverage, where an enrollee can indicate by checking the box that they disagree with the plan determination and have a separate check box for the provider. This approach would require the document to then be submitted to CMS for tracking purposes. It might help in identifying plans who are struggling with access to care issues.
- **Clarify the application of "course of treatment" to PAC services.** The proposed rule seeks to reduce the number of required prior authorizations and re-authorizations for a "course of treatment. LeadingAge members are highly supportive of this provision but believe the definition of "course of treatment" requires further refinements to ensure it applies to the provision of PAC services in SNFs and HHAs. In the proposed rule, "course of treatment" is defined as "a prescribed order or ordered course of treatment for a specific individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider. (A course of treatment may, but is not required, to be part of a treatment plan)." For the purposes of PAC services, a provider orders PAC services from a SNF or HHA for their patient. That action would appear to be covered under the "course of treatment" definition because the provider orders the service ahead of time related to the individual's needs. However, the specific skilled and therapy services the individual needs and

receives and the duration for which they receive them are not determined by that order but instead by a series of assessments conducted once the individual is admitted to either the SNF or HH. This intake process and assessments can take 5 – 8 days to complete and culminates in the development of an individualized care plan (ICP). Of note, 42 CFR Part 409, subpart D indicates that *"A beneficiary in an SNF is also considered to meet the level of care requirements of 409.31 up to and including the assessment reference date for the initial Medicare assessment… and the assessment reference date… must be set for no later than the eighth day of posthospital SNF Care."* This would argue MA plans should be required at a minimum to approve SNF care during the assessment period and then approve the remaining care based upon the ICP. The ICP outlines the care and services that will be received and a target discharge date.

For HHA services, traditional Medicare authorizes a 30-day episode in which HHAs conduct assessments and identify the number of visits required as part of an individualized care plan (ICP). HH services are paid and operate as an episode and they are paid a fee for that 30-day episode. The episodic payment is tied to the clinical "grouping" that the beneficiary is grouped into which is based on a detailed assessment (OASIS). Beneficiaries are entitled to indefinite 30-day episodes as long as they continue to meet the criteria for home health and that care is medically necessary. However, not only are beneficiaries not receiving multiple episodes of home health if needed, but they often do not receive the equivalent episode that they would have under traditional Medicare. Most plans only authorize a discrete number of visits not a full episode. To achieve parity with traditional Medicare, home health should be approved for a 30-day episode and a determination made thereafter about eligibility for further episodes, just as in traditional Medicare. In addition, when considering how to ensure "course of treatment" applies in PAC settings, CMS should also consider that the full traditional Medicare benefit includes up to 100 days of SNF and indefinite 30-day episodes of HH care. The specific number of SNF days or HH visits per episode are dependent on the individual's needs as identified in the individual beneficiary's care plan, which is based upon an in-person assessment.

Without further clarification, PAC providers are concerned the plans will continue to require numerous reauthorizations. Currently, plans approve SNF care for a certain number of days (e.g., often fewer than 7 days) and then require repeated re-authorization to continue coverage (e.g., typically continued coverage only lasts 2 days). They approve a small number of HH visits (sometimes only 1) and they require reauthorization for each additional visit. In addition, MA plans and their third-party care management companies often disagree with the provider's assessment of a beneficiary's need even though the plan often is only conducting a paper review or applying an algorithm based upon general population experiences and has not seen the person for whom they are making coverage determinations. Most concerning is when plans tell the PAC provider that they will only pay them for a lower level of care than the assessments indicate, and the providers will not be paid unless they submit a claim for payment at the lower level indicated by the plan. This practice should be prohibited unless a plan can transparently support their reasoning. Providers want to make sure that plans approve a "course of treatment" and that this term includes the duration and services identified in the individual's care plan for post-acute care.

Recommendation: We believe the definition of "course of treatment" requires further refinement to ensure that PAC services can also benefit from the proposed language which would limit the number of times services need to be authorized for the same episode or "course of treatment". We also recommend that CMS provide illustrations and examples as guidance for application of the final definition.

Approved prior authorizations cannot be denied for payment based upon medical necessity.
LeadingAge appreciates CMS's proposed clarification that if a plan approves prior authorization requests, it cannot later deny payment for the approved service because medical necessity has already been established. This language, though, also permits the plan to deny the payment if it is concerned about fraud. We hope this proposed change will limit those inappropriate denials but are concerned about the plans still challenging these claims under the guise of "fraud". We have seen this play out – some plans egregiously audit every claim submitted and therefore are denying every pre-authorized claim. One LeadingAge provider shared that they have a 4-foot stack of paper from plans challenging all or part of a payment for services previously authorized and delivered. For each one, they need to compile and submit at least 30-50 pages of documentation that has already been submitted when making the initial prior authorization or re-authorization requests. Numerous PAC providers have noted that plans lookback 2-5 years to audit payments. These excessive practices must stop. There is a cost to the system due to the administrative burden and financial strain that these practices place on PAC providers. These significant resources – time, financial, and personnel – are much better spent on patient care.

Recommendation: We ask CMS to examine current plan audit practices and establish regulatory policies that limit these overly burdensome audit practices. Traditional Medicare has some standards about audit practices that govern the sample size, assistance provided when patterns of non-compliance occur, and limits on how far back claims can be audited. We hope CMS will look to these to establish greater parity regarding these practices and to make a concerted effort to reduce the corresponding administrative burden of these policies.

Gold Carding

CMS does not propose any rules regarding MA plan use of assigning a "Gold card" status to certain providers, which relaxes or reduces prior authorization requirements for these providers but does encourage plans to utilize such a process. Conceptually, we support efforts that reduce the administrative burden placed upon providers by the prior authorization process. However, we are concerned that if CMS does not establish some guardrails for such a process that MA plans will instead give preferential treatment to providers based upon criteria such as ownership of a provider that allows them to leapfrog over other contracted providers. At least one LeadingAge home health provider has observed plans assigning such status to providers that they own with no evidence of compliance. One LeadingAge home health (HH) provider in Georgia has experienced an MA plan "poaching" enrollees referred to their home health agency. The situation is the MA enrollee is referred by their physician to the LeadingAge HH provider due to their expertise (e.g. wound care) and outcomes related to the enrollee's need. The LeadingAge HH agency submits the required prior authorization to initiate services to the MA plan and while awaiting the plan's prior authorization determination, the plan deploys its owned HH agency to initiate services without a prior authorization. The enrollee just knows they are to

get HH services and may not remember the agency name so allows the plan's owned provider in the door. This may not serve the beneficiary well in cases where the plan's own HH provider does not have the specific expertise the physician believed was important. Without guardrails, we can expect similar practices to be adopted that may not be in the best interest of the MA enrollee. In addition, it is our understanding that in places with established "gold card" processes, the standards have been set very high requiring 90% of a provider's prior authorizations to be approved by the plan. The result is few qualify.

Recommendation: We ask CMS to require plans to be transparent by clearly identifying the criteria and process for attaining "gold card" status and ensure all contracted providers who meet the criteria are eligible for the status not just plan-owned providers (or those providers owned by the same corporate group).

Utilization Management (UM) Committee

LeadingAge believes this is an important step but alone, it is an inadequate enforcement mechanism for ensuring coverage criteria for traditional Medicare are being followed and are understood. It is good for no one when these processes require numerous submissions for a single authorization because the "right form" wasn't used to submit the required documentation or request. Plans should include this information in their provider manuals and should be required to offer regular training opportunities to their contracted providers. Our providers have noted much inconsistency in these processes where the provider completes the same steps multiple times but sometimes the request is kicked out and other times it moves forward and is approved. In addition, each plan has its own process, preferred communication channel (e.g. phone, fax, portal) and criteria. As part of the UM review, the committee should also have to identify ways to reduce administrative burden on providers, provide education to providers to assist with ensuring they understand the UM procedures and include policies and procedures in the provider manual or other similar document and actively push out this information annually to providers with the offer of training.

We support the requirement that an internal committee of the MA Plan review the plan's utilization management policies and procedures to ensure alignment with traditional Medicare coverage requirements. We agree that the plan's medical director should lead this group and that it should include at least one participating physician who is conflict-free, and at least one practicing physician with expertise in care for the elderly or disabled individuals. However, we think it is insufficient to just be a practicing physician with expertise in care of the elderly or disabled. To be effective, the committee needs to have someone who has expertise or experience with the services provided by skilled nursing facilities and home health agencies.

Recommendations: Require the committee to include a practitioner(s) with experience or expertise in both SNF and HH. Require plans to consult their contracted providers for input on current policies and procedures including how to minimize the administrative burden of these processes on providers. Once a UM Committee finalizes the policies and procedures, this should be communicated to providers and provider training offered to optimize compliance and first-time approvals. To fulfill CMS's commitment to making sure UM tools are not a barrier to accessing services, then the UM committee should not only review the processes and procedures to ensure alignment with traditional Medicare for A and B coverage criteria but also to reduce the administrative burden of the process on beneficiaries and

providers and seek to lower their appeals. The UM committee could do this through quarterly review of their data related to number of prior authorizations by service type, number of approved/denied, number of appeals, and number of appeals overturned and reason overturned (e.g. reviewer missed documentation that supports authorizing the service). This will help the plans identify and remedy problems within their procedures and systems. Finally, given OIG's report on current prior authorization denials and appeals, CMS should consider imposing penalties and/or require a corrective action plan for MA plans who exceed a certain threshold of non-compliance with traditional Medicare coverage criteria. For this to be valid, there needs to be a more robust mechanism to track complaints. As we recommended above, this might be as simple as having an enrollee check a box on the Notice of Medicare Non-Coverage when they don't agree with the determination and have that documented submitted to CMS. Not every enrollee will appeal, even when it is warranted. Appeals are time-consuming and if unsuccessful, the enrollee could be required to pay privately out of pocket for care received while awaiting a decision. Many enrollees don't have those resources to take that chance.

Ensuring plan accountability for safe transitions and discharges

Although not explicitly discussed in the proposed rule, it is critical that coverage determinations and notification processes ensure safe discharges for all Medicare beneficiaries.

While SNFs are required to ensure safe discharges for all those they care for, it is easier in traditional Medicare where they determine the appropriate discharge timing as part of the care plan in consultation with the patient and their family and within the Medicare coverage requirements. SNFs are placed in a more difficult position when MA plans make the determination to terminate coverage. Under MA, the plans make the discharge determinations issued as a Notice of Medicare Non-Coverage (NOMNC). SNF providers have observed that these determinations often fail to consider all of the challenges the individual will face returning home (e.g. 5 steps to enter the house but person is only able to navigate one step) including the availability of family caregiver support (e.g. frail spouse unable to assist, children live far away and can't help purchase groceries).

Also, it is not uncommon for an enrollee to receive a NOMNC, for example, late on a Friday afternoon, requiring a Sunday morning discharge. For a several reasons, discharging on a weekend day or holiday may not be practical or safe for a beneficiary/enrollee. Many residents will need services to be delivered at home, such as by a HHA or other provider, which requires considering options, confirming that a preferred provider has capacity to help, and completing the intake process necessary for services to begin. In addition to arranging services, discharging Medicare Advantage enrollees may need prior authorization for durable medical equipment, such as a hospital bed, oxygen concentrator or other equipment, but many plans don't conduct prior authorizations over a weekend.

In many cases, it may not be possible to complete all the necessary arrangements on a weekend, even with the facility's support of the resident through discharge planning, referrals, and development of the discharge summary that supports coordination of post-discharge care.

Therefore, in some cases, the SNF will disagree with the MA plan determination to end coverage, and yet, the SNF is still obligated to ensure a safe discharge often with limited notice. In these circumstances, the financial burden of these decisions falls to the family, if they can afford to pay, or the SNF, when they cannot privately pay for the additional days of care.

To illustrate these challenges, consider this example shared by a family member in Minnesota whose wife received 6 weeks of care in a LeadingAge member SNF. While they were pleased with the SNF care they received, they were surprised by the little notice they received regarding a discharge date especially given the fact that it was a holiday weekend when few services were accessible. They received the NOMNC on a Wednesday afternoon indicating her discharge would be Friday morning (less than 48 hours). They had no way to arrange HH services on such short notice especially because it was the week between Christmas and New Year's, and they didn't believe the SNF resident was ready to go home. The husband caregiver, who is 83 years old, felt the 2-calendar day notice was inadequate and should have been at least 3 days. Due to their concerns, they paid out of pocket privately for two additional days of SNF care (e.g. roughly $1000) after their appeal was denied. The wife then returned home on Jan. 2 with the 83-year-old husband serving as her home health aide. She fell that night and he was unable to pick her up off the floor requiring him to call the fire department for help. He was told by social work staff that "premature discharges" are common among MA plans. He asked us if we could advocate for more notice to ensure others don't encounter similar situations.

This is an important area where MA plans and providers need to better communicate, and plans should share accountability for safe discharges for enrollees. Beneficiaries should not be surprised that their coverage for the SNF stay is ending and immediately be faced with appealing, paying out of pocket or quickly being discharged. It is unclear why some plans are not using their care coordinators to assist enrollees with establishing services and pursuing necessary authorizations to ensure safe transitions and discharges.

Recommendations:

For these reasons, we offer the following items for consideration for inclusion in this or future rules or guidance on MA policy.

- **Change NOMNC notice requirement from 2 calendar days to 3 days.** The current 2-calendar day requirement counts the day the notice is issued, even if delivered late in the day. It does not require a full 48 hours. For the reasons we have outlined above, we believe enrollees and their families, with support from care coordinators and SNF staff, need additional time to make the needed safe arrangements.
- **Require MA plans' care coordinators to ensure safe transitions:** Given that the MA plans make the non-coverage or discharge determinations, CMS should add a provision clarifying that MA plans are accountable for ensuring safe discharges and transitions of care for their enrollees and that care coordinators are expected to assist enrollees with establishing any needed service or obtaining required authorizations.
- **Require plans to conduct prior authorization reviews 365 days a year or authorize service automatically during weekends and holidays:** Plans often require prior authorizations for HH services and/or ordered durable medical equipment, but they do not staff prior authorization reviews over the weekend or holidays even though they are discharging an enrollee home. This can leave their enrollees without needed care and supports not only over a weekend but often for several additional days, delaying access to needed care. We ask CMS to consider adding a requirement that plans with prior authorization processes must either: 1) staff them 365 days a year because enrollees need care over weekends and holidays, in addition to weekdays; or 2) they can choose not to staff these functions over weekends/holidays, but then medically necessary services needed during these times would be automatically approved and paid until the plan made a

determination on a weekday. Without these changes, prior authorizations and weekend termination of services only prevents enrollee access to needed services.

Network Adequacy

As we noted in our response to the CMS Request for Information on Medicare Advantage in August 2022, inadequate post-acute care provider payment rates and excessive administrative burden on network providers will lead to access to care issues for beneficiaries. We are hearing increasingly from members that they are unable to find a home health agency who will admit certain MA enrollees for services. We have heard hospital frustration that MA enrollees are sitting in their beds with no place to discharge them to because PAC providers are either full, don't have adequate staffing to take more admissions, and/or they can't afford to take an MA enrollee and lose hundreds of dollars a day to provide their care. For these reasons we support CMS's interpretation of the statutory and regulatory requirements that would require plans to arrange for any medically necessary covered benefits with out of network providers, when in-network providers or services are unavailable or inadequate to meet an enrollees need and that these services should be provided at the in-network cost sharing rates. We support the clarification that this policy applies not only to specialty care but all medically necessary, covered services.

Recommendation: LeadingAge would like CMS to also clarify in this section that in these circumstances, plans must pay out of network providers the Medicare fee-for-service rates for their services not a discounted rate. In addition to CMS's existing plan oversight processes, we reiterate that current processes for submitting complaints or identifying non-compliance should also include a channel for providers to notify CMS of beneficiary inability to access care through network providers, or errors in provider directories that misrepresent a plan's network adequacy.

Enrollee notification requirements for MA provider contract terminations

Under section 422.111 (e), we recommend CMS limit "for cause" termination notices in this section to those situations where the provider has been terminated for poor quality, fraudulent behavior or where harm has been caused to beneficiaries. Providers' reputations should not be tarnished by these notices because, for example, they refuse to enroll all their nursing home residents into the Medicare Advantage Organization's (MAOs) institutional special needs plan(ISNP). We also think it would be best to distinguish when a provider has voluntarily chosen to leave a plan network.

Current MA compliance related to medical review and system errors

CMS solicited input on section 422.503(b)(4(vi). What is most interesting about this section is that it focuses on external provider and supplier compliance -- not plan compliance. It also assumes that the plan understands accurately what determines compliance. This plan compliance program is focused on the plan's assurance that providers and suppliers are not acting suspiciously or fraudulently. It does not assure that the plan is complying with prompt payment of providers, following traditional Medicare coverage criteria in ensuring equitable access to Medicare benefits, and aren't misplacing documentation provided to it by providers for coverage decisions. LeadingAge providers have experienced repeated instances of plans missing and/or misplacing information contained in documentation (system errors), which would support coverage approval for beneficiaries. Currently, there is no clear mechanism for providers to report these issues about plan non-compliance except to assist beneficiaries with appeals. In addition, some plans repeatedly misplace documentation that supports medical necessity for a service as well as the corresponding payment but they appear to be able to continue losing this information with impunity and instead penalizing providers with the administrative burden of redundant data requests and resubmissions.

We have outlined in recommendations above mechanisms that we believe would enhance current efforts to ensure plans make appropriate medical reviews and coverage determinations. We believe those recommendations are also applicable here.

Cash equivalent benefits

We support CMS's intent of incentivizing healthy behaviors among enrollees through MA Reward and Incentive programs. We do not have a position on this topic but wanted to raise an issue related to potential cash equivalent incentives such as gift cards used for both the R &I programs or offered as a supplemental benefit. Receipt of these cash equivalent benefits at certain levels may have unintended consequences for residents of affordable housing and dual eligible enrollees. For housing residents, it is possible that these cash equivalent benefits will be treated as additional income possibly triggering a rent increase depending upon the amount of the benefit. While we have not heard similar issues yet for dual eligible individuals, we wonder if these cash equivalent benefits may also result in dual eligible individuals being required to pay more to spenddown each month to maintain their Medicaid eligibility or other income eligible benefits. Given these concerns and the fact that these cash equivalent benefits are designed to help avoid certain medical interventions or address social determinants of health, we would suggest CMS seek to clarify that these cash benefits be treated as funds for medical expenses and as such excluded from consideration for HUD housing and Medicaid income eligibility purposes. This approach would align with current HUD guidance on income exclusions in its Occupancy Handbook, which excludes from income those, "Amounts received by the family that are specifically for, or in reimbursement of, the cost of medical expenses for any family member."

Continuity of Care – Studies show patients who have an established relationship of trust with their providers experience better outcomes.[2] While a 90-day transition may be appropriate for some types of care, it is difficult to apply a blanket approach to all types of care. For example, Medicare covers a maximum benefit period of 100 SNF days but on average Medicare beneficiaries need around 20 days of care. This care is provided in a residential environment, ideally close to one's home and family. Being forced to change providers in the middle of an episode of SNF care would be disruptive and likely cause the individual to back track and require a longer duration of care. It would be highly disruptive to require a resident of a SNF to change SNFs in the middle of their therapy and skilled care. Alternatively, home health care is authorized in traditional Medicare for 30-day episodes and an episode should be honored as it is particularly challenging for an individual to trust someone to come into their home to provide care. We would suggest instead that continuity of care be tied to a course of treatment, once that definition is finalized in rule and ensures post-acute care services are appropriately covered by the definition.

---

[2] Impact of the Doctor-Patient Relationship: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732308/ ; "Assessing the Longitudinal Impact of Physician-Patient Relationship on Functional Health": https://www.annfammed.org/content/18/5/422 and https://patientengagementhit.com/news/good-patient-provider-relationship-proves-to-boost-outcomes

MA plan star rating system changes

We understand CMS's rationale for proposing to reduce the weight of patient experience/complaints and access measures in the MA Star Rating for 2026. While alignment across programs is usually a desirable goal, it seems ill-advised at a time where the Senate Finance Committee report highlighted that marketing complaints have more than doubled in the past year, let alone complaints for inappropriate care denials. We think CMS should postpone adoption of this change until the complaint trend demonstrates improvement. The heavier weight rightfully focuses plan attention on these critical areas, which are of great importance to beneficiaries.

Prohibiting the use of deceptive marketing practices by plans and their agents

LeadingAge is pleased to see and is highly supportive of CMS's efforts to curb deceptive marketing practices and the distribution of misleading information by MA plans and their agents. We highlighted this as a great concern from our members, as they are the ones who often must explain to the person in their care that they are enrolled in an MA plan (not a Medigap plan) and that the plan determines from which providers they can receive care and how much care they receive. We think CMS's proposals to require agents to collect certain information from prospective enrollees using a standardized list of questions and to then provide the prospect with information on the impact enrolling in a particular plan may have on their Medicare coverage is critically important.

Recommendations:

- CMS provide a template for the information plan brokers/agents must collect and a standardized format for how information is delivered to the prospective enrollee to ensure the data is provided in a consistent and comparable format.
- CMS should make further investments – funding and promotion of the option to Medicare beneficiaries -- to support State Health Insurance Programs (SHIPs) that can provide a critical role in helping beneficiaries assess their options for receiving their Medicare benefits through an unbiased process.

Affordable Care Act Provisions on Reporting and Returning Overpayments in Medicare Parts A and B

In section III.W.3(a), CMS proposes to amend 42 CFR § 401.305 by removing current paragraph (a)(2) and adopt by reference the False Claims Act definition of "knowing" and "knowingly," meaning a provider or supplier has actual knowledge of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.

Under § 401.305(b) the deadline for reporting and returning overpayments is the later of the date which is 60 days after the date on which the overpayment was identified, or the date any corresponding cost report is due, if applicable. Current paragraph (a)(2) states that a person "has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment *and quantified the amount of the overpayment*. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment" (emphasis added).

In the preamble to the 2016 final rule (see 81 FR 7661) enacting the current provision, CMS explained that the 60-day time period begins when either the reasonable diligence is completed or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment, and that part of identification is quantifying the amount which requires a reasonably diligent investigation. In its explanation of the proposed rule change, however, CMS does not address the matter of quantification.

Recommendation:
We ask CMS to provide further guidance on two issues: first, to clarify that providers will continue to have a reasonable opportunity to determine the scope of an overpayment and quantify it, a process that commonly can take longer than 60 days to complete; and second, to explain what it means to be in "reckless disregard" or "deliberate ignorance" that the provider received or retained an overpayment.

Program of All-Inclusive Care for the Elderly (PACE) Changes

Amending the PACE Organization's (PO's) initial contract year to allow for a longer trial period prior to the trial period audit.

LeadingAge believes there are benefits both to allowing for a longer initial contract year and maintaining the current timelines. In some cases, a PACE Organization (PO) may need additional time to finalize marketing, recruit participants, and hire and train staff. There are many factors that may contribute to a PO needing this additional time to grow and stabilize their PO prior to their initial trial audit including available workforce, geographic or weather-related barriers, and local familiarity with managed care. For these reasons, we believe a PO should have flexibility to request a longer initial contract year, as proposed by CMS.

Amending the initial contract year for all POs could inhibit expansion and growth of the PACE program. Well-established providers may have an easier time setting up a PACE program and reaching a more static operating state than a smaller provider. For these providers, their ability to expand and grow should not be hindered by a longer initial contract period prior to their audit.

Recommendation: Allow POs to choose between two trial period timelines – the current timeline and the longer proposed contract year – with clear guidance on whether the decision is binding and any additional guidance.

Parameters that would designate an application as substantially incomplete

We appreciate CMS' desire to outline requirements for the PACE application and expansion process. We believe it is inappropriate for PACE Organizations submitting otherwise complete applications to be punished until the subsequent quarter's submission date because of errors made by a State Administering Agency (SAA). Members have shared errors in state documents that would have caused significant delays in their applications being accepted by CMS. LeadingAge understands that submission of an application completely lacking an assurance from the SAA is a reasonable instance when a PO could be required to wait until the subsequent quarter. Failure of the SAA to accurately provide their assurance should not unnecessarily hold-up application approvals. We believe some POs would be uncomfortable noting to their SAA that errors are included in the SAA assurances or other paperwork. While we hope that professionalism prevails, beginning a relationship between a provider and their regulatory oversight body with critique could tarnish future interactions. For this reason, we think the CMS review of the SAA's documents is more appropriate. One member shared that their application was

delayed because a state borrowed documentation from another state and failed to update to their own state's name, program specifics, etc. This caused the provider's application to be delayed for a quarter. Requiring a PO to resubmit their application in the subsequent quarter could cause additional financial strain on the PO by postponing enrollment and revenues.
Recommendation: CMS should consider whether the error was made by the applying PO, or the SAA. If the error was made by the SAA, the application should be suspended until the SAA provides corrected documentation. At the time all documentation is submitted, the application should be accepted for review to determine approval, denial, or issuance of a RAI. The PO should not be required to resubmit an application in the subsequent quarter based solely on errors by their SAA.

CMS review of past performance in new applications and Service Area Expansion (SAE) applications
LeadingAge is generally supportive of the concept of past performance review for providers and parent organizations seeking to expand and open new sites. Review of financial viability, any existing bankruptcy proceedings, and prior suspension of payment or enrollment are reasonable steps to assure prospective PACE participants are protected from historically underperforming or at-risk providers. While the proposal does not deem that CMS will affirmatively deny applications which do not pass scrutiny of the above clauses, it says CMS *may* deny these applications. This is an important distinction, and we urge CMS to maintain this distinction. CMS defines financial viability as having a positive net worth following the trial period (36 months of financial statements following opening). High quality providers could assume significant debt to open a new PACE site or enter the PACE market. Even maintaining debt through a 36-month period is not indicative of poor fiscal management, but rather could demonstrate sound service delivery. Increased service provision and higher staffing will cost the PO more in operational costs thus reducing their margin to pay down debts quickly. This proposed provision could incentivize reduced staffing, service delivery, and operational costs to increase funds for administrative debt management. This would not optimize the care and services provided to PACE recipients but could enable a provider to meet eligibility for an expansion.
Recommendation: We appreciate the intent but urge ongoing flexibility to approve SAE applications if quality care and services are being offered and rendered to participants.

If CMS feels it necessary to impose a fiscal assessment of new POs following their trial period, LeadingAge recommends consideration of a more lenient debt:assets ratio of 3:2 at the conclusion of the trial period. As responsible POs grow, some may have interest in seeking a SAE to help with participant recruitment. In discussion with providers, it seems net zero debt:assets could be difficult to achieve in 3 years. Slow and steady growth in PO participation and fiscal bottom line demonstrate responsible leadership that can continue to meet the needs of participants without rapidly and unexpectedly outgrowing their staffing capacity. Either way, LeadingAge is supportive of CMS ability to deny or approve applications regardless of the outcome of the financial review.

The use of a 13-point threshold for denial of expansion applications is unclear. It seems to propose that CMS will not use compliance citations issued during reviews or audits (460.194(a)(2), but could use other issued citations. It is unclear how consistent administration of this proposal would look. Additionally, this proposal lacks considerations for large parent providers which may receive nominal citations at each of multiple sites, that may reach the 13-point threshold for denial. Smaller or single site providers would not experience this need for scalability of the points threshold.

Recommendation: We urge CMS to consider ways to create a sliding scale of compliance that would not disproportionately disqualify larger and more established parent organizations.

Regarding the 13-point threshold, it is unclear from where the points would be accrued. It seems the points are only accrued during a SAE application, through the use of sections proposed in § 460.19(b)(1) through (6)- if this is the case, we have some concerns. Proposing fully new regulatory reviews that could result in denial of SAEs lacks transparency. Neither stakeholders nor POs understand how CMS will apply these provisions in review, and therefore cannot be sure that the standards are consistent and fair.
Recommendation: We recommend a period in which CMS demonstrates to stakeholders and providers how the newly proposed points system will be applied to better assess the effect it's imposition would have on application denials, therefore delaying implementation of these provisions.

Elimination of period to remedy deficiencies prior to imposition of CMPs or payment/enrollment suspension
The elimination of a period in which POs could remedy a deficiency prior to CMS imposing CMPs or suspensions of enrollment or payment is concerning. The levels of non-compliance that would lead to issuance of CMPs or suspensions are unclear and should be better defined through sub-regulatory guidance. Upon the provision of more clarity on thresholds for non-compliance, POs would be better equipped to implement changes to mitigate the identified deficiency. The transition from collaborative improvement in service of participants to punitive enforcement is discouraging.

- **Recommendation:** We recommend CMS not implement this change.

Personal medical clearances of staff and contractors with direct participant contact
The codification of medical clearance processes and procedures in protection of PACE participants is welcome though we caution CMS against over-regulating in this section. The flexibility to develop and adopt procedures around staff and contractor communicable disease risk assessments to fulfill annual requirements for medical clearances is welcome.

- **Recommendation:** Review of risk assessments could be completed by non-clinical staff when the assessment is free of indication of any risk. This flexibility would maintain more clinical staff time devoted to PO participants instead of administrative reviews. These flexibilities and assurances would be outlined in the PO's policies for medical clearances and risk assessments. For all assessments that indicate any exposure or possible risk of communicable disease, the requirement for review by a physician, physician assistant, nurse practitioner, or registered nurse remains reasonable.
- **Recommendation:** When considering vaccination requirements, we urge CMS not to impose regulations that are more onerous than in other health care settings. Workforce in all sectors is stretched very thin and requiring more stringent vaccination requirements than acute and post-acute settings would not better serve the PACE population. We also believe the landscape of communicable disease has been changed by the COVID-19 pandemic. Enumerating specific vaccinations or diseases for which vaccination are required is cumbersome and not reflective of rapidly progressing epidemiology. Omission of a list is more nimble and would eliminate supremacy confusion with existing state health regulations.

PACE Contracted Services

We appreciate the problem CMS states it is attempting to solve through the codification of required contracts between POs and 25 commonly used specialists. We don't believe the proposal solves the identified issue of assuring timely access to services identified as necessary. Members of LeadingAge have noted that even being within the broader umbrella of a large insurer with a very broad and diverse network, their ability to schedule timely specialist appointments remains difficult. CMS notes that 70% of POs that were cited for failure to provide necessary services included failures to provide access to specialist appointments in a timely manner. This statistic doesn't show how many providers weren't cited for failure to provide necessary services and is an inadequate data point to rationalize codifying the specialist contracting requirement.

- **Recommendation:** LeadingAge suggests CMS does not impose requirements on POs to contract with the listed 25 common specialists. While most POs already meet this threshold, the requirement does not serve the intended outcome.

Timeframes for Coordinating Necessary Care

LeadingAge appreciates the review of challenges and ultimate decision not to propose strict service delivery timeframes. Many organizations shared their challenges getting appointments scheduled with specialist offices. In many cases, scheduling of appointments, even with in-network providers, still requires multiple phone calls and call-backs.

- **Recommendation:** The included timeframes proposed for coordination of services should be extended to 48 hours for medications and 12 calendar days for all other services. This extension does not meaningfully change the spirit of the requirements and ensures that POs have adequate time to coordinate with busy specialist offices. Flexibilities should remain for documentation of inability to schedule/coordinate in the specified timeframes.

Care coordination requirements and timeframes

The CMS proposal creates explicit parameters outlining IDTs' responsibilities across all settings, including for participants residing in nursing facilities. This includes the interdisciplinary team's (IDT) responsibility to order, approve, and authorize all necessary care. This provision is impractical for participants receiving care in an in-patient setting and could delay care to participants. For a participant residing in a NF, the IDT doesn't have purview to order services provided by the nursing facility, though the IDT would and should consult with the NF about recommendations and maintain coordination efforts.

CMS also proposes to impose maximum timeframes for IDTs to review, assess, and act on recommendations regarding a participant's care. For recommendations from emergency departments, hospitals, or urgent care, the PO must review, assess, and act no later than 24 hours post discharge. The requirement for a full IDT review and assessment of recommendations from acute care within 24 hours is administratively burdensome, not feasible, and would be costly over weekends and holidays. In many instances, the discharge plans are not electronically available within 24 hours.

- **Recommendation:** CMS should consider extending this timeframe to a point after documentation is included in the medical record; 96 hours is feasible and recommended.

For internal recommendations from staff or contractors, the IDT must review, assess, and act within 5-calendar days of the recommendation being made. As the proposal is composed, it is unclear how the

five-day timeframe would be triggered. The five-day time period could be difficult for compliance in some instances. For participants and requests where additional information is necessary or consultation with additional specialists a more appropriate timeframe would be ten calendar days so long as the participant's needs and conditions have not progressed to need more expedient coordination.

- **Recommendation:** LeadingAge believes 10 days is a more reasonable timeframe for coordinating these services.

Standardization of Care Plan and timeframes for initial and review

The proposal makes significant changes and additions to sections of the rule related to care planning: timing, minimum requirements, documentation of identified need, change in participant status, and goal setting. These additions and amendments will require POs to develop policies and retrain staff. By increasing requirements and required documentation, the process of care planning and the care plan itself could be less person-centered. The introduction of minimum care plan requirements limits participant ability to designate their own desires through care planning. Participant choice to not have a service or identified need addressed in the care plan should be retained. The proposal, as written, doesn't seem to afford that option.

- **Recommendation:** We urge CMS to allow POs flexibility to collaboratively develop the care plan with the assistance of the participant- this includes the flexibility to document or omit areas of identified need in which the participant may select not to include in their care plan. LeadingAge also suggests that CMS allow flexibility in the identification of goals for all functional limitations and interventions. The care planning process should be led by participant needs and desires; over documentation of a participant's limitations may not be their wish and may cause dissatisfaction and anxiety in their review and approval of the care plan.

This section imposes timeframes for development of a care plan within 30 days of the participant's enrollment and review every 180 days. We believe 30 days is an appropriate timeframe for development of initial service plans. For some participants, assessment and service plan development is a complicated and collaborative process that includes the IDT, the participant, and family or friends providing informal supports.

- **Recommendation:** For both timeframes, we believe it is important that flexibility be granted for both timeframes when accounting for complex needs. This could be established through an exception process established by POs in policy. If CMS feels POs would abuse this flexibility, CMS could impose a limitation on the percentage of plans of care operating in an exception timeframe. We suggest CMS consider 85% of plans of care fall within the regulatory timeframes proposed.

Defining all dissatisfaction as grievances and prescribing policy development and timeframes

The effort to formalize the grievance process and characterize all complaints or dissatisfaction as a grievance is ill advised. While we appreciate CMS' intention to formalize processes and timeframes for dealing with actual grievances, we caution that not all complaints or confessions of dissatisfaction should rise to the same specter as grievances. In leveling the field and administrative obligations associated with all dissatisfaction to the same requirements as notification of egregious errors or omission in care quality we are reducing the importance of more significant concerns. CMS even addresses this concern in their analysis yet continues with the proposal to consider all complaints as

grievances. The proposal expands the persons eligible to lodge grievances beyond the individual participant. While we agree that a formal grievance process should be in place, including consistency in timeframes and administrative data collection, we feel that including all dissatisfaction or ad hoc complaints as grievances is a disservice to any egregious actions by POs that should be categorized as grievances. We support the ability to notify participants of resolution of their grievance either orally or in writing.

- **Recommendation:** LeadingAge suggests that CMS revisit their definition of grievance to better reflect the day-to-day interaction between PACE participants and staff/contractors of the PO. CMS should consider both a grievance and complaint process with the complaint process being more appropriate for lower-level concerns such as those that the participant does not seek remedy or those which do not intersect with quality of care.

Service determination request extensions can be confirmed orally

We appreciate and commend the flexibility to allow service determination request extensions to be delivered either orally or in writing.

Disclosure of past non-compliance to participants and those interested in enrolling in PACE

The proposal to require POs to disclose information on the POs performance and contract compliance to current and prospective PACE participants is inconsistent with requirements for other health care providers. It is unclear how CMS is requiring this disclosure.

Regardless of this addition, there is no prohibition from PACE enrollees discussing dissatisfaction, or delays in service delivery with other participants. In these cases, participants would be encouraged to file a grievance or complaint, upon which time the PO would investigate and act to remedy. Transparency is always welcome, though consistency in standard administration must be achieved before true transparency is valuable. Idiosyncratic differences in PACE program administration and flexibility that promotes person centered planning and nimble response to individual needs doesn't always demonstrate a full picture in reviews and issued deficiencies.

- **Recommendation:** We suggest that performance and compliance related information be available upon request of the applicant or participant for most areas of non-compliance. LeadingAge can see some instances where disclosure to participants and prospective participants could be valuable. CMS should consider required notification to participants and those considering participation upon issuance of CMPs or suspensions of either payment or enrollment. If CMS is staunch in their requirement that POs notify participants of all instances of non-compliance, we urge CMS to accept the posting of notice that the PO's records of non-compliance are available for review and discussion by request.

We appreciate your partnership in fixing the challenges we see to ensure that all Medicare eligible beneficiaries have the same access to Medicare benefits and we reduce the burden to attain that access. We look forward to working with you to make the improvements necessary to preserve the Medicare Advantage program as a choice for Medicare beneficiaries.

Sincerely,

Nicole O. Fallon

Vice President, Health Policy & Integrated Services

Director, Center for Managed Care Solutions and Innovations

LeadingAge

nfallon@leadingage.org