**LeadingAge Request for Feedback from Members on Medicare Advantage Experience for Responding to CMS RFI on MA**

LeadingAge will be responding to the Center for Medicare and Medicaid Services (CMS) Request for Information ([RFI](https://public-inspection.federalregister.gov/2022-16463.pdf?1659039318)) on Medicare Advantage (MA) and is interested in member feedback in one or more of the following areas, please respond to any or all of the questions below by emailing Nicole Fallon at nfallon@leadingage.org. All information provided by members will be aggregated and de-identified when including it in the LeadingAge comments on the RFI. Members’ comments will not be individually identified. All information submitted by members will be used for this RFI and other advocacy efforts in both the Administration and Congress.

* **MA Provider Payments and Contract Terms:** Each provider must sign a contract with an MA/SNP plan to be part of their provider network. Plans prefer their contract terms are nearly the same for all providers in a given provider type but the payment rates and the duration of the contract may vary.
	+ What percentage of your costs does your MA payments cover? And/or how does it compare to what you get paid for a similar patient/resident under Medicare FFS?
	+ How are you paid by MA plans (identify all that apply): percentage of Medicare fee-for-service rates, based upon tiers or levels of care, value-based arrangement, other?
	+ Have you refused to contract with any MA or SNP plans because of the contract terms they have offered? If so, what were the unacceptable terms and how has this decision not to contract impacted your revenues, if any?
	+ Do you contract with MA/SNPs to provider supplemental benefits?
	+ What could incentivize plans to contract with smaller providers to ensure access to an array of diverse and geographically disperse providers
	+ If you are in a market where MA enrollment is 50% or higher, describe your experience related to contracting with MA plans?
	+ What is your biggest headache related to your participation in MA?
* **Value-Based Payment Arrangements with MA plans:** Value-based arrangements (VBAs) might include being paid a bonus payment for performing well on a defined list of quality measures, having a portion of your total payment withheld and earned back based upon performance on pre-defined metrics, or being paid a sub-capitated or bundled payment to care for individuals at a certain level, diagnosis or for a specific duration.
	+ What has been your value-based contracting experience with MA plans (e.g., I don’t have the option; we’ve asked but the plan won’t discuss a VBA; we have one but it is a new; we’ve received a bonus payment; it is an earn-back arrangement where they withhold a portion of payment based upon performance; we have negotiated a sub-capitated or shared savings amount for certain services/diagnoses)?
	+ Do you currently contract with any MA/SNP plans in a VBA? If so, how many such contracts do you have and which plans contract with you this way? Are the terms – payment structure and quality measures similar – among the plans?
	+ How is your VBA structured -- e.g. a bonus payment, withhold with an earn-back feature, a capitated or bundled payment, shared savings or other?
	+ What quality measures does the plan assess your organization on?
	+ How do they compare to arrangements you may have with an area Accountable Care Organization or Bundled Payment entity, or Medicaid FFS or managed care plan? Are the expectations similar, different?
	+ How could CMS support more value-based contracting between providers and MA plans?
* **Prior Authorizations:** Often plans require providers to submit certain services or items for approval prior to delivering the service or item to the beneficiary. This is one of many utilization management techniques that plans use to control beneficiary costs.
	+ What items or services must you submit for prior authorization to MA plans?
	+ What must you submit for documentation?
	+ How could the prior authorization process be more efficient and accurate (e.g. online portal, etc.)?
	+ How long does it take to receive a determination on a prior authorization request?
	+ How often are these requests denied?
	+ How often do you appeal a denial? If you have appealed, how often have you been successful?
	+ If you work with multiple MA/SNP plans, how do their prior authorization requirements differ (e.g. services/items for which prior authorizations must be obtained, process for obtaining approval, turnaround time for decision, etc.) Are there any practices they have in common?
* **Access to Care:** CMS is interested in ensuring that all enrollees in MA plans have equitable access to their Medicare benefits.
	+ What steps should CMS take to better ensure that all MA enrollees receive the care they need?
	+ What barriers have you observed to MA enrollees accessing care?
	+ Have you observed any populations who have more challenges accessing care when on an MA plan?
	+ Are there examples of when MA plans work well to ensure beneficiary access to care, coordination of care and identification of social determinants of health?
* **Plan networks:**  MA/SNP plans must ensure that they have adequate numbers of providers by type in their network. CMS establishes time and distance standards the plan must meet to ensure that at 85-90% of enrollees have access to certain providers.
	+ What criteria are plans using to determine whether a provider is included in their network? What factors have been used to drop your organization or not include your organization from a plan’s network? If dropped from a network, were you told the reason for no longer being included?
	+ Besides considering the time and distance one must travel to access a network provider, what other requirements should MA/SNPs meet in developing their provider networks (e.g., quality rating, available beds or accepting new clients, etc.)?
* **Administrative Burden of Contracting with MA/SNPs**: Unlike Medicare Fee-For-Service, every contract and process for submitting payment, seeking prior authorization of services, credentialing, etc. is different depending upon the plan.
	+ Estimate how much time you spend and/or how many FTEs you dedicate to administering your MA/SNP plans to retain your in-network status, billing/claims, appeals, credentialing or other.
	+ What ideas do you have for ways in which CMS could support reducing the administrative burden related to contracting with MA/SNP plans?
* **Data Collection**: CMS currently tracks quality measures for MA/SNP plans and collects other data.
	+ What data elements should CMS collect about MA/SNP plans that could assist beneficiaries in selecting MA vs. Medicare FFS?
	+ What data could be collected on MA/SNP plans that would help providers related to care delivery, prior authorizations or other utilization management?
	+ What data could CMS collect to help them better understand value-based contracting in MA/SNPs?