



January 5, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-4205-P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically.

Dear Administrator Brooks-LaSure,

LeadingAge appreciates the opportunity to comment on the Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescriptions Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications” (CMS-4205-P which will be referred to in this letter as “proposed rule”).

This year’s rule proposes some important changes with the intent to further integrated care and services for dual eligible individuals, remove barriers to MA enrollees receiving an independent review of their appeal of a plan coverage determination, and greater transparency regarding available benefits and plan practices. We are supportive of the intent but believe the means to the intended end may require some additional consideration for some of these proposals.

To provide some context for our comments, let us share a little about LeadingAge. Our mission 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, SNPs and PACE programs. Our comments will focus on issues that impact their ability to effectively deliver services and be paid for those services. We have outlined the issues of greatest interest below.

Issue: Data Collection

CMS notes that the proposal would lay the groundwork for new data collection to be established through the Paperwork Reduction Act (PRA) process, which would provide advance notice to interested parties and be subject to public comment. It offers the following as an example of the types of data that might be collected through such a future effort: service level data for all initial coverage decisions and plan level appeals, such as decision rationales for items, services, or diagnosis codes to have better line of sight on utilization management and prior authorization practices, among many other issues. LeadingAge agrees strongly that additional data collection in the MA program is necessary to better understand utilization patterns, effects of utilization management policies employed by the plans and whether this model is a cost-effective use of taxpayer dollars to deliver Medicare benefits. We believe we would benefit from collecting the data about plan coverage decisions broken out by service level, as well as information on care denials and appeals at the plan level. We have seen it reported and also heard from some skilled nursing facilities (SNFs) that they have seen an uptick in plans denying SNF care to residents of long-term care facilities following a hospitalization. This is evidence that the plans do not understand that there are considerable differences between the custodial services and supports provided to long-term stay residents of a nursing home and the skilled level of care and rehabilitation provided to those in a short, post-acute care stay. So, tracking care denials on a service level could prove telling. At some point, it may also be helpful to include such information on Medicare plan finder. We also hope CMS will consider collecting data from the plans on supplemental benefit utilization. Rebate dollars are dedicated to these benefits, and it would be good to know if MA/SNP enrollees are availing themselves and benefitting from these offerings. We think understanding their utilization could prove an important first step in shaping future policies related to supplemental benefits. We also think that now that Medicare beneficiaries are equally enrolled in original Medicare and MA/SNPs, it would be a good time to examine certain outcome or quality measures between the two delivery models. As an example, we could collect data on average length of stay in SNF or number of home health visits and rehospitalization rates for these individuals. If we find promising practices, this information could be shared across programs to improve outcomes for all Medicare beneficiaries and potentially even lower costs.

Issue: MA enrollee appeal rights parity for independent review entity

LeadingAge strongly supports the proposal to remove two key barriers – timeliness of the request (24

hours) and whether the person has left the care site – to MA enrollees being able to have an independent review entity consider their appeal for a denial or discontinuation of non-hospital services. We believe access to a second set of eyes on a situation outside of the MA plan is important as the April 2022 OIG report noted that plans are missing information that would support the medical necessity of services and therefore their approval or continuation. Enrollees and their families could easily miss appealing within 24 hours of receiving the denial. Permitting them to still have access to a fast-track IRE beyond this timeframe is important and as noted in the proposed rule, it offers parity with original Medicare. In addition, we know some enrollees and their families lack the funds to pay privately for care when it is still needed but denied by a health plan, and as such, they may discharge from a skilled nursing facility or the SNF may write-off this cost even though the MA plan should have covered the care. As noted, currently, discharging from a facility prevents them from the fast-track, IRE appeal. Therefore, we believe the CMS proposal to permit individuals who return home to still receive a fast-track, IRE appeal removes an important barrier for these individuals. Income should not be a barrier to receiving medically necessary care. Therefore, we applaud CMS for taking the initiative to remove these two barriers and more closely aligning this process with original Medicare. We intend to spend time in the coming year more closely examining the challenges our providers face in assisting beneficiaries with the appeals process and identifying additional areas for improvement to ensure timely access to medically necessary care and safe care transitions for enrollees, and to enhance opportunities for our providers to advocate on behalf of those they serve in these appeals on behalf of beneficiaries (e.g., a plan told one of our SNFs after 8 months that they didn't have standing to challenge the plan's inaccurate assessment of cost sharing on one of its enrollees). We look forward to sharing what we discover and any possible future recommendations.

Issue: Network Adequacy - Facility-Based Institutional Special Needs Plan Exception. LeadingAge supports the CMS proposal to create an additional exception to the network adequacy requirements that is specific to the unique nature of care delivery patterns for individuals enrolled in facility-based I-SNPs. We agree with CMS that facility based ISNPs deliver care to their enrollees at a specific location where the enrollees reside daily and therefore are unique in comparison to other SNPs that may deliver services across numerous counties and residences. Facility-based ISNP enrollees receive most of their care and services on-site and when unable to provide a service, the facility will make arrangements for the person to be seen by the appropriate physician or specialist along with transportation to these appointments. In addition, facility based ISNPs enrollment tends to be lower making it challenging to competitively contract with certain providers especially when those providers know they will receive little volume from this payer source. Therefore, we support the proposed change to allow this limited group of ISNPs to receive network adequacy exceptions if they can substantiate that the enrollees continue to have adequate access to basic benefits through either telehealth or out-of-network care at in-network cost sharing. CMS notes in its proposal that it will require the facility-based I-SNP to provide “evidence” to support its claim of an inability to contract with certain specialists. The proposed rule offers one example of what might be acceptable “evidence”, but we would suggest that this section might benefit from further sub-regulatory guidance with additional examples of other “evidence” that would be accepted to support the sought exception. Our facility based ISNP members will appreciate

this recognition of their residential care delivery model and the unique challenges and opportunities it presents.

Issue: Open Enrollment Period for Institutionalized Individuals

The rule seeks to clarify when the open enrollment period (OEP) for institutionalized individuals ends, which is the last day of the second month after the individual ceases to reside in a qualifying institution. We do not oppose the proposal but would encourage CMS to further amend this section to clarify that the OEP for institutionalized Medicare beneficiaries also permits them to enroll in a special needs plan (SNP) or a program for all-inclusive care for the elderly (PACE) in addition to an MA plan or returning to original Medicare. We think it is important to be clear they have the full menu of options available to them to ensure they can identify the one that will best meet their needs. The language currently only references MA plans or election of original Medicare.

We also support CMS's proposal that MA plans recognize the beneficiaries preferred effective date for their new election in cases where more than one election period applies and that the default is to the earliest possible disenrollment date when the beneficiary cannot be reached.

Issue: Proposals related to Dual Eligible Special Needs Plans (DSNPs)

CMS proposes several key measures to further enrollment of dual eligibles into integrated models of care and specifically doing this through DSNPs. LeadingAge has long-supported integrated care delivery models for dual eligibles as well as other populations. We also agree that exclusively aligned models, where one entity is responsible for the payment and coverage of both Medicare and Medicaid services, is optimal. However, we believe the proposals contained within the proposed rule require some refinements and additional consideration before moving forward.

First, CMS proposes to replace the current special quarterly enrollment period (SEP) with a once per month SEP to allow these populations to return to original Medicare and elect a Part D plan. On its face, it appears to be a good idea but frequent shifting between plans and/or payers can lead to lags in providers being notified of these changes in payer source and coverage information, which could result in delays in access to needed care, prescriptions, etc. If CMS continues to pursue this monthly SEP for duals, we would like to make sure that the regulation is amended to clarify that the individual could also elect to enroll in a PACE program, as this is an exclusively aligned model, and that is the goal CMS is trying to achieve with many of these proposals is to get more duals enrolled in an integrated model. The ability to make monthly changes could exacerbate these situations but if this policy is adopted, we would ask that these enrollees also be permitted to enroll in a PACE program.

CMS also proposes a new integrated care SEP permitting dual eligibles a monthly option to elect an integrated D-SNP. We have the same concerns about the potential for a dual eligible to change plans monthly resulting in a lack of care continuity and possible gaps when providers aren't aware of the change in coverage policies and benefits, provider networks, etc. Secondly, this proposed integrated care SEP only permits the dual to change from their current Medicare or MA election to an integrated

DSNP. We would ask that if CMS chooses to finalize this proposal that it also permit duals to elect to enroll in a PACE program, if one is available. PACE is regulated under the MA rules and offers a proven, integrated model of care. We believe that duals should continue to have the ability to select from the full array of integrated options and providers available to them. In addition, we have been told by our PACE providers that their existing enrollees have been targeted in recent years by some MA/SNP plans encouraging the PACE enrollees to disenroll from their PACE program and enroll in the MA/SNP product. These enrollees have been convinced to change their enrollment to these MA/SNPs enticed by extra benefits (e.g. cash card for groceries, etc.) without understanding that they may be losing access to their current integrated care and providers via their PACE program. For this reason, we would like these individuals to have the option to return to their PACE provider and other duals to have the option to enroll in PACE for the first time under such an integrated care SEP. In addition, some duals who reside in an “institution”, may be better served by an institutional SNP than a DSNP, especially if future MA policies encouraged states to coordinate or align Medicare managed care plans with ISNPs.

We are strong proponents of exclusively aligned, integrated programs/models as we believe they are better equipped to ensure true integration and more whole-person view for addressing the needs of a dual eligible. We also think simplifying the choices a dual eligible has can be a positive. Therefore, conceptually, we support the final two proposals related to integrated DSNPs -- 1) limiting DSNP enrollment to those in the affiliated Medicaid managed care plan beginning in 2027 and 2) limiting each parent organization to offering a single D-SNP in a given service area. However, we worry that either policy might have the unintended consequence of creating further market consolidation. As it relates to required coordination with states, we could see states desiring to further limit the number of DSNPs or other integrated plans with which they will contract, either through issuing Requests for Proposal requiring statewide coverage or other criteria that may make it less desirable or possible for smaller and/or local/regional plans to participate. Efficiency and administrative burden on the state of administering these programs is certainly a consideration but our providers have found, at least anecdotally, that regional/local plans tend to be more responsive and accountable to the communities they serve. As CMS notes in this proposed rule, the larger national plans have more financial resources at their disposal to meet these RFP terms. No one can blame the states for limiting their own administrative burden but in alignment with the Biden Executive Order on Promoting Competition in the American Economy (#14036), we think we should evaluate whether these policies will preserve, “a fair, open and competitive marketplace” or further contract the MA market. We are interested in making sure there are options for small, regional plans as well as larger players to participate and offer products. Our providers are sensitive to this issue as many of them are already experiencing the effects of the current market consolidation which are negatively impacting their reimbursement from MA/SNP plans. They are paid at rates below original Medicare for the same service but with significantly greater administrative burden imposed by plan policies and practices. These inadequate provider reimbursements are already resulting in access issues in some markets with higher MA/SNP penetration leaving hospitals unable to discharge patients and beneficiaries unable to receive timely, needed care.

Finally, as CMS considers policies that will increase the number of dual eligibles in integrated models of care, we wonder if another tactic might not be considered – making further investments in unbiased counseling such as that provided by state health insurance programs (SHIPs) for dual eligibles regarding the full array of integrated care options. Dual eligibles are not all the same. Some reside in a single-family home or apartment in the community, others in a nursing home. Some have family support and others don't. They may be young and disabled or a frail older adult. Some may only have access to MA plans while others may be able to choose among DSNPs, ISNPs or PACE programs that can address their needs and coordinate their Medicare and Medicaid benefits effectively. This set of proposals

We applaud CMS's efforts in this proposed rule to drive more duals to integrated programs, but we recommend CMS take a broader view of ensuring duals have access to and an ability to elect from the full menu of integrated care models available with clear information about the benefits of each before finalizing these proposals.

Issue: Limit cost sharing in DSNP PPOs to in-network levels for all providers. We understand the benefit of CMS's proposal to limit the costs to state Medicaid agencies by its proposal to require DSNP PPOs to limit cost sharing for both in-network and out-of-network providers to the in-network (lower) amount. We want to raise two considerations related to this proposal. First, we wonder if this proposal will reduce the number of DSNP PPOs offered going forward. PPOs, typically, offer their enrollees a broader provider network from which to address their needs. We understand for dual eligibles that can result in a higher cost for state Medicaid agencies. Furthermore, it should be noted that a patient's cost sharing is typically collected by a provider and part of the provider's total reimbursement for the service(s). By reducing this amount, it in turn reduces their reimbursement. For duals, providers often receive limited or no cost sharing from their state Medicaid agencies for dual eligibles enrolled in MA/SNP plans. They are instead "write offs". Therefore, this policy is likely to have a limited effect. Nonetheless, we felt it was important to note that changes to cost sharing impact provider reimbursements.

Issue: Changes related to supplemental benefits

LeadingAge has long supported the expansion of supplemental benefits that plans are able to offer to Medicare Advantage enrollees. The benefits plans have added, since the expanded definitions took effect beginning in 2019, largely recognize the importance of social determinants of health like access to healthy foods, support with rent and utilities under SSBCI, transportation for both medical and social activities. However, roughly 5 years later, we still lack information on how often MA enrollees access these benefits. This proposed rule attempts to achieve two important goals: 1) ensuring beneficiaries are aware of the supplemental benefits they have access to through a mid-year notification; and 2) ensuring that Special Supplemental Benefits for the Chronically ill (SSBCI) that are offered improves or maintains the health or overall function of the enrollee.

We support efforts to that help beneficiaries better understand what supplemental benefits are available to them under offered MA/SNP plans and how to access such benefits once enrolled. We know many beneficiaries sign up for a particular plan because of these enticing supplemental benefits. We want to see utilization of these benefits that are designed to improve the health of the individual.

We support CMS's proposal to require plans to send a mid-year notification to its enrollees identifying supplemental benefits available to them that they have not yet accessed. We will be interested to see if such a notification has an impact on utilization of these services. It remains to be seen whether beneficiaries aren't accessing the supplemental benefits because they are unsure how to do so or have forgotten they are available, or if instead, associated cost sharing may pose a barrier. To that end, we think CMS should also consider collecting data from plans on supplemental benefits utilization. To implement the notification, the plans will have to analyze and determine which benefits an enrollee is eligible for and which ones have been accessed, if any. Since this data collection will be done, it might be beneficial to have plans share this information with CMS to inform future policy. Understanding current utilization of supplemental benefits would also help more effectively determine if this type of notification is necessary and whether some benefits are easier to access than others. What we won't learn from the enrollee notification nor from the data collection is what barriers might exist that keep enrollees from accessing these benefits.

CMS also proposes two key changes related to Special Supplemental Benefits for the Chronically Ill (SSBCI): 1) requiring plans to include a disclaimer in all marketing and communications to enrollees that makes it clear which chronic conditions are eligible for the benefits and that even if the beneficiary has one of the eligible chronic conditions that the enrollee may have to meet other criteria in order to receive the benefit; and 2) requiring plans to provide bibliographies of evidence that a given SSBCI has a reasonable expectation of improving or maintaining the health or function of chronically ill person.

We believe the increased transparency from the required marketing and communications disclaimer will help beneficiaries make more informed choices. We like that this disclaimer cannot be in smaller font than other key text in print communications and must be read at a comparable speed to other plan information for radio/tv ads. SSBCI and other supplemental benefits continue to be a draw for beneficiaries so we believe this effort will help ensure that they are not misled about which benefits might be available to them.

On the issue of plans providing a bibliography of evidence in support of the SSBCI's impact related to improving or maintaining a chronically ill person's health or function, we support the idea behind the proposal but have a few questions and possible concerns about how it might work in practice. SSBCI allows for benefits to be offered that aren't necessarily "primarily health related." For example, benefits could cover a person's utility costs or rent if it would help them maintain their housing. Therefore, we wonder if this new requirement for a bibliography of evidence might dampen plans' pursuit of more

innovative benefits that have limited evidence or case studies. We also appreciate the need to ensure that frivolous enticements aren't being offered to get someone to enroll but that have no positive effect on their health or function. We wonder if CMS might consider a mechanism where untested benefits might be tried over 1 or 2 plan years before outright being rejected, if evidence from those years is provided to CMS. As far as the quantity of evidence a plan must prove, it appears that they must provide all evidence available in the past 10 years on a particular service or intervention. While we understand the need to make sure plans don't cherry pick only those studies that support their SSBCI, we wonder if it is reasonable to expect "all" evidence be provided. In addition, what if a particular SSBCI had evidence of its efficacy that is more than 10 years old and more current studies pro or con don't exist? Would the plan be prohibited from offering such a benefit? We respectfully ask CMS to consider these thoughts in finalizing these proposals.

Issue: Enhancing guardrails around broker and agent compensation

We support CMS's efforts to ensure a competitive marketplace that provides beneficiary with access to and information about the full array of plans available to them. As we have noted in more detail in other parts of this letter, we are concerned about the market consolidation we already see that appears to be squeezing our smaller and/or regional/local plans. We hope that these proposals to eliminate compensation disparities results in less biased information or steering in the market. We would be remiss if we didn't also advocate for additional support for state health insurance programs (SHIPs) and other unbiased sources of advice. Ideally, there should be advisors that can help Medicare-only beneficiaries as well as dual eligibles, effectively.

Issue: Medicare Plan Finder recommendations for improvements

CMS asked for feedback on potential enhancements to Medicare Plan Finder as it relates to information displayed on DSNPs and AIPs. This is an issue that requires more thought. Realistically, dual eligibles probably don't distinguish between the benefits they receive under Medicare vs. Medicaid. When a DSNP or other available plan only lists available Medicare and supplemental benefits, this may be confusing to them. Ideally, a comprehensive view would be best, but this is also a logistical nightmare as there is considerable variation between state Medicaid benefits. We wonder if it might be better to fund states to provide counseling to dual eligibles on their options as they would be more knowledgeable about the available Medicaid benefits and how they work with any potential Medicare benefits. At a minimum, it would be helpful to identify which Medicaid managed care plan is aligned with which dual product or if there is no alignment, list "N/A." As we continue to see DSNPs provide misleading marketing information about their plans, we think setting some additional standards around how these plans communicate benefits they offer that overlap with Medicaid might be an important first step. We think there are many opportunities to improve plan finder to give all beneficiaries critical information about plans they are considering like the number of complaints a plan as had in a given year or their denial rate for Medicare services.

Issue: Programs for All-inclusive Care for the Elderly (PACE)

LeadingAge appreciates the limited updates proposed in the proposed rule as they relate to PACE organizations (POs). Regarding the updates related to PACE organizations (POs), LeadingAge member POs have expressed concerns and frustration over recent audit practices that have evolved from solution-seeking to punitive. We commend proposed additional flexibility in monitoring of corrective actions, likely saving significant PO staff reporting time and state and CMS staff monitoring time, independent of compliance. We are concerned that codifying current sub-regulatory guidance around complaint tracking may not meaningfully change participant experience and creates further opportunity for punitive action.

LeadingAge and our PACE members appreciate the proposal in § 460.194 to allow state administering agencies (SAAs) and CMS additional flexibility in monitoring of corrective actions. If both states and CMS deploy this flexibility appropriately, all involved will see reductions in reporting and response monitoring of corrective actions without changing results or efforts to comply and implement corrective actions. One PACE member has indicated needing about half of a full-time employee to comply with reporting requirements for a corrective action plan. The corrective action was not concerning participant care or well-being but related to compliance with documentation of PO action in multiple locations because of systems interoperability challenges. Codifying flexibility that can limit unnecessary reporting by POs and subsequent monitoring by CMS and the SAA is a responsible first step; we hope compliance teams within SAAs and CMS heed and use this flexibility.

Complaint resolution and outreach requirements: Proposed provisions in 42 CFR 417.472(l), 422.125, 423.129, and 460.119 codifying timelines and definitions for contacting and resolving participant complaints are substantially similar to existing guidance to POs. Because these standards are already in practice within PACE organizations, there is little push back to the content. Members expressed concern that inclusion of this level of detail within regulation is a further push towards compliance over person-centered care. Mandatory timelines to contact a participant about their submitted complaint within 3 calendar days does not guarantee the participant will get meaningful feedback about how the complaint is being addressed but could receive a sanitized and confusing response that lacks meaningful attribution to their complaint. Instead, we urge CMS to amend the requirement to indicate that complainants will be contacted upon resolution of, or a determination that would resolve their complaint.

LeadingAge supports the concept underpinning the proposal in 460.121 to require documentation of service requests prior to development of a new participant's initial plan of care. Our PACE members expressed that this practice is already in place for service requests. However, we would like to note that there our POs have expressed some concern about a grey area between a potential participant asking questions about what services a PO covers and provides, versus what services a potential participant will or is likely to receive once enrolled in the PACE organization. For example, an ambulatory individual considering joining a PACE may ask questions of a community liaison about whether the PO covers

wheelchairs or motorized scooters. While PACE would cover that, should that conversation be considered a request for a scooter that is documented in the initial plan of care by the IDT? It may be helpful to clarify which conversations with unenrolled individuals rise to the level that they need documentation if the person does decide to enroll in PACE.

Future opportunities

While this year's rule covers a lot of issues, we observe some opportunities to improve the MA program further that are not addressed. Therefore, we wish to draw CMS's attention to areas that we would be pleased to work with them on for future regulations as this program's influence over older adults and the health care system grows.

- **Reducing administrative burden and ensuring provider payment adequacy in the MA program.** We continue to be concerned about the administrative burden and provider payment inadequacy issues we are seeing for skilled nursing facilities and home health agencies. These challenges are already impacting beneficiary access to these services in certain marketplaces. It is not uncommon to hear hospital social workers tell a family member or Medicare beneficiary, "oh you're not in MA, so we will have no trouble finding SNF care or a home health agency to serve you." With more than half of beneficiaries now in MA, we worry that access to services will continue to be threatened. Financial pressures on these post-acute providers continue even though the public health emergency has ended. They are exacerbated by MA plans that pay these providers less than Medicare FFS for the same service but also have policies-- such as prior authorizations, audits of every claim, and other practices --that have increased the administrative burden and costs for these same providers resulting in a net negative. As noted in a [Modern Healthcare article](#) (12/25/2023), rural hospitals face similar challenges and some are now opting to no longer contract with MA plans. While these issues are not addressed in this rule and are perhaps beyond the scope of regulatory authority, we believe it is critical that we keep these challenges in the forefront and seek solutions both through CMS and Congress to ensure that taxpayer dollars pay for the full cost of services, preserve access to care providers and don't just fall to the bottom line of health plans.
- **Establish a Mechanism for Providers to Report MA plan Non-compliance Issues.** Providers present a critical set of eyes and ears on the ground observing MA plan policies and practices in real time. They can help identify where compliance issues are trending so CMS can help plans with further instruction on how to comply and to correct errors or issues that present barriers to beneficiaries getting medically necessary care. While we appreciate our ability as an association to communicate directly with CMS staff about non-compliance issues our providers have identified, we still believe it would be good to establish a mechanism such as online form through medicare.gov to enter complaints into complaint tracking system or make CMS aware of the breadth of the issues. With MA enrollment exceeding 50%, it is critical that we identify and correct non-compliance issues that prevent beneficiaries from accessing care.

Thank you again for the opportunity to share our perspective on your proposals for CY2025 MA policy changes. We appreciate your willingness to listen to our concerns, as well as our suggestions for improving the Medicare Advantage program. Please reach out if we can answer any questions related to our comments.

Sincerely,

A handwritten signature in blue ink that reads "Nicole O. Fallon". The signature is written in a cursive, flowing style.

Nicole O. Fallon

Vice President, Integrated Services & Managed Care

LeadingAge

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