

March 1, 2024



The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Ave SW, Room 445-G  
Washington, DC 20201

Dear Administrator Brooks-LaSure:

We have appreciated the opportunity to work with you and your staff at the Centers for Medicare and Medicaid Services (CMS) to improve the Medicare Advantage (MA) program and protect Medicare for all its beneficiaries. CMS has demonstrated a strong commitment to ensuring that the Medicare regulations are followed and that equitable access to Medicare A & B services are preserved. We write to you today regarding the Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage and Part D Payment Policies (referred to in this letter as “CY2025 MA Advance Notice”) and our concerns about the threats to provider viability, beneficiary access to Medicare services, and the solvency of the Medicare Trust Fund both currently and in the future without further action.

As an organization representing more than 5,400 nonprofit and mission driven aging services providers and other organizations who touch millions of lives every day, LeadingAge believes we are at an inflection point related to Medicare Advantage. Action is warranted before we find few providers remaining to serve the more than 65 million Medicare beneficiaries, including the nearly 33 million who now receive their Medicare benefits via an MA plan as of January 2024. We applaud CMS for taking steps in this proposal to reduce the additional costs associated with upcoding in the MA program.

This CY2025 MA Advance Notice also calls for a 3.7% increase in payments to plans in 2025 but the MA plans counter that the rates don’t reflect a hypothetical risk score increase of 3.86% and view it as a 0.16% cut in their rates. It has been suggested that benefits and provider payments from the MA plans would be cut if the proposal is finalized. This is of grave concern to LeadingAge members.

LeadingAge and its Skilled Nursing Facility (SNF) and Home Health Agency (HHAs) members have the following concerns and suggestions as CMS considers this proposal and future payment policies:

- **Plans express concerns these proposed payments do not reflect current utilization, inflation, and risk score growth, but many plans disregard these same considerations when negotiating**

**rates with providers.** As an organization representing post-acute care providers, we are concerned that MA plans will act to further reduce payments to our SNF and HHA providers. In years past, LeadingAge has advocated for MA plan rate increases under the delusion that at least some of these increases would make their way to the providers who actually deliver the care and services to the MA enrollees. This has not been the case. Even before the implementation of this CY2025 payment, MA plan contracted rates with SNFs and HHAs have been, at best, 60-80% of what these providers would have been paid under traditional Medicare. Increasingly, these providers are telling us that they are now being offered Medicaid rates (which are for custodial care) to provide skilled care services that require greater staffing and intensity. Further reductions would be untenable.

Some SNFs have not been able to negotiate a rate increase from the MA plans in their market for more than a decade even though MA plan rate increases have averaged 3.69% annually during this time and in 2023, the MA plans received an 8.5% rate adjustment. In contrast, in 2023, SNF rate increases under Medicare Fee For Service (FFS) were only 2.7% and HHAs were cut 3.93%. This is important as sometimes contracted rates with providers are based upon FFS. In addition to plans paying providers inadequately, MA plans have added layers of administrative burden onto these providers requiring them to hire additional staff just to manage prior authorizations, navigate the multitude of MA plan claims processes and portals, and fight to keep plans from clawing back funds months and years after the service was delivered. In other words, providers are being asked to do more and being paid less.

Alternatively, MA plans appear to be doing fine. UnitedHealth Group CEO Andrew Witty told shareholders, “UnitedHealth Group enters 2024 well prepared to build on our efforts to improve patient care and consumer experiences broadly, and to continue delivering strong and balanced growth.” ([Citation](#)). The document also shows net margins in the 6% range on average for the prior two years. In contrast, an annual report from CliftonLarsonAllen notes, “SNFs faced a –0.6% operating margin” in 2022 and it would have been –3.6% if public health emergency funding were excluded. The report highlights the contributors to this situation including inflationary pressure, payer mix, which is heavily Medicaid and increasingly MA, increased labor costs resulting from a need to use contract staff to meet demand and wage pressures, and a 2.3% rate reduction to PDPM. MA plan contracts with these providers do not acknowledge any of these financial pressures and the need for provider rate increases. So, the MA plans pay these providers less and burden them with excessive administration.

We recognize that CMS’s hands are tied by the “non-interference clause” from establishing a rate floor for what plans must pay, or requiring plans to provide value-based arrangements to providers but this issue needs to be addressed before these providers can no longer pay their own bills due to insufficient payments. As MA enrollment grows, the pressure on providers is reaching a decision point. An adequate supply of aging service providers is critical for not only Medicare Advantage and Medicare but the entire health care system. For example, most nursing homes provide both post-acute, skilled care services covered by Medicare, and custodial long-

term services and supports often covered by Medicaid. If these providers continue to receive inadequate payments and close, it prevents discharges from hospitals and places stresses on the remaining system to address individuals' long term care needs either in other residential care settings or in their private homes. This situation must be addressed now.

- **Documented overpayments to the MA plans threaten the future of the Medicare Trust Fund.** CMS takes important steps in the CY2025 MA Advance Notice to rein in documented overpayments to MA plans, but MedPAC suggests there is even more opportunity for adjustment. MedPAC projects that in 2024 the combination of coding intensity and favorable selection will result in overpayments to MA plans of 23% or \$88 billion. This, in turn, is accelerating the draining of the Medicare Trust Fund. This overpayment pattern cannot continue. We think it is critical to examine ways to further reduce these overpayments including other MedPAC suggestions to address coding intensity concerns, such as excluding Health Risk Assessments from being used in calculating risk scores. However, MedPAC research also notes payment inequities among MA plans. We are mindful that any future adjustments should consider whether certain plans are driving these overpayments through their practices. The effect of a blanket approach to addressing these overpayments could further market concentration in a handful of plans who have financial resources that would allow them to weather such adjustments while potentially penalizing smaller, non-profit, or more regionally based plans. This would not be good for beneficiaries or providers.

While the CY2025 MA Advance Notice does not entertain this idea, we encourage CMS in future rate notices to reexamine the quality bonus program with a goal of shifting away from an add-on bonus to a penalty reduction off their rate for inadequate reporting of data and a payment withhold that can be earned back based outcomes performance. This approach is analogous to programs that post-acute care providers are subject to under their quality reporting and value-based payment programs. In addition, this would reduce spending on the MA program and the related stress it places on the Medicare Trust Fund for paying these bonuses. As CMS increases its use of encounter data to establish risk scores the fact that this data is often incomplete or inaccurate is concerning. One way to incentivize plans to ensure completeness in encounter data and other critical data elements would be to apply a rate penalty for inadequate reporting.

In addition, we encourage CMS to move toward a value-based payment for MA plans that is based upon a withhold not a bonus. This is not a new concept. [MedPAC](#) concluded in June 2020 that the MA quality bonus program is costly and doesn't effectively judge the quality being provided and these concerns are echoed by the [Urban Institute](#). MedPAC recommended a new MA Value Incentive Program (MA-VIP) to replace the current system. A key element of the MA-VIP approach is that it would distribute plan-financed rewards and penalties at a local market level. Local plans would be compared against their peers in the same market area not at the organizational level. It would provide a more accurate assessment of a particular plan's quality. This approach is analogous to how Medicare provider value-based programs work where a portion of the provider's Medicare payment is withheld and pooled with funds from all

providers, and then redistributed based upon outcomes on a set of defined measures. Some of the funds are even returned to the Medicare Trust Fund. In contrast, today, MA plans receive a quality bonus on top of the base per member per month that they receive to provide Medicare A and B services. Arguably, some MA plans are not delivering on the basic requirements today of ensuring beneficiaries have access to core Medicare A and B services, as noted in the [Office of Inspector General Report in April 2022](#). Therefore, it is unclear why these plans are given a quality bonus over and above the per member per month they were already given to deliver these services. However, a value-based incentive payment could be used as a compliance tool. For example, it could be tied to metrics such as the number of times Medicare services or items are wrongfully denied or terminated. This would incentivize plans to better understand the regulations and ensure compliance. The reality is there are costs throughout the system when plans don't approve a prior authorization or terminate services inappropriately. These costs manifest in more work for overburdened providers, potential stress and out of pocket costs for beneficiaries while they are appealing these inappropriate determinations and administering a robust appeals system. A program like MA-VIP that withholds payment and allows a plan to earn it back if they comply with an established benchmark rate could address two issues: compliance and financial stewardship of Medicare Trust Fund dollars. This could encourage plans to take more time to review prior authorizations the first time (in contrast to the ProPublica [findings](#) that during a two month period in 2022, Cigna doctors denied more than 300,000 claims using artificial intelligence, spending an average of 1.2 seconds on each case) and work with providers to identify any missing information early so the error does not make its way to an appeal. Withheld funds from noncompliant MA plans would be returned to the Medicare Trust Fund.

As an association of non-profit and mission-minded aging services providers, we feel it is imperative to be good stewards of the Medicare program funds and as such can no longer support these quality bonuses paid out of the Medicare Trust Fund in cases where MA plans are consistently non-compliant with covering basic benefits. The MA program was supposed to save money for the Medicare program and the Medicare Trust Fund. This has not transpired. If we fail to act now, the promise of Medicare will be compromised for current and future generations.

We as taxpayers are paying more for MA to deliver Medicare benefits for more than half the eligible population and while the MA program offers benefits above traditional Medicare such as limited out of pocket costs, lower to no premiums and important supplemental benefits, the cost of inadequate provider payments and improper care denials and terminations for beneficiaries is proving to be too high a trade off.

We support CMS's efforts to phase in course corrections in the MA payments based upon practices observed in the market. Our interest is not in destabilizing the market or negative impacts for beneficiaries but instead we seek to ensure the long-term viability of health care providers and the solvency of the Medicare Trust Fund, while preserving options for Medicare beneficiaries such as the MA plans. We acknowledge that phasing in changes to payment policies must be carefully considered but the time is now. Times have changed. The market has changed, and payments must be changed to

reflect this new normal. As always, please reach out with questions.

Sincerely,



Nicole O. Fallon

Vice President, Integrated Services & Managed Care

LeadingAge

*LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information visit [leadingage.org](https://www.leadingage.org).*

### **Citations**

- MedPAC January 2024 [Medicare Advantage Report](#)
- [Replacing the Medicare Advantage quality bonus program](#), Chapter 3, MedPAC, June 2020
- MedPAC Favorable Selection and Future directions for Medicare Advantage Payment Policy [report](#) March 3, 2023. – “Suggests that using the FFS population as the basis of benchmarks is becoming less viable.”
- [Favorable selection in Medicare Advantage report](#), MedPAC, November 3, 2023.
- ProPublica article, “Congressional Committee, Regulators Question Cigna System That Lets Its Doctors Deny Claims Without Reading Patient Files”, May 16, 2023, as accessed here: <https://www.propublica.org/article/cigna-health-insurance-denials-pdx-congress-investigation>