May 29,2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4207-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Comments submitted electronically

Dear Administrator Brooks-LaSure:

LeadingAge is pleased to share our recommendations on CMS' request for information (RFI) related to Medicare Advantage (MA) data (CMS-4207-NC). 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 the Medicare Trust Fund empty, and 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 asking the question of what data can help us better understand and regulate the MA program.

In establishing the MA program, much flexibility was given to plans to determine which services should be covered and how providers should be paid. MA was implemented with the idea that it would save the Medicare Trust Fund money. However, now MedPAC reports that MA plans are paid 22% more to cover services for Medicare beneficiaries and the Office of the Inspector General (OIG) reports a disturbing number of requests for basic Medicare A and B services are wrongfully denied by MA plans even though the plans receive more funds to care for beneficiaries. This flexibility has resulted in plans acting with impunity because data either isn't collected or isn't publicly available. Greater transparency is needed.

Policymakers need data to regulate the burgeoning MA program and understand the impacts that Medicare Advantage Organizations (MAOs) have on the broader healthcare system to effectively hold MA plans accountable. With more than 53% of Medicare beneficiaries enrolled in MA, it has become evident that not only is the necessary data lacking, but additional data is critical for planning, budgeting, and ensuring MA plan accountability.

Consumers need data to determine whether a plan will provide them access to required services, deliver better outcomes, limit their out-of-pocket costs and be a better choice than traditional Medicare. They should also know which organizations own the plan they are enrolling in, as well as the quality being delivered in different settings and to different populations. Additionally, consumers should be able to evaluate the quality of the providers they will have access to within a MA plan's network.

Providers need information to assess which plans are in their market, understand their level of regulatory compliance and the administrative burden imposed. Data on plan behavior can also inform what staff resources a provider must have to process and advocate on behalf of beneficiaries on prior authorizations, to submit required documentation and ensure claims are paid, and to defend against endless audits. Most importantly, providers need MedPAC to assess payment adequacy in the Medicare program based upon both payments from CMS for traditional Medicare and those from MA plans, as together they make up the revenue picture for Medicare providers.

Taxpayers need to know how the payments to MA plans translate into care outcomes, an improved health care system and good stewardship of the Medicare Trust Fund dollars. We must know more about how the plans operate, their coverage decisions, and what we are paying for. Data can help us determine if outcomes differ by type of plan (e.g., SNP vs. MA) or ownership (managed care led vs. provider led, for-profit vs. not-for-profit), if vertical integration impacts care and payments, what impacts market concentration has on provider payments and plan offerings, and finally, evaluate if the current payments to plans incentivize the outcomes we desire.

For these reasons and others, we make the following recommendations of data that should be collected, analyzed and reported on the MA program and its impacts for the following purposes:

1. **Consumer Data Needs**
   Medicare beneficiaries are increasingly choosing to enroll in Medicare Advantage plans often enticed by the supplemental benefits offered without fully understanding the tradeoffs they are making -- such as narrow networks, prior authorizations, reduced care and services-- until they need to access certain services like skilled nursing facility (SNF) or home health services. These services require prior authorizations. The OIG has reported some plans are inappropriately denying coverage for medically necessary care. This is information consumers should be able to view and compare across plans. For these reasons we recommend the following data be collected and reported to assist consumers in informed decision-making.

   Prior authorization data must be tracked and reported on Medicare plan finder.
   We are pleased to see the prior authorization data collection and reporting requirements in the Interoperability and Prior Authorization rule (CMS-0057-f) finalized in April 2024. However, we do not believe having plans report this data on their individual websites will be as effective in helping consumers evaluate their plan choices. This information should also be included on Medicare plan finder. Consumers should be able to compare plans' rate of prior authorization approvals, denials, appeals and overturned decisions.

   Recommendation: Require prior authorization data required to be collected and reported by plans in the Interoperability and Prior Authorization rule (CMS-0057 -F) to be reported in a standard format to CMS and on Medicare plan finder. This will make it easier for consumers to compare plans on these measures versus requiring them to find this information on each plans' website, which would be considerably time consuming and therefore, less likely to occur. It will provide greater visibility of these metrics and greater accountability. Further, we encourage CMS to amend these prior authorization reporting requirements to require the data to be collected and reported to CMS broken out by broad service categories or provider types (e.g., post-acute care, acute care, labs, etc. or SNF, HH, Hospital, Physician, DME), as we believe this is more informative of where denials are most prevalent, and types of care or services being

delayed or prevented. It may also be useful to report the top reasons for prior authorization denials by a plan to correct inappropriate barriers to medically necessary care and services. Finally, we believe CMS should collect the data on these metrics from the plans and use it for ensuring plan compliance with rules and to identify trends over time. For example, if insufficient documentation is identified as a main reason for many denials and delays in access to needed care, CMS could audit plan records to determine if the correct documentation was present (as the OIG report found in numerous cases) and missed or never provided. Plans are not incentivized to undertake such a review, as it could lead to approving more services, and in turn, increasing plan care costs. Understanding the barriers to appropriate prior authorization approvals for medically necessary care can help identify needed policy changes to ensure timely and equitable access to needed services but this requires CMS to collect the data.

Create a care experience scorecard to help beneficiaries compare MA to traditional Medicare. As noted above, consumers have limited information upon which to base their decision about whether to receive their Medicare benefits through traditional Medicare or a MA plan. As MedPAC and others have noted, the quality measures for MA plans require a new look. Consumers need to understand how their care experience may be different between traditional Medicare and MA plans, and among MA plans. For this reason, we recommend CMS begin to collect data at the plan level that describes the care experience a consumer can expect and tracks comparable, key quality measures required in Medicare such as those reported by providers under the IMPACT Act so that outcomes can more readily be compared between traditional Medicare and MA by consumers and policymakers.

Recommendation: We recommend collecting the following data and reporting it by plan on Medicare plan finder or make available in a report for the public as a consumer care experience scorecard.

- **Average number of days in hospital per hospitalization**. MA plans are not incentivized to move individuals out of hospitals quickly as they typically pay a flat rate regardless of days of care.
- **Average time between submission of a service request or authorization and a determination (broken out by standard and expedited requests).** Plans choose to require prior authorizations but often do not adequately staff these functions. Prior authorization functions are not typically staffed 24/7. Therefore, weekends and evenings are void of determinations. These practices delay care. One such example is Anthem Blue Cross is now being sued by the California Hospital Association on the basis of inadequate provider networks, failure to ensure timely access to care due to delays in prior authorization determinations and sometimes no determination at all. Plans typically don't pay providers for any services delivered before an authorization is given. Providers who choose to provide these services while waiting risk absorbing those costs even if the service is ultimately approved. If providers await the authorization, it delays beneficiary access to the needed services. Further delays occur when a prior authorization is denied and the provider/patient pursue an appeal. Therefore, this measure can help a consumer understand if they will have timely access to care and services.
- **% of prior authorizations denied.**
- **% of denials appealed and overturned.**

- **Number of days between care/service authorization and receipt of post-acute care services by service**. This information could provide another view of network adequacy and access to care for MA enrollees. Our home health providers have reported that some MA plans will only approve an initial visit and then require an authorization for future visits after they have reviewed documentation and notes from the initial visit. This practice often delays receipt of additional home health services by up to a week.
- **Average length of stay in post-acute care (PAC) by type** (e.g., SNF, LTCH, IRF). By collecting this data and rehospitalization information, we could evaluate whether plans' choice to reduce length of stay results in better outcomes for the individual.
- **Average number of home health visits per episode**. Like length of stay, it would be important to be able to evaluate whether fewer visits result in better long-term outcomes for the individual.
- **% of MA enrollees with a readmission within 30 days following PAC services.** Plans report All Cause Readmissions as part of their star rating system, but this is reported as stars not a percentage, which would be more informative.
- **Average MA Spending Per Beneficiary on Care** (non-supplemental benefits). This would help policymakers examine spend in comparison to outcomes to determine whether plans are delivering better value to taxpayers.
- **Plan compliance information.** Consumers should know the number of complaints lodged against a plan and whether they are being sanctioned, as it is an important factor in selecting an MA plan. We report this information on providers and plans should be held equally and transparently accountable.

While this information is important for consumer decision making, we also believe CMS should use it to identify plan issues. Therefore, this data should be audited as well as reported. We recognize that this could create a significant burden for CMS and may require additional resources to be executed effectively. Our recommendation is that audits be conducted based on the risk of the contract and the identification of outliers to reduce the operational burden that conducting audits on a data set of this nature could create.

2. **Cost of Care and Payment Data**

One of the goals of the MA program was to lower spending in Medicare. However, MedPAC reports that MA plans are not paid less to deliver Medicare A & B services but 22% more and any savings achieved accrue to the plans not taxpayers. Americans value and look forward to the day that they become eligible for Medicare benefits. Until that day, they pay into the Medicare Trust Fund to ensure those benefits. It is Congress' and CMS's job to make policies to protect the use of these funds. One of these tasks is to provide oversight of these funds and guarantee beneficiaries' continued access to the services covered under Medicare. In turn, providers must be paid adequately to cover their costs of delivering care and services to make sure services remain available for beneficiaries. In this regard, MedPAC plays an important role and is charged with reporting to Congress annually on Medicare payment adequacy by provider type. However, as funding shifts to Medicare Advantage, MedPAC's ability to evaluate provider payment adequacy is increasingly limited now that more than 53% of Medicare beneficiaries are enrolled in MA. Policymakers need data to determine what are we getting for that extra spending and ensure the solvency of the Medicare Trust Fund. For these reasons, we recommend the following actions be taken and data collected and analyzed.

Recommendations:

- **CMS collect revised encounter data from MA plans identifying payments made to all providers and whether the claim was paid or denied. MedPAC use the data to assess provider payment adequacy within the MA program.**

  For Congress and CMS to provide the necessary stewardship of the Medicare Trust Fund dollars and oversight of MA plans, it is critical that CMS revise the encounter data requirements to collect the specific payment amount made and include a field that identifies claims status even when denied. Both pieces of information are needed to provide a complete picture of payment adequacy, as providers are increasingly experiencing partial or complete payment denials from MA plans after services have been delivered.

  We also suggest that the data be made available in its entirety to MedPAC so it can conduct its annual analysis of payment adequacy. MedPAC is charged with assessing payment adequacy by provider type within the Medicare program. By providing them with complete encounter data for all providers by plan, MedPAC can preserve plan proprietary information on payment rates while also evaluating rate adequacy by provider type. The benefit of this annual analysis is that access to certain types of providers and care can be protected, taxpayers can be assured that they are neither overpaying or underpaying for services and overall, we ensure the sustainability of the program. However, with each passing year, MedPAC's ability to determine the financial health of providers via the adequacy of payment is increasingly hampered because MedPAC is blind to more than half of provider payments as more Medicare beneficiaries enroll in Medicare Advantage plans. Therefore, collecting and analyzing provider payments via encounter data allows policymakers to make good policy, preserve the Medicare program for future generations by assuring our dollars are being spent judiciously, and ensure that providers' financial sustainability and therefore beneficiary access to care.

  Our members, who are Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs), report that MA payments for their services range from 50-80% of Medicare fee-for-service and, more recently, we are hearing they are being offered Medicaid rates for the delivery of more resource-intensive Medicare SNF and HHA services. Some policymakers have asked these providers to provide copies of their MA contracts so they can see for themselves whether the payment terms are fair. However, first, most of these contracts prohibit the providers from divulging their contracts to outside sources and second, the payment terms in these contracts do not guarantee that providers are paid each of the outlined rate tiers in the contracts. For example, providers can be instructed by their contracted MA plan to down code a patient's assessment to a lower payment level or the plan will deny the claim. Therefore, a better indicator of MA provider payment adequacy would be to review claims paid, denied and payments required to be paid back to obtain a more complete picture of revenues received by providers.

  Without these critical data points from MA claims/encounter data for all providers and all claims, policymakers will not be able to judge whether MA provider payments have the potential to destabilize not only the Medicare program and services but potentially the entire health care system if provider rates are deemed financially unsustainable for them to continue providing services and cover their costs including staff salaries.

- **CMS should consider amending provider cost reports to break out revenues between traditional Medicare, MA, and other payer types and possibly cost information.** MedPAC should also review the costs providers incur under MA. Rates that are less than Medicare FFS do not adequately cover the costs of providing services to MA enrollees as the resources required to provide care (e.g., staff time, assessments, admissions, etc.) are the most intense at the start of care in a new setting, and MA plans increase the churn of admissions and discharges. Finally, the administrative burden of the prior authorization/re-authorizations for continued care processes and subsequent appeals, plus the audits of payments for approved and delivered services has led to provider organizations being required to pay for more staff just to manage these functions. In other words, the cost of providing services is higher. For these reasons, we think CMS should consider updating Medicare provider cost reports to delineate revenues and costs by payer type. Currently, providers report MA revenues in the "other" category sometimes with commercial payments, etc. If this information was broken out separately and by plan, it could provide a better view into total revenue received (accounting for claw backs as well as partial payments).

- **Collect and report average beneficiary out of pocket costs by benefit type and plan.** Again, to assist consumers in selecting the best option for how to receive their Medicare benefits, CMS should include average annual out of pocket spend per beneficiary data on Medicare plan finder delineating the following information:

    - Average out of pocket spending for all Medicare A& B services
    - Average out of pocket spending for all Part D services
    - Average out of pocket spending for vision, dental and hearing supplemental benefits
    - Average out of pocket spending for all other supplemental benefits

- **Reporting on plan adoption of value-based arrangements**.
  CMS strategic goals seek to have all Medicare beneficiaries in accountable care relationships by 2030 but equally important to this goal is to ensure all providers are incentivized to provide value-based care. To be successful, it is optimal when provider payments and care delivery goals are aligned. For this reason, we believe it is important to understand to what degree MA plans are entering into value-based arrangements (VBAs) with providers and what types of arrangements are being pursued. While plans report they are undertakings VBAs with providers, it appears these efforts are focused on physicians and hospitals, not PAC or other Medicare providers. Collecting this data can inform future policy direction to incentivize and support these endeavors by plans.

  Recommendation: CMS require plans to annually report the following information to assess the level of adoption of value-based arrangements among different types of providers:

- **% of contracts where providers are paid under a value-based arrangement by provider type** (e.g., SNF, HH, physician, hospital) **or category** (e.g., primary care, PAC, Acute care, etc.)
- **Type of value-based arrangement** (e.g., pay for performance – bonus vs. earn-back a withheld amount, bundle/episodic payment, shared savings, sub-capitated arrangement, other) **by provider type**
- **Measures used to determine payment amounts.**

As part of this report, CMS might also ask plans to identify what prevents them from entering into VBAs (e.g., systems not able to process payment accurately).

- **Annual report on MA supplemental benefit costs and utilization.**
LeadingAge has long supported the expansion of supplemental benefits within the MA program, especially those benefits that address social drivers of health. We are pleased to see that CMS has begun collecting utilization and cost data on these supplemental benefits.

Recommendations: We encourage CMS also consider reporting out their findings related to beneficiary utilization, how much plans are spending on these supplemental benefits in aggregate in comparison to the rebate dollars received, and the out-of-pocket (OOP) costs for beneficiaries for accessing these benefits. Plan level information should be included in MA plan finder on percent of beneficiaries accessing supplemental benefits during the plan year, average OOP costs incurred by type of supplemental benefit. This information could help beneficiaries better weigh their choices between a separate dental plan, for example, versus costs for dental care under their MA plan.

3. **Data for Oversight and Enforcement**

One of the most important areas for which MA data can be used is to ensure that plans are following the rules and enforcement of those rules. Here are some areas where we believe additional data could inform compliance, enforcement and future MA policies.

Supplemental Benefits.
LeadingAge is pleased to see the new reporting requirements for MA plans related to the utilization and costs of MA supplemental benefits. We are optimistic that CMS will complete an analysis of what they are seeing in the data and for transparency will share that information publicly. We would like to identify one data point we believe is missing from this information and warrants additional consideration. Our provider members have observed an uptick in the number of plans offering cash card benefits for beneficiaries to pay for a variety of services. We believe data on this specific approach to benefits should be reported including what benefits can be purchased and are purchased with the card and what safeguards are in place to make sure the beneficiary is the recipient of these plan benefits. We have heard reports of family members enrolling their loved one in MA plans offering these benefits and then using the card for their own needs. We have also observed PACE (Program for All-inclusive Care for the Elderly) enrollees being lured away based upon these benefits not understanding the benefits they are losing by being disenrolled from PACE. In addition, supplemental benefits that offer the

beneficiary cash benefits can negatively impact individuals living in certain types of affordable housing if these benefits were to be counted as income. For these reasons, we believe these specific benefits deserve increased scrutiny so we can understand how they are being used and the outcomes that result.

Recommendation: Revise the Supplemental Benefit Utilization and Cost technical specification sheet to add a section that requires plans to report if they offer benefit cash cards, the amounts of the cash benefit on a monthly basis, the services or products for which the card can be used, eligibility criteria for the benefit and utilization of the benefit.

Seeking more complete picture of plan compliance.

Providers continue to be a good source of plan compliance information. Currently, plan compliance appears to be focused on the frequency of appeals for care denials by plans. Beneficiaries face financial consequences of pursuing appeals of care denials and terminations, and often feel ill-equipped to succeed in these requests not being intimately familiar with the MA and Medicare rules. Therefore, information on appeals alone is an incomplete measure of plan compliance. Audits of MA plan compliance often do not occur annually and do not offer real-time remedy especially for ensuring timely access to care issues.

Recommendation: Establish a dedicated CMS confidential provider support line to accept complaints and address plan compliance concerns.

Establishing a provider support line could assist in identifying trends and real-time issues of plan non-compliance with laws and regulations. SNFs and HHAs have reported numerous instances where they are unable to resolve an issue with a plan due to being transferred around at the health plan and later having the call disconnected without resolution. Typically, these situations involve helping an individual in their care get the medically necessary services they need. Our providers continue to see numerous cases where plans are wrongfully terminating skilled care services before treatment is complete, refusing to continue services when the person's progress plateaus (in conflict with the Jimmo Settlement) and claiming there is insufficient or no documentation to prove medical necessity even when there is direct evidence that this information was provided to the plan. In each of these situations, the beneficiary is the one who loses. When providers are met with these roadblocks, there is nowhere to turn. This is why we propose establishing a provider-specific hotline for reporting these issues with plan non-compliance and ideally, connecting the provider with a plan contact to resolve the issue. In the rare instances, where we have sought CMS assistance in making these connections, beneficiaries have prevailed. We believe the data collected would also present a better indicator of plan compliance with the rules and how often they construct barriers to access to care. This information could then be reported on MA plan finder to assist consumers in choosing more compliant plans or this data could be added to plan star ratings.

Prior Authorizations. We are pleased to see the data collection and reporting requirements on MA plan prior authorizations that are contained in the Interoperability and Prior Authorization final rule (CMS-0057-F). Hopefully, this will begin to show the volume of these requests and speed the decision-making timeline.

Recommendations: We again recommend that this data be reported to CMS in a standardized format for the purposes of identifying trends and potential non-compliance issues with changes made in the CY2024 Medicare Advantage Policy and Technical rule (CMS -4201-F) related to

prior authorizations. We also believe these data would be more valuable if reported by provider categories or types (e.g. PAC or acute care; SNF or physician services). Plans have been voluntarily eliminating some prior authorizations for certain services, while we see the pace of required authorizations continuing in the PAC settings. We would also recommend collecting and tracking data not only on initial prior authorizations requests but also those requests made for authorization to continue care. This would provide a more complete picture of whether prior authorizations are covering a "course of treatment" or if the cycle of repeated authorizations continues with providers being required to submit a request for needed services to continue after a few days or visits. Considering the California Hospital Association lawsuit against Anthem, we encourage CMS to add data collection around how plans staff their prior authorization functions to determine adequacy to meet the plan's own requirements. Finally, we ask CMS to also consider requiring plans to report their top denial reasons. This information may be able to help us identify underlying issues that could/should be corrected through education of plans and/or providers to ensure beneficiaries' access to care occurs without unnecessary delays.

Market competition effects should be tracked, and policies developed to prevent negative impacts.

Recommendation: With MA enrollment now exceeding the 50% mark and even higher in numerous markets around the US, LeadingAge believes now is the time to collect data and conduct an analysis of the impacts to beneficiaries and providers. Policymakers need to understand this information to set appropriate policies. Questions that may be asked include: What effect, if any, does market concentration have on provider payments, contracting pressure and financial solvency; beneficiary premiums, plan supplemental benefit offerings, network quality and plan complaints? Are there any trends in the types of plans that dominate markets (e.g., for-profit vs. non-profit, vertically integrated, managed care led vs. provider led, national vs. regional)? At what threshold of market concentration, are negative impacts observed?

MA Plan Ownership Should Be More Transparent.

CMS produces monthly reports that update MA enrollment by county and state and plan. As MA organizations (MAOs) continue to merge or acquire other MA plans in a given market, we have observed that the plan names do not change and therefore, when the data is reported, it is less obvious which MAOs control a market. For example, if United Health Group (UHG) owns the United Healthcare plans with 30% market share but also the Sierra Health plans with 15% market share in a given market, this 45% concentration of MA enrollees into plans owned by UHG impacts provider decision making on which plans or MAOs with which to contract and could affect beneficiaries access to care or benefits. In addition, if a beneficiary has a bad experience with a plan owned by a particular MAO, they should know which other available plans are also managed by that same MAO.

Recommendation:

- **MAO or parent company data of a specific MA plan should be displayed on Medicare plan finder.**

- **CMS to report MA enrollment data also by county and state rolled up to parent organization level.** This provides important information to providers to assist in

contracting. Often plans will require providers to sign a contract or be in network for all business lines.

Plan audit practices should be reviewed by CMS.
MA plans are permitted to audit provider payments for good cause or where they see fraud. However, our SNF and HHA providers are experiencing plans who audit nearly every payment claim and deny all or part of it claiming lack of prior authorization or documentation to support even though the plan previously authorized the service. Providers then must spend hours collecting all the data again for a particular claim/episode, for services often provided months or years earlier. These plan practices are increasing the administration burden on these providers and in turn, driving up costs in the health care system.

Recommendation: LeadingAge asks CMS to collect data and audit plan practices related to these excessive audits and claw back patterns to determine if plans are following the rules for when they can audit a claim for a previously approved and delivered service.

Thank you for the opportunity to share some of our ideas for how data could be used to improve the Medicare Advantage program, help beneficiaries make better informed decisions about how they receive their Medicare benefits, to ensure plans are complying with the regulations, and to preserve the long-term viability of health care providers and the solvency of the Medicare Trust Fund. These data are critical as more and more beneficiaries shift to the MA program. We must be able to monitor that the funds are being used to help beneficiaries access needed care and achieve high quality outcomes. 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.