October 8, 2024

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Attn: PRA Reports Clearance Officer
Mail Stop C4-26-05
Baltimore, MD 21244-1850

*Comments submitted electronically*

LeadingAge is grateful for the opportunity to offer our support for and provide input into CMS' Service Level Data Collection for Initial Determinations and Appeals (CMS-10905). As an organization representing more than 5,400 nonprofit and mission driven aging services providers and other organizations who touch millions of Medicare beneficiaries' lives every day, LeadingAge has long advocated for CMS to collect additional information regarding Medicare Advantage plans prior authorization determinations for services to ensure accountability and transparency in these processes.

We appreciated the many clarifications contained within the CY2024 MA policy and technical rule around prior authorizations and utilization management. This data collection effort represents an important next step in determining if the CY2024 MA policy clarifications have had an effect on ensuring beneficiary access to medically necessary care and can also serve as an enforcement tool.

We are supportive of the thoughtful list of data points CMS has proposed for collection. For example, the inclusion of data on when a request is received and when the decision is made can show how long these processes are taking, whether they are delaying access to needed care and services, and if plans need to dedicate additional resources to these activities. In addition, by collecting site of the service information, CMS will be able to analyze whether decision timelines and authorization decisions vary across types of services, geographies or size of plan.

To ensure a complete picture of these service determinations and their impacts on beneficiaries' access to care and services, we have identified some areas that require further clarification or could be enhanced:

- The data collection appears to only collect data on Initial determinations; however, this is but one piece of the puzzle about beneficiary access to services. Particularly in skilled nursing facility (SNF) and home health (HH) services, there are multiple subsequent requests for authorization to continue care, which are sometimes called concurrent reviews or re-authorizations. It is these requests where providers and plans do not always agree on the beneficiary's need for continued services. We recommend CMS also collect and track these subsequent requests and determinations in addition to initial prior authorizations. Together, these data will provide a more complete picture of whether prior authorizations are covering a "course of treatment" or if the cycle of repeated authorizations poses unnecessary barriers to care or excessive administrative burden. It will also be more representative of an MA enrollee's care journey and where potential obstacles exist.

- Section I, item K – Can you clarify what information is sought related to "date of service?" For Skilled Nursing Facilities (SNFs), typically, this care is provided over a series of consecutive days vs. a physician visit that is a single date in time. For home health (HH) care, visits may be spread out over as much as a 30-day period. Therefore, we are curious if CMS is trying to capture what date a service begins after being authorized or if instead, CMS seeks to understand service utilization patterns by provider type based upon these MA plan service determinations. We believe there is benefit in understanding both situations. The initiation of service in relation to plan authorization for the services offers insights into where delays may occur. For example, some of our SNF and HH members have reported circumstances where a plan decision takes so long that the first provider is no longer available to provide the requested service. In these circumstances, it is our understanding that the prior authorization process must start over with a new request for the same service but authorized for a different provider further delaying the next level of care. We also think there is value in understanding the duration of services provided to better understand service delivery patterns, such as the number of SNF days or HH visits approved per MA plan authorization and how they compare to care duration within traditional Medicare.
- Section I, Item I – Could CMS clarify whether this refers to the "processing priority" requested by the provider or the one determined by the MA plan? In recent months, we have heard of more cases where plans are treating requests as standard when they were previously considered expedited. It might be beneficial to know if a provider submitting the request asked for it to be expedited and it was treated as standard request.
- Section I, Item P requires the plan to report the "decision rationale." Does CMS envision this being a drop-down list of standard denial reasons or would this be free form? We recommend that this item or a related item capture the actual rationale language contained in the letter to the enrollee to ensure it provides an adequate level of detail for the beneficiary to understand the decision and determine if an appeal is warranted.
- Section I, item Q – If the answer is "yes" to this item, it seems that there should be a follow up item where the plan cites the internal coverage criteria used. This could provide CMS with important information to examine the frequency with which certain internal coverage criteria are utilized by plans and whether further clarification in these areas may be warranted.

**These Data Should Be Published Annually**

It would be a lost opportunity if this data was not shared with the public and consumers in an easily digestible way to help them understand and compare their MA plan options across plans and with traditional Medicare. While not within the scope of this data collection proposal, we would recommend CMS consider annually reporting this data in one or more of the following ways: 1) a single report that compares plans across metrics; 2) include key data points by service category (e.g. post-acute care) on Medicare plan finder to assist consumer decision making; and 3) incorporate key metrics in the MA Star Rating program as part of beneficiary experience domain.

We understand that the Interoperability and Prior Authorization rule (CMS-0057-f), finalized in April 2024, calls for plans to report on some of these same items but instead of reporting it to CMS, the rule calls for plans to report this data on their individual websites. We believe this will be much less effective in helping consumers evaluate their plan choices and in holding plans accountable for regulatory compliance.

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 publish key plan-level metrics from this data collection effort 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 reporting the following information by plan on Medicare plan finder or make it available in a report for the public as a consumer care experience scorecard. We ask that CMS also consider breaking out this information by broad service categories or provider types (e.g., post-acute care, acute care, primary, etc. or SNF, HH, hospital, etc.) as we believe this would be more informative of where denials are most prevalent, and types of care or services are being delayed or prevented. It may also be useful to report the top reasons for prior authorization denials by plan to correct inappropriate barriers to medically necessary care and services. Such a report may include:

- **% 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.

Additionally, CMS might also consider whether some of this data and corresponding analysis should be added to the MA Star Rating Program as part of a beneficiary experience domain.

**Data for Oversight and Enforcement**

We agree that these data can play a critical role in ensuring plan compliance with rules and in identifying trends or issues that require further attention. 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. These data 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.

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.

Thank you for the opportunity to share some of our ideas for how the proposed data collection on service authorizations and determinations could be enhanced to achieve its goals to ensure compliance with regulations and guidance and support enforcement. These data are critical for transparency as more and more beneficiaries shift to the MA program to ensure they have access to the Medicare A and B services to which they are entitled. 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.*