October 25, 2024

Paul Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission
425 I St NW Suite 701
Washington, DC 20001

Subject: Public Comment on MedPAC's October 2024 public meeting

Dear Director Masi,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services, including skilled nursing, home health and hospice, and our 36 state partners in 41 states, LeadingAge appreciates the opportunity to provide public comment on the Medicare Payment Advisory Commission's (MedPAC) October 2024 meeting and the following presentations: Medicare beneficiaries in nursing homes, supplemental benefits in Medicare Advantage, work plan for a mandated final report on the impact of recent changes to the home health prospective payment system, and initial estimates of home health care use among Medicare Advantage enrollees.

Medicare Beneficiaries in Nursing Homes

LeadingAge nursing home members are mission-driven, not for profit organizations that take care of the most vulnerable adults at the end stages of their lives. It is difficult and rewarding work and needed in the current continuum of long-term services and supports. As a national association representing 2,000 nursing homes, we take our responsibility seriously in listening to our members as we shape our policy platform. We regularly hear from them about the significant challenges they face in day-to-day operations and their frustrations with burdensome and repetitive regulations, reimbursement not covering care costs, and an inconsistent, punitive survey and certification process.

LeadingAge attended the MedPAC public meeting on October 10 and would like to offer insights on several critical challenges facing nursing homes, in both urban and rural areas. These challenges include quality of care measures, workforce shortages, access to services, and the survey process for regulatory compliance. As MedPAC evaluates policies affecting Medicare beneficiaries in nursing homes, LeadingAge believes that addressing Medicare payments and nursing home operations is vital to improving care and helping nursing homes thrive to be able to take care of some of the most vulnerable adults.

Nursing Home Quality
Improving the quality of care in nursing homes should remain a top priority for MedPAC. While quality measures have evolved over time, a more nuanced approach to performance assessment is still needed. Current metrics, though important, often emphasize process measures rather than outcomes that truly reflect residents' well-being. During the meeting, commissioners raised questions about the Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) program, which incentivizes skilled nursing facilities (SNFs) to improve the quality of care.

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

For the FY 2025 program year, CMS bases SNF-VBP performance on a single measure: all-cause hospital readmissions (SNFRM). CMS withholds 2% of Medicare FFS Part A payments to fund the program, redistributing 60% of that withhold to SNFs as incentive payments, while the remaining 40% is retained in the Medicare Trust Fund. Incentive payment multipliers are calculated based on SNFs' performance, which are then applied to the adjusted federal per diem rates. Despite these efforts, this "pay for performance" system has long been criticized as offering too little financial incentive—often considered "pennies for performance."

As outlined in the article "[Paying for Nursing Home Quality: An Elusive But Important Goal"] by David Grabowski, Amanda Chen, and Debra Saliba, value-based payment initiatives in U.S. nursing homes date back to the 1980s with a study demonstrating improved outcomes and lower costs with incentive payments at several San Diego nursing homes. It then took two decades for federal efforts to catch up, and consistent success with value-based models has remained elusive.

Past challenges include rewarding nursing homes on a narrow set of quality measures, raising concerns that providers may focus on the rewarded areas while neglecting other critical aspects of care. To enhance the effectiveness of pay-for-performance (P4P) models, LeadingAge urges MedPAC to consider recommending quality measures that capture resident-centered outcomes, such as quality of life, emotional well-being, and satisfaction with care. Linking reimbursement to performance on these types of resident-centered outcomes, rather than focusing solely on process measures, could lead to more meaningful improvements in care.

Additionally, nursing homes serving a higher proportion of residents with complex medical needs often struggle to meet standard quality benchmarks. Policymakers should adjust quality metrics to reflect the varying acuity levels of residents that impact care delivery in these settings. MedPAC's insights on how to better support these facilities through targeted funding or innovative care models could help bridge this gap and ensure that residents receive the care they deserve. CMS has implemented the Health Care Confidentiality Health Disparities Feedback Report in the Quality Reporting Program (QRP) for post-acute providers. LeadingAge suggests MedPAC review the intent and results of these reports as opportunities to learn and help shape future recommendations.

LeadingAge encourages MedPAC to consider reforms that integrate quality incentives with access to care, including telehealth, telemedicine, and adequate reimbursement. During discussions, commissioners raised questions about the status of rural nursing homes, particularly patterns in closures and the challenges they face in surviving under current conditions. To help keep rural nursing homes stable and operational, it is essential to establish a funding structure that protects facilities in rural and underserved areas from being penalized for factors beyond their control.

While LeadingAge members are innovative in implementing programs and leveraging technology, such as telehealth to combat social isolation and improve communication and care delivery, current regulations and reimbursement limits pose significant challenges. MedPAC could explore and recommend programs that reward innovation, including the adoption of technology and new care models. This broader approach would enhance nursing home quality and provide critical support to rural nursing homes

In addition, MedPAC should explore policy options to stabilize nursing homes in rural and disadvantaged areas. This could include targeted financial incentives, increasing reimbursement rates for facilities serving a higher proportion of Medicaid residents, and offering support for telehealth services to expand

access to specialized care. Ensuring equitable access to nursing home care is essential for maintaining the health and dignity of vulnerable populations.

Workforce Shortages
Workforce shortages are one of the most pressing issues in the nursing home sector, particularly in rural areas. Recruitment and retention of skilled staff, such as licensed nurses, and certified nursing assistants, are increasingly difficult. These shortages can impact both the quality of care and the overall sustainability of nursing homes. It would be beneficial for MedPAC to explore recommendations on how to better support workforce development, such as expanding training programs, offering incentives to work in rural or underserved areas, supporting overdue immigration reforms, and providing pathways for career advancement.

The quality of nursing home care is closely tied to the strength and stability of the workforce. Chronic staffing shortages, high turnover rates, and limited career advancement opportunities have placed tremendous strain on nursing home staff. MedPAC should prioritize policy recommendations aimed at bolstering the nursing home workforce. Other opportunities and initiatives could include offering loan forgiveness for those entering the field, and strategic financial incentives for choosing long term care.

During the meeting, commissioners suggested hosting focus groups with current nursing home staff to gather insights through qualitative interviews with medical directors and directors of nursing on how to improve quality and what they value about working in nursing homes. LeadingAge supports this idea and encourages MedPAC to broaden its scope to include both direct and indirect care staff in these qualitative interviews. Hearing from staff would give important insights into the successes and challenges in nursing homes.

Survey Process and Regulatory Burden
The current survey process, while crucial for ensuring that nursing homes meet regulatory standards, can often be burdensome, especially for smaller rural facilities. The complexity and frequency of surveys, combined with limited staff, create additional strain on operations, sometimes diverting attention from resident care. LeadingAge supports streamlining the process or providing additional support during surveys could help nursing homes focus more on quality improvement rather than compliance-related paperwork.

Another challenge is the variability in surveyor interpretation of regulations, which can result in inconsistent outcomes and unfair penalization. This can, in turn, lead to financial distress for facilities due to monetary penalties. LeadingAge has identified key priorities for survey and certification reform. MedPAC may consider reviewing LeadingAge's work and recommend enhancing surveyor training to ensure they are better prepared to address the nuanced issues in nursing homes, particularly in caring for residents with complex medical needs. In addition, we ask MedPAC to recommend introducing national guidelines for surveyors that promote consistency and fairness across different states and regions. This would help prevent subjective discrepancies in how nursing homes are evaluated.

LeadingAge urges MedPAC to consider these critical issues as you evaluate Medicare policies affecting nursing homes. Addressing the unique needs of rural facilities, helping to improve quality measures with realistic financial incentives, supporting the workforce, and rethinking regulatory burden will be vital to ensuring that nursing homes can provide high-quality care to all residents, regardless of geographic location. LeadingAge strongly promotes and supports transparency and accountability, and we expect

MedPAC to recommend reforms that also emphasize transparency and accountability in how nursing homes utilize funding to enhance resident care.

Supplemental Benefits in Medicare Advantage

Focus group findings

We appreciate the fact that MedPAC incorporates focus group insights into its work. While we agree with commissioners that those reflections may not represent the whole, the focus groups nonetheless provide more detailed and experiential responses than can be achieved through a survey. As you continue this work, we would ask you to consider the following recommendations for future focus group activity:

- We would recommend taking steps to ensure that those who reside in assisted living or long-stay nursing homes or have had a hospitalization have an opportunity to participate in focus groups, as their experience with access to certain services (e.g., post-acute care) might be different from those residing in the community. It would be good to factor in their experiences to provide a more complete picture of the MA enrollee experience. One way to achieve this might be to host a focus group at senior living community that includes several levels of care including long-stay nursing home services, as these individuals may not be able to otherwise travel to an offsite meeting either due to lack of access to non-medical transportation or frailty.
- It would also be interesting to delineate input from individuals who are in MA plans vs. Special Needs Plan (SNPs) to see if the model of care required for SNPs has an impact on enrollee experience, care coordination, and access to care.
- In addition to interviewing clinicians, it might be interesting to speak with discharge planners at hospitals, SNFs and other PAC settings to see what issues they encounter in trying to secure the next level of care (e.g., find a SNF bed for an MA, find a home health agency able to take someone).

Related to clinician experience with MA/SNPs, our SNF and home health agency (HHA) providers echo the experience of the clinicians in the focus group. Many of our SNF and HHA members report needing to hire one or more full-time equivalent positions just to manage the prior authorization and concurrent review or re-authorization burden imposed by plans. Some providers have reported that each request takes 30 minutes or more; recent data collected and reported by our members suggest that one patient may require an initial prior authorization and up to four to five concurrent reviews during a SNF stay. On the home health side, plans are increasingly only approving an initial assessment visit before approving any additional home health visits unlike in Medicare fee-for service where home health care is approved for a 30-day episode of care. The piecemeal approach by MA plans leaves a frail older adult without services while awaiting a plan decision which sometimes can take seven to 10 days.

Still more staff are needed to secure payment from the plans for services delivered and prior approved. Often, plans partially or fully deny nearly all claims or clawback payments months and years after the original claim was submitted. This requires providers to reconstruct all the documentation related to the claim including providing evidence of the prior authorization for the services rendered.

In addition, it is interesting the MA plans prioritize in-home health risk assessments for their enrollees to increase coding, while at the same time down coding SNF and home health care services so they can pay providers less than Medicare fee-for-service. Our SNF members have noted that, lately, MA plans instruct them to submit a claim for a lower level of care than indicated by the CMS-required MDS assessment or

the plan will not pay the provider if they submit the code generated by the MDS assessment, which identifies the level of resources needed to care for the individual appropriately.

We recommend future MedPAC surveys and focus groups include post-acute care providers who provide critical, medically necessary care following a hospitalization to aid older adults in recovering and being able to return home. As the Senate Homeland Security Permanent Subcommittee on Investigations' Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-acute Care report demonstrates, the three largest national MA organizations (MAOs) have increased their denials of post-acute care services not based upon medical necessity grounds but the MAO's financial gain. At the same time, these plans are not only squeezing PAC providers on service utilization but also paying them rates that are substantially lower than Medicare fee-for-service. Some providers report MA plans offering them Medicaid rates to provide the complex, service intensive skilled care services. This is unconscionable.

As MedPAC has recommended originally in its June 2019 report, MAOs must be held accountable to submit complete and accurate encounter data, including subjecting them to a payment withhold that is only refunded if the submission thresholds are met. It is likely that the data reported also needs to include additional fields so that, ultimately, MedPAC has the data necessary to assess the adequacy of the rates paid to providers by MA plans. We strongly believe that it is abhorrent for plans to be paid 22% more than Medicare FFS, while underpaying SNFs and HHAs by 20-50%. This trend cannot continue, or we risk not only depleting the Medicare Trust Fund sooner but also risk destabilizing the health care system more broadly. It is a long-held practice that Medicare (rightfully or wrongfully) has subsidized Medicaid but now even this alliance is untenable.

Supplemental benefits
During the commission meeting it was reported that in the focus groups that, "Over-the-counter cards were frequently mentioned, and beneficiaries reported using them in a variety of ways, including paying utility bills and buying groceries. Other popular benefits included incentives for preventive health and wellbeing, like gym memberships."

As you further examine these benefits, we wanted to bring your attention to an unintended consequence of these flexible benefit cards that has just recently come to light and its potential impact on certain MA enrollees' access to other government assistance.

As you are aware under the Value-Based Insurance Design (VBID) and the Special Supplemental Benefits for the Chronically Ill (SSBCI) authority, MA and SNP plans can offer certain at-risk populations special supplemental benefits. One such benefit being offered more frequently by plans are these flexible benefit cards, which are loaded with a monthly amount that the enrollee can use to purchase from a plan-determined menu of items and services selected for their potential impact on enrollees' health outcomes. These items may include things such as over-the-counter medications or groceries. In other cases, plans seek to address enrollees' health-related social needs, like helping them maintain stable housing by permitting the flex card allowance to be applied to the person's rent or utility costs. Plans appear to be increasingly offering these flex card benefits and some of the cards provide as much as $450/month (as reported in Pennsylvania) to an MA enrollee to use for these purposes. At this amount, it serves as a huge incentive for Medicare beneficiaries to choose such an MA plan.

However, while these benefits can be key in addressing social risk factors, for enrollees eligible for government assistance, the availability of such a flex benefit card may jeopardize their eligibility for this

assistance, including in programs like Medicaid, SSI, and rental assistance through the Department of Housing and Urban Development (HUD), and the amount of the assistance received through these programs. This is because in the absence of clear federal policy some providers and state agencies are counting the available amount of the flex benefit cards as income. Therefore, some may lose their assistance altogether while others have their support reduced. The trouble is compounded because these flex benefit cards cannot always be used for their intended purpose and those enrolling in an MA plan do so unaware of the potential consequences.

For example, some affordable housing properties are unable to accept the card to pay for a portion of the person's rent. On top of that, the person's rent is increased because the housing provider was told that the amount of the card must be counted as income. So, now, the person not only cannot reduce the amount of their current rent but is subject to paying a higher monthly rent without any additional income to meet the requirement. We have raised this issue with the Center for Medicare and Medicaid Services, HUD, and Congress.

We hope you will take a closer look at these flex card benefits in your June 2025 analysis of the encounter data to determine the number of beneficiaries who have access to the cards, the amounts available to them through the cards, and the amount of the card benefit being utilized. This is important as we are hearing reports that often the grocery benefit can only be used at one particular store that an individual may not be able to access on a bus line, or the transportation benefit is Uber or Lyft and the person has a wheelchair that cannot be accommodated by these vendors making the benefit a ruse for some enrollees.

Broadly, as you examine the encounter claims data related to supplemental benefits, we will be curious to learn what percentage of the rebate dollars given to a plan are spent on the supplemental benefits themselves (vs. any costs to administer the supplemental benefits, etc.). And, what percentage of enrollees use the supplemental benefits? In this regard, it would be helpful to look at utilization of the various categories of supplemental benefits broken out by categories such as vision, dental and hearing; primarily health related, VBID and the SSBCI. Right now, the minimum loss ratio rolls in all basic and supplemental benefits claims plus quality improvement and compares it to the total revenue received by the plan. We think an analysis of rebate dollars to supplemental benefit spend would be useful in determining the value of what the MA plans are offering through these extra benefits.

We support your work to examine the value of these supplemental benefits and determine their utilization by beneficiaries.

Work Plan for a Mandated Final Report on the Impact of Recent Changes to the Home Health Prospective Payment System

We appreciate the insight provided into the work plan for the Congressionally mandated report on the Patient Driven Groupings Model (PDGM), which was implemented in 2020 for home health providers. LeadingAge would like to take this opportunity to echo the comments and concerns of several Commissioners during the presentation and also highlight additional issues MedPAC staff should take into consideration as they complete this analysis.

First and foremost, we support Dr. Dusetzina's and Dr. Konetzka's recommendation to exclude 2020 data or, at the very least, to use 2020 as a transition year and to control for variations, e.g., where state and

local governments implemented orders to avoid spreading COVID and therefore individuals may have rejected care due to the greater risk of COVID infection.

Subcategories of Analysis: MedPAC staff shared they are planning to conduct analysis of subcategories of both beneficiaries and providers and how payment impacted those groups.

- *Difference by agency type:* We strongly support analysis of PDGM impact by provider type. LeadingAge represents predominantly nonprofit organizations, which is an increasingly small percentage of the sector. Looking at the PDGM impact by ownership status is essential to understanding an increasingly consolidated sector. We would also recommend including other agencies' characteristics, such as chain affiliation, average daily census, geographic location (urban vs. rural) etc.
- *Clinical conditions:* We agree with the Commissioners' recommendation to review specific clinical conditions, especially those that are either more resource intensive, and do a comparison of outcomes with and without home health agency (HHA) services. We would also like to see a review of post-acute (institutional) vs. community populations to better understand the impact of the payment reductions on community admit episodes.
- *Patient characteristics:* We agree with the concern in accessing care in rural areas but agree that rurality does not tell the whole story. While looking at county level data could be valuable, we note that counties, especially in western states, vary in size and physical geography. Looking at zip codes could be more effective. Additionally, we would argue MedPAC needs to look at other indicators such as social deprivation indexes and socioeconomic status. These can capture the needs of rural populations but also underserved populations in large metropolitan areas that experience similar deprivation. In the context of duals, the impact that Medicaid services may have on someone's home health outcomes need to be considered separately from near duals or others with a lack of resources – either because of their geography, their SES, or other factors
- *Reduced number of beneficiaries:* The population of fee-for-service home health users has dropped during the implementation of PDGM. It is critical to understand the populations which are no longer receiving care and if that is related to the changes in payment or the reduction in the access to home health providers. This work also needs to be cross-referenced with MedPAC's Medicare Advantage (MA) work, i.e., how is MA plan enrolment impacting access to care?
- *Maintenance Care:* MedPAC's work plan outlines the quality of care measures it will review. Change in beneficiary mobility and change in beneficiary care, while critically important for rehabilitation cases, do not adequately capture, and may be detrimental to, the needs of maintenance care beneficiaries. We strongly encourage MedPAC to look into ways to assess the impact of PDGM on patients who are not expecting to improve per the *Jimmo v. Sebelius* settlement.
- *Lack of Family Caregiver:* According to the *Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations*, "About 32 percent of HHAs and 25 percent of physicians reported the inability of the patient/family/caregiver to provide necessary support as an important factor contributing to admission issues-- suggesting that the presence of a caregiver may play a role in access to home health. In addition, 27 percent of HHAs and 18 percent of physicians reported patient living conditions or local area safety as an important factor contributing to admission issues." This older data already highlighted an access problem that has continued to grow: the lack of a caregiver or availability of a caregiver that can support the complexity of need being seen in home health populations. MedPAC should

consider an analysis to identify this population and others who were included in the vulnerable patient study and the impact of PDGM on their access and outcomes under home health.

Evaluating Complexity
Coupled with the need to assess the accuracy of access is the need for further patient-level analysis on increased complexity. Some of the subgroup analysis should provide insight into whether PDGM is capturing complexity in a way that actually matches the need of the populations. However, we hope the Commission might consider taking this a step further. Both Accountable Care Organizations (ACOs) and MA use hierarchal condition category coding (HCC), which takes into account not only clinical complexity but socioeconomic complexity. There are incentives for payers to take on these populations and that is clear in the huge penetration of MA into the more disadvantaged urban areas served by our members. Beneficiaries in these areas end up choosing MA because they appear to be cheaper on paper but may indeed be costly in terms of inability to access care. We understand MedPAC does not have access to complete MA data, but ACOs and other shared savings demonstrations often use HCC scoring as well. Applying this to home health payments would go a long way to providing support for these populations.

When CMS proposed its first cuts to the home health payment based on the statutory requirements to look at aggregate payments, we argued that HCC should be used to review patient complexity. CMS rejected our argument stating that HCC scores are dependent on beneficiaries having a claims history (which may be limited for those newly enrolled in Medicare), and therefore, they did not think HCC would be appropriate to use as it may limit their ability to capture beneficiary characteristics needed for case-mix adjustment.

MedPAC could utilize its expertise and look at the current home health fee-for-service population using the HCC scoring to confirm, or as we suspect, reject CMS' statement that there are not enough claims data to capture beneficiary characteristics. MedPAC's own analysis finds the home health population to be considerably older and, therefore, likelier to have more complex care needs than the younger Medicare population. There should be consistency and common understanding between payers and providers regarding the complexity of patients and who is serving those patients.

The current analyses MedPAC conducts are not getting a clear picture of the complexity of these patients. We would argue MedPAC could do a matched population study on certain complexities of underserved populations. There is a lot of evidence that the home health population generally is becoming more complex but especially this underserved population. CMS' current interpretation of statute, emphasising the aggregate costs and aggregate reductions, is simply baking existing inequities into the current payment system without solving any access issues.

Additionally, we ask MedPAC to revisit the need for a "safety net" designation in home health, The presentation on this idea in 2022 did indicate more research was necessary and we ask that you take up this mantle.

Other Issues for the Commission to Consider Evaluating
Home Health Referral Acceptance: Dr. Cherry presented a critical piece of the discussion that has, to date, been hard to capture: beneficiaries coded by hospitals as referred to home health and did not receive it. The reasons for not receiving home health remain uncaptured. While Mr. Christman laid out the reasons for the wrinkles in the data well, we still believe this is worthy of a clear discussion in the mandated report along with clear recommendations based on MedPAC's analysis for how to solve for the issue of not receiving home health with referred, and, additionally, clear expectations for hospital

discharge planners with regard to coding for home health services. We do not believe that the Condition of Participation (CoP) change proposed by CMS in the CY2025 Home Health will help with this issue as we outlined in our comments.

Fraud in Los Angeles County, California: We are increasingly concerned that the number of home health agencies has declined, which will not sustain access regardless of the definition used and, as detailed above, we believe access in certain geographies and for certain populations is already impacted. It has come to our attention that some of the same fraudulent practices experienced in hospice are occurring in home health, particularly in California.[1] It appears, in fact, that many of the same owners have both hospice and home health and switch the patients back and forth between the services and/or start the patients out on home health and switch them to hospice. Much like the hospice fraud reported on in 2022, California, and specifically Los Angeles County, appear to be at the center of exponential home health enrollments.[2] According to MedPAC's own 2024 Health Care Spending and the Medicare Program Databook, much of the growth in home health agencies since 2018 has been concentrated in California. When the state is excluded from overall industry growth, the supply of agencies actually declined by about 2% between 2018 and 2023. [3]

We recommend MedPAC's look into these trends related to LA County include:

- What percentage of all FFS periods occur in LA county? LA County has a large Medicare Advantage penetration so a large percentage of periods in LA county would be amplified as an outlier in FFS data.
- What percentage of FFS spend occurs in LA County?
- How do the periods in LA county year over year compare to national trends?
- What do LUPAs look like for LA county compared to the national average?
- What do the percentage of early institutional episodes look like compared to the national average?
- Conversion episodes with 2nd period and non-LUPA outlier vs. national average.

If LA county appears to be a major outlier in these regards (and any others the Commission notes), we recommend running other analyses for this report with LA County included and excluded and reporting on the differences observed.

We believe that this growth and potential fraud could be disproportionately impacting the assessment of payments and behavioral adjustments for the entire industry, leading to the needless closure of many agencies serving communities across the country. By all means we would support the removal of LA County from the analysis. Is essential that if MedPAC is concerned about fraudulent practices they communicate that to Congress and make recommendations for actions Congress can take to remedy the impacts on the payment system these outliers (potential fraud) may have caused.

Clinical Upcoding: Dr. Casalino asked a clarifying question about the potential impacts of clinical upcoding in the new payment system. MedPAC staff stated clinical groups did not shift very much across the years and that the stricter enforcement of physician orders helped curb upcoding issues. This is contrary to CMS' analysis and the subsequent behavioral changes that have led to devastating decreases

---

[1] https://homehealthcarenews.com/2024/01/hospice-fraud-back-in-the-spotlight-with-new-data-also-raising-questions-about-home-health-care/

[2] https://www.newyorker.com/magazine/2022/12/05/how-hospice-became-a-for-profit-hustle

[3] https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf

in payment. MedPAC should include in their final report clear analysis of behavioral changes in PDGM around upcoding.

Potentially Preventable Hospitalizations: LeadingAge echoes the concerns of Dr. Casale that the potentially preventable hospitalizations measure does not accurately account for the presence of primary care team to support coordination. It would be useful to look at that measure in concert with the individual receiving any sort of primary care services or supports.

Initial Estimates of Home Health Care Use Among Medicare Advantage Enrollees

The commissioners' conversation echoed our concerns about the growing disparities between fee-for-service Medicare beneficiaries and Medicare Advantage (MA) beneficiaries. MA plans paying well below the traditional fee-for-service rates for home health services. We request that MedPAC specify to Congress what data is needed (and what is missing) to ensure that MedPAC can adequately compare FFS and MA rates to verify what we hear from our home health and skilled nursing facility provider members consistently and loudly. The plans are also creating additional, unfunded administrative burdens for providers, and making financially- rather than clinically-driven decisions about the number of visits allowed to patients. While several of our members run MA plans to support individuals in their communities, we find they are not participating in the same practices and wish to partner with the Commission and policymakers in offering insights on how to ensure access to care across all of the Medicare program and advocating for better data transparency to enable this goal.

LeadingAge would like to take this opportunity to echo the comments and concerns of several Commissioners during the presentation and also highlight additional issues MedPAC staff should take into consideration as they continue to analyze MA home health issues.

Patient diversion: As the only association represented both nonprofit, mission driven skilled nursing and home health agencies, we would like to echo Ms. Barr's concerns about diverting patients from skilled nursing to home health. There is more evidence than ever, including a recent report for the Senate Committee Permanent Subcommittee on Investigations, that this is occurring in MA plans. Every part of the continuum has a role to play in supporting beneficiaries after hospitalization. Diverting individuals from SNF to HHA does not support individuals. On the home health side, some of the beneficiaries diverted cannot be appropriately served by the agency that cannot provide the level of care or around the clock care that a facility can and unnecessary rehospitalizations may occur as a result. Even when a home health referral is appropriate, the report showed that home health agencies were being reined in regarding the number of visits that a beneficiary could receive, which in turn would hamper HHAs in ensuring high quality care.

Plan characteristics: We would also agree with Dr. Sarran on reviewing the data with an eye to plan characteristics, including national vs regional and provider sponsored vs. commercial insurance. Based on discussions with our members, there are differences in plan behavior based on some of these factors and it is important to understand where the problems lie.

Network adequacy: Ms. Upchurch's comments on network adequacy are also critical to consider in any further analysis. We hear from members in rural states that plans are not meeting their obligations related to network adequacy because, in large part, as Ms. Upchurch's notes, an agency is unable to drive to the patient due to the lack of reasonable reimbursement. Plans are not adjusting reimbursement in order to maintain network adequacy.

Denials and appeals: We agree with Dr. Sarran's concerns about looking at percent of denials and appeals as well as some metric to get a feedback loop when beneficiaries and families believe they are not getting service they need. LeadingAge launched an effort among our provider members, including home health and skilled nursing facilities, to understand what their experiences with prior authorizations including the denial and appeals process looks like. We would be grateful for the opportunity to speak with MedPAC about this data collection effort.

In addition, MedPAC's longstanding definition of access only captures fee-for-service Medicare beneficiaries and not those enrolled in Medicare Advantage, which often pays home health agencies well below Medicare fee-for-service rates. The lack of data available to MedPAC on Medicare Advantage payments, as we discussed, is unacceptable and is continuing to skew the analysis of the organization meant to inform and advise Congress on the full Medicare program.

We ask that MedPAC consider expanding its recommendations to Congress beyond traditional fee-for-service updates to highlight places where MedPAC lacks insights to round out their perspective and to make recommendations regarding what action is needed from Congress to ensure that MedPAC can fully assess the current payment system realities.

Thank you for your attention to these important matters.

LeadingAge appreciates the opportunity to provide input and looks forward to any future discussions on how we can improve care and financing for older adults across. For your reference, nursing home questions can be directed to Janine Finck-Boyle, nfinck-boyle@leadingage.org; MA questions can be directed to Nicole Fallon, nfallon@leadingage.org: and Home Health questions can be directed to Katy Barnett, kbarnett@leadingage.org, and Mollie Gurian, mgurian@leadingage.org.

Sincerely,

Linda Couch
SVP, Policy & Advocacy

About LeadingAge: *We represent 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.*