January 27, 2025

Jeff Wu, Acting CMS Administrator

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-4208-P

P.O. Box 8013

Baltimore, MD 21244

Submitted electronically.

Dear Acting CMS Administrator Wu:

LeadingAge appreciates the opportunity to comment on the Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescriptions Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE);" (CMS-4208-P), which will be referred to in this letter as "proposed rule"). We appreciate CMS's continued commitment to clarify expectations of Medicare Advantage (MA), Special Needs Plans (SNP) and PACE programs to ensure beneficiaries receive the medically necessary Medicare benefits for which they are eligible.

To provide some context for our comments, let us share a little about LeadingAge. Our mission is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Our comments reflect the perspective and experiences of providers of post-acute care, long-term services and supports, and home and community-based services who contract with MA and SNPs to provide services. In addition, we also have providers who lead MA plans, SNPs and PACE programs. Our comments will focus on issues that impact their ability to effectively deliver services and be paid for those services.

We offer our support for the following proposals:

- **Marketing and Communications.** We think the additional information proposed to be added to the list of items brokers and agents discuss with Medicare beneficiaries, such as their future eligibility for Medigap insurance, are important additions. We will discuss below in our comments on supplemental benefit flex cards that we think CMS should further amend this list of required communications to beneficiaries also require brokers and agents explain that utilization of certain supplemental benefits may negatively impact the beneficiary's eligibility for certain types of government assistance and benefits such as Supplemental Security Income and HUD rental assistance.

- **Improving Experiences for Dually Eligible Enrollees.** LeadingAge has long advocated for both administrative and clinical integration for the dually eligible population. Therefore, we support the proposals that would direct Applicable Integrated Plans to provide a single member identification card for both the Medicare and the Medicaid coverage; and conduct a single, integrated health risk assessment would be positive changes for these dual eligible enrollees. We also strongly support CMS' proposed improvements to the individualized care plan and limiting these changes to the AIPs. These proposals reflect important steps toward the goal of true integration for these individuals.

On the proposals below, we offer some issues for CMS to consider before finalizing these sections and ideas for further improvement to achieve beneficiary access to eligible Medicare benefits and clarity on how the proposals apply.

MA Supplemental Benefits and Flex Cards

LeadingAge has long been supportive of the expansion of primarily-health related supplemental benefit offerings and holistic view of special supplemental benefits for chronically ill (SSBCI) as they seek to support MA enrollees by addressing related social risk factors that influence their ability to maintain or improve their health and functioning. In recent years, MA plans have begun offering some of these benefits via flexible benefit cards, which are loaded with a monthly amount that the enrollee can use to purchase from a limited menu of items and services. These items may include items such as over-the-counter medications and 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. Regrettably, this delivery mechanism has revealed several concerns in need of addressing.

1. **Benefit cards cannot always be used for a particular service.** Our providers have observed two types of situations where an enrollee cannot access a particular supplemental benefit: 1) the benefit is offered through a limited number of vendors (e.g. grocery benefit available at a particular grocery chain that the beneficiary cannot travel to) or 2) certain vendors are unable to accept the flex card for purchasing one of the eligible items (e.g. paying for rent through affordable housing provider that cannot process credit cards or the flex cards).

   We appreciate and support the CMS language in the proposed rule reminding plans that <u>all</u> benefits they offer, including supplemental benefits, must be accessible and adequate to the enrollees. In addition, CMS clarifies in cases where certain vendors are not accessible, other options must be made available to the enrollee to access the benefit. Given our affordable housing providers experience of not being able to accept the flexible debit card to pay for a resident's rent, we also support the proposal that plans provide enrollees alternative options to access the benefit. These alternatives could and should include the enrollee paying for the services and items available to them under their MA plan and submitting receipts for reimbursement to the plan, or the plan directly issuing a check to the housing provider to cover the allotted amount of rent and/or utilities. We also strongly support the proposals that would ensure MA plans provide customer service to help beneficiaries navigate and access the supplemental benefits for which they are eligible and may have been a factor in them enrolling the plan in the first place.

2. **Marketing of the flex card benefits continues to be misleading, aggressive and/or deceptive.** There is no doubt that these supplemental benefits are popular and often entice Medicare beneficiaries to enroll in an MA or SNP plan. However, several PACE organizations have reported situations where these brokers do not act in the person's best interest failing to inform the person that they will lose their integrated Medicare and Medicaid benefits offered through their PACE program if they choose to enroll in an MA plan. In several cases, individuals have disenrolled from their PACE program for a flex card benefit only to learn that the benefits are not appropriate for them (e.g. the plan doesn't provide transportation to the grocery store to access the benefit, or transportation is offered through Uber/Lyft but these vendors do not transport individuals requiring a wheelchair). Other times, the Medicare beneficiary thinks they are signing up for an additional benefit not even considering this action will lead to their disenrollment from PACE. In North Carolina, a broker chased a senior affordable housing resident across the housing complex to the pick-up spot for their PACE transportation. The person did not want to change plans – and was clearly enrolled in a PACE program. However, the broker ignored the individual's request to be left alone.

3. **Without greater transparency, flex card benefits can jeopardize beneficiaries' access to other assistance.** Medicare beneficiaries must weigh their options for how to receive their Medicare benefits (e.g. FFS, MA, SNP or PACE) but this works best when they are well-informed about their choices and any potential consequences of choosing certain options. Currently, federal policy across federal agencies is not aligned on whether flex card benefits should be counted in income for the purposes of government assistance. Therefore, in some cases, beneficiaries' income is increased by including the value of these benefits, which can jeopardize their eligibility for other types of government assistance. For example, Supplemental Security Income (SSI) defines "income" to include "in kind contributions" when determining a person's eligibility for SSI, which would include these supplemental benefits. In addition, the Department of Housing and Urban Development (HUD) recently issued FAQs clarifying that MA supplemental benefits used for rent and/or utilities must be counted in a person's income when determining their eligibility for and level of rental assistance.

   The trouble is beneficiaries are unaware that enrolling in an MA plan offering these supplemental benefits could jeopardize their eligibility for government assistance or benefits thereby reducing the amounts they have available to meet their basic needs versus expanding them. For this reason, we think it is essential that brokers inform prospective MA enrollees that MA supplemental benefits may be counted as income when determining their eligibility for certain types of government assistance.

   Recommendation: In the absence of a national policy to exclude MA plans' supplemental benefits from counting as income, we recommend CMS further expand its list of items that agent and brokers are required to communicate to Medicare beneficiaries prior to enrollment to include: notifying beneficiaries MA plan's supplemental benefits may be counted as income when determining eligibility for some government assistance programs such as HUD rental assistance or SSI and this may preclude them from these types of assistance or reduce the amount of these benefits.

Enhancing Rules on Internal Coverage Criteria.

LeadingAge supports CMS's proposed updates on Medicare Advantage Organization's (MAOs) use of internal coverage criteria (ICC), which build on the 2024 final MA policy and technical rule (CMS-4201-F). We believe that existing Medicare regulations, specifically 42 C.F.R. § 409 (Subpart D and E), clearly establish coverage criteria for skilled nursing facility (SNF) and home health services. This was also reaffirmed by CMS in the 2024 MA final rule that MA plans must adhere to these traditional Medicare coverage rules for these services.[1] As such, there should be minimal need for ICC in these areas. However, SNF and home health providers continue to encounter cases where services clearly covered by traditional Medicare are either denied or cut short even when physician-ordered and/or medically necessary.

Many of the rules ICC proposals respond to concerns we raised with CMS in 2024. We fully support CMS's position that ICC should be rare and only used to supplement existing Medicare coverage rules, not to replace or override them. We also support the new protections for beneficiaries, requiring plans to demonstrate that ICC is in place to support patient safety, not to act as a barrier to necessary care.

The updated ICC definition clarifies that ICC may only be used to interpret or supplement existing Medicare coverage rules—not to add new, unrelated criteria. It also prohibits plans from using ICC to restrict access to or payment for medically necessary services, and clarifies this standard extends to third parties as well.

However, we seek further guidance on how certain provisions will be applied. For example, will CMS's new regulation text - ICC "includes any coverage criteria that restrict access to, or payment for, medically necessary Part A or Part B items or services based on the duration or frequency, setting or level of care or clinical effectiveness of the care" -- prevent plans from refusing to pay a claim for SNF services unless it is submitted at a lower payment level than determined by the MDS assessment? Will it prevent plans from limiting home health services to two visits, even when one is needed for the required OASIS assessment? Will it stop plans from denying therapy services identified by an OASIS assessment that would typically be covered under traditional Medicare (e.g. speech therapy)?

Additionally, we question whether the use of algorithms by plans to predict SNF care duration—based on average data for patients with similar diagnoses—would be considered third-party ICC. These algorithms often do not reflect the unique needs of individual patients but are treated not as guidance but the prescribed timeline.

We also support the proposed guardrails that:

- **Prohibit ICC when there is no clinical benefit to the individual and the ICC only exists to reduce utilization.** This provision may help address our concerns about MA plans disproportionately denying post-acute care services at a higher rate than other services as detailed in a October

[1] 42 C.F.R. § 422.101(b)(2): "[Each MA organization must comply with] General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR 412.3, services and procedures that the Secretary designates as requiring inpatient care at 42 CFR 419.22(n), and requirements for payment of **Skilled Nursing Facility (SNF) care, Home Health Services under 42 CFR part 409**, and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3)**.**" (emphasis added).

2024 Senate report. It may be difficult to demonstrate that the criteria are only established to reduce utilization. What evidence does CMS envision would need to be provided?

- **Prohibit MA plans from adopting blanket policies that automatically deny coverage for essential benefits based on ICCs, without considering the individual circumstances of the enrollee**. This guardrail could resolve an issue our SNF providers seem to routinely encounter -- plans denying concurrent review requests to continue care so individuals can complete their IV therapy (a covered SNF benefit under traditional Medicare).
- **Prohibit plans from discriminating based upon any factors related to one's health status**. This guardrail may help prevent situations where plans deny coverage for skilled post-acute care for older adults who reside in long-term nursing facilities simply because they wrongly assume that SNFs and long-stay nursing homes provide identical services.

Recommendation: We encourage CMS to finalize all of the changes related to ICC quickly and hope you will provide additional examples that address concerns or questions we have raised here. In addition, given the lack of significant change in plan behavior since implementation of the 2024 MA final rule, we urge CMS to continue monitoring and auditing MA plan compliance with these provisions to ensure that beneficiaries can access the full range of Medicare benefits when medically necessary. We believe providers can both support and supplement CMS efforts related to identifying issues of MA plan non-compliance. Providers present a critical set of eyes and ears on the ground observing MA plan policies and practices in real time. They can help identify trends of non-compliance so CMS can provide plans with further instruction or clarification on how to comply and to correct errors or issues that present barriers to beneficiaries getting medically necessary care. However, there is no clear portal or mechanism for post-acute care providers to report compliance issues to CMS. Therefore, we encourage CMS to establish a mechanism, such as online form through medicare.gov or a designated email inbox, to enter complaints for inclusion in the complaint tracking module With MA enrollment exceeding 50%, it is critical that we identify and correct non-compliance issues that prevent beneficiaries from accessing care swiftly.

Availability and Accessibility of MA Internal Coverage Criteria

LeadingAge strongly supports CMS's proposals to ensure that internal coverage criteria (ICCs) used by Medicare Advantage (MA) plans are not only available but also easily accessible to patients, providers, and the public. These proposals represent a much-needed step toward improving transparency around plan practices. While current regulations require MA plans to make their ICCs publicly available, we have found that this information is often difficult to locate. It is frequently buried within existing plan policies or hidden behind registration or login requirements on the plan's website.

We fully support CMS's proposal, effective January 1, 2026, that requires each MA plan to clearly list its ICCs, along with the rationale and supporting evidence, including how they benefit enrollees. Specifically, we appreciate CMS's expectations for plans to:

- **Prominently display** this information on their websites, including in the website footer;
- Ensure the information is **freely accessible** without requiring any fees, logins, or account registrations;
- **Label** or mark all ICCs referenced in plan policies for clarity.

Finally, we recommend that CMS adopt a policy to require plans to submit their list of ICCs directly to CMS, in addition to posting it on their individual websites, and make this information available to the public in a centralized location. This would reduce burden for both providers and beneficiaries in finding the information for multiple plans, while enhancing transparency and improving CMS's ability to monitor plan compliance efficiently and identify potential issues with unclear coverage criteria.

In sum, we believe these proposals will greatly improve transparency, reduce confusion, and ensure that Medicare beneficiaries have access to the care they need without unnecessary barriers.

Revisions to Annual Health Equity Analysis of Utilization Management Policies and Procedures Across Populations.

Additional transparency regarding MA organizations' (MAOs) utilization management practices is needed given that recent reports(2024 Senate Refusal of Recovery report , 2022 OIG report on MA Denials have demonstrated that access to post-acute care services is being disproportionately denied to MA enrollees. We think this information is particularly important for disadvantaged populations, such as dual eligibles. Currently, as of January 1, 2025, MAO's Utilization Management committees are charged with conducting an analysis on the impacts their use of prior authorizations has across populations. When this analysis was proposed, LeadingAge argued for CMS to require plans to report more granular level data such as the service or item level as we have seen great variability in MAO prior authorization practices across provider and service types as noted in 2024 Senate Refusal of Recovery report.

Regrettably, some of our nursing home members have reported that older adults who reside in a long-term care nursing homes and receive assistance with activities of daily living (ADL), are now being denied for more intensive post-acute skilled nursing services following a hospitalization because the MAO states that this can be provided by the long-term care nursing home. While a nursing home may provide both custodial/ ADL services and skilled nursing care, these services are not interchangeable and skilled care is to be covered under Medicare. Long-stay nursing home residents in traditional Medicare are permitted skilled nursing facility care following a minimum 3-day hospitalization. Therefore, MAOs are required to meet at least that coverage standard. One can only assume then that MAOs are using their own internal coverage criteria in this instance to deny care that would otherwise have been provided in traditional Medicare.

LeadingAge supports CMS's proposal to require MAOs to report on required metrics by item and service not in the aggregate, as this more granular level data will be more actionable for identifying specific services or items where prior authorization is unnecessarily posing a barrier to care.

Clarifications on MAO Determinations, Their Appealability, Provider Notifications and Payment Protections for Concurrent Reviews in Inpatient Settings

LeadingAge appreciates CMS's ongoing efforts to ensure MA enrollees receive all the Medicare A and B benefits for which they are eligible, to remove barriers to accessing, and clarify MAOs responsibilities in this regard.

LeadingAge strongly supports the proposed changes in this section and believe they are needed to enhance beneficiary protections related to coverage determinations, clarify that all of these coverage decisions are appealable and ensure providers are informed about these decisions as they play an integral role not only in the enrollee's care but also in assisting with appeals. However, we were

disappointed to see that not all proposed changes in this section are applicable to post-acute care service providers such as SNFs and HHAs, in addition to inpatient hospitals, as our providers encounter very similar situations in their interactions with the plans on various organization determinations.

1. **Clarifying the Definition of an Organization Determination to Enhance Enrollee Protections.**

   We support the proposed clarification that organization determinations should apply to decisions made before, during, and after an enrollee's receipt of services. We view the addition of concurrent reviews in the definition as a positive one as it extends important rights to MA enrollees. This proposal is particularly important for SNFs and HHAs, which face similar challenges to inpatient hospitals regarding concurrent reviews.

   Often an initial authorization for SNF services is for a limited number of days. While Medicare regulations permit SNFs up to 8 days to complete their CMS-required MDS assessments which inform the individual's care plan, the plan may have approved fewer than 8 days of service. In these situations, the SNF submits a concurrent review requesting to continue the enrollee's care. Many SNF stays require at least 2-3 concurrent review requests. Therefore, we appreciate the inclusion of concurrent reviews in the "organization determination" definition ensuring enrollee appeal rights, as the bulk of requests SNFs and HHAs submit are for the ability to continue to deliver needed care (e.g. concurrent reviews).

   Also, can CMS confirm that by amending the definition of "organization determination" to include concurrent reviews, that this change would also mean that plans must make concurrent review decisions within the required decision timeframes specified in 422.572? Finally, it would be helpful if CMS established a communication channel through which providers could report when plans are not meeting the prescribed timelines for making organization determination decisions. Enforcement of the rules is critical for ensuring plan compliance and preventing care delays for beneficiaries awaiting medically necessary care and services.

2. **Permitting enrollees to appeal adverse retrospective review decisions (§422.562(c)(2))**. LeadingAge supports this proposal as it provides critical protections for the enrollee as these retrospective reviews could have significant financial implications for the enrollee. When plans change an enrollee's hospitalization from inpatient to outpatient or observation stay, the effects of that decision go beyond the hospital services as under Medicare regulations it would make them ineligible for SNF services. These retrospective reviews are especially problematic when the enrollee may have already been admitted to the SNF, as it could place the entire liability for paying for the SNF services on the enrollee not the plan. While plans can waive the 3-day inpatient hospital stay requirement, our SNF members report numerous times where an enrollee admitted to the SNF is surprised that their SNF care is not covered because their hospital stay was not inpatient but observation. In these cases, an individual would be expected to pay for the resulting SNF services out of pocket.

   Regrettably, our SNFs experience similar situations where the MAO notifies the SNF that they disagree with the outcome of the CMS-required MDS assessment's level of care determination and that the SNF will only be paid if they submit a claim for a downgraded level of care approved by the plan. This second-guessing of an in-person assessment should not be permitted either.

3. **Require plans to notify providers who make an organization determination request on behalf of an enrollee, of the resulting decision.**

We were surprised to learn that MAOs are not always required to notify providers when they make an organization determination, especially when the provider has submitted the request on behalf of the enrollee.

We understand that MAOs are required to notify enrollees in writing. We don't know if the same written requirement would apply to providers. There are concerning reports of delays in enrollees receiving notifications, resulting in cases where they are discharged prematurely. In one case, the gentleman wasn't stable, but the MAO had notified him that his SNF services were being terminated. He appealed the decision but did not receive the notice that the MAO's decision was overturned on appeal until after his discharge. He received the written notice days later that he could have continued to receive the needed SNF services. Ultimately, during this time, he experienced deteriorating health and was required to be readmitted to the hospital.

We ask CMS to clarify the expectation for how this information would be communicated to providers and ensure that multiple channels are permitted to ensure providers are informed timely, and that there is a mechanism to verify receipt, to prevent care interruptions.

In addition, we appreciate the propose technical change to § 422.572(f) that would clarify that the failure to provide timely notice of an expedited determination to the enrollee and the physician or prescriber, when appropriate, would constitute an appealable adverse organization determination and as such its appealability. However, this raises another concern about misaligned timeframes. The current standard allows plans to give as little as two days' notice before terminating services, which often doesn't align with the 72-hour timeframe for expedited determinations. This discrepancy could lead to medically necessary services being discontinued before a decision is received. We recommend CMS further align these two timeframes to better protect enrollees. We encourage CMS to consider future amendments to better align these two timeframes and to protect enrollees from disrupted care.

4. **Application of Expedited Reviews for SNF and Home Health Services**

We appreciate CMS's reinforcement that, in many cases, pre-service and concurrent reviews for inpatient services require expedited determinations.

We seek clarification on whether SNF services are considered "inpatient services" for the purpose of expedited reviews. SNF and home health services are often critical to enrollees' ability to regain maximum function, and delays in accessing and receiving these services can jeopardize their health. We would argue that they should also be treated as expedited reviews in most cases. We've received recent reports from SNF providers in multiple states where at least one national MAO is failing to meet expedited review standards for SNF placements, causing significant delays burdening hospitals, and negatively effecting patient health status upon discharge. The plan's case managers are "so overwhelmed" with their concurrent review process that they tell the providers to "keep sending in the concurrent reviews and they will get

to them at some point" and "no news is good news" on concurrent reviews. Not only is the plan not complying with its regulatory obligations, but this is also a double standard. Some MAOs have been found to set unreasonable deadlines for providers submitting data, only to deny coverage if the data is slightly late, even if the service is medically necessary. Noncompliance and double standards are detrimental to enrollee outcomes and provider viability. We urge CMS to address these issues of noncompliance and ensure that plans adhere to timely review requirements.

5. **Modifying Reopening Rules Related to Decisions on an Approved Hospital Inpatient Admission (§§ 422.138 and 422.616)**

LeadingAge agrees with CMS's proposal to limit a plan's ability to reopen a plan-approved inpatient hospital admission for good cause based on new information. This logic should also apply to prior authorizations for SNF and HHA admissions. In all of these cases, decisions are made based on the information available at the time. New information that arises during a course of treatment should not allow the plan to reopen the original determination, especially when the provider delivers services in good faith, expecting payment.

We would appreciate CMS clarifying why the prohibition on reopening prior authorization decisions due to new and material evidence applies only to inpatient hospital admissions. SNF and HHA services often involve short-term prior authorizations with numerous concurrent reviews. Any new clinical information will inform the organization determinations related to continuing that care (e.g. concurrent reviews). However, the original prior authorization for SNF or HHA services should not be reopened based on new clinical data.

We request that CMS extend the proposed policy prohibiting the reopening of decisions based on new and material evidence to cover prior authorizations for SNF and HHA admissions, in addition to inpatient hospital admissions.

Artificial Intelligence (AI) Guardrails

We continue to believe that AI demonstrates considerable potential for all of us in health care to work more efficiently. However, AI is only as good as its inputs so when the inputs are misaligned with what the law requires related to Medicare beneficiaries access to eligible benefits, then we think it is important to ensure someone who knows the rules reviews coverage determinations including prior authorizations and concurrent reviews to ensure there are no unnecessary delays or errors that prevent someone from accessing needed care for which they are eligible. Therefore, LeadingAge supports CMS's proposal to refine the definition of "automated systems" to include "artificial intelligence" and the addition of a definition of "patient decision support tool" as these are becoming predominant elements of health care coverage decision making. To the degree that these mechanisms are used in MA plan service or coverage determinations, we think it is important to ensure AI does not serve as a barrier to medically necessary services. Regrettably, we've heard of situations where individuals who live in long-stay nursing homes receiving assistance with their activities of daily living are told by MA plans that they cannot receive Medicare-level skilled nursing care following a hospitalization. This would be an example of a plan not following 42 CFR 422.110 (a).

Provider Directory Updates

While we have no objection to ensuring that plan provider directories include supplemental benefit providers who provide care in the home and the incorporating these directories into the Medicare Plan Finder, we think it fails to address the broader issue of the accuracy of these directories and the administrative burden to providers and plans of building and maintaining this information that is constantly changing. Aging service providers submit core organizational, licensure, certification, quality and other data into multiple systems (e.g., CMS payment, PECOS, CDCs- NHSN, MDS, Federal Government grant applications to FEMA & HRSA). In addition, documentation of this information must also be copied and shared with multiple managed care plans at least annually.

LeadingAge recommends CMS re-examine the efficiency and burden reduction of developing a national health care and services provider directory that could be used by private plans and federal agencies. We have articulated the many advantages of such an initiative in our comment letter on an CMS request for information on establishing a National Directory of Health Care Providers and Services (CMS-0058-NC). By creating a single source of truth for provider information, we could eliminate the duplicative data collection across plans, providers and government agencies, ensure more consistent data regarding provider service locations, and reduce providers' administrative burden by only requiring a single portal to report and update their data that could then populate federal and state government databases and also be accessible for plans to download for their files. It could also make it easier for the federal government to track fraudulent providers. This could also reduce the number of people responsible for collecting and updating this data within the federal government.

MA and Part D Medical Loss Ratio (MLR) Reporting

In general, LeadingAge understands and supports CMS efforts to align MLR calculations across Medicare Advantage, Medicaid and Commercial insurance. However, we believe some proposals require additional consideration for their unintended impacts before being finalized.

- **Limit only provider incentive and bonus arrangements tied to clinical or quality improvement measures to be included in the MLR numerator**

  Plan flexibility is a key aspect of the Medicare Advantage program that allows plans to deliver care and services differently, to innovate, and to reduce unnecessary cost. While we favor greater transparency within the program, we are concerned that CMS's proposal to only permit plans to include incentive and bonus payments in the MLR numerator if they "are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers" may inadvertently exclude payment arrangements (e.g. shared savings) that are indirectly tied to quality outcomes or the delivery of quality care and largely championed by policymakers. For example, some of our provider-led MA/SNP plans enter into shared savings arrangements with providers. In these situations, the shared savings payment received by the provider may not be tied directly to a specific quality measure, such as reduced hospitalizations per 1000 lives. Nonetheless the plan is unlikely to achieve these savings without a provider making efforts to improve upon this metric. The way we read this proposed change is those arrangements would not be able to be counted in the MLR numerator. We think this is a mistake.

  In addition, for integrated D-SNP or Medicare-Medicaid Plans, some states require provider payment arrangements to be reviewed and approved by the states. In New York, for example, the

state has approved shared savings arrangements in addition to those payment arrangements directly tied to specific measures.

If this provision were to be implemented, it would hamper payment innovation and could result in a return to more FFS payments to providers. This would be detrimental to providers as today many of our SNFs and home health agencies are paid 20-50% less than Medicare FFS to provide the same complex care to MA enrollees and must endure substantially more administrative tasks imposed by the plans including frequent prior authorizations and concurrent reviews, and voluminous data submissions. Alternative payment arrangements could create an opportunity for providers to be paid for the additional work required and rewarded for improved care quality and transformation efforts.

Recommendation: LeadingAge encourages CMS not to finalize this proposal as written without revision to include a broader array of payment arrangements that either directly or indirectly tie to quality.

- **Exclude the administrative costs from quality improvement activities from the MLR numerator**

  While the proposal to exclude administrative costs for quality improving activities from the MLR numerator may appear to make sense, we are concerned that it would inadvertently exclude activities such as investments to support primary care medical homes, help providers initiate telehealth services, nurse call lines, provider and participant education, case conferences between the interdisciplinary team members. All of these investments can improve the experience of care and outcomes for the enrollee.

  Recommendation: LeadingAge encourages CMS to delay finalizing this proposal until it carefully reviews the definition of "administrative" costs related to quality improvement activities to ensure that investments detailed above are not excluded them from the MLR numerator. Excluding these activities from the MLR numerator may disincentivize these desired investments and activities.

- **Reporting on Provider Payment Arrangements**
  CMS proposes to require MAOs to report aggregate expenditures by provider payment arrangement type in MA as part of the MLR report in three categories ordered from lowest to highest financial accountability for providers: fee-for-service (FFS), Alternative Payment Models (APMs), and population-based payments. We agree that collecting this information further supports transparency and oversight activities related to these payment arrangements. However, we would note that many of these provider arrangements are already included in Part C reporting requirements and as part of plan bids.
  Recommendation: LeadingAge asks that CMS first evaluate why the existing information collected under the Part C reporting requirements and as part of plan bids is inadequate, and if necessary, revise the Part C reporting to reflect the missing information, instead of creating an additional and potentially duplicative reporting requirement.

Request for Information (RFI) on MLR Policies to Address Vertical Integration Concerns.

LeadingAge appreciates the opportunity to provide our perspective on future policies to address to vertical integration. Overall, we favor of efforts to ensure transparency in how taxpayer dollars are being spent in the MA program and that these dollars are directed to addressing MA enrollees' need for care and services to support their health, function and well-being. We understand policymakers are grappling with ways to address concerns about MAOs that are vertically integrated with providers, pharmacies

and other related health care entities and how premium dollars flow among these entities. However, we encourage CMS to methodically approach how to address these concerns by clearly identifying the specific issues they are trying to correct related to vertically integrated entities and the characteristics of those entities that they believe to be acting inappropriately before implementing any further policies.

LeadingAge members include non-profit and mission-minded aging services providers such as skilled nursing facilities and home health agencies and some of those providers have opted to establish their own MA and SNP plans because they believe they can improve outcomes for those they serve by managing both the care provided and the dollars allotted for that care. Therefore, these organizations, too, are to varying degrees are vertically integrated but their enrollment is small and often targeted to Medicare beneficiaries they serve as providers in their nursing homes, assisted living, affordable housing and home health agencies. Due to their smaller size any additional administrative burden/costs are spread over a smaller population and so we ask CMS to carefully consider the impact of future policies on smaller entities. We are concerned that if future policies are designed to inhibit practices of the larger, national plans or based upon an average, they may disproportionally impact smaller, provider-led plans and ultimately make them less able to compete. Less competition and fewer plan options does not serve the American taxpayer nor the beneficiary well.

We recognize policymakers concerns about payments being made by MAOs to related entities. We hope CMS will carefully craft any future payment arrangement limitations balancing accountability with flexibility and innovation that supports care delivery and funding transformation. Our provider-led plans report they enter into gain sharing and other value-based payment arrangements with their contracted providers. Many of these arrangements are tied to specific quality measure expectations but others reward providers for participating in administrative tasks like engaging with an interdisciplinary care team around the needs of an enrollee or for process measures such as timely completion of Model of Care training and health risk assessments so individualized care plans can be developed and executed quickly. Arguably, gain sharing or shared savings arrangements indirectly tie to quality outcomes and should be permitted. They often require less administrative burden to implement and yet expected savings targets are typically unachievable without providers engaging in appropriate care management, enrollee engagement and working to reduce unnecessary hospitalizations. In these cases, the specific quality metrics may not be tracked but the quality work must be done to achieve the shared savings payments. Other MAO provider payment arrangements are designated as “administrative” but support providers investments in infrastructure such as technology to assist in health information exchange, electronic health records and telehealth services, or support nurse call lines and provider education. These payments also support improved quality of care for enrollees. We think these arrangements should not be hampered by future policies.

As CMS evaluates its next policy steps, it should utilize existing and potential future data collection around the types of provider payment arrangements in MA. For example, what percentage of MAO provider payments are in each of these types of arrangements? Are vertically integrated MAOs only making favorable payments to their related entities and not other contracted providers?

Codifying Obligation of PACE Encounter Data Submission

The proposed rule seeks to codify the existing practice of requiring the collection and mandatory submission of risk adjustment data (in accordance with § 422.310) by PACE programs by adding a new paragraph at 42 CFR 460.180(b)(3)). Our understanding is that codifying this existing practice should not create any new requirements or make changes to payment for PACE programs. While we understand responsible data collection is a priority for CMS, we urge you to maintain consideration for the

administrative burden any additional data collection efforts place on providers. We also see that in the "Advanced Notice of Methodological Changes for CY2026 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies" that CMS proposes to use the risk adjustment data being collected under this proposed codification to initiate PACE organizations transition to a new risk adjustment model beginning in 2026.

Recommendation: We request CMS consider obtaining further stakeholder input from PACE organizations on this transition prior to finalizing it. Some of our PACE organizations do not share CMS's view that this data collection is already working well and for that reason beginning a risk adjustment model transition may be premature in 2026. The PACE model is unique and making it difficult to capture its nuances through traditional Medicare reporting structures.

Technical Changes to PACE Participant Rights Clarifying Nondiscrimination Requirements

LeadingAge recognizes these changes are intended to clarify participants' rights relative to the appropriate and timely treatment of their health conditions, ability to reach their highest level of functioning, and avoid discrimination on the basis of sexual orientation and gender identity. Understandably CMS sees these changes as minor and with little effect on PACE programs, we respectfully disagree.

LeadingAge, and our PACE members, support these changes in theory and concept. Operationally, PACE programs already meet the requirements for participants' access to appropriate emergency care if a need arises. Additionally, codifications of the PACE programs obligation to assure a participant has access to goods and services that support their highest practicable well-being appears to have nominal effect on PACE program operations and its participants. This concept is inherent in the ethos of PACE programs; arguably it is baked into the cake of financial incentives to keep participants healthy. Requirements for PACE programs to abide by the CMS nondiscrimination rule were already codified in 2024. CMS acknowledges these are small, insubstantial changes to participant rights, but fails to recognize that their implementation will result in significant administrative time and financial outlays by PACE programs. These "small" changes impose incommensurate burden on PACE programs requiring them to rework numerous materials such as participant rights posters, flyers, notices, and other policy documentation and obtain multiple rounds of approval, legal review, design reworking among other tasks. Given that the nondiscrimination rights are already finalized, cross reference could easily wait for a future schedule, as PACE organizations must already comply with these nondiscrimination rule updates. Our PACE members have said it feels like CMS is nickel and diming them on participant rights edits as they are constantly changing, but the underlying compassion toward participants and their rights to care and services remain largely the same.

Recommendation: Therefore, we suggest CMS not finalize these changes but instead adopt a regular schedule for implementing technical and other necessary updates, such as every four years to minimize the administrative burden on PACE programs.

Thank you again for the opportunity to share our perspective on your proposals for CY2026 MA policy changes. We appreciate your willingness to listen to our concerns, as well as our suggestions for improving the Medicare Advantage program. Please reach out if we can answer any questions related to our comments.

Sincerely,

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