Medicare Advantage: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192) – Request for Information

June 2025

On January 31, 2025, President Trump issued Executive Order 14192 "Unleashing Prosperity Through Deregulation" that stated in part that for each new regulation introduced, federal agencies must identify at least 10 prior regulations to be eliminated. In response, the Centers for Medicare & Medicaid Services (CMS) issued a Request for Information on April 11 to assist in identifying regulations that could be considered for elimination from the Medicare Program.

LeadingAge submitted deregulation recommendations covering regulations for home health and hospice, Medicare Advantage, nursing homes, and Programs of All-Inclusive Care for the Elderly (PACE). What follows below are the LeadingAge recommendations for deregulating, reducing the costs and administrative burden associated with the Medicare Advantage program through proposals to streamline, standardize, and simplify aspects of it, while also better aligning and coordinating it with Medicare regulations.

Streamline Regulatory Requirements

Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

LeadingAge recommends CMS codify a clarification on interrupted stays from a February 6, 2024 guidance that instructs Medicare Advantage (MA) plans to follow the Medicare interrupted stay policy and prohibits MA plans from requiring skilled nursing facilities (SNFs) to request another, duplicative prior authorization for a situation defined as an interrupted stay and therefore, part of the same episode of care.

Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

LeadingAge appreciates the opportunity to provide input on ways to reduce administrative burden in Medicare Advantage (MA). LeadingAge Skilled Nursing Facility (SNF) and Home

Health Agency (HHA) providers cite navigating the fragmented and duplicative administrative processes in the MA program for prior authorizations (PA), appeals, claims adjudication, and payment systems across plans as some of their most administratively and financially burdensome tasks. These processes, while intended to ensure program integrity, have become a significant source of administrative burden and cost for providers and plans alike—without improving patient outcomes and timely access to services.

Providers routinely contract with 3 to 10 MA plans, each with its own: prior authorization and concurrent review processes, appeals and documentation requirements, claims submission and payment systems and often use of third-party vendors (e.g., NaviHealth, Availity) to manage these tasks with varying rules. Despite CMS requiring all MA plans to follow Medicare Part A and B coverage criteria, the lack of standardization across plans leads to: duplicative work and delays in care, increased staffing costs for SNFs and HHAs (e.g. need to add full-time equivalent staff to manage the varied processes), payment denials and claw backs for services that were approved and provided; and billions in unnecessary administrative costs—estimated at $18 billion annually. Additionally, an April 2022 OIG report (OEI-09-18-00260) found that 18% of denied MA provider payment requests met Medicare coverage rules and the MAO's own billing rules, yet providers were forced to resubmit documentation to receive payment.

LeadingAge encourages CMS to streamline claims payment processes in MA by waiving or modifying current requirements that allow each MA plan to maintain its own administrative infrastructure and instead:

1. **Create a centralized payment and claims portal** that:
    - Uses existing Medicare coverage criteria for A and B services
    - Standardizes the information requested the required documentation and submission formats
    - Allows CMS to monitor MA plan payments, denials, and recoupments
    - Provides real-time access to decision rationales
2. **Enhance encounter claims data** to collect additional data points to create a more robust picture of amounts paid to, denied, and recouped from providers by MA plans; and more service-level detail for oversight and audit purposes
3. **Enable MedPAC to assess provider payment adequacy** in MA using this enhanced encounter claims data—just as it does for original Medicare.

Benefits of Streamlining These Requirements

- Reduces administrative burden on providers and plans through a uniform process

- Improves payment accuracy and timeliness as it is tied to Medicare requirements
- Centralizes payment data to enhance CMS oversight and enforcement
- Enhances transparency into MA plan behavior and provider sustainability
- Preserves beneficiary access to high-quality Medicare services

CMS has a clear opportunity to reduce administrative burden without compromising program integrity by standardizing and centralizing MA administrative processes. A single, CMS-managed portal for claims and payments—paired with enhanced data collection—would streamline operations, improve transparency, and ensure that MA delivers value to beneficiaries and taxpayers alike.

Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?

Over half of Medicare beneficiaries are enrolled in Medicare Advantage (MA)with an average of 43 plans available per county. Providers must contract with and navigate the unique prior authorization (PA), concurrent review (CR), and claims processes of multiple MA plans. These processes vary widely and, even within plans, often lack consistency—requests and plan responses are communicated via an array of channels including plan-specific portals, email, fax, or phone—and often result in delays, duplicative reviews, and administrative errors. Due to the nature of Skilled Nursing Facility (SNF) and Home Health Agency (HHA)services, the quantity of these requests is substantial.

Establish Single, Standardized Prior Authorization Portal Across All MA Plans

Over half of Medicare beneficiaries now receive services through MA plans, with an average of 43 plans available per county. Providers contract with and navigate the unique PA, CR, and claims processes of multiple MA plans. These processes vary widely and often lack consistency within plans—requiring submissions and delivering responses via an array of channels including plan-specific portals, email, fax, or phone—and often result in delays, duplicative reviews, and administrative errors. A transparent, standardized approach could reduce back-and-forth communications between plans and providers, speeding up decision making.

Current plan processes are denying post-acute care (PAC) services at much higher rates than all other services according to the 2024 Senate "Refusal of Recovery" report and a January 2025 KFF report notes 81.7% of appealed denials are overturned suggesting many denials are unjustified or due to documentation issues. An April 2022 OIG report on MA supports this

conclusion. Delays leave patients without medically necessary care and burden hospitals who are unable to discharge patients because the next site of service has not been authorized.

The current approach adds administrative burden and costs to providers and plans. SNFs and HHAs report needing to add highly qualified full-time equivalent staff solely to manage the myriad submissions and processes, further driving down provider operating margins. Initial PAs do not cover the full duration of required SNF or HHA services. Each admitted SNF patient requires 2-8 subsequent CR requests for the course of treatment to continue. HHAs report reauthorization requests take as much as one week to be approved after the initial PA, disrupting continuity of care because patients forgo care due to lack funds to cover these services if not covered by their plan. The current system isn't working –it increases costs, often is non-compliant with the rules, and delays or disrupts needed care.

Recommendations: We advocate for the implementation of a single, standardized PA portal and process across all MA plans. Such a system would reduce administrative cost and complexity, centralize PA and CR data collection increasing transparency and compliance, prevent records and decisions from being lost, and improve timely care delivery while aligning with CMS's regulatory goals. We ask CMS to:

- Establish a standardize set of criteria that all plans use for prior authorizations and another set for concurrent reviews that align with Medicare clinical coverage criteria (as required by the current MA rules). Also, identify the required supporting documentation for each.
- Implement a single portal or Application Programming Interface (API) following the parameters outlined in CMS-0057-F for a PA API to be used by all providers and MA plans based off of the standardized criteria. Functionally, the portals should allow providers to check if a PA is required, submit PA and concurrent review requests from their EHRs using the portal/API, check status, and receive a plan response/determination. Plan decisions on the PAs and CRs should also be saved here for future reference for pursuing payment. In turn, CMS could then eliminate the requirement for each plan to develop their own PA API under CMS-0057-F reducing administrative burden and costs on the plans.
- Require plans to obtain approval of any internal coverage criteria, as its use should be rare. This approach would ensure appropriate interpretation of and compliance with Medicare regulations.

Taking the above actions could achieve multiple goals identified by this Request for Information:

- Reduce provider administrative burden and cost by providing a consistent format and a single portal for submitting requests and ease of submitting supporting documentation directly from a patient's electronic health record (EHR).
- Eliminate certain MA plan costs and regulatory requirements including the need to separately report this data to CMS under various regulations and data collection initiatives as it would be housed in a single portal accessible by CMS. It would also eliminate the need for each MA plan to develop its own PA API under CMS-0057-F.
- Facilitate faster plan responses through standard format making key information easily accessible, enabling potential automation of request and document reviews.
- Improve MA plan compliance with Medicare A/B coverage criteria through built-in system rules, increasing first-time PA approvals, reducing review volume, appeals, and overall costs for plans and providers.
- Enhance data transparency by centralizing all PA data, creating a longitudinal record that enables faster CR request reviews through access to prior documentation**.**
- Enable more efficient CMS oversight by providing access to centralized PA data, and ability to conduct AI-driven analysis to identify trends in denials, approvals, appeals, and enforcement needs.

Establish presumptive eligibility for initiating PAC services when physician certified need established.

To reduce prior authorization (PA) volume and administrative burden, CMS could adopt a presumptive eligibility model for PAC services. Under this approach, when a physician certifies the need for PAC, providers would be allowed to initiate services without an initial PA for a defined period tailored to each PAC setting.

This initial period would:

- Authorize service delivery and reimbursement.
- Align with the time needed to admit and stabilize the patient.
- Allow completion of Medicare-required assessments.

At the end of this period, a single concurrent review—based on updated assessments and patient progress—would determine authorization for continued care.

This approach is akin to UnitedHealthcare's recent policy for outpatient therapy, which allows a pre-determined level of services before requiring PA. CMS could implement a similar standard for PAC, enabling timely care while maintaining oversight.

Recommended Initial Periods by Setting:

- **Skilled Nursing Facilities (SNFs):** Minimum of 7 days to allow patient acclimation, therapy initiation, clinical monitoring (e.g., drug interactions), and completion of initial assessments.

- **Home Health Agencies (HHAs):** Minimum of 12 visits to support timely initiation of therapy, nursing care, and OASIS assessments for safe home transitions.

This approach would streamline access to care, reduce delays, and lower administrative costs for both providers and plans, while preserving CMS's ability to monitor and manage utilization through a structured review process.

Prior Authorizations Should be Tied to Service, Not Specific Provider.

Currently, MA prior authorizations (PAs) for post-acute care (PAC) are issued for a specific provider rather than the service itself. If the authorized provider becomes unavailable—often due to delays in plan approval—a new PA must be submitted for another provider offering the same service. This creates unnecessary administrative burden, delays patient care, and contributes to hospital discharge bottlenecks.

To streamline care and reduce delays, MA PAs should authorize the service, not the provider. Once medical necessity is confirmed, patients should be able to use the PA with any eligible provider (e.g., in-network for HMOs, any provider for PPOs). This approach would:

- Eliminate redundant PA requests.
- Accelerate initiation of PAC services.
- Reduce administrative workload for plans and providers.
- Improve hospital throughput by enabling faster discharges.
- Empower patients to choose from available providers once a PA is approved.

By focusing PAs on clinical appropriateness rather than provider assignment, CMS can reduce system inefficiencies and improve patient timely access to care.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

MA Payments to Providers Must Be Faster and Patient Cost Share Data Accessible More Timely

LeadingAge urges CMS to address the disproportionate administrative and financial burdens Medicare Advantage (MA) plans place on post-acute care providers. MA plan delays and

excessive post-payment reviews and recoupments are negatively impacting provider bottom lines.

MA plans are allowed up to 60 days to process clean claims—more than four times longer than original Medicare's 14-day window. These delays are compounded by high rates of wrongful denials, and one national plan conducts post-payment review of nearly every SNF claim even when a PA approval was received. A June 2025 Health Affairs article found 17% of initial claims are denied, with most later reversed, resulting in a 7% net revenue loss for providers. Premier, Inc. estimates these inefficiencies cost providers $18 billion annually. Medicare provider and MA plan costs could be reduced and their margins improved by shortening the amount of time to process clean claims and as the Office of Inspector General recommended by CMS directing MAOs to "identify and address vulnerabilities that lead to manual review errors and system errors."

Reimbursement rates under MA are also significantly lower. CLA's 39th SNF Cost Comparison Report shows over 49% of SNFs operate at a loss. HHAs report all-payer margins of -2.1%, with their MA margins at -47.11%. These financial pressures are unsustainable.

Additionally, providers often lack real-time access to patient cost-sharing information, making it difficult to collect co-pays and coinsurance after discharge. A centralized benefits portal or API would enable providers to access this data at the point of care, improving reimbursement and reducing administrative burden.

We urge CMS to shorten MA claim processing timelines to align with original Medicare, enforce stricter oversight of denial practices as recommended by the OIG, and require real-time cost-sharing transparency. These steps would reduce unnecessary costs and support the financial viability of PAC providers.

Reducing Provider Burden of Inappropriate MA Payment Denials and Recoupments

PAC providers spend considerable time defending post-payment reviews by MA plans and fighting to have recoupments returned. In theory, MA plans are only permitted to re-open a claim if there are indications of fraud or for "good cause", but SNF and HHA providers encounter plans revisiting paid claims often and sometimes years later even when the services were pre-approved. CMS clarified in this FAQ document on the 2024 MA Final rule (CMS-4208-F), that " § 422.138(c) states that if an MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at 42 CFR § 405.986) or if there is reliable evidence of fraud or similar fault per the reopening provisions at §

422.616." One Wisconsin SNF reports a 3.5-foot stack of claim denials requiring their finance staff to defend by resubmitting documentation triggered by these reviews. When MA plans challenge payments, it allows them to further delay or recoup payments from providers sometimes even years later. One national MA plan has a reputation among PAC providers as initially denying or recouping payments for nearly every claim. When providers can afford the staff and time resources to challenge these denials, they typically win. However, those that cannot afford to challenge these denials abandon the claim and take the loss. According to a Premier article, "70% of denials were ultimately overturned and the claims paid but only after multiple, costly rounds of review." Premier estimates providers incur $18 billion in avoidable costs. This excessive administrative and financial burden must be reined in.

To reduce this unnecessary and excessive burden and cost to providers, we suggest that MA plans be limited to conducting an audit of only a limited sample of provider claims. If the provider sample shows they are largely compliant and appropriate payments, no further action should be taken unless there is evidence of fraud. If there is a pattern of errors, then further review would be appropriate.

Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.

Streamline Provider Data Reporting and Plan Credentialing

We think CMS should revisit the idea of instituting a National Provider Directory (NPD), which could serve as a single source of truth on Medicare and Medicaid providers. Today, providers must update organizational data in numerous CMS websites and complete repetitive credentialing processes for multiple Medicare Advantage Organizations (MAOs). An NPD could reduce the administrative burden on providers by only requiring them to enter and update their organizational information including documentation of their Medicare certification and Medicaid licensure in one place – the NPD. Once implemented, MAOs could use the NPD to create and update their provider directories by using a single national provider identifier (NPI) linked in the NPD resulting in more timely updates and greater accuracy. The NPD would also allow CMS to repeal the MA credentialing requirements. CMS could use data in the NPD to root out fraud, waste and abuse as all provider information would be housed in a single location. Technology could be used to identify providers using the same address for multiple licenses, cross check claims submissions, etc. SNFs must enter their information into the Provider Enrollment, Chain and Ownership System (PECOS) on form CMS- 855A and maintain data in Automated Survey Processing Environment (ASPEN). In addition, providers must also report data to states and to MAOs. It would be more efficient to house this information in one place that can be accessed by the federal and state governments and in the case of provider credentialing, used by MAOs.

Identification of Duplicative Requirements

Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

Assessments: Medicare regulations require each provider type to conduct a specific assessment as part of their licensure and Medicare conditions of participation. Medicare Advantage (MA) rules require plans to conduct health risk assessments. If an individual is a dual eligible, they may have an assessment as a Medicaid beneficiary and as a MA enrollee. We would encourage CMS to examine if and how these assessments overlap, ask beneficiaries the same questions or could be coordinated or revised to be more effective. Some MA plans defer to their internal assessments for what services they will cover and to determine the level of provider payment, even when it contradicts an in-person assessment conducted by a provider delivering current

PAC services. This duplication underscores the need for this information to be shared between plans and providers to improve beneficiary outcomes and reduce system costs.

Quality metrics: While certain performance measures may be unique to a particular program, provider or plan type, we could benefit from more uniformity in some core metrics that are tracked across programs, providers and plans. These metrics should not only be uniform in name but also have the same definitions used across original Medicare and MA. This will help policymakers better assess and compare outcomes and value delivered between MA and original Medicare programs.

How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

Improved Coordination Between CMS Divisions Needed to Align MA Payments with Provider Compliance Requirements. Medicare providers are integral to the efficacy of the Medicare Advantage (MA) program and outcomes for MA enrollees, and yet, the two divisions of CMS that regulate and provide oversight to MA plans and providers show no sign of coordination. Additionally, it is often suggested that MA plans pay providers less due to provider inefficiencies. However, the reality is that providers face fixed regulatory costs that are essential to delivering safe, high-quality care. These include:

- Mandatory assessments (e.g., MDS, OASIS)
- Minimum staffing levels to meet patient needs
- Staff training and competency requirements
- Quality measure reporting
- Infrastructure and facility-based fixed costs
- Ongoing regulatory compliance

These obligations are enforced by the division of CMS that certifies and surveys Medicare providers—such as Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs)—to ensure compliance with the conditions and rules of participation.

While MA Organizations (MAOs) have greater flexibility in how they deliver and pay for care, they do not have the authority to waive these federal regulations for providers. This creates a disconnect: CMS aims to reduce the cost of care, but it must also account for the cost of ensuring that care meets federal standards. Lower payments do not necessarily reflect greater efficiency—they may simply reflect underpayment for mandated services. Currently, MAOs are

reimbursing providers at rates 20–50% lower than traditional Medicare for the same services, while adding substantial administrative burden to providers. This trend threatens providers' ability to maintain adequate staffing and deliver high-quality care.

The CMS division that regulates MA plans is separate from the division that regulates Medicare providers such as SNFs and HHAs. MA program staff have acknowledged limited familiarity with the regulatory obligations providers must meet. Better coordination between these two branches of CMS would help in identifying policies that are at cross purposes and undermine care delivery and provider financial sustainability.

For example, providers are required to abide by Medicare regulations like completing CMS-prescribed assessments (e.g., MDS, OASIS) but some MA plans disregard the results of these assessments including the identified resource needs and corresponding payment level.

Another regulation requires SNFs to ensure safe discharges (42 CFR § 483.21(c)), which makes sense in traditional Medicare where the SNFs make the decision, in conjunction with the patient and their family, on when to discharge. In contrast, MA plans do not have a specific regulatory obligation for safe discharges, when they are the ones who terminate SNF services. This places SNFs in a difficult situation: they must abide by the safe discharge requirements but won't be paid when the plan decides to terminate services if they feel the person is not ready to discharge and care continues. This seems unfair. In these instances, this disconnect can lead to dangerous outcomes. In one case, an MA plan terminated SNF services for a woman. She opted to pay to receive a few additional days of SNF services out of her own pocket as she, her husband, and care team agreed she was not yet ready to return home even though the plan disagreed even upon appeal. Once discharged, she was unable to get home health services initiated timely because it was over the holidays. Regrettably, there was an incident during this time. She fell and her elderly spouse had to call the fire department for help as he was unable to lift her from the floor.

To prevent such outcomes and ensure fair, sustainable care delivery, CMS should look for ways to improve coordination between the MA and provider regulatory oversight divisions. Greater alignment and mutual understanding of regulatory requirements—especially conditions and rules of participation—are essential to creating policies that support both cost control and quality care for Medicare services.

How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

- In the LeadingAge 2017 white paper "Integrated Service Delivery: A LeadingAge Vision for America's Aging Population," we offer the core elements that have proven to work in creating effective integrated service models including: a single point of contact to help navigate and facilitate care for an individual, a single assessment and individualized service plan that is site agnostic, and pooled funding with risk sharing. We provide examples of providers who have successfully implemented such models. Of course, disease prevention through healthy choices and chronic condition management are both critical. Timely initiation of hospice and palliative care can reduce end of life care costs and preserve quality of life. Data sharing and interoperability across the health care delivery and payment systems are essential.

- We also encourage CMS to look at the recommendations on how to better engage long term care providers in value-based care models like Accountable Care Organizations. These recommendations were developed by a broad group of provider groups and the National Associations of ACOs (NAACOs). We believe we've identified some key improvements that could make nursing home resident attribution in ACOs more effective in improving outcomes and lowering costs while creating financial incentives for all the providers participating in coordinating and delivering care to these older adults.

Additional Recommendations

We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.