Fulfilling the Promise:

MEDICARE ADVANTAGE

Policies to Support Providers and Ensure Beneficiaries' Equitable Access to Needed Post-Acute Services

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LeadingAge®

Summary

One in five Medicare beneficiaries discharged from a hospital will need post-acute care. Those with Medicare Advantage (MA) plans (rather than traditional or fee-for-service [FFS] Medicare) may run into significant challenges in trying to access post-acute care (PAC). Many find they cannot get the care they need; as a result, they may use more hospital and outpatient care and prolong the episode. Policymakers must attend to the details of how MA plans contract with providers, pay for care, and determine quality; similarly, consumers must receive clear information about their PAC coverage before they enroll in MA plans. Today, nearly half of Medicare beneficiaries have opted to enroll in MA plans and with the rapid aging of the population, the number of MA enrollees will continue to rise. Medicare beneficiaries deserve clear, unbiased information about MA plans so they can make informed choices. The PAC providers who serve them deserve transparent, fair relationships with MA plans. We can do better.

This paper describes the most difficult challenges providers face in assuring beneficiaries access to top quality care and outlines a set of actions the Centers for Medicare & Medicaid Services (CMS) should take to address these problems. Solutions include:

1. Make payment rates adequate and predictable.
2. Understand and address challenges with prior authorizations (PAs).
3. Bring the vision of high-quality care closer to routine practice by making value-based arrangements workable.
4. Give beneficiaries a true choice of high-quality providers by addressing network adequacy.
5. Address transparency concerns by improving data collection and sharing.
6. Actively support beneficiary needs and rights.

LeadingAge believes most of this could be achieved administratively, though a few elements will require legislative action. If CMS is unable to achieve the administrative changes, we suggest to improve the MA program, Congress must take steps on those program modifications as well.

Introduction

As of January 2023, MA enrollment represented 29.5 million Americans, 46% of all Medicare beneficiaries on average nationally, but within regions across the country rates are much higher. In 14 states and Puerto Rico, 50% or more of Medicare beneficiaries are enrolled in MA plans in 2023.[1] The Congressional Budget Office projects that by 2032 the share of Medicare beneficiaries enrolled in MA plans will rise to 61%. As of 2023, 3,998 MA plans are being offered but enrollment is concentrated in just a few plans—84% of MA beneficiaries are served by just seven Medicare Advantage Organizations (MAOs) and 46% of all enrollees are in either a Humana or United Healthcare plan nationally. People eligible for Medicare choose MA plans for a variety of reasons, including individual plans that offer supplemental benefits such as dental, hearing, vision, and reduced cost sharing (i.e., co-pays). Another 18% of MA enrollees are in employer- or union-sponsored group MA plans. CMS pays more for Medicare coverage provided through MA plans (estimated to be 104% according to MedPAC) than fee-for-service Medicare (FFS). The reality is that when MA doesn't work, there are ripple effects not only for the Medicare program but the entire health care system.

[1] CMS MA State/County Penetration, January 2023

In this paper, LeadingAge offers a set of solutions to improve the MA program, so it better serves older adults who use post-acute care services and works more effectively for the provider organizations that deliver these services. LeadingAge represents more than 5,000 nonprofit aging services providers and other mission-minded organizations. A LeadingAge letter to CMS in August 2022, plus comments submitted in February 2023 on the CY2024 proposed policy and technical rules, expand on these points and provide examples.

The following sections represent the topline barriers and challenges providers face when they try to deliver the best-quality, most efficient care to MA enrollees.

Contracting

MA plans contract with health care providers for services. The plans largely control who is in their networks and the nature of the contracts. Section 1854 (6)(B)(iii) of the Social Security Act states that, "In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part." The intent of this provision is to promote competition. However, it was drafted in a time when MA comprised only a small fraction of the marketplace. It is out of step with current developments and enrollment patterns and needs to be amended to ensure adequate provider payments and beneficiary access to high quality providers. It is this provision in law that prevents CMS from intervening in provider-plan contractual arrangements, setting a provider rate adequacy floor and even establishing quality criteria for provider networks.

In addition, MA enrollees seeking PAC services face several financing, access, and quality challenges that are rooted in contracting policies and procedures.

Payments don't always cover costs but providers in some markets have no meaningful choice about whether to participate. Low provider payment is the number one concern of LeadingAge members including skilled nursing facilities (SNF), home health agencies (HHAs), and hospice organizations.[2] They have watched their payments from MA plans diminish in the past 5-10 years at the same time enrollment in MA has grown 21% over the past 10 years.

MedPAC assumes that providers accept these contracts because payments from MA plans are adequate.[3] This does not reflect the reality providers face in many markets where they have no choice but to contract because the MA plan enrollment represents 50% or more of all beneficiaries. In some cases, a single plan controls more than 50% of the market. Choosing not to contract would result in

[2]Hospice organizations currently only participate in the Medicare Advantage program through the Value-Based Insurance Design (VBID) demonstration at the Center for Medicare and Medicaid Innovation (CMMI). They are already experiencing issues with contracting for payment in this demonstration and are concerned that their futures will resemble what our SNF and HHA members are currently experiencing.

[3] Skilled nursing facility services: Assessing payment adequacy and updating payments, MedPAC, March 2022 https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch7_SEC.pdf

insufficient service volume, so they sign contracts with inadequate payment terms, creating a financial death spiral.

For example, one SNF reports that it is paid a flat rate (75% of typical Medicare FFS payment) by the plan regardless of the patient's acuity. Another SNF indicated that it is expected to accept MA rates equal to the state Medicaid rates, which experts agree don't begin to cover the costs of that custodial care, let alone the more intense skilled care provided through SNFs and HHAs. This SNF is a preferred referral partner for the large hospital system in its area because it is a high-quality, 24/7 responsive provider and helps patients return home safely and quickly. The plan refused to consider increasing the provider's proposed rate and instead pursued contracting with less sophisticated SNF providers.

Even when contract terms appear more reasonable, plans sometimes find ways to skirt contract provisions. For example, a contract may offer tiered rates based on acuity, but the plan never approves payment beyond the lowest tier. Another contract indicates it will pay when an individual's IV antibiotic cost exceeds $100/day. However, the patient is prescribed two medications for this purpose totaling $150/day and because each medication is less than $100, the provider isn't reimbursed to cover their actual costs. HHAs are regularly paid per home health (HH) visit by MA plans rather than for a 30-day episode of care, as is the case in Medicare FFS, where the HHA determines the number of visits necessary to achieve the enrollee's goals within the episodic payment.

Plans reduce their overall costs in three key ways: 1) pay less for each unit of service (e.g., days, visits); 2) authorize fewer units of services; and 3) categorize an enrollee at a lower level of care than the enrollee's assessment indicates resulting in a lower provider unit payment. These are not value-based contracting terms that drive quality care, but merely mechanisms to pay providers less, generating profits for the plan.

Challenges collecting co-payments and co-insurance. Post-acute care (PAC) payments are further reduced since providers have difficulty collecting the co-payments and co-insurance that the plans charge their enrollees. These co-pays vary by plan and service provided, so it is difficult to pre-collect these amounts. PAC providers are forced to chase patients for payment long after the services have ended and often write off bad debt due to co-payments and co-insurance that MA enrollees don't pay.

MA rate increases are not passed on to contract providers. MA plan payments from CMS will have grown more than 13% between 2021 and 2023. However, no similar rate increases have been passed along to the providers who deliver the care to the beneficiaries enrolled in these plans. Some provider contract rates have remained unchanged for more than a decade, while costs have continued to rise. The pandemic especially escalated costs for staffing, food, and infection control supplies.

Lack of quality standards for selecting which providers plans contract with. MAOs are required to ensure adequate numbers of providers by type in their networks. CMS establishes time and distance standards that a plan must meet to ensure that 85-90% of enrollees have access to certain providers. Among MA enrollees, 58% are enrolled in an HMO, limiting their care to in-network providers.[4]

[4] Medicare Advantage 2023 Spotlight: First Look, KFF, November 10, 2022 accessed at: https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look

However, there is no quality threshold that must be met. LeadingAge PAC providers raise these concerns about MA networks: 1) smaller providers are increasingly excluded from networks as the plan feels it is more efficient to contract with large provider groups; 2) high-quality providers who refuse financially unsustainable contract terms are being replaced with lower-quality providers;[5] and 3) regulatory changes made in CY2021 allow for less provider access in rural areas. The cumulative result is that MA enrollees have fewer options and less access to high-quality providers. This is a trade-off that MA enrollees are often not aware of until they need to access these services.

Potential conflicts when providers offer their own plans. Some PAC providers are establishing their own Special Needs Plans (SNPs) to better meet residents' and clients' needs and to improve their organization's financial sustainability. However, some MA plans require providers to contract with an MAO for all products – Commercial, Medicaid, Medicare, etc., including the MA plan's own SNP. For institutional SNPs (ISNPs), this means the provider's ISNP must compete with the MAO's ISNP to enroll the provider's nursing home residents. Further, providers who must contract with an MAO's Medicaid managed care business line are forced to contract also with its MA product even if the rates are extremely low. This practice may well violate anti-trust regulations, but providers are reluctant to fight for fear of retribution as well as concern for costly legal battles.

Beneficiary Access to Services

Medicare Advantage PA requirements often mean delays or denials for MA enrollees attempting to access essential care that would have been covered under Medicare FFS.

Too many unnecessary delays in accessing needed care. According to a JAMA article in October 2022,[6] 99% of MA enrollees are in plans that require PAs for some services. While assuring that services provided are effective and needed is a worthy goal, the PA process is often riddled with problems. An April 2022 Office of Inspector General (OIG) report[7] found that MAOs sometimes delayed or denied MA enrollees access to services, even though the requests met Medicare coverage rules. Most were the result of human error (misplacing submitted documentation or system software programmed incorrectly). OIG also reports that MAOs overturned about 75% of their own PA denials on appeal. Unfortunately, MA enrollees often don't appeal because they are concerned about being stuck with the bill if the appeal is denied and feel ill-equipped to challenge the rules. In one case, a frail, hospitalized 92-year-old woman was ready for discharge but still required help to get out of bed. The doctor believed she could benefit from PAC SNF rehabilitation. However, he decided to abandon his referral because plan PA determinations take too long—extending the hospital stay—and he believed the plan would ultimately deny coverage for the service even when warranted. They concluded the delay would be bad for the patient and gave up on the PA request. Prior authorization delays prevent timely access to medically necessary care.

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[5] Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared to Fee-For Service Enrollees: https://pubmed.ncbi.nlm.nih.gov/29309215/

[6] "Improving Prior Authorization in Medicare Advantage," Journal of the American Medical Association, October 2022 as accessed at: https://jamanetwork.com/journals/jama/article-abstract/2797197

[7] Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," Office of the Inspector General, April 27, 2022, as accessed at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

Too much process, more paperwork than needed. To obtain PAs for initial or continued PAC services, providers must submit reams of documentation, in different formats, composition, and methods for the various MA plans. The timeframes for receiving the necessary PA from the MAO can vary from one day to 30 days. This timeline extends further when requests are made over weekends and holidays because many plans don't staff their PA processes seven days a week even though care is still needed. If coverage is denied, the appeals process adds additional waiting time. The impact is that the MA enrollee is hospitalized for a longer time before initiating skilled care, rehabilitation services, or home health care. If a PAC provider accepts the patient while authorization is pending, the provider must issue a Notice of Medicare Non-Coverage to the beneficiary because it is unknown whether the service will be covered by the plan. This puts both the provider and the beneficiary in financial jeopardy.

When approvals are granted, they are often for only a short duration (e.g., two HH visits or five to seven SNF days) and the provider must again submit reams of documentation to receive authorization to continue needed services. There is no standardization across forms, information required, formats, or means of transmission among plans. LeadingAge SNF and HH providers are increasingly seeing denials for needed PAC services ordered by physicians discharging patients from the hospital—services that would be provided under Medicare FFS. Prior authorization processes place significant ethical and administrative burdens on providers, and stresses and costs on beneficiaries.

Payment and Claims Processing

Payments are late, and there is no appeals mechanism for unpaid claims. Once services have been authorized and provided, the next challenge for providers is getting the claims processed and paid. Providers report that they can bill a claim one month and have it denied, but next month submit a claim the same way and it is paid. Often, denials seem random. Denied claims require repeated calls to the plan to resolve and hours on hold. Some PAC providers note that clean claims are not paid in a timely way. Unlike Medicare FFS claims which must pay within 14 days of a clean claim, one provider indicated that MA plans are taking six to eight weeks to pay a clean claim submission. MA regulations require MA plans to pay clean claims from in-network providers within 30 days of receipt or pay interest on the claim to the provider; and pay non-contracted providers within 60 days. Unfortunately, there is no recourse or process for providers when MAOs fail to meet this requirement.

MA plans audit claims and PAs after the fact and take back payments, sometimes years later. PAC providers report that plans refuse to pay for some pre-authorized services or in other cases, pay but then, upon audit, require the provider to return payment for services appropriately authorized. Sometimes these recoupments of payment occur years after the service was delivered. One provider had a plan take back a payment five years after the service was authorized and the claim paid. In contrast, Medicare auditors are limited to three calendar years. Providers can appeal, and often win, but this significantly delays final receipt of payment and uses costly staff time— yet another huge administrative burden. One provider reports a four-foot stack of full or partial payment denials, following audit, that staff must go through and prove (for a second time) that the claim should be paid for a service rendered. Providers have little recourse and often give up because they don't have the resources to repeatedly pursue claims.

OIG has recommended that CMS enhance its oversight of denials and appeals and provide that information to MA enrollees. The April 2022 OIG report found MAOs denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Further, the OIG notes that in 2018 MAOs denied 56.2 million payment requests overall (9.5%) in the MA program. Medicare beneficiaries should receive the care they need, and providers should be paid to provide it in predictable, fair, and straightforward ways.

Third party management of post-acute care does not always align with beneficiaries' best interests. MA plans are increasingly using third parties (PAC management companies) to manage post-acute services. While there is nothing inherently wrong with contracting out for specialized expertise, the incentives for these contractors should align with beneficiaries' best interests, not simply cost savings for the plan. MA plans provide incentives to these contractors to reduce the use of post-acute care.

Some of these contractors use generalized data or algorithms to determine the need for and duration of care for an MA enrollee instead of the enrollee's specific circumstances. They also are increasingly challenging providers' in-person patient assessments and requiring them to downgrade the patients' level of care or the provider risks not being paid. MAOs have other tools to reduce costs such as use of their three-day stay waiver or encouraging more community admissions to HH to stabilize individuals with chronic conditions to avoid unnecessary hospitalizations. Instead, often the approach is just to eliminate SNF or HH use and shift the care burden to the individual or family members.

Beneficiaries don't typically know what they are getting into when they choose MA. Many Medicare beneficiaries do not understand the difference between traditional Medicare (FFS), Medicare Advantage, and a Medicare supplemental plan and what the pros and cons of each may be. Providers indicate that some beneficiaries think they have signed up for Medicare Supplemental Insurance and don't understand that they have co-pays and co-insurance, or that the plan must approve certain services and the beneficiary can only access a limited provider network. Many beneficiaries read the MA marketing materials and are attracted by the additional benefits described but do not grasp the nature of MA plans. Therefore, hospitals, SNFs, and HHAs end up being the educators on benefits and coverage when beneficiaries are in precarious circumstances. This responsibility seems misplaced and ill-timed.

MA plans should be required to explain PAC coverage to all MA plan enrollees or their Power of Attorneys before enrollees transition to post-acute care. The Senate Finance Committee issued a report on November 3, 2022 on deceptive MA marketing practices, noting that complaints doubled between 2021 and 2022, including some about Medicare beneficiaries being enrolled into MA plans for which their current providers are not in-network. We are pleased CMS's CY2024 proposed rules for MA plans (CMS-4201-P) takes strides to remedy these practices, and ensure beneficiaries receive individualized information about how their MA plan choices can impact their access to providers and services.

The Bottom Line

As a result of these contracting, access, quality, payment, and consumer information shortcomings, MA enrollees are not able to obtain the benefits they think they signed up for, especially troublesome when they are in crisis and need post-acute care.

The cumulative consequences of these concerns are that MA enrollees are often denied needed services unless they pay out of pocket (which isn't an option for many families), have limited choices of providers that may best fit their needs, and often don't realize this until they have an immediate need for post-acute care. These enrollees are often denied basic Medicare post-acute services, resulting in unnecessary rehospitalizations. The net effect for PAC providers is that low payment rates, extreme administrative burdens, increased costs, and frequent denials of needed care jeopardizes their continued existence and quality of care, which impacts the entire health care system. With limited provider networks, access to high-quality care—particularly in rural areas—is shrinking.

While MA plans were held harmless for quality ratings during the pandemic, quality ratings have now been reinstated. In 2023, the number of plans with at least four stars has dropped by 16%. Only 51% of plans are now at or above four stars, down from 67%. Overall, plan performance declined slightly on several measures, but the biggest performance changes showed more members choosing to leave the plan, having challenges getting appointments and care quickly, or getting needed care.[8]

Recommendations: Beneficiaries Deserve Better

In this section, we offer immediate administrative actions HHS/CMS could take to address the barriers described earlier in this paper and improve access to post-acute care for MA beneficiaries and better value for the taxpayers who foot the bill for the Medicare program. For more details, LeadingAge provided detailed recommendations to CMS with specific examples of problems and potential solutions.

1. MAKE PAYMENT RATES ADEQUATE AND PREDICTABLE.

1A. Establish a rate floor: Congress must amend the non-interference clause to permit this action and instruct the HHS Secretary to establish a rate floor that plans must pay unless the plan can negotiate a pay-for-performance or other value-based arrangement (VBA) with the provider. CMS could ensure rate adequacy by establishing Medicare FFS rates as the floor for payment. Plans would either pay that rate or negotiate a VBA that is advantageous for the plan and the provider.

1B. Pre-authorized services must be paid without further documentation unless fraud is suspected. CMS proposes such a provision in its CY2024 rule (CMS-4201-P) requiring plans to pay for services that receive prior approval for medical necessity unless there is suspected fraud.

[8] https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings

1C. Limit number of audits plans can initiate and the lookback period. Medicare FFS allows for a sample of claims to be audited and the lookback period for these audits is also limited.[9] CMS should establish similar guardrails for MA plans to follow regarding provider payments to ensure greater predictability and reduce administrative burden on providers. Auditors—whether in the FFS program or in the MA program—should also be held to the same timeliness standards that providers are held to.

1D. Prohibit plans from requiring providers to downgrade to a lower level of care than indicated by assessment to be paid. Providers conduct required assessments for all Medicare beneficiaries to determine the level of their PAC needs and the corresponding payment. Some plans instruct PAC providers to submit a claim for a lower level of care than the assessment indicates and tell the provider they will not be paid if they submit a claim at the assessed level.

2. UNDERSTAND AND ADDRESS CHALLENGES WITH PRIOR AUTHORIZATION TO ENSURE BENEFICIARIES RECEIVE THE CARE THEY NEED.

2A. Create a single portal and/or standardized PA form for traditional Medicare A & B benefits that all MA plans must use to achieve uniformity, consistency, and simplicity. A standardized form or single portal offers three key benefits: 1) it ensures plans are complying with traditional Medicare coverage determination requirements; 2) it reduces administrative burden on providers by eliminating a multitude of forms and processes; and 3) it could expedite the review process at the plan level as critical information would be provided in a uniform format making it easier for a plan reviewer to confirm coverage criteria are met. Implementing a single portal could allow for standardization of other common plan processes, such as provider credentialing/re-credentialing, claims processing, and appeals, etc. The portal data could offer CMS a better view into care delivery patterns in MA plans and across geographies and identify ways to guide improvement to ensure MA enrollees do not experience poorer outcomes than their Medicare FFS counterparts.

2B. Require PAs to cover entire course of treatment. We support CMS' proposal in CMS-4201-P proposed rules requiring plans to cover PAs for an entire "course of treatment" to reduce or eliminate the current cycle of re-authorizations that must be requested. We recommend that CMS clarify that "course of treatment" clearly encompasses necessary care identified in an individualized, assessment-based care plan developed by a SNF or HH provider. Re-authorizations should be limited to changes in condition that warrant additional services or duration of service beyond the initial approval. This is an important step to reduce administrative burden on providers and MA enrollees.

2C. Require plans to conduct PA reviews 365 days per year or authorize service automatically during weekends and holidays. Requiring PAs is a choice MA plans make for certain services and equipment. Beneficiaries often do not have a choice when they are going to need medically necessary care. Therefore, if plans require a pre-authorization of services,

[9] Medicare Fee-For-Service Recovery Audit Program, 1/29/2018 : https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/ADR-Limits-Institutional-Provider-Facilities-January-29-2018.pdf

then they must ensure those decisions can be made without delay. If MAOs aren't willing to staff weekends/holidays, then medically necessary services at these times should be subject to automatic approval and payment until a coverage determination is made by the plan. Delayed care is denied care.

2D. Establish penalties for plans that fail to meet the established PA timeliness standards. CMS should establish shorter turnaround times for PAs and plans should be subject to penalties when they fail to meet these timeframes. MA enrollees should not linger in a hospital awaiting a determination for PAC already ordered by a licensed provider. The rule of thumb is for every day in a hospital, it takes three to four days for the patient to return to their pre-hospitalization function. Therefore, all PAs for PAC should be expedited with decisions made within no more than 24-48 hours after request. But MA plans aren't motivated for quick discharges from the hospital because the hospital is paid a flat rate regardless of the number of days, whereas PAC services are a new cost. No beneficiary should sit in a hospital because a timely determination of coverage has not been made. We support CMS's "Advancing Interoperability and Improving Prior Authorization Processes" rule (CMS-0057-P) proposal to reduce standard PAs timeframes to no more than seven calendar days but encourage CMS to reduce expedited reviews to no more than 24-48 hours.

2E. Require plans to issue Detailed Explanation of Non-Coverage (DENC) instead of Notice of Medicare Non-Coverage. When plans deny or discontinue coverage, the notice should include the person-specific reason (e.g., diagnoses were missing from documentation) the request was denied not a generic notice (e.g., insufficient information to support approval). CMS should provide guidance on the required specificity to ensure the information is actionable and not a form letter. This approach could expedite a successful readmission or help a patient determine if it warrants appeal. CMS might also consider amending these forms to include a check box for the provider and/or enrollee to indicate if they do not agree with the determination but perhaps feel they are unable to appeal due to financial risk. This information could be submitted to CMS and help identify plans who need additional oversight or training on traditional Medicare coverage requirements.

2F. Require plans to be responsible for safe discharges home when coverage is denied. Given that the MA plans make the non-coverage or discharge determinations for their enrollees, CMS should clarify that MA plans are accountable for ensuring safe discharges and transitions of care for their enrollees, and that care coordinators are expected to assist enrollees with establishing any needed service or obtaining required authorizations (PA) at the next stage of their recovery.

2G. Require plans to report data on PAs. MA plans should report annual plan-level information on certain PA metrics to CMS including: the services for which they require PAs; the percentage of PAs approved by category of service (e.g., post-acute care, hospital, physician); the percentage of PAs denied and approved following appeal; and average time from PA request to determination for both standard and expedited requests. A link to a plan's annual report should be included in the Medicare plan finder to assist beneficiaries in making better informed enrollment decisions.

3. **BRING THE VISION OF HIGH-QUALITY CARE CLOSER TO ROUTINE PRACTICE BY MAKING VALUE-BASED ARRANGEMENTS WORKABLE.**
CMS should develop a combination of incentives and tools that create greater opportunities for PAC providers to enter VBAs with plans and other payers, including:

3A. Develop guidance or templates that establish a roadmap for an array of VBA payment options and milestones. VBA templates specific to post-acute care could broaden adoption of VBAs by plans and CMMI model participants by making it easier to implement. A standardized template may incentivize plans to upgrade their systems to support such arrangements. Templates should offer an array of VBAs from minimal risk (e.g., pay-for-performance) to full-risk, allowing for a phased-in approach so that both providers and plans can learn and adapt.

3B. Establish goals for the percentage of provider payment contracts that should be in VBAs by provider types. This is already occurring in some state Medicaid managed care programs.

3C. Encourage VBAs between providers and MA plans serving specific or high-need populations. Provider-plan VBAs could target communities with identified Social Determinants of Health (SDOH) needs and/or those facing health disparities and focus on key metrics such as avoidable hospitalizations and readmission.

3D. Invest in health information exchange. PAC providers can capture data that would assist MA plans to improve on HEDIS measures such as medication reconciliation. However, PAC providers did not benefit from the financial investments for meaningful use as physicians and hospitals did. Plans should provide all types of providers ready access to their HIE systems and incentivize them through "pay for reporting" of health information. Congress should invest in health IT infrastructure for those providers that never received meaningful use funding.

4. **GIVE BENEFICIARIES A TRUE CHOICE OF HIGH-QUALITY PROVIDERS BY ADDRESSING NETWORK ADEQUACY.**

4A. In addition to time and distance standards, add a third factor requiring plans to contract with providers of all quality levels to ensure comparable choice for MA enrollees. MA networks should not be made up entirely of lower quality providers. CMS could publish a list, as it does for Accountable Care Organizations, identifying providers who are three-star or higher.

4B. Make network quality information public. Require plans to annually audit their provider networks for quality and publish a report listing the quality of the providers in their network by provider type, geography, etc. CMS should link the plan's annual quality report on MA plan finder.

4C. Do not allow plans to exclude providers simply based on size. Consider an any-willing-provider clause to ensure access to smaller providers offering person-centered experiences (e.g., Green House models) or those whose size is limited by provider type. Eliminating

providers based on size may hinder equity by eliminating providers who serve targeted ethnic or religious populations or low-income neighborhoods.

4D. Prohibit lower standards in rural areas. Repeal lower network adequacy standards for rural areas.

4E. Limit Certificate of Need and telehealth credits in rural areas.

5. ADDRESS TRANSPARENCY CONCERNS BY IMPROVING DATA COLLECTION AND SHARING.

5A. Share data transparently. MA data is critical to understanding outcomes for traditional and supplemental benefits, improving care and processes, ensuring equity, and compliance. It must be shared with CMS, providers, and beneficiaries to ensure transparency. At present, CMS has limited access to the data being collected by MA plans. One such area, as noted above, is information on PA/access to care practices by plans. By identifying and quantifying problems, administrative and/or Congressional solutions can be developed.

5B. CMS should establish its own all-payer database (as some states have) so that it has a robust view of utilization, outcomes, and care delivery patterns across payers.

5C. Improve original Medicare using lessons gathered from MA Supplemental Benefits. Collecting and sharing information about the supplemental benefits MA plans are offering, the frequency with which they are being accessed, and the outcomes associated with their use would help CMS determine if these benefits are a good investment and should be incorporated into the Medicare FFS benefit package.

6. ACTIVELY SUPPORT BENEFICIARY NEEDS AND RIGHTS.

6A. Standardize both the intake questions that MA plans/agents use to collect information on beneficiaries and the report that communicates the impact enrolling in a particular plan may have on the beneficiary's Medicare coverage. As proposed in CMS rulemaking a uniform set of questions and a uniform report will ensure that beneficiaries are more likely to receive unbiased and comparable information to make an informed decision about how to receive their Medicare benefits (e.g., traditional vs. MA plan).

6B. Add measures to the MA star rating system to ensure access to care and quality outcomes for MA enrollees. Penalties should be imposed when MA plans repeatedly and wrongly deny coverage for services and refuse to pay providers for claims that follow the Medicare coverage rules. In addition, the MA Star rating system should incorporate a hospital readmission measure to track outcomes for MA enrollees compared to Medicare FFS beneficiaries to ensure parity and should retain a heavier weight for patient experience/complaints and access to care measures until plans demonstrate a significant reduction in complaints.

6C. Establish a dedicated CMS confidential provider support line to accept complaints and address plan compliance concerns. CMS could coordinate complaint review with states' departments of insurance or other agencies which might own or share jurisdiction over these issues. This would also assist in identifying ongoing issues or patterns of noncompliance with laws and regulations, as well as identifying unnecessary administrative burdens.

6D. Survey providers to better understand beneficiary barriers to care. An annual survey of provider experiences with MA plans would provide insights into issues that should be addressed. It would also be interesting to know the number of MA enrollees who pay privately to access services that their MA plans will not cover and the number who have incurred debt due to an end of plan coverage.

Will Congressional Action be Needed?

LeadingAge believes that all or most of these recommendations could be implemented administratively, with no legislative changes.

However, one possible obstacle to developing solutions and adopting at least some of these recommendations is that there are few mechanisms to oversee and force change. The non-interference clause (Sec 1854 (6)(b)(iii) of the Social Security Act) is often cited as limiting the role CMS can play. The limits of this non-interference clause are not clearly established; amending this statute might clear the way for needed program improvements, assurances of provider payment adequacy, greater accountability, access, and quality.

In addition, Congress could pass a law instructing CMS to undertake some of the key improvements articulated here in the MA program. For example, CMS has taken steps in recently proposed rules (2022) to address issues related to PAs that were first articulated in Congress' Improving Seniors' Timely Access to Care Act legislation.

Ideas to Test for the Future

In addition to addressing the pressing problems with MA that hobble providers and thus impede beneficiary access to post-acute care, there are possibilities for improving MA plans for the future. Some promising ideas to explore include:

- The co-creation of MA enrollee care plans by a team composed of providers and the plan's care management team, like the concept of the Patient-Centered Medical Home model.
- CMS could test the ability of nursing home/assisted living-led ISNPs to auto-enroll their Medicare FFS residents into their ISNPs, while retaining resident choice to opt out or select another plan.
- CMMI could explore a demonstration designed to test and incentivize the appropriate use of HH care to improve outcomes on key quality measures and reduce overall spending.
- CMS could permit healthy food and produce to be offered as supplemental benefits to those MA enrollees with an identified SDOH need and perhaps their households.
- CMS could provide additional flexibility to address caregiver needs. Expanded respite care, virtual care management social services, a call-in support line, on-demand caregiver best practice and competency training and resources all would support caregivers. Standardized

caregiver burden assessments could be developed and used by the caregiver's primary practice to connect the caregiver to community resources. Caregivers are often what stands between the beneficiary and costly hospitalization or long-term residential care.

- CMS could test whether payment for in-home support services and adult day services should be a regular part of the Medicare program, not just an MA supplemental benefit offering.
- Preserve hospice capitation as a stand-alone payment separate from the MA plan bid, and prohibit PAs for hospice care, as is the case in the MA VBID model. This ensures timely access to hospice care. It is imperative that the comprehensive hospice benefit remains intact to ensure hospice-related outcomes.
- Currently, the definitions and use of palliative care are flexible, allowing MA plans to explore different models. While flexibility is essential to foster creativity during the demonstration period, in the longer term a standard definition of core palliative services will be needed to assure beneficiaries receive a comprehensive and comparable set of services across plans.
- Transitional Concurrent Care (TCC) is an important innovation and CMS should educate physicians and other provides on its meaning. TCC allows beneficiaries to have increased access to continued curative treatments likely leading to earlier willingness to elect hospice. It also needs to be distinguished from treatments that have a palliative rather than a curative intent (such as targeted radiation to shrink a tumor for the patient's comfort rather than aiming at remission or cure).

Conclusion

The demographics of aging in the United States warrant a close look at all Medicare programs to ensure that older adults receive the care they need in effective and cost-efficient ways. LeadingAge believes that in order for the Medicare programs to work, their policies must work not only for beneficiaries, but also for the organizations that provide the services. At this point, MA plans are costing taxpayers more than Medicare FFS and are more problematic for beneficiaries and providers in many ways. Failure to address issues in the MA program and consider the interplay of policies among MA, Medicare FFS, and CMMI models jeopardizes care delivery and access across the health care system. There are ways to address these concerns and these recommendations are a place to begin.