AHCA AMERICAN HEALTH CARE ASSOCIATION
NCAL NATIONAL CENTER FOR ASSISTED LIVING

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.AHCA/NCALncal.org

March 5, 2018

Submitted via regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8013

Re: AHCA/NCAL Comments on Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter

Dear Ms. Verma:

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) is the nation's largest association of long term and post-acute care providers representing more than 13,000 member facilities who provide care to approximately 1.7 million residents and patients every year. Thus, we play a critical role in all Medicare-financed post-acute care (PAC) and Medicaid-financed long-term services and supports service (LTSS) delivery policy and programmatic development for both fee-for-service (FFS) and managed care.

In 2017, 19 million, or 33%, of all Medicare beneficiaries were enrolled in Medicare Advantage (MA) versus traditional Medicare FFS. Between 2008 and 2017, the enrollment in MA nearly doubled, from 9.7 million to 19 million beneficiaries and researchers predict further increases in future years. Such a significant shift from FFS to managed care is resulting in a variety of challenges for PAC and LTSS providers which were of less concern when MA penetration rates and enrollment numbers were lower.

The Advance Notice and draft Call Letter issued on January 31, 2018 includes a number of operational and technical modifications that will not only affect sponsors of MA and Part D plans, but will also have a significant impact on beneficiaries and providers. While AHCA/NCAL appreciates CMS' continuing efforts to reduce the administrative burden on MA and Part D programs, we are concerned by impact reductions in several areas will have on beneficiary safeguards and respectfully submit the comments that follow.

AHCA/NCAL appreciates the opportunity to comment on the proposed rule and would welcome the opportunity to speak with CMS on these and other MA topics. Please contact Mike Cheek at mcheek@AHCA/NCAL.org or 202-454-1294 with any questions or requests to discuss our comments.

Section-by-Section Comments

Health Related Supplemental Benefits

AHCA/NCAL appreciates CMS' proposal to allow plans to offer supplemental benefits beyond the traditional benefit package to improve or maintain health or overall function. For beneficiaries receiving post-acute and/or long-term care, coverage of services that are not traditionally associated as primary health care services may allow MA plans and contracted providers to tailor care delivery to meet the very specific beneficiary needs.

However, while the AHCA/NCAL believes that such flexibilities can help MA plans manage complex enrollees, we are concerned that plans may attempt to substitute supplemental benefits for traditional Part A/Part B services, which would violate benefit parity requirements that seek to ensure beneficiaries have access to needed services. If CMS adopts this proposal, we believe that the Agency must analyze plan bids to make sure that plans are not seeking to reduce coverage of traditional benefits.

AHCA/NCAL also suggests that CMS monitor MA quality and outcomes with respect to use of supplemental benefits to ensure that there is no negative impact on quality of care received. Additionally, AHCA/NCAL encourages CMS to review the services to be included as health related supplemental benefits with respect to overlap with Medicaid and other state-funded programs.

Transparency and Timelines in Prior Authorization Processes

CMS included a statement in the draft Call Letter to remind MA organizations "that they should be transparent and provide adequate notice of any coverage restrictions, such as prior authorization (PA) requirements, to providers and enrollees." AHCA/NCAL appreciates this statement in recognition of challenges posed to providers by PA under MA. AHCA/NCAL hopes that by CMS drawing attention to the need for transparency, there will be improvement; however,

AHCA/NCAL also encourages CMS to impose specific requirements of plans regarding PA. For example, timeliness of prior authorizations as well as clear guidance from plans to providers on securing prior authorization is critical. AHCA/NCAL members have indicated that cumbersome prior authorization processes often result in disruptions to or delays in beneficiary care.

Meaningful Difference Requirements

CMS proposes to eliminate the meaningful difference requirement beginning in 2019, as originally announced in CMS' proposed rule, issued November 28th, 2017. AHCA/NCAL previously provided comments to CMS regarding this change.

Specifically, we are concerned that elimination of the meaningful difference requirement may create greater challenges for beneficiaries to choose a plan from an increased number of similar options that may proliferate if the meaningful difference requirement is eliminated. This analysis requires plans to calculate the actuarial difference between the various options offered by a plan in a county to prevent an organization from offering an excessive number of substantially similar plans. CMS has estimated significant savings that would inure to plans by avoiding the need to calculate meaningful difference and does not anticipate the number of similar plans in a market will necessarily increase significantly or that there will be increased beneficiary confusion related to the number of plan options. However, AHCA/NCAL is concerned that it will be more challenging for beneficiaries to choose a plan from an increased number of similar options. AHCA/NCAL urges CMS to continue to enforce meaningful difference requirements to preserve the integrity of beneficiary choice.

MA Uniformity Requirements and Segmented Service Area Options

CMS reiterates its proposal from the November 28th, 2017 proposed rule which would allow plans to tailor benefits for beneficiaries by allowing plans to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria. AHCA/NCAL provided comments to CMS on this proposal in our response to the proposed rule and restates those comments below.

First, AHCA/NCAL is concerned these variations on plan choice will lead to confusion for beneficiaries when selecting a plan. For example, rather than evaluating a plan based on traditional metrics, such as out-of-pocket spending, quality metrics, and provider network, beneficiaries will also need to understand whether a plan offers targeted supplemental benefits or cost-sharing for select sub-groups of beneficiaries. This will undoubtedly inhibit beneficiaries' ability to make meaningful choices regarding their coverage.

We are also concerned that the proposal provides too much leverage to plans to decide which benefits will receive reduced cost sharing. This could lead to "cherry-picking" by plans for beneficiaries with low-cost conditions while discriminating against those with higher-cost chronic conditions – an outcome contrary to CMS' stated objective of improving care for medically vulnerable beneficiaries. Beneficiaries served by AHCA/NCAL members are more likely to have multiple chronic conditions and/or higher-cost conditions and, thus, could be adversely impacted by some cost-sharing changes.

AHCA/NCAL fears that plans may attempt to use cost-sharing as a means of reducing the use of high-cost services such as SNF stays, which have shown to be beneficial and critical for those with chronic needs. This could also result in steering by health plans and providers from Medicare FFS to MA due to enticement to enroll them for financial gain rather than quality of care.

AHCA/NCAL recommends that if CMS goes forward with this proposal they work with all stakeholders, including providers, to put in place more safeguards and protocols regarding how a plan may select the conditions that would qualify for lower cost benefits and include provisions to limit cost-sharing on critical services, such as SNF care.

Stars New Measures for 2020

CMS has proposed several new measures for 2020, including measures related to post-acute care management and follow-up. We support CMS' continuing efforts to improve MA quality through the Stars program; however, expansion of the program should not impose additional administrative burden on providers. CMS requests feedback on whether the Agency should adopt a new NCQA measure or adopt the Plan All-Cause Readmissions (PCR) measure to evaluate acute facility readmissions among Medicare beneficiaries during or after a SNF stay. AHCA/NCAL strongly believes that CMS should not adopt a new measure. SNF providers already are required to report on a wide array of quality and efficiency measures. We urge CMS to select from existing measures to minimize provider burden.

Encounter Data as a Diagnosis Source

AHCA/NCAL applauds CMS for recognizing the importance of encounter data collection and analysis to inform MA policy development. When compared with the information available in the Risk Adjustment Processing System (RAPS), MA encounter data can provide CMS with more comprehensive information on all enrollee diagnoses as well as the cost and types of services and items provided to enrollees.

AHCA/NCAL strongly encourages CMS to publish available encounter data as well as any relevant analyses of encounter data in order to provide stakeholders, researchers, and policymakers with the appropriate financial and clinical information to evaluate the MA program and compare costs and outcomes with those in traditional Medicare FFS to inform future policymaking.

However, given the current uncertainty around the accuracy and completeness of encounter AHCA/NCAL recommends maintaining the proposed proportion of encounter data at 15 percent rather than increasing to 25 percent. We urge CMS to exercise continued caution in increasing the reliance on encounters to mitigate concerns that a rapid increase will encourage MA plans to impose additional reporting requirements on contracted providers, resulting in a substantial administrative burden. AHCA/NCAL is also concerned if the encounter data is

incomplete or inaccurate, increased reliance on this data for risk adjustment purposes could result in inadequate payments to plans and subsequently to contracted providers. Increased financial pressure on plans may result in unwarranted cuts to provider reimbursement and/or reductions in authorized beneficiary lengths of stay, which may compromise providers' ability to deliver quality care. AHCA/NCAL cautions CMS against further expanding the rate blend for encounter data for purposes of risk adjustment until the impacts on plans and contracted providers are identified and documented, and all stakeholders have an opportunity to review and comment on these impacts.

SNP-Specific Networks

While CMS indicates that the Agency will not develop SNP-specific networks at this time, CMS seeks stakeholder feedback on the potential benefits of establishing separate network adequacy evaluations of SNP-specific networks AHCA/NCAL has previously provided comments to CMS on this topic, and generally supports the development of requirements regarding SNP-specific networks; however, we urge CMS to include providers along with other stakeholders in the development of the requirements.

All SNPs are required to limit enrollment to beneficiaries who meet the eligibility criteria for the type of SNP and to follow the same rules as non-SNP MA plans, but the key difference is that SNPs provide focused care to special target populations based on their unique healthcare needs. Beneficiaries served by SNPs comprise the most vulnerable populations. A disproportionate number of members of Institutional and Dual-Eligible SNPs (I-SNPs and D-SNPs) reside in SNFs and long-term care facilities as their primary residence. These beneficiaries have significantly higher rates of serious health conditions, physical impairments, and cognitive limitations than traditional Medicare-only beneficiaries. Beneficiaries enrolled in SNPs typically require care from multiple provider types in a vast array of settings. SNF and long- term care providers are not only essential for inclusion in a SNP network but can also provide valuable intelligence regarding necessary network composition to serve beneficiaries' unique and complex health needs.

CMS should ensure that any network adequacy requirements include standards beyond time and distance standards, such as the ability of healthcare professionals to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with physical or mental disabilities. As the majority of beneficiaries enrolled in SNPs are dual-eligible, we suggest access standards that are similar to those used for Medicaid. As highlighted in recent Office of Inspector General (OIG) report, *"Access to Care: Provider Availability in Medicaid Managed Care,"* time and distance standards are not adequate indicators of access.[1]

[1] Department of Health and Human Services Office of Inspector General. Access to Care: Provider Availability in Medicaid Managed Care. November 2014.

In addition, most states have adopted Certificate of Need (CON) programs to regulate the number of Nursing Facilities (NFs) in a designated area and ensure NF availability is based on the needs of the population. As a result, many states have already determined the appropriate number of NFs needed to comprise an adequate network. AHCA/NCAL encourages CMS to consider these CON programs as they relate to network adequacy for SNPs.

Medicare Advantage Value-Based Insurance Design (VBID) Model Test

CMS has again expanded the number of states included in the test and released a Request for Applications for 2018. AHCA/NCAL has previously submitted our concerns regarding the test to CMS and summarize them here:

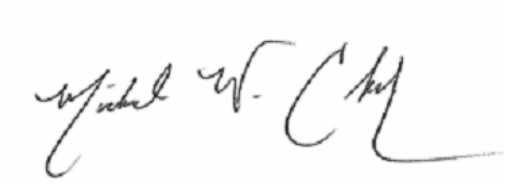
Identification of High-Value Providers – AHCA is concerned with the lack of standards and transparency for the identification of providers. Furthermore, inconsistency would create difficulties in data reporting and collection for purposes of comparing and evaluating plan interventions. AHCA urges CMS to work with relevant stakeholders to identify appropriate criteria for selection of high-value providers. Such an approach should address the following:

- Ensure methodologies do not exclude high-performing providers who treat or specialize in treating vulnerable populations presenting a risk of high utilization.
- Create consistency and transparency in criteria across plans to avoid creation of additional burden and confusion for providers that may contract with several participating plans.
- We also encourage CMS to make this criteria publicly available to inform provider quality improvement efforts as providers seek to align their practices with CMS and plan goals.

Changes in Beneficiary Cost Share Evaluation

CMS is considering the elimination of the current total beneficiary cost (TBC) evaluation in future years and requests stakeholder feedback on this matter as well as suggestions for other approaches to TBC evaluation. AHCA/NCAL is concerned that eliminating the TBC evaluation would have significant impacts on beneficiary decision-making and beneficiaries' ability to make meaningful choices regarding their coverage. Beneficiaries can currently use this evaluation to understand the costs would incur under various plan options. AHCA/NCAL encourages CMS to maintain the current approach of utilizing a TBC change threshold to evaluate plan changes from one year to the next.

Sincerely,



[Transmitted Electronically]

Michael W. Cheek
Senior Vice President, Reimbursement & Legal Affairs