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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 Medicare Program Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-For-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

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. The percentage of Medicare beneficiaries enrolled in MA is flat versus 2015; however, the number of MA enrollees has increased by 5%. Between 2008 and 2016, the enrollment in MA has nearly doubled, from 9.7 million to 17.6 million beneficiaries and researchers predict further increases in future periods. 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 CMS proposed rule for policy changes and updates to MA and Part D, issued on November 16, 2017, includes several changes that will not only affect plan sponsors, but will also have a significant impact on beneficiaries and providers. While AHCA/NCAL appreciates CMS' efforts to reduce provider burden, we are concerned with the impact that reducing several areas of regulatory requirements will have on beneficiary safeguards and respectfully submit the comments that follow.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

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.org or 202-454-1294 with any questions or requests to discuss our comments.

Section-by-Section Comments

(Section IV.A.7.) Seamless Conversion/Default Enrollment Flexibility

AHCA/NCAL applauds CMS' continuing evaluation of seamless conversion for beneficiaries newly eligible for Medicare, and appreciates CMS' efforts to limit this practice; however, we believe that any situation where a beneficiary does not affirmatively choose to enroll in the MA plan fundamentally undermines beneficiary choice and informed decision-making. Under CMS' proposal, Medicare's most vulnerable beneficiaries would not have the opportunity to actively choose their coverage or to determine if a selected plan is the best option for their needs.

This practice could also result in significant disruptions in care, particularly for dual-eligible beneficiaries who require a wide array of Medicare and Medicaid services from a variety of providers. As CMS is aware, providers who contract with an organization's Medicaid plan do not necessarily participate in the organization's MA plan. Therefore, beneficiaries may be subject to different provider networks without proactively making that choice. Inconsistencies in provider networks may negatively impact beneficiaries' continuity of care. AHCA/NCAL strongly urges CMS to eliminate all use of seamless conversion to avoid these concerns.

Should CMS decide to move forward with this proposal, we encourage CMS to develop continuity of care protections, such as beneficiary access to out-of-network providers, to minimize disruptions in care. In addition, LTSS providers should be notified of any change in coverage or plan enrollment to better coordinate care for their patients as they become Medicare eligible. This should not pose an undue burden for the affected MA plans as they have visibility to claims data due to their role as Medicaid payor for these beneficiaries.

(Section III.B.1.) Passive Enrollment for Integrated Care for Dual-eligible Beneficiaries

AHCA/NCAL appreciates the goal of minimizing disruption to beneficiaries that may result from market changes that result from states' Medicaid contracting practices and/or due to termination of D-SNP plans; however, as discussed above with respect to seamless conversion, passive enrollment does not align with CMS' goals of preserving beneficiary choice, and would result in even more significant disruptions to care due to differences in the provider networks and approaches to care. Specifically, for beneficiaries receiving SNF services, changing plans could result in beneficiary displacement due to changes in network composition and/or changes in care plans. Such changes will negatively impact continuity of care for post-acute services disproportionately when compared to acute or primary care. For these reasons as well as those discussed in the section above, AHCA/NCAL encourages CMS to eliminate all use of passive enrollment. In instances of plan termination or changes resulting from states' Medicaid contracting practices, beneficiaries should revert to FFS Medicare coverage.

If CMS elects to adopt the proposed passive enrollment practices, AHCA/NCAL encourages CMS to define beneficiary notification requirements that ensure beneficiaries are aware of and understand their conversion as well as the process to opt out. AHCA/NCAL also strongly encourages CMS to develop continuity of care protections for post-acute and LTSS users to minimize disruptions in care. Specifically, we recommend: 1) exploring guidance to plans on out-of-network payments for beneficiaries who may enroll in MA plans following a plan termination that do not have contracts with their current PAC providers; and 2) requirements for terminated plans to pay in full any outstanding claims with providers.

(Section IV.C.2.) Compliance Program Training Requirements for FDRs

AHCA/NCAL applauds CMS for recognizing the burden imposed by the need to complete certain compliance training requirements and supports the CMS proposal to eliminate the requirement for first-tier, downstream and related entities (FDR) to take the required CMS compliance training. AHCA/NCAL members, like other FDRs, are required to complete numerous, often redundant trainings for the various MA plans with whom they contract. This has been a tremendous administrative burden and AHCA/NCAL appreciates CMS' attention to this matter.

(Section II.B.13.) Provider Burden – Medical Record Documentation

AHCA/NCAL greatly appreciates CMS' recognition of the administrative burden placed on providers by MA plans and the stated objective of exploring ways to reduce the burden on providers. We are in favor of any action which results in a reduction of the administrative cost burden carried by providers. AHCA/NCAL members frequently receive requests for post-service audit, resulting in increased costs to the provider and requiring documentation above and beyond traditional Medicare.

AHCA/NCAL recommends that CMS work closely with providers, particularly providers of post-acute and long-term care services, to understand the current documentation requirements and practices and to identify existing, burdensome requirements that can be eliminated.

(Section II.A.3.) MA Uniformity Requirements and Segment Benefit Flexibility

CMS indicates that under existing statute, the Agency has the authority to permit MA 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. This flexibility aims to target the most medically vulnerable enrollees, especially those with high chronic care needs. Specifically, CMS encourages MA organizations to offer more tailored plan options and benefits with lower cost-sharing and deductibles for enrollees with specific medical criteria; however, the proposed rule does not provide any specificity around what qualifies as "special criteria."

First, AHCA/NCAL is concerned these variations on plan choice will inhibit beneficiaries' ability to make meaningful choices regarding their coverage. For example, rather than evaluating a plan based on traditional metrics, such as out-of-pocket spending, quality metrics, and provider network, which already creates significant confusion for beneficiaries when making choices regarding coverage, these individuals would also need to consider that a plan may offer targeted supplemental benefits or reduced cost-sharing for select services or providers for select sub-groups of beneficiaries. If beneficiaries are not aware of these additional flexibilities, they may believe that they will have equal choice across all network providers, only to realize after enrollment that they would be encouraged to receive care from select providers in certain settings.

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 needed services such as SNF stays, which have shown to be beneficial and critical for those with chronic needs.

While AHCA/NCAL shares CMS' commitment to a quality-driven, innovative and efficient healthcare system, we believe CMS should delay expanding benefit design flexibilities until the MA Value-Based Insurance Design (VBID) Model demonstration is complete. All stakeholders should have an opportunity to review the results of the evaluation to ensure that plans, when offered additional flexibilities, did not engage

in discriminatory practices that compromised access to care for vulnerable populations.

If CMS goes forward with this proposal, AHCA/NCAL recommends that CMS 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.

(Section IV.C.3.) Meaningful Difference Requirements

CMS proposed to eliminate the required meaningful difference analysis which plans must include with their annual bids. This analysis calculates the actuarial difference between the various plan options offered for 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. CMS 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.

(Section 2.A.4.&5.) Maximum Out-of-Pocket (MOOP) and Cost-sharing Limits

CMS proposes several changes to the approach to setting MOOP and cost-sharing limits on an annual basis, including several that would have the effect of reducing MOOP limits. AHCA/NCAL is concerned that this proposal could lead to higher cost sharing for certain service categories, particularly for beneficiaries with special needs. For example, plans could raise cost sharing in return for a lower MOOP which may make it difficult for beneficiaries to distinguish between these plans. AHCA/NCAL is particularly concerned with the potential impact of this emphasis on promoting lower MOOP plans in exchange for higher cost sharing for other benefits. Specifically, AHCA/NCAL is concerned a plan may raise cost sharing limits for critical services frequently utilized by the most vulnerable beneficiaries, such as SNF services, in return for a lower voluntary MOOP. Plans may look at an increase in cost-sharing for PAC and SNF services as a trade-off that impacts few members; however, these highly vulnerable members would be disproportionately harmed by such a change.

In line with our comments regarding meaningful beneficiary decision-making in previous sections, AHCA/NCAL is also concerned that these additional variations on plan choice will lead to beneficiary confusion for the most vulnerable beneficiaries when selecting plan options, such as the choice between lower voluntary MOOP and

higher cost sharing. This may make it more challenging for a beneficiary to select a suitable plan as the choice between a may lead to plan choice confusion, while also leading to higher cost for necessary services.

(Section II.C.1.) MLR Reporting

CMS proposes to add fraud reduction activities under "Activities that improve health quality (§422.2430) and, thus, included in the numerator of the calculation of medical loss ratio (MLR). The MLR threshold requirement helps ensure that an appropriate level of funds is expended on services for beneficiaries. AHCA/NCAL understands that fraud reduction is an essential health plan activity; however, we are concerned with an addition which dilutes the MLR, and potentially reduces spending on direct services to beneficiaries.

CMS also proposes to significantly reduce the detail by which plans report the annual MLR and self-report their calculation of the remittance due, if any. CMS has noted that the calculation of the MLR for Medicare Advantage has differed from the requirements for commercial plans due to differences in the nature of the plans with respect to benefits, beneficiaries, etc. The basis for the different approach for Medicare Advantage is supportive of greater transparency and rigor in the reporting requirements for MLR. Given the number of adjustments that are made to the traditional MLR in order to calculate the Medicare MLR, we feel it is vital that this level of detail continues to be available as a means of monitoring the percentage of Medicare funds that are paid to providers for direct beneficiary services. While AHCA/NCAL supports the overall objective of reducing regulatory burden, we believe that MLR reporting is vital to oversight of Medicare Advantage plans. Further, self-reporting would require an increased audit burden on both CMS and plans to validate the plans submissions, which would offset some or all of the savings realized by reduced reporting.

(Section II.B.4.) Electronic submission of paperwork to beneficiaries

CMS proposes to eliminate the requirement for plans to provide hard copies of a number of documents to all beneficiaries who are enrolled in the plan. Instead, plans will be able to post the documents on their websites and provide hard copies only upon request. AHCA/NCAL would like to point out that while studies show that approximately 67% of seniors use the internet, the nearly one-third of adults ages 65 and older that say they never use the internet[1] represent a significant number of beneficiaries who are enrolled in MA plans. In addition, our members typically serve beneficiaries affected by a variety of physical and cognitive impairments, a significant cohort who are unlikely to be able to access or meaningfully review their documents on a computer. While AHCA/NCAL supports the reduction of paperwork and enhanced ease of administration, we believe that plans should continue to provide hard copies of required documents unless a) the beneficiary has established and

[1] Pew Research Center, May 2017, "Tech Adoption Climbs Among Older Adults"

utilized an online account and b) the beneficiary has specifically opted into receiving online information.

(Section IV.C.9.) Stars Measures

We support CMS' proposal to add measures which evaluate quality from, among other things, the perspective of beneficiaries with respect to the ease, simplicity and satisfaction with the experience with the plan. Increased emphasis on measures related to beneficiary satisfaction will help ensure that organizations place appropriate emphasis on activities that directly benefit beneficiaries. We also applaud and support CMS' consideration of including measures of provider experiences. Beneficiaries' experiences with their MA and drug plans are largely driven by their interactions with providers and activities directed at measuring and improving the satisfaction of providers can be expected to yield positive results for beneficiaries. CMS specifically references physicians; however, AHCA/NCAL strongly encourages the inclusion of non-physician providers, including SNFs, as well.

Sincerely,

[Transmitted Electronically]

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