March 1, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2018-0154

Submitted electronically

LeadingAge appreciates the opportunity to comment on the 2020 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies (the Advance Notice) and Draft Call Letter ("Call Letter").

The mission of LeadingAge is to be the trusted voice for aging. The members of LeadingAge and partners impact the lives of millions of individuals, families, employees and volunteers every day. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is a 501 (c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports, and home and community-based services and focus on issues with potential impact on their ability to effectively deliver services and be paid for those services. Therefore, our comments will be restricted to the following sections of the Call Letter:

- The proposed MA plan rate increase and policies.
- Special Supplemental Benefits for Chronically Ill (SSBCI).
- Dual Special Need Plan "look alike" plans.
- Crossover claims for dual eligibles enrolled in MA plans.
- Improving the accuracy of provider directories.

MA Plan Rate Policies: LeadingAge is concerned that the proposed 1.59% rate increase for 2020 is insufficient to account for projected spending growth in the Medicare program of 7.4% between 2018-2027, according to the CMS Office of the Actuary projects, or the 5.5% projected growth in the National Health Expenditures. In addition, LeadingAge shares the concerns of other health plan organizations regarding how the county benchmark is currently calculated using all Medicare FFS beneficiaries, not just those who are enrolled in both Part A & B. These rate policies have two potential negative consequences: 1) increased downward pressure on provider payment rates, which ultimately can jeopardize access to services; and 2) reducing the ability of MA plans to test the new supplemental benefit options available to them.

Low rate increases for the MA plans will only trickle down to their payments to providers. Skilled nursing facility providers have struggled in recent years with MA plan contracts that pay them below Medicare fee-for-service rates in many markets. While providers can refuse a contract, some providers (e.g., small single site) feel they have little leverage or ability to turn down contracts when a majority of

the individuals they serve are covered by the plan or served by their main referral hospital who is part of the plan's network. If plans are not given adequate increases that reflect projected spending growth, then we can only anticipate further pressure on provider rates at the same time that more is being expected of these same providers. Providers are increasingly being expected to take on more responsibilities and tasks under managed care such as coordinating care beyond their walls, changing care delivery patterns (e.g., shortening length of stay), submitting prior authorizations for continuation of needed services, negotiating contracts with multiple plans and submitting claims to these plans through different processes all for less money. While providers want to do more for the people to whom they provide needed services, it is increasingly challenging to undertake these new expectations for significantly less money. Provider organizations still need to invest in and pay their workforce. Post-acute care (PAC), long-term service and supports (LTSS) and home and community-based services (HCBS) providers can play a critical role in reducing utilization of unnecessary, high cost services but only if paid adequately.

Finally, the timing of this lower rate increase is most inopportune given the new options CMS and Congress have made available to plans to offer supplemental benefits that can lower overall utilization of high-cost services by investing in HCBS or targeted services that can help an individual with a chronic illness better manage their condition without a hospitalization. Specifically, we are concerned that inadequate MA plan rates could have a negative impact on a plan's ability to bid below benchmark, as they do not accurately reflect the costs of care for this population. In turn, this inability to bid below benchmark limits plans' ability to offer supplemental benefits at the same time that new supplemental benefit options are being made available such as HCBS that meet the 2019 definition of "primarily health related" and the Special Supplemental Benefits for Chronically Ill individuals that are discussed in this Call Letter.

With all these concerns in play, we would ask CMS to re-examine its rate policies to ensure plans are adequately funded to: meet the needs of their enrollees; have a legitimate opportunity to test and pursue new supplemental benefit options that could have positive effects on reducing utilization of high-cost services and costs while delivering more person-centered benefits; and ensure that adequate payment to providers under their contracts with MA plans.

Special Supplemental Benefits for the Chronically Ill (SSBCI): The new Special Supplemental Benefits for the Chronically Ill (SSBCI) plan option hold much interest for aging services providers. LeadingAge is pleased MA plans have a new option to address the needs of individuals with chronic illnesses through Special Supplemental Benefits that do not need to be primarily health related. We also recognize that allowing the customization of SSBCI for chronically ill individuals is a very person-centered approach to addressing an individual's needs.

However, we raise the following concerns with CMS's approach to implementing the SSBCI provisions by giving MA plans considerable flexibility to determine that a particular benefit has "a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease." How will a beneficiary know which SSBCI services they specifically should be eligible for? Could this approach set up a potential bait and switch situation where the benefit package and evidence of coverage outlines a broad set of services but the chronically ill beneficiary is denied one or more of the services listed because in the opinion of the MA plan they don't think the service(s) have "a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease." These subjective determinations could result in confusion for

beneficiaries and great variability in what services are delivered. In addition, practically speaking, how could a beneficiary, or a provider on their behalf, appeal such a determination?

We support the provision that SSBCI can include benefits that aren't primarily health related and as such may address social determinants of health. We encourage CMS to include in its April guidance letter additional examples of benefits that could be offered under SSBCI. Under the new SSBCI, would any of the following benefits comply: remote in-home monitoring technology, financial assistance to pay utility bills in order to ensure the person as electricity to run needed medical equipment (e.g., CPAP machine) in their home; hospice or palliative care services; purchase of prescription dispensing device to ensure medication compliance; window air conditioning unit or air filters for someone with COPD; housekeeping services; social services; service coordination services provided to residents of HUD housing; pay for an aide or other person to accompany the enrollee to health care visits; companion services; paying for monthly internet service to support electronic devices that can promote socialization, ensure communication with care coordinator or provider; or purchase of electronic devices (e.g. a smartphone) to deploy apps that can assist the individual in self-management of their chronic illness, deliver video exercise content or communicate key changes in condition.

We also suggest CMS reconsider its prohibition on capital or structural improvements such as ramps. While a ramp used to come and go from one's home improves the quality of life for the individual, it does not always increase property values. Therefore, we believe ramps should be a permissible benefit under SSBCI if it meets the other criteria, "a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease." The addition of ramps can allow a person to be more independent and make it easier for them to leave the house to go to health care visits, shop at the grocery store, eat out at a restaurant or attend religious services. We are confident that plans will only fund those benefits that they believe deliver an appropriate return on investment and as such, will not invest in lavish remodels of a beneficiary's residence or unnecessary devices.

In response to CMS's solicitation for feedback on whether "financial need" should be a consideration in determining permissible SSBCI, we would support permitting plans to use this as a way to determine whether a SSBCI should be approved. Ability to pay for services can have a negative effect on an individual's health (e.g., limited income individuals who must choose to buy their medications or food or pay a utility bill). Having said that, we do not believe that SSBCI should only be available to those in financial need, as it would create an uneven benefit for the plan enrollees who could similarly benefit from a service and pay the same premiums.

LeadingAge is pleased that CMS has noted that plans may contract with community-based organizations to provide new supplemental benefits and that CBOs can help with eligibility determinations for the SSBCI benefit.

We look forward to further clarification from CMS on how the SSBCI will be implemented as many questions remain. It will be interesting to see how these benefit options will be made available in practice within an eligible MA plan. Will they require prior authorization? How will plans contract with providers of non-medical transportation or grocery-delivery services that may not be Medicare providers or have an NPI number? How will beneficiaries know they have access to these services? Will they be able to search for them on Medicare.gov or will they need to compare by examining individual Evidence of Coverage documents from multiple plans?

Dual Special Need Plan (DSNP) "look alike" plans: CMS notes that there has been a rise in MA plans offering benefit packages that look like those offered by DSNPs and that these plans have high proportions of dually eligible enrollees. LeadingAge shares CMS's concern that the DSNP "look-alike" plans are disproportionately enrolling dual eligibles but not offering the same breadth of benefits – periodic risk assessments, individualized care plans or coordination of benefits – that DSNPs are required to include. We also support CMS's enforcement of the marketing and other regulatory requirements to clear the confusion for dual eligibles and ensure they enroll in the best plan to meet their integration and coordination needs. However, while CMS enforcement of existing regulations is important, we also encourage CMS to consider reviewing whether any states' policies (e.g., to limit the number of DSNPs with which they will coordinate benefits) may play a role in the rise of these plans. Ultimately, any policy related to DSNP "look-alike" plans should ensure that dual eligible consumers continue to have the option to select from a variety of plans that truly integrate and coordinate their care and services, and that plan selection tools through Medicare.gov clearly show the differences in options and benefits between DSNPs and a "look-alike" plan.

Crossover Claims for Dual Eligibles Enrolled in MA Plans: LeadingAge strongly supports CMS efforts to implement automatic crossover claims for dual eligibles enrolled in MA plans. This cannot only lead to reduced administrative burden for providers but can also prevent any inadvertent, unnecessary billing of dual eligibles for cost sharing. As we are not intimately familiar with how CMS's automated crossover claims process works in Medicare FFS, we are unable to suggest how to achieve this objective but encourage CMS to continue to pursue it and perhaps reach out to states that may already be facilitating a similar process for ideas or models that could be implemented more broadly.

Simplifying Data Collection to ensure Provider Directories' Accuracy: Today, as we understand it, plans collect data from providers as part of the credentialing process, which is then used to populate the provider directory. In practice, this means each plan requests the same information from each provider in their network but in different formats. This is an unnecessary duplication of effort as the information that is obtained by the plan through this process is information that CMS should already have for all Medicare providers (e.g., provider/organization name, national provider identifier (NPI), license number, address). It is inefficient and does not lend itself to uniformity or any standardization of this critical consumer information. Therefore, this exercise, while perhaps required currently as part of the credentialing process, is redundant and produces inaccurate results that unnecessarily burdens providers and plans collecting the information. We believe by simplifying and centralizing some of this data collection can result in better provider directories, and reduced administrative burden for plans and providers. We offer the following ideas for achieving this centralized approach, whose data will feed the production of more accurate and timely-updated provider directories. CMS could establish an online portal or use an existing provider portal where providers enter and update all data on their organizations. This data is already captured in through the Medicare enrollment and the application for a NPI number processes. CMS could require providers to annually (or more frequently) confirm the accuracy of the data (e.g., is the responsible party or chief contact still the same, has the phone number changed, etc.) or alternatively, require these data to be updated within a prescribed period of time when there is a key change (e.g. leadership/responsible party; physical location or provider name). This centralized provider information could then be accessed by Medicare Advantage, Special Needs Plans and Part D plans on their network providers either through:

- Monthly provider reports pushed to plans by CMS (similar to beneficiary files), which could be used to update their provider directory; or

- Establishment of a centralized provider verification system, which would allow MA, SNP and Part D plans to enter provider NPI numbers to confirm and download provider data with which to populate their directory.

There are many benefits to this approach:

- CMS could standardize how the provider information is collected so provider or organization names and addresses are consistent across programs, plans and platforms and reported in the same format. This could reduce or eliminate the unintentional multiple listings of the same provider due to, for example, an address or the provider organization's name using an abbreviation in one reference and spelled out in another (e.g., Avenue vs. Ave.; St. Johns vs. Saint Johns).
- Providers would only need to update this information in one place for all payers. Having a single access point to update organizational data could make it easier to ensure that this task is completed. Today, a provider organization name change could require staff to ensure Medicare, Medicaid and multiple managed care plans receive this information, and it is not always clear all of the places where this updated information must be submitted even within CMS.
- Due to the automation of this process and resulting uniformity, the Medicare.gov plan selection tool might more accurately list providers allowing beneficiaries to find those MA, SNP and Part D plans that are the best match for them to retain their current providers.
- Plans and providers could redeploy staff resources once dedicated to these functions to other tasks that benefit the plan enrollees.

We do not believe removing these basic provider identification data collection responsibilities of the credentialing process will result in any increase in fraudulent activity as plans will continue to be required to confirm the existence of a provider, have a signed contract and obtain an NPI number.

Again, LeadingAge appreciates the opportunity to submit comments on the proposed rule. Please do not hesitate to contact us if you wish to discuss any of these comments further.

Sincerely,

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LeadingAge