

February 13, 2023

Submitted via regulations.gov

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

Re: ***CMS-4201-P***

Subject: ***Medicare Programs: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications***

Dear Administrator Brooks-LaSure:

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) values the opportunity to comment on the *Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Health Information Technology Standards and Implementation Specifications*

AHCA/NCAL is the nation's largest association of long term and post-acute care providers representing more than 14,000 member facilities who provide care to approximately 1.08 million residents and patients every year. 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.

The members of AHCA/NCAL continue to seek opportunities to assume greater leadership for and meaningfully participate in the full care experience of these vulnerable residents and patients. In keeping with its mission, AHCA/NCAL established the Population Health Management (PHM) Council, in 2019, to convene and support long term care (LTC) providers who are engaged in value based care and population health management (PHM) initiatives. The Council's mission is to strengthen long term care provider-led PHM models through advocacy, education, and quality improvement data, thereby enhancing the quality of care and quality of life for beneficiaries in senior living settings. The Council consists of AHCA/NCAL member providers who have leadership in a PHM model including provider-led Special Needs Plans (SNPs).

LTC providers own about 36 percent of the I-SNPs offered to nursing home and assisted living beneficiaries, with 29 percent of the total number of I-SNP beneficiaries enrolled in LTC provider-led plans. These LTC provider-led SNPs are not owned by large insurers and do not have other large MA or commercial products; instead, these plans are designed specifically for residents of LTC facilities,

operated by LTC companies with experience supporting LTC populations who only specialize in providing care to LTC populations.

Thus, we play a unique and 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 with perspectives from both the provider and plan.

General Comments:

- AHCA/NCAL strongly supports the proposed provisions in this rule related to beneficiary protections and enhancing beneficiary access to care through the purposeful reform of utilization management and prior authorization strategies. The proposals are directionally an improvement from the status quo, and are a strong start, but additional provisions are needed to better align with the patient and provider protections available under the Medicare-For-Service (FFS) programs.
- In keeping with CMS’s commitment to vulnerable and underserved populations, we request that CMS right-size network adequacy requirements to reflect typical patterns of care for I-SNP beneficiaries thus promoting beneficiary access, meaningful competition, and enhanced primary care.
- We request that CMS modify star ratings to accurately reflect the quality of SNPs, enabling beneficiary decision making.

Section by Section Comments

Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (422.101, 422.112, 422.137,422.138 and 422.202)

Proposed Change: Prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in this rule.

Comment: Prior authorizations are a key component in accessing timely, appropriate care for beneficiaries. Current prior authorization processes vary from MA organization to MA organization and sometimes from plan to plan within an organization. The process has become administratively burdensome, confusing, and a barrier to care. This has been exacerbated by a practice that is becoming more and more common, the delegation in part or whole of this function to external third parties.

AHCA/NCAL strongly endorses the new provisions related to prior authorizations and offers the following suggestions to secure beneficiary timely and appropriate access to care.

1. Provisions should extend to any entity a health plan delegates the prior authorization function to.
2. Compliance with these new regulations must be monitored through timely auditing processes. This could be accomplished more easily if CMS required a uniform prior authorization form that outlines the information the plan is required to provide. Standardization would significantly reduce the administrative burden placed on providers to understand and adhere to the variations in forms and processes dictated by the multitude of plans and delegated entities. With the current catastrophic

shortage of healthcare workers, high quality patient care should be the primary focus for all staff, not navigating administrative barriers erected to protect plans over patients.

Proposed Change: An approval granted through prior authorization processes be valid for the duration of the approved course of treatment and that plans provide a minimum 90 day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan.

Comment: AHCA/NCAL supports the efforts from CMS to ensure beneficiaries are receiving timely care and providers are spending more time with patients than navigating administrative barriers to care.

In the long term care nursing facility setting the utilization management process can be extraordinarily confusing and time consuming. From the point of receiving a referral to obtaining an authorization and providing updates sometimes daily, valuable staff time is diverted from patient care.

To ensure the process is effective but also not unduly burdensome we request CMS provide additional guidelines and guidance related specifically to post acute care settings as the OIG has noted in its report these settings are disproportionately affected by inappropriate utilization management tactics.

Suggestions to strengthen CMS' efforts in this area include the following:

1. **A uniform prior authorization form required for use by all payers.** CMS uses standardized forms in other areas in the MA program to ensure clarity and facilitate timely and effective care. This is an area where the same methodology can be applied and is most needed. The form should include the information necessary to confirm diagnosis or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in this rule.
2. **Transparent evidence-based parameters for prior-authorization periods are needed.** CMS should prohibit MA plans from applying arbitrary, short prior-authorization periods that result in the need for time consuming reauthorizations that often disrupt care. Typically, plans approve SNF care for a certain number of days (i.e., 3-5 days) and then require ongoing authorizations (i.e., every 2 days or so) to continue coverage. CMS should ensure that the "course of treatment" comprises the full traditional Medicare benefit based on beneficiary need. Prior-authorization period duration determination should be representative of the unique need of the beneficiary based on Traditional Medicare statutes and regulations, NCD, LCD or other current evidence in widely used treatment guidelines or clinical literature, regardless of patient condition, care needs, and discharge disposition goals, or be established solely by algorithms that are not transparent.

CMS should require plans to approve a minimum of 8 days of SNF care consistent with the initial assessment period under the Patient Driven Payment Model (PDPM). Following the initial assessment, plans should follow the care plan developed to meet the beneficiary's medical, psychosocial, cognitive, and behavioral needs. PDPM was designed to address the unique needs of each Medicare beneficiary independently thereby increasing accuracy and a more person-centered care model and should be the tool utilized by plans versus obscure, proprietary rubrics. In the absence of a reasonable prior authorization duration the regulation will be rendered ineffective. The status quo will endure, with lengthy, frequent reauthorizations diverting staff time and creating anxiety for patients and families; families who are uncertain of the length of stay and left unprepared as a result of sudden and unpredictable discharge dates setting up a less than optimal scenario for a safe return home. Clarity for both the provider and the beneficiary at the beginning of

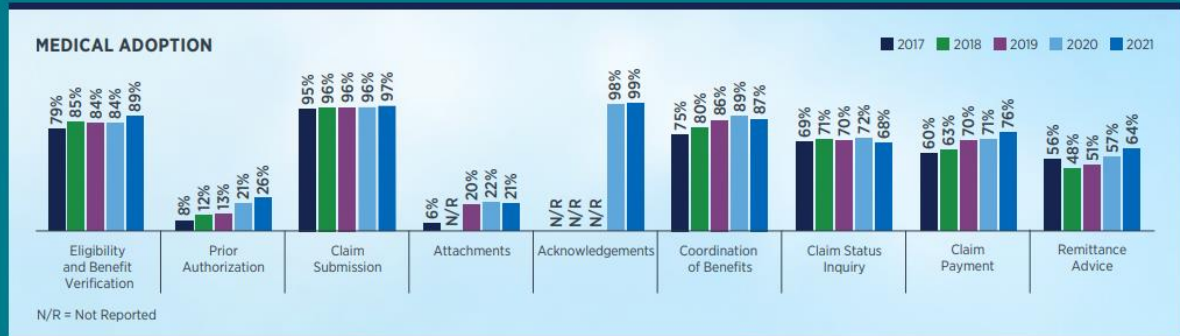
a course of treatment will result in individuals better prepared to participate in treatment, secure safe and appropriate accommodations in the home and a return home fully confident in their abilities.

3. **Should re-authorizations or post-payment review be necessary, providers should only be required to submit new information.** Unless there is an absolute dearth of documentation from the discharging hospital, physician and facility to support the medical necessity of the prior authorization and course of treatment the plan must not be able to create a long and burdensome process to challenge and deny the stay as determined in the prior auth with either a pre payment or post payment audit/review process. It is common practice for facility staff to have to submit extensive documentation during a patient's stay to plan case management staff and then submit the same information again to different plan staff when attempting to collect payment. This repetitive submission of duplicate information is a gross misuse of the UM process designed to place undue burden on the provider and discourage billing and collections. If information has been provided once to the health plan the responsibility should be on the plan to retain that information so that it is accessible to staff in other departments that may need access to it. Further, requiring providers to fax and email protected health information multiple times to multiple people within the health plan significantly increases the risk of this information being inappropriately accessed and/or lost endangering beneficiary rights to privacy.

4. **MA plans must be encouraged to automate prior authorization processes for SNF services.** The reduced scope of what would be permitted for prior authorizations as proposed by CMS through "*...a new § 422.138(b)(1) through (3) to limit the use of prior authorization processes only to confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service, to ensure basic benefits are medically necessary based on standards specified in § 422.101(c)(1), or to ensure that the furnishing of supplemental benefits is clinically appropriate.*(87 FR 79503)". If finalized, this requirement, should create a pathway for more automation of prior authorization processes, particularly if CMS were to require a standardized prior authorization format consistent with the new limitation on what could be considered under the prior authorization process.

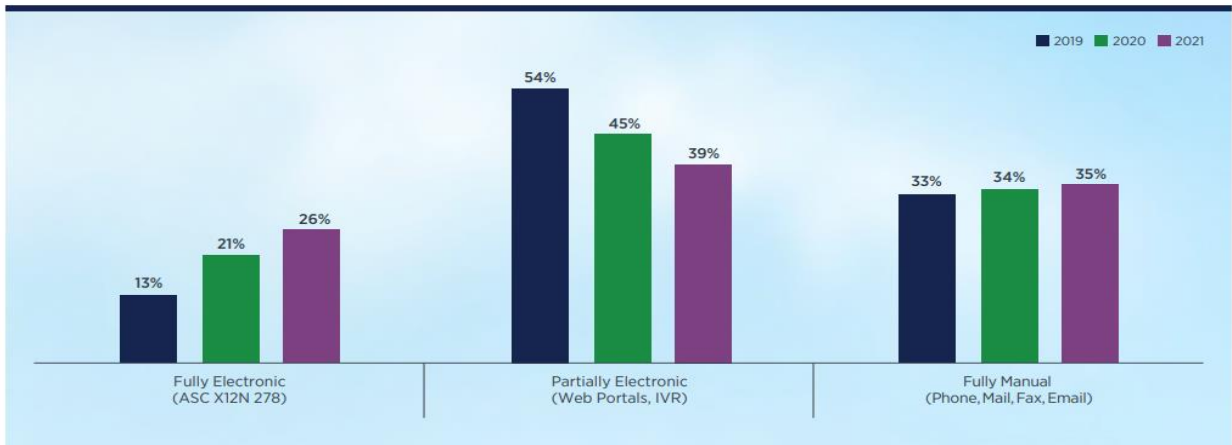
A recent study by the Council for Affordable Quality Healthcare (CAQH), the 2021 CAQH Index, provides data on administrative functions performed by providers and health plans, the percent completed electronically, the cost of those functions, and the cost and time savings opportunities that could be realized if processes were fully electronic.

**Medical Plan Adoption of Fully Electronic Administrative Transactions
 2017-2021 CAQH Index**

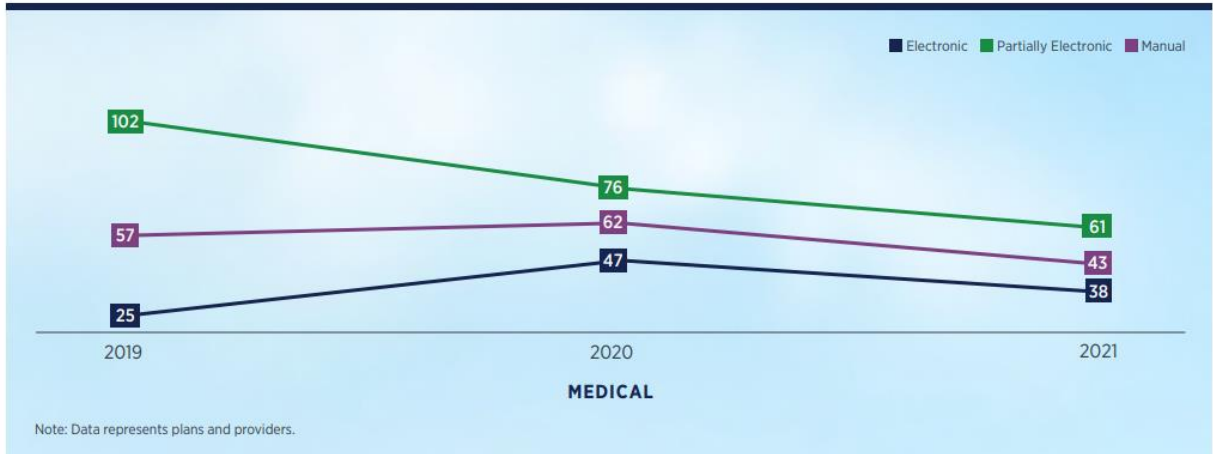


As illustrated, prior authorizations and attachments (medical records submission for payment of claims) have the lowest adoption of fully electronic transactions. While it is increasing, the savings in time and cost that could be realized by providers and plans are significant. Additionally, prior authorizations are the most critical transactions impacting timely beneficiary access to care yet have the second lowest full electronic adoption.

**Medical Plan Adoption of Prior Authorization
 2019-2021 CAQH Index**



**Estimated National Volume of Prior Authorization by Mode
 2019-2021 CAQH Index (in millions)**



While fully electronic adoption is growing it makes little sense that fully manual prior authorization processes still be the second most common method of transmission. Of note, savings that could be yielded from moving to electronic prior authorization is significantly more for providers than health plans.

SPEND & SAVINGS

**Prior Authorization: How Much is Spent and Saved With Full Adoption?
 2020-2021 CAQH Index (in millions)**

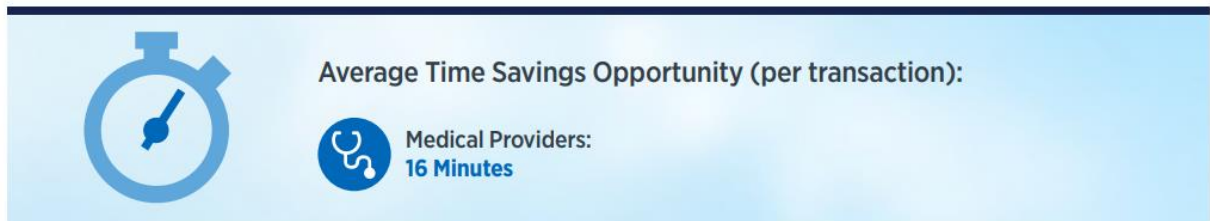


Electronic Prior Authorization: Cost Savings Opportunity



TIME SAVINGS OPPORTUNITY

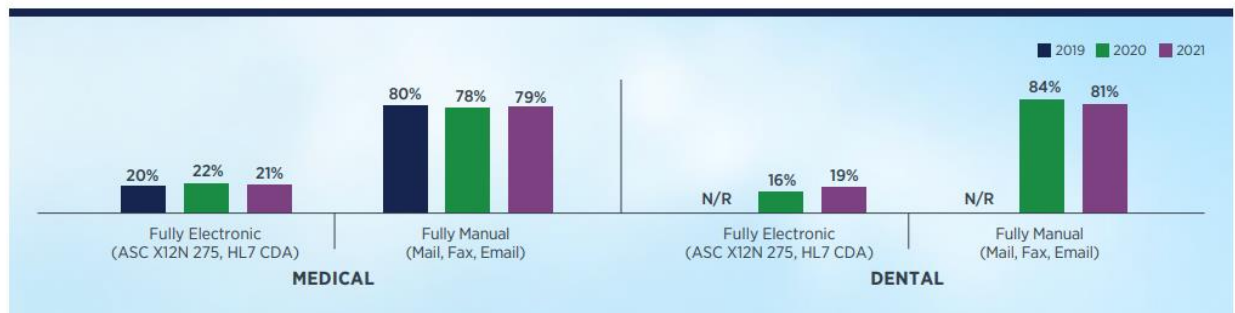
Electronic Prior Authorization: Time Savings Opportunity



Lastly, and most significantly, the time savings for medical providers are significant when you account for the volume of transactions that are conducted on a regular basis. In a post acute care setting where prior authorizations require coordination between hospitals, skilled nursing facilities, and health plans it is entirely likely that the time savings could be significantly more if fully electronic.

Equally important and relevant to the recommendation that CMS require medical record submission requests from health plans not be duplicative, is the significant cost and time expended when attachments are not fully electronic and requested multiple times.

**Medical Plan Adoption of Attachments
 2019-2021 CAQH Index**



CAQH data below illustrates the cost, time and savings that could be realized if health plans moved to electronic transactions for attachments. It also emphasizes the scope of potential breaches of

protected health information with the volume of mail, fax and email that exists in the current process.

Electronic Attachments: Cost Savings Opportunity

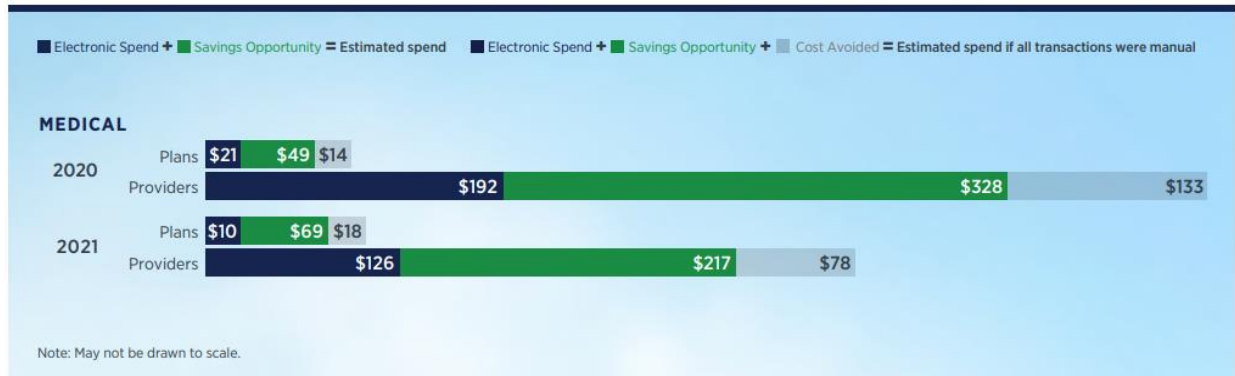


TIME SAVINGS OPPORTUNITY

Electronic Attachments: Time Savings Opportunity



**Attachments: How Much is Spent and Saved With Full Adoption?
 2020-2021 CAQH Index (in millions)**



5. Create a transparent appeals process. The current MA appeals process is designed in such a way that it deters beneficiaries from appealing in spite of provider support to assist with the process. Beneficiaries and families are dealing with a lot of stress and anxiety at a time of illness and the appeals process is time consuming and more importantly, stressful. beneficiaries and families are worried about the notification on the Notice of Medicare Non-Coverage that reads “You may have to pay for any services you receive after the above date”. Anecdotal experience suggests that beneficiaries who are of a higher socioeconomic status and education are more likely to appeal the decision. The current system appears to disproportionately disadvantage those from lower

socioeconomic brackets as they are much more concerned about the ability to pay should the appeal be denied. Thus, beneficiaries often forgo the appeals process.

From a provider perspective, the appeals process is not any easier and is both time consuming and resources intensive. Further, the limited appeal process is controlled by the insurer who offers three levels with the final being a peer review with a health plan physician. Some MA plans put barriers around which physicians may participate on behalf of the SNF provider and don't allow the medical director or other physician paid by the facility to participate. We encourage CMS to consider instituting a process that allows appeals to be heard under the federal appeal system after exhausting the initial redetermination and reconsideration levels with the MA plan provider.

Proposed Change: MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS.

Proposed Change: MA plans cannot deny coverage of a Medicare item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies. When there are no applicable coverage criteria in Medicare statute, regulation, NCD or LCD, MA organizations may create criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees and providers.

Comment: AHCA/NCAL strongly supports CMS' efforts to provide transparent and evidence-based rationale for coverage of Medicare services. While AHCA appreciates the direction CMS is proposing to make MA coverage policies more evidence-based and transparent through public posting requirements like the requirements of NCDs and LCDs in the FFS programs, we do not believe the protections go far enough. There does not appear to be any provisions related to an opportunity for public comment or CMS review prior to finalization of the internal MA coverage policy, nor does there appear to be any mechanism to request revision or rescission of a published policy, particularly if it contradicts Medicare statute, established NCDs or LCDs, or that does not consider scientific evidence that contradicts evidence used by the MA plan to establish the policy. Somewhat aligning with Traditional Medicare requirements is not sufficient. These protections should be the same regardless of whether the coverage policy is established under Medicare FFS or MA programs. We also recommend that CMS make it clear that these requirements extend to third-party organizations that health plans delegate UM functions to.

Additionally, we recommend that CMS establish a provider hotline, much like 1-800-Medicare, where providers can report issues they are experiencing with health plans around these guideline modifications along with other issues.

Proposed Change: Require that all MA plans establish a Utilization Management Committee to review all utilization management, including prior authorization, policies annually and ensure they are consistent with current, traditional Medicare's national and local coverage decisions and guidelines.

Comment: AHCA/NCAL is supportive of the establishment of internal oversight through the formation of a Utilization Management Committee. We recommend that the UM Committee include professionals who have expertise in the medical and rehabilitation needs of the SNF population and who have worked in the field. Feedback from network providers should also be included in the UM Committee process. We recommend that the Committee review compliance data resulting from audits of the implementation of

these new standards. The Committee should review and approve the audit process that is developed, and the resulting data collected. Additionally, approval of plans of corrections and evidence of the efficacy of those corrections should be reviewed and validated.

Transparency should be highlighted here and results of audits, Committee findings and minutes published for public review. Tying audit results and compliance to new standards should be considered as a STAR rating measure. This will provide transparency and an opportunity for beneficiaries to evaluate the ease with which they may access services when determining which health plan to join.

Proposed Change: Prohibition on diverting patients to settings other than recommended by the physician.

Comment: We strongly support this important distinction by CMS to prohibit MA plans from diverting a patient to a different level of care than recommended by the patient's physician (for example diverting a patient to home health when the physician requests a SNF admission) when the patient otherwise meets all the clinical criteria appropriate for the setting requested by the physician.

Gold Carding.

Comment: We strongly support and encourage the concept of gold carding as in theory it could significantly increase timely beneficiary access to care and reduce burden on providers that demonstrate high quality of care and good compliance with other requirements. However, we believe that CMS should establish at least minimum standards for what a MA plan can and cannot include in the gold carding process. For example, we believe that CMS should prohibit any consideration of the provider's negotiated rate within any gold carding criteria. Gold carding should be used as incentive for providers to improve care and compliance – not as another lever for the plans to punish good providers at the negotiating table by saying their negotiated rate is above what the plan is willing to pay to qualify for gold carding. Essentially, gold carding should not be tied to a requirement of accepting a lower reimbursement rate.

Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (422.111 and 422.2267)

Proposed Change: Establish specific enrollee notification requirements for no-cause and for-cause provider contract terminations and adding specific more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. Revising the requirements for the content of the notification to enrollees about a provider contract termination.

Comment: We agree this is an important action for CMS to take as availability of accurate provider data facilitates greater access to care. We suggest that CMS take this a step further to ensure that providers are not inadvertently harmed or perceived as having been terminated from the network. Providers have reported on multiple occasions that inconsistencies around accurate network data has created confusion and adversely impacted their residents/patients. Several examples are outlined below:

- A Provider has negotiated in good faith with a plan but determined that they cannot join or continue participation in a plan's network. With the increased administrative burden, low census post pandemic, ratcheting down of rates and staffing challenges it is simply not feasible to participate in contracts with some plans. As providers have notified plans of their intent to

terminate a contract or not join a network they have experienced various outcomes. Some who have voluntarily terminated their contracts with plans are never removed from the provider directory and current/former patients/members are not notified of the change in network status. This is especially concerning when the facility is the only one in a county or meets time and distance standards according to CMS HSD tables. The plan continues to offer their product in the county without meeting network adequacy and the hospitals and beneficiaries continue to believe the provider is in network. This confusion adds barriers to hospital discharges and ultimately beneficiary access to care.

- During COVID if a provider lost a contract or became an out of network provider plans began contacting residents about contract terminations and offering to move them to other facilities.

It is critical that providers are not portrayed as having been terminated for cause when they have voluntarily resigned from participation. We ask that CMS clarify that any notification to beneficiaries of provider/network adequacy changes do not paint providers who refuse participation or terminate contracts voluntarily as subpar providers.

Behavioral Health in Medicare Advantage (MA) (422.112 and 422.116)

Proposed Changes: Propose to (1) add Clinical Psychology Licensed Clinical Social Worker, and Prescribers of Medication for Opioid Use Disorder as specialty types that will be evaluated as part of the network adequacy reviews. The rule seeks to codify standards for wait times that apply to both primary care and behavioral health services, and clarify that some behavioral health services may be emergency services, and not subject to prior authorization requirements.

Comments: AHCA/NCAL supports CMS's efforts around health equity and its recognition of the importance of behavioral and mental health in a holistic approach to person centered health care.

In keeping with CMS' commitment to ensure access to enhanced primary care for medically complex, frail, and highly vulnerable populations especially duals and rural populations, AHCA/NCAL would like to draw CMS's attention to challenges with the current network adequacy requirements as it relates to those residing in long-term care facilities. Network adequacy requirements for I-SNPs are already barriers to plan development with provider types and numbers of providers based on a sampling of beneficiaries in an entire county not just those residing in the I-SNP nursing facilities. Due to the nature of the I-SNP population utilization of community based providers for Prescribers of Medication for Opioid Use Disorder and Clinical Psychology are providers that likely have very low utilization by long term care nursing facility residents. The opportunity exists for the CMS to enhance beneficiary access to LTC provider-led I-SNPs, promote meaningful competitions, specifically in rural areas, and reduce excessive administrative cost and burden by implementing solutions without compromising the key tenets of the network adequacy standards (i.e., access and undue burden). The solutions offered below reflect the localized patterns of care and specialty utilization of I-SNP beneficiaries. These solutions could be implemented either through instituting I-SNP-specific requirements or through the exceptions process of the network adequacy guidance.

1. Base the number of providers needed to meet network adequacy on the eligible population within a facility (or each facility in the case of a multi-facility plan) instead of a sampling of Medicare beneficiaries in the entire county.
2. Base the types of providers and facilities required on the needs and utilization patterns of individuals enrolled in such a plan, excluding those provider types for which claims for services provided to institutionalized residents represent five percent or less of total claims submitted on an annual basis and allowing for broader use of telehealth and other options to achieve network adequacy for low utilization specialty and provider types.
3. Reduce network adequacy time and distance standards for I-SNPs to a limited radius around a facility that more accurately reflects actual patterns of care and utilization.
4. Apply a concept similar to the Essential Hospital designation exception that exists for Regional PPOs to I-SNPs. If an I-SNP has in good faith made attempts to contract with the single hospital within a county and has offered at least Medicare rates and the hospital still refuses to contract, allow the I-SNP to use the hospital out of network, meeting network adequacy standards and thus not excluding that plan from operation in that county.
5. Alternatively, apply a comparable approach used for employer group waiver plans/MA private FFS plans in which plans are deemed to be in compliance if at least 50 percent of all services will be provided to plan enrollees by providers with written contracts with the plan; and plan enrollees who receive covered services from out-of-network providers have a cost sharing obligation no greater than what they would have had if the services were provided by in-network providers and shall be held harmless for any liability for such services provided by out-of-network providers.
6. Create a clear pathway in the exception review process for I-SNPs beyond the current specific provisions such as permitting a “good-cause” exception that would allow an I-SNP to obtain an exception from the network access standards for good cause.

Rationale: Network adequacy requirements were instituted to ensure beneficiaries have access to medically necessary services without placing “undue burden” on beneficiaries pursuing covered services. The CMS’ current number and type of specialties, time, and distance requirements as part of its network adequacy standards are appropriate for traditional MA plans that have a diverse and dispersed enrollee population. On the other hand, I-SNPs by design, enroll a Medicare beneficiary population that is limited to the contracted institutional LTC facility. These settings typically have population-relevant physicians and other primary care providers who deliver services onsite. Further, many I-SNP plans have mobile providers outside of PCPs, podiatry, hearing, dental, etc. that provide services at the nursing facility. Under current MA network adequacy requirements, I-SNPs that target and enroll a localized, subset of Medicare beneficiaries, must have enough primary care providers contracted to cover a sampling of beneficiaries across the entire county, not just those residing within the facility, even though the preponderance of primary care is delivered within the LTC facility.

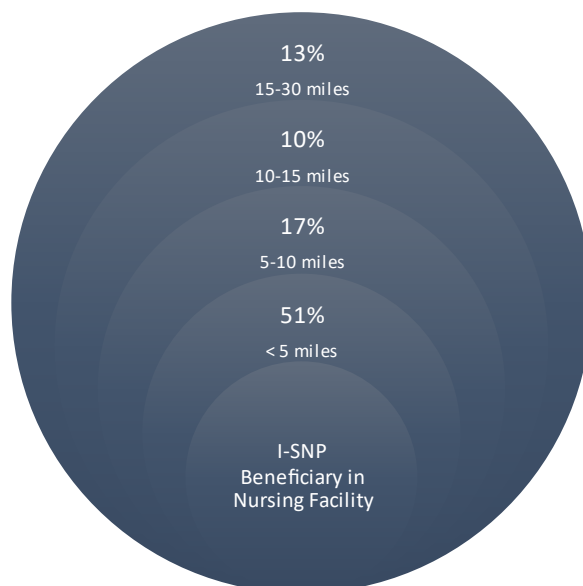
Given the requirements to meet an institutional level of care, residents of LTC facilities generally present with certain characteristics. These individuals rarely require the services of certain specialties such as plastic surgeons, allergists/immunologists, obstetricians and gynecologists, chiropractors, endocrinologists, and others. Of the small percentage of I-SNP enrollees who travel to receive care, the average travel radius from the facility is 11 miles (urban) and 31 miles (rural). Yet, I-SNPs are required

to meet network adequacy standards that address a utilization pattern of a general Medicare population across an entire county. The challenge with universally applying network adequacy standards to I-SNPs is that it disproportionately disadvantages locally committed, LTC provider led I-SNPs; as these plans are generally smaller and unable to leverage larger MA or commercial products to secure contracts with providers. Physician offices are not looking to incur the administrative burden of executing contracts, especially for patients they will rarely or never see.

Lastly, LTC provider-led I-SNPs have limited revenue impact on large health systems or hospitals given their smaller membership and utilization patterns. As these essential providers look to limit their own administrative burden and narrow the pool of contracting payers, LTC provider-led I-SNPs are at a significant disadvantage. This is a considerable issue in urban areas where consolidation of health systems has occurred and in rural areas where there is only one hospital or large market share by a provider. LTC provider-led I-SNPs have struggled with not securing a contract with a hospital even at above 100 percent of Medicare rates, which is the typical contract offer of LTC provider-led SNPs. The resulting lack of LTC provider-led I-SNPs not meeting the blanket application of traditional MA network adequacy standards is plan preclusion in those counties, thereby reducing access and choice for eligible beneficiaries to these specialized plans.

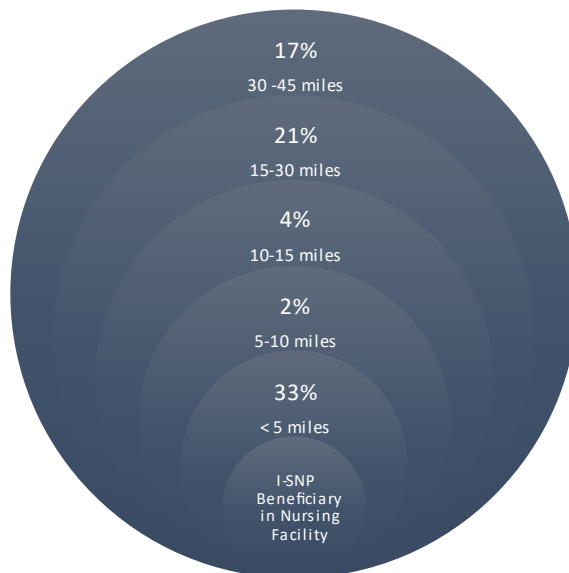
AHCA/NCAL's analysis of member reported data obtained from claims for the period 2019-2021 demonstrate the above points.

- 85% of total primary and specialty care is provided in the member facility primarily by advance practice professionals (NP/PAs).
- 96% of all advance practice care offered to I-SNP beneficiaries are offered in the facility.
- Of the 15% of providers seen off site (office/other), the average travel radius was approximately 15 miles (across urban and rural).
 - Average urban travel radius was 11.4 miles with over 50% within 5 miles or less and over 90% within 30 miles



Urban Travel Radius From Nursing Facility for Specialty Care

- Rural average was 31.1 miles with 33% within 5 miles and 77% within 45 miles.



Rural Travel Radius From Nursing Facility for Specialty Care

- Of the over 1.4 million claims, 26 out of 33 specialties are below 3% and nurse practitioner, internal medicine, family practice and physician assistants comprise 71% of all claims.
- Claims by specialties least often accessed include plastic surgery, 0.03%; allergy and immunology, 0.03%; Ob/gyn 0.06%; cardiothoracic surgery 0.01%; and chiropractors 0.3%.

Defining Institutional Special Needs Plans and Codifying Beneficiary Protections (422.2)

Comment: AHCA/NCAL supports the clarification of I-SNP types. We request that the types of I-SNP and enrollment numbers be included in the CMS MA monthly publicly available enrollment reports to better understand the growth in these plans.

CMS requested comment on whether regulatory text needs to more specifically address information sharing or other issues related to plan access to members residing in a facility. This is in response to reports CMS has received that providers sometimes fail to share relevant information regarding an enrollee’s health or need for care with the ISNP staff. We recommend that prior to any regulatory text revisions the issue be reviewed for substance and specifics. Best practices related to facility and plan staff joint participation could provide some useful examples. Plan reliance on requesting paper documentation over in person or virtual participation in facility activities is a sub optimal alternative. AHCA/NCAL providers would be happy to participate in discussions with CMS around these best practices.

We appreciate CMS’s acknowledgment that, as reported by MedPAC, I-SNPs perform better than other SNPs and other MA plans on the majority of available quality measures for SNPs and had much lower than expected hospital readmission rates than D-SNPs and C-SNPs. We recommend that CMS take this into consideration when addressing solutions for integration of Medicare and Medicaid with a nursing facility population. I-SNPs can play a significant role in furthering integration of these benefit packages for nursing facility residents and, based on the data referenced above, produce good if not better outcomes for this

specific population. We look forward to working with CMS on including I-SNPs in the array of dual integration solutions.

Amending the Definition of Severe or Disabling Chronic Condition; Defining C-SNPs and Plan Types; and Codifying List of Chronic Conditions (§ 422.2)

Comment: We support CMS amending the definition of severe or disabling chronic conditions to “have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits overall health or function, have a high risk of hospitalization or other adverse health outcomes, and require intensive care coordination and that is listed under [section 1859(f)(9)(A) of the Act].” In addition, we support CMS’s proposal to expand the C-SNP conditions to 22 chronic conditions and commend the expert panel on the recognition of the complexity of chronic conditions and the interplay of health, function, and outcomes.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (42 CFR 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186) (pg. 513)

Proposed Changes: A health equity index reward to further incentivize Part C and D plans to focus on improving care for enrollees with social risk factors (SRFs), and several changes to the star quality rating system.

Comment: The current quality system does not effectively capture the high risk, medically complex populations. Many of the current measures are not applicable to a SNP population, especially an I-SNP population. For example, there are no palliative care exclusions for Part D measures, yet there are beneficiaries on palliative care and some circumstances when beneficiaries will accept palliative care but not hospice care. Medications, such as RAS inhibitors, Statins, oral diabetic medications may no longer be appropriate for individuals nearing end of life. With the complexity of this population, adherence to these medications can prove to be difficult. The providers who are responsible for their clinical care are making decisions on medications based on the expected outcomes of their patient. This population simply cannot be viewed through the same lens as a standard Medicare beneficiary.

Given that the majority of LTC provider-led plans tend to be smaller, locally committed plans, many will never reach the enrollment threshold required to produce valid results for HEDIS and other measures. This results in an inability to be rewarded for quality under the Star Ratings system even when significant improvements in quality of care are being achieved. SNPs are caring for some of the most complex and frail Medicare beneficiaries, but most do not have access to the quality incentive program other MA plan types do. The inability to participate in the Star Ratings program also disadvantages SNP enrollees as plans are not able to increase the amount of rebate dollars they allocate to supplemental benefits. While individuals who participate in these plans, particularly I-SNP, their social needs are fully met. However, if plans could achieve an overall Star rating and receive the quality performance bonus, the availability of needed additional benefits could be provided.

Recommendation: We encourage CMS to reevaluate the Star Ratings system keeping in mind the high risk, medically complex population and considering exclusions to better reflect the SNP populations. These plans are serving the most vulnerable of the senior population and additional services are needed to continue to drive the quality outcomes CMS desires from the Star Rating program. These services come with a price and reevaluation of the program to account for these challenges is needed. We fully support

CMS' efforts in promoting health equity yet encourage CMS to evaluate the impact of the HEI reward factor and if it does not achieve the expected results, be open to methodological changes.

Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

Proposed Changes: Several proposals prohibiting deceptive marketing practices by MA plans and their agents such as prohibiting certain types of ads and use of imagery (e.g. Medicare logo, etc.) from being used; requiring agents to disclose all plans they represent; requiring agents to collect certain information from the prospective enrollees using a standardized list of questions prior to enrolling them into a plan and provide the prospective enrollee with information on how enrolling in a new plan will impact their current Medicare coverage; prohibiting marketing of benefits in a service area where those benefits are not available, and prohibiting marketing of savings available to potential enrollees that are based on a non-comparative population; and prohibiting the use of certain superlatives in advertising.

Comments: AHCA/NCAL supports CMS' efforts to ensure beneficiaries have the ability to make genuinely informed decisions when deciding on a plan and are protected from confusing, inaccurate, misleading information or those incongruent with their needs.

An example of marketing incongruencies is a D-SNP plan that is offering a monetary annual healthy food supplemental benefit, clearly an important and valuable benefit for those residing in the community. However, the plan is also aggressively marketing this benefit to those who reside in assisted living. Most assisted living residents have a structured/formalized dining program in place, which renders this benefit unnecessary. It appears that residents may be utilizing the money at certain grocery stores for items other than food or health related. Given this is a duals population, there may also be duplication of services that are provided and being paid for by Medicaid under the room and board rate.

Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (§§ 422.326(c), 423.360(c), (§ 401.305(a)(2))

Proposed Changes: Modify the legal standard for identifying an overpayment (from the current standard of "reasonable diligence" to the False Claims Act definition of ("knowingly") and create a lookback period and a timeframe to complete overpayments and underpayment notices, as well as a de minimis threshold for refunds and recoveries. This requirement would apply to payments under Medicare Parts A, B, C and D.

Comments: The changes to the legal standard for identifying overpayments contained in the proposed rule fails to account for the differences of maintaining a compliance program that is used to determine the existence of overpayments (or underpayments) and remediation of any discovered overpayments (or underpayments), from false claims enforcement. Although it is unclear exactly why CMS believes it is necessary to change its approach, the proposed rule incorrectly suggests that it is legally required to do so. The text and history of the relevant statutory provision (42 U.S.C. § 1320a-7k(d)(2)(A)) indicate that CMS must afford overpayment recipients with sufficient time to conduct audits and investigations to identify the size, scope, and nature of overpayments, so long as that overpayment recipient demonstrates good faith while working to identify the exact amount it must return to the Secretary. The proposed rule would in essence materially hamper or eliminate the ability of a payment recipient to have the time necessary to

ensure in good faith that it has identified size, scope and nature of overpayments so that the exact amount is returned to the secretary.

In fact, for good reasons Congress adopted this approach to permit the payment recipient to have the time necessary to ensure in good faith that it has identified size, scope, and nature of overpayments. A 60-day timeframe for returning overpayments, without an appropriate period to investigate and quantify the overpayment, is impractical. Once a potential overpayment is identified, the recipient's compliance and revenue cycle teams must conduct an extensive and rigorous audit investigation to collect facts, identify the source of the discrepancy, mitigate any continuing circumstances if the issue is ongoing, and determine exactly how much money must be returned. This requires identifying every claim that may have been overpaid by claim number, dates of service, and amount billed and paid. It also may involve complex statistical sampling followed by quality checks, as well as consultations with the Medicare Administrative Contractor. Given the six-year lookback period, moreover, in many instances claims data is already archived or stored on legacy systems and must be "restored" such that it can be queried for the unique claims at hand. And in some cases, identifying refunds involves applying different legal standards to different years of claims because Medicare rules change over time, further complicating the analysis and identification.

Previous CMS rulemaking on this topic, including the 2016 Final Rule on Reporting and Returning Overpayments, appropriately recognized these practical realities and clarified that up to six months is permitted to conduct a necessary investigation and appropriately quantify an overpayment. HHS should not depart from this current practice and enforce an unrealistically strict 60-day deadline on providers and plans to return overpayments. Instead, once an overpayment is known, HHS should permit a reasonable timeframe for the provider to identify repayment amounts before any 60-day clock is triggered. No judicial decision —and certainly no statute — requires any change in CMS's existing approach. To that end, HHS should withdraw this portion of the proposed rule and/or restore the portions of the 2016 Final Rule that afford providers with the necessary time to investigate and accurately identify overpayments.

Health Information Technology Standards and Implementation Specifications

In Sections S and T of the proposed rule, CMS is proposing several regulatory changes to electronic prescribing and health information technology standards to modernize the standards, as well as to align these evolving technology standards that serve multiple regulatory purposes in a single regulatory location so that changes in standards would apply simultaneously to all aligned programs.

- **Section III.S. Standards for Electronic Prescribing (§ 423.160) (pages 79548-79552)**

In this section of the proposed rule, CMS proposes a novel approach to updating e-prescribing standards by cross-referencing Part D requirements with standards adopted by the Office of the National Coordinator for Health Information Technology (ONC) and the standards adopted for electronic transactions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. A joint approach to adopting and updating electronic prescribing standards aims to mitigate potential compliance challenges for HHS and the healthcare industry that may result from independent adoption of such standards.

Specifically, CMS proposes updates to the standards to be used by Medicare Part D prescription drug plans for electronic prescribing (e-prescribing) as follows:

1. Adopting the National Council for Prescription Drug Plans (NDPDP) SCRIPT standard version 2022011 at 45 CFR 170.205(b), and retiring the current NCPDP SCRIPT standard version 2017071, as the e-prescribing standard for transmitting prescriptions and prescription-related information (including medication history and electronic prior authorization (ePA) transactions) using electronic media for covered Part D drugs for Part D eligible individuals. A transition period where either standard may be used would continue through December 31, 2024, at which time the NDPDP SCRIPT standard version 2022011 would be the only version permitted,
2. Requiring the NCPDP Real-Time Prescription Benefit (RTPB) standard version 12 proposed for adoption at 45 CFR 170.205(c) as the standard for prescriber real-time benefit tools (RTBTs) supported by Part D sponsors, and
3. Revising current regulatory text referring to standards for eligibility transactions to conform with the proposed changes above.

- **Section III.T. Adoption of Health IT Standards (45 CFR 170.205) (pages 79552-79556)**

In this section of the proposed rule, ONC proposes to adopt standards for electronic prescribing and related activities on behalf of HHS under the authority in Section 3004 of the Public Health Service Act (42 U.S.C. 300jj-14). ONC is proposing these standards for adoption by HHS as part of a nationwide health information technology infrastructure that supports reducing burden and health care costs and improving patient care. ONC is proposing to adopt these standards on behalf of HHS in one location within the Code of Federal Regulations (45 CFR 170.205) for HHS use, including by the Part D Program as proposed in section III.S. of this proposed rule. These proposals which would permit multiple HHS programs to cross-reference the adopted standards, reflecting a unified approach across the Department to adopt standards for electronic prescribing activities that have previously been adopted separately by CMS and ONC under independent authorities. This new approach is intended to increase alignment across HHS and reduce regulatory burden for stakeholders subject to program requirements that incorporate these standards.

Comment: AHCA supports the health information technology standards and implementation specifications changes and implementation timelines described in Sections III.S and III.T of the proposed rule. We note that per the Calendar Year (CY) 2022 Physician Fee Schedule (PFS) Final Rule (CMS-1751-F), nursing facility providers will need to comply with the Medicare Part D Electronic Prescribing of Controlled Substances (EPCS) requirements for long term care (LTC) prescriptions for controlled substances effective January 1, 2025. The proposed simplification and coordination of the regulatory backbone for the technology standards, and the completion of the transition period to the proposed updated standards prior to the nursing facility e-prescribing compliance date will be very helpful.

AHCA/NCAL is dedicated to improving lives by offering solutions for quality care. We thank CMS for the opportunity to offer comments on the 2023 MA and Part D proposed rule and would be happy to discuss 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.

Sincerely,



[Transmitted Electronically]

Michael W. Cheek
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