



Charles N. Kahn III
President & CEO

March 5, 2018

Electronically Submitted on www.regulations.gov

Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: 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 [CMS-2017-0163]

Dear Director Kouzoukas:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Many of our members contract with Medicare Advantage Organizations (MAOs) to provide services to Medicare Part C beneficiaries. We believe that it is important for the Centers for Medicare & Medicaid Services (CMS) to consider the views of direct providers of patient care to these beneficiaries in order to structure the Part C program to best serve beneficiary interests.

We are pleased to provide CMS with our views in response to the above-referenced *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA), Part C and Part D Payment Policies and the 2018 draft Call Letter* (draft Call Letter), published on February 1, 2018. In particular, the FAH is pleased that CMS is proposing

an increase in MAOs' baseline payment rates for 2019.¹ The development and adoption of adequate payment policies is critical for ensuring MAO enrollees' access to quality health care services, and CMS's proposed base rate helps achieve that goal. We are eager to meet CMS staff to discuss our concerns further and to answer any questions you might have regarding hospital operations and the care our members provide to Medicare beneficiaries.

Enhancements to the 2019 Star Rating System and Future Measurement Concepts

Integrating "Observation Stays" Would Improve the Accuracy of the Hospitalizations for Potentially Preventable Complications Display Measure and the HEDIS Plan All-Cause Readmissions Measure (pages 141 and 145)

We strongly support updating the specifications for the Hospitalizations for Potentially Preventable Complications display measure, as well as the HEDIS Plan All-Cause Readmissions measure, to consider "observation" stays in conjunction with inpatient admissions in calculating the measure.

As we have explained in previous comments to CMS, some MAOs inappropriately reclassify inpatient hospital stays as outpatient observation stays even when a beneficiary's admission to a hospital is based on an attending physician's written orders and meets nationally-recognized clinical management criteria for inpatient admission status. (See attached comments to Proposed Rule CMS-4182-P (Appendix A), at page 3, and comments to the draft Call Letter for CY 2018 (Appendix B), at pages 4-6.) When an inpatient admission is recategorized by the MAO as an outpatient observation stay: (1) hospitals are paid at a lower rate that is significantly less than the cost of the inpatient care provided to the beneficiary; (2) the beneficiary is confused regarding the retroactive reclassification of their stay and the appropriate level of cost-sharing involved; and (3) the MAO's performance on each of these quality measures is misstated because the rate of inpatient admissions is artificially reduced. **Integrating outpatient observation stays in the number of hospitalizations for the purposes of the Potentially Preventable Complications measure, and in the numerator and denominator for the purposes of the All-Cause Readmissions measure, will improve the accuracy of these measures, and we strongly support this change.**

Transitions of Care: The MAO Should be Responsible for Identifying and Connecting with the Primary Care Physician to Facilitate Smooth Transitions of Care (Part C) (p. 148)

We appreciate CMS's focus on improving transitions of care through a potential new HEDIS Transitions of Care measure, but urge CMS to focus responsibility for identifying and contacting the patient's primary care practitioner on the MAO. The first two indicators proposed for the transition of care message focus on notification of the primary care practitioner upon inpatient admission and transmission of discharge information to the primary care practitioner upon discharge. At present, hospitals face significant difficulties in identifying the patient's primary care practitioner, particularly when an MAO hospitalist oversees the patient's hospital

¹ Under the draft Call Letter, baseline MA payment rates for 2019 will rise by 1.84 percent on average. See CMS Fact Sheet, *2019 Medicare Advantage and Part D Advance Notice II and Draft Call Letter* (Feb. 1, 2018), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-01.html>.

care. Frequently, the patient’s primary care practitioner is not identified on their benefits card, the primary care practitioner identified on the card is incorrect, or the patient simply does not know who is his primary care practitioner.

Because the MAO is in a better position to identify and communicate with the patient’s primary care practitioner, the burden of doing so should be borne by the MAO. Along these lines, the first two indicators for the proposed Transitions of Care measure should be revised to emphasize the MAO’s role in contacting the primary care practitioner. **At a minimum, we urge CMS to add the following indicator if the proposed measure is adopted: “MAO identifies the primary care practitioner to the hospital within 24 hours of receiving the admission notice.”**

Inclusion of Admissions that Follow a Skilled Nursing Facility Stay May Create Perverse Incentives for MAOs (pages 145 and 150)

We urge CMS to exercise caution in counting admissions that follow a stay at a skilled nursing facility (SNF) for the purposes of calculating total readmissions for the purposes of the All-Cause Readmissions measure, or adopting this as a new measure called Readmissions from Post-Acute Care. The draft Call Letter notes, “A readmission event during or after a SNF stay may be the result of inadequate provider communication during care transitions and poor discharge planning.” (Page 150.) We agree that communication is critical during these transitions, and we support the goal of pursuing coordination of care.

We are concerned, however, that inclusion of post-SNF admissions in a new or existing measure of readmissions may create an incentive for an MAO to delay a beneficiary’s transition from an acute care setting to a SNF longer than is clinically appropriate. This strategy would improve an MAO’s performance on the measure because it eliminates the potential for a hospital readmission from the SNF. But any improvement in the MAO’s score would not represent higher quality of care, and the cost of care would have *increased* because of the extended time in the more costly inpatient space.² The MAO may also be inappropriately shifting its costs to hospitals, whose payments are typically fixed, by avoiding payments to SNFs. And, importantly, the result is that the beneficiary is kept in a more restrictive inpatient setting than is necessary.

We encourage you to consider these risks when deciding whether or how to integrate post-SNF admissions in either of these measures.

Improving Measures of Beneficiary Access (pages 140-141, 157)

We appreciate CMS’s efforts to improve measures of beneficiary access. The Star Rating System provides much-needed transparency in this area, and several current measures – including Plan Makes Timely Decisions About Appeals and Reviewing Appeals Decisions – provide critical insight into whether MAOs appeals processes are effective and fair.

² In contrast, post-SNF admissions may prove to be a useful criterion for consideration in setting star ratings for SNFs.

CMS has proposed to modify the Plan Makes Timely Decisions About Appeals measure to take into account appeals dismissals that are dismissed by the Independent Review Entity (IRE) because the MAO has subsequently approved coverage or payment. **We laud this initiative to only favorably consider dismissals that result from a determination to extend coverage. But we would also like to see a negative impact on an MAO's performance on the measure for appeals dismissed for procedural reasons.** This would encourage plans to reach the merits of beneficiary coverage disputes.

Transparency, Increased Cost-Sharing, and Beneficiary Confusion

The draft Call Letter sets forth several policies that would provide MAOs with greater flexibility but could limit transparency and increase beneficiary cost-sharing and confusion.

Total Beneficiary Cost (TBC) (p. 171)

The FAH supports CMS's denial of plan bids that propose too large an increase in cost-sharing or decrease in benefits from one year to the next. CMS currently uses the TBC standard (i.e., the sum of the plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs) to make that determination, but indicates in the draft Call Letter that it is considering eliminating this method in the future. **The FAH urges CMS not to eliminate the TBC without an effective replacement methodology in order to comply with the statute and protect beneficiaries from significant increases in cost or decreases in benefits. Additionally, regardless of the methodology used, CMS should require plans to send beneficiaries a separate notification of the upcoming plans year changes – as well as an accounting of year over year changes for that plan.** Such a requirement would assist beneficiaries in making their annual election decision and give them insight into plan trends affecting their costs.

Maximum Out-of-Pocket (MOOP) Limits (p. 174)

The FAH supports the requirement that MA plans must limit enrollee out-of-pocket spending to at or below the annual maximum amounts set by CMS. This requirement ensures that beneficiaries do not face large fluctuations in their out-of-pocket spending from year to year and provides transparency for beneficiaries regarding their financial obligations under a given plan. **The quality of information provided to beneficiaries could be improved, however, by requiring that supplemental benefits are also subject to the MOOP, rather than allowing MAOs to determine their treatment.** The current, voluntary approach to supplemental benefits means that some MAOs include them in the MOOP while others do not. This results in an apples to oranges comparison that is confusing for beneficiaries when selecting an MA plan. Beneficiaries would be better served by enabling them to make a simple, direct comparison of MOOP limits that include supplemental benefits.

Part C Cost-Sharing Standards (p. 176)

The FAH urges caution in allowing MAOs to shift costs to enrollees in an effort to manage utilization, as these strategies are simply inappropriate for Medicare beneficiaries. We are specifically concerned that CMS is proposing to allow increased enrollee cost-sharing

obligations for emergency visits up to \$120 for plans that adopt the voluntary MOOP and \$90 for plans that adopt the mandatory MOOP, an increase of \$10-20 over the 2018 plan year cost-sharing obligations.³ This would be the second year in a row where CMS adopted a 20 percent or greater increase to the cost-sharing limit for outpatient services.

There is an incorrect belief that emergency departments are routinely over utilized by patients as a replacement for primary care. When Medicare beneficiaries visit the emergency department, the visit often results in an outpatient observation stay or admission for an inpatient stay. Fully 96 percent of Medicare beneficiaries report having a usual source of care, and 87 percent of MA enrollees reported that they could “always” or “usually” make a timely appointment for routine care.⁴ **With that in mind, the FAH is troubled by efforts to discourage emergency department visits among Medicare beneficiaries through increased cost-sharing or coverage denials,⁵ and we urge CMS to maintain the 2018 cost-sharing amounts for the 2019 plan year.**

In many cases, these cost-sharing obligations are simply too burdensome for enrollees, and hospitals are left with unpaid bills. Our members have anecdotally reported that for every \$100 that an MA plan increases beneficiary inpatient copayments, a hospital is left with an additional 1 percent of their expected net revenue as bad debt from enrollees in that plan. Unlike original Medicare, MAOs are not specifically required by regulation to reimburse providers for their uncollected beneficiary cost share (i.e., copayments, co-insurance, etc.), with narrow exceptions in the context of certain dual-eligible beneficiaries. This occurs despite the fact that costs for Medicare bad debt are built into the capitation rates the Medicare program pays to MAOs. Because CMS does not require MAOs by regulation to reimburse providers for the bad debts of their enrollees, many hospitals, especially those in smaller systems and individual facilities, have been unable to negotiate such reimbursement from plans. Thus, hospitals are regularly seeking payment from patients, and reasonable efforts to collect these cost-sharing amounts are often unsuccessful. From 2014 to 2016, the amount of cost-sharing that some of our member hospitals could not collect from MA plan enrollees grew by about 5 percent on an already considerable portion of uncollectible accounts, likely now approaching a collection rate of just below 50 percent of such accounts. Even where cost-sharing amounts are successfully collected, the collection costs for providers are also substantial. **To ensure collection risks are more fairly allocated between providers and MAOs, we urge CMS to require MAOs to reimburse providers for their enrollees’ unpaid cost-sharing obligations.**

Because beneficiaries do not generally misuse emergency departments, and because increasing beneficiaries’ cost-share generally results in more bad debt for hospitals, emergency services are inappropriate targets for MAOs’ cost-cutting strategies, and efforts to manage utilization by shifting costs for these services to enrollees and providers are simply misguided. **We therefore strongly encourage you to limit MAOs’ ability to impose higher cost-sharing**

³ According to the Final CY 2018 Call Letter, this amount is currently \$100 for plans that adopt the voluntary MOOP and \$80 for plans that adopt the mandatory MOOP. CMS, *2018 Final Call Letter* at p. 125 (April 3, 2017), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf>.

⁴ Kaiser Family Foundation analyses of the 2011 Medicare Current Beneficiary Survey (MCBS) Access to Care File and the 2012 Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

⁵ We also encourage you to consider whether increased cost-sharing for emergency department visits might be discriminatory in violation of 42 C.F.R. section 422.100(f).

for emergency services. If CMS is going to allow MAO flexibility in assessing cost-sharing by enrollees, including for those MA plans that adopt the lower, voluntary MOOP, **CMS should ensure those costs are not shifted to providers by amending its regulations to specifically require that MAOs reimburse providers for the uncollected debt of their enrollees.** After all, MAOs are in a much better position than providers to collect cost-sharing from enrollees, as they are the creators of the plan's benefit design.

Tiered Cost-Sharing of Medical Benefits (p. 181)

The FAH continues to have strong concerns about tiered cost-sharing, which can undermine meaningful access to affordable health care for beneficiaries. Usually, beneficiaries have no familiarity with this concept when choosing medical services, which causes them confusion in navigating their insurance coverage. For example, tiered cost-sharing can be misleading and result in an inadequate number of providers in a network or deprive patients of access to high quality providers. Beneficiaries may choose a plan because a certain provider is in a plan's directory only to find out after the fact that their cost-sharing obligations effectively prohibit access. Further, despite CMS's requirement that plans disclose tiered cost-sharing amounts to enrollees, these disclosures are often so confusing to enrollees that they are surprised by high out-of-pocket costs when they visit in-network providers. Moreover, tiered cost-sharing does not lend itself to many types of services, especially emergency procedures and inpatient admissions from the emergency department. Beneficiaries who need immediate treatment are not in a position to compare prices, and it is particularly unfair to burden them with differentiating among their in-network providers. Not only is this a challenge to informed plan selection for beneficiaries, but it also results in unexpectedly higher cost-sharing for necessary, life-saving services.

As the marketplace evolves, caution is needed to ensure that these tiered cost-sharing strategies do not inappropriately undermine beneficiary access. **A provider's in-network status should be determined by its contracting status and should not fluctuate on a per-service, per-enrollee basis.** These distinctions could cause beneficiary confusion and threaten to disrupt meaningful beneficiary choice and access, patient-provider relationships, and coordination of care.

Outpatient Observation Status (p. 182)

The FAH supports CMS's efforts to ensure that cost-sharing for observation services is more transparent for beneficiaries by distinguishing the cost-sharing for observation services from other outpatient services. The FAH has previously expressed concerns about observation status in the MA program, specifically that some MAOs inappropriately reclassify inpatient hospital stays as outpatient "observation" stays. We reiterate here that determining patient status – whether inpatient or observation status – is a clinical decision made by a highly-trained medical professional; it is not in the purview of an MAO to second-guess that judgment.

MAOs may describe this reclassification as an effort to discourage unnecessary inpatient stays and manage costs, but whether a patient should be admitted to the hospital is a clinical decision and not one that the patient is in any position to influence. As we have described before

in our comments on the Advance Notices of Methodological Changes and draft Call Letters for CYs 2017 and 2018, as well as in our comments on the recent Proposed Rule, MAOs often reclassify hospital stays as outpatient observation stays even when the patient was admitted based on an attending physician's written orders that meet nationally-recognized clinical management criteria for inpatient admission status. MAOs may impose greater cost-sharing on outpatient services than on inpatient services. By reclassifying an inpatient stay as "observation status," even after an enrollee has already been discharged from the hospital, an MAO can shift more costs to the enrollee and ultimately bring about an overall payment rate to the hospital that is significantly below the cost of care provided to the beneficiary. Given how frequently MAOs change the status of claims from inpatient to observation, MAOs are routinely putting enrollees at financial risk by deploying these cost-cutting tactics.

In order to address the concerns of patients and providers, the FAH suggests that CMS use the fee-for-service Two-Midnight Rule as informative guidance for MAOs when reviewing inpatient admissions vs. observation stays. The FAH agrees with CMS that the Two-Midnight rule, as updated in the CY 2016 Hospital Outpatient Perspective System Final Rule, appropriately emphasizes "the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries."⁶ **An MA program policy modeled after the Two-Midnight Rule would improve transparency for providers and patients and prevent inappropriate, post-stay reclassifications by MAOs that increase cost-sharing for beneficiaries and decrease payment for providers.**

Provider Directories and Network Adequacy

Enforcement Actions for Provider Directories (p. 165)

The FAH appreciates CMS's reminder to MAOs in the draft Call Letter that inaccurate provider directories "could result in compliance and enforcement actions," including "Civil Monetary Penalties (CMPs) and other enforcement actions." The FAH has long-agreed with CMS that "inaccurate provider directories can impede access to care and bring into question the adequacy and validity of the Medicare Advantage Organization's (MAO's) network as a whole."

A recently released CMS report found that over 50 percent of the provider directories reviewed between September 2016 and August 2017 had at least one inaccuracy, including: inaccurate provider location; incorrect phone number; or inaccurately listed the provider as accepting new patients.⁷ Importantly, CMS found "that these findings were not skewed by a few

⁶ Under the Two-Midnight Rule: inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation; and for stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review. See CMS Fact Sheet, *Two-Midnight Rule* (Oct. 30, 2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html>.

⁷ CMS, *Online Provider Directory Review Report* at p. 1 (Jan. 19, 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf. (footnote continued)

organizations, but were widespread in the sample reviewed,” leading CMS to conclude that “MAOs are not adequately maintaining the accuracy of their directories.”⁸ **The FAH was pleased to see that, based on the results of the report, CMS issued compliance actions against a number of MAOs,⁹ and we strongly encourage CMS to continue these enforcement actions to ensure that beneficiaries have accurate information when selecting plans and providers.**

CMS Should Undertake Enforcement Actions for Network Adequacy

While the FAH was pleased to see CMS continuing to address inaccurate provider directories, we are disappointed that CMS has not addressed our concerns about MAOs’ lack of compliance with network adequacy requirements. As the FAH has previously noted, an MAO’s apparent compliance with network adequacy standards may obscure issues with actual network adequacy and the scope of represented provider options to enrollees within the network, if the MAO uses downstream organizations to provide administrative and health care services to beneficiaries. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees’ de facto provider network.

Unfortunately, network adequacy looks at the whole network a plan identifies, not at the sub-network to which many enrollees are relegated. These “networks within a network” are often far narrower than the provider network depicted in the provider directory or the Health Service Delivery (HSD) tables on which CMS based its approval of an MAO, thus creating a more narrow network as the beneficiary moves through the healthcare continuum. Enrollees may have selected a particular MAO plan on the basis of its provider network, only to realize later that a downstream organization will discourage enrollees from accessing particular providers. This is especially problematic when a hospital is identified as in-network in the provider directory, but the physicians affiliated with the hospital, while in the main network, are not a part of the physician or provider group to which the downstream organization directs enrollees. Moreover, the downstream organization’s sub-network may not meet the network adequacy standards to which the MAO is subject.

Additionally, our MA patients also experience situations in which a patient stay no longer meets the standards of care for inpatient services, but there are no medically appropriate post-acute settings available for discharge. This occurs because the MAO faces no additional financial costs to extend a patient’s hospital length-of-stay under the MS-DRG system, but would face additional costs if it transferred the patient to the appropriate post-acute provider of care. Patients have a right under the Medicare Act to be treated in an appropriate environment, and this includes a discharge from the inpatient hospital setting when appropriate.

The FAH recommends four actions CMS could undertake to address these concerns. **First, CMS should implement audit protocols that identify and review these downstream**

⁸ *Id.* at 7.

⁹ CMS issued: 23 Notices of Non-Compliance, 19 Warning Letters, and 12 Warning Letters with a Request for Business Plan. See *Id.* at 9.

organizations and take enforcement actions, as necessary, for noncompliance with network adequacy standards. Second, CMS should require that MAOs demonstrate meaningful access, including a review of availability of listed post-acute providers that are accepting MA patients. Third, we also urge an audit of MAO practices associated with approving timely discharges to an appropriate post-acute care setting. Fourth, CMS should include a standard in the Star Ratings Program to promote the adequacy and stability of an MAO's network. Specifically, CMS should design a measure to ensure that beneficiaries are aware of the historical problems that any MAO has had both with the initial adequacy of its networks and with the changes an MAO has made during the course of a year that affect its networks.

New Medicare Card Project (p. 167)

The FAH appreciates CMS's efforts to educate stakeholders about the upcoming change from Social Security Numbers (SSN) to the Medicare Beneficiary Identifiers (MBI) on Medicare cards. The FAH also appreciates that health care providers and MA plans can use either the SSN or the MBI to exchange beneficiary information with CMS during the transition period (April 1, 2018 – December 31, 2019). **We continue to encourage CMS to undertake the necessary testing to ensure that MA plans are ready for this transition and to ensure that providers are able to connect a beneficiary's MA plan number to the MBI.**

CMS Should Maintain the Meaningful Difference Requirement to Reduce the Risk of Beneficiary Confusion When Comparing Enrollment Options (pages 170-171)

In our comments to the recent Proposed Rule on the Medicare Advantage Program, we urged CMS to retain the meaningful difference requirement in order to ensure that beneficiaries are not overwhelmed or confused by their range of choices of MA plans. Please refer to our previous comments for a discussion of the value of the meaningful difference requirement. (See Appendix A at pages 4-5.)

CMS Should Make Clear that Added Flexibility in Satisfying the Uniformity Requirement Does Not Allow MAOs to Impose Greater Cost-Sharing or Reduce Any Benefits (pages 184-185)

In our comments to the recent Proposed Rule on the Medicare Advantage Program, we expressed our general support for CMS's new interpretation of the uniformity requirement set out in 42 C.F.R. section 422.100, subdivision (d). (See Appendix A at page 3.) We support CMS's efforts to provide MAOs with flexibility to better serve beneficiaries with chronic conditions and special needs, and we appreciate CMS's sensitivity to the risk that such flexibility may be abused to discriminate against beneficiaries with particular health needs.

In our previous comments, we also urged CMS to clarify that this new interpretation of the uniformity requirement would allow MAOs to provide supplemental benefits or reduce cost-sharing, but would *not* allow MAOs in any case to *reduce* benefits or *increase* cost-sharing. We view this requirement as essential to ensuring that MAOs do not use any new flexibility in satisfying the uniformity requirement in order to discriminate against beneficiaries with certain health care needs, and we urge you to make this clear in the Final Call Letter.

Parts A and B Cost-Sharing for Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program (p. 190)

The FAH appreciates CMS's desire to ensure that individuals enrolled in the QMB Program are not incorrectly made responsible for coinsurance, copayments, and deductibles. FAH member hospitals are knowledgeable about and supportive of the different cost-sharing obligations for QMB Program participants and appreciate CMS's recognition in the draft Call Letter that "timely access to enrollees' QMB status is critical to inform, monitor, and promote provider compliance with these requirements." CMS is correct however that health care providers are often unaware of a patient's QMB status. Plans are best situated to both know their enrollees' status in the QMB Program and to provide that information to health care providers. Thus, **rather than simply encourage plans to provide this information to providers, the FAH recommends that CMS require plans to "affirmatively inform providers about enrollee QMB status information,"** such as through online provider portals, phone queries, the Explanation of Payment document, and via member identification cards.

Prior Authorization Processes Should be Transparent, Timely, and Reliable (p. 193)

The FAH appreciates CMS's focus on transparency and timeliness where an MAO requires prior authorization for a covered service. **We also urge CMS to affirm that prior authorizations must also be reliable for the enrollee and provider.** As noted in the draft Call Letter, a prior authorization is a pre-service organization determination, meaning that it is a pre-service determination by the plan with respect to payment for post-stabilization care, urgently needed services, or other covered health services. **An MAO that provides prior authorization for an inpatient admission or a procedure should then be bound by that pre-service organization determination at the time of payment.** MAOs, however, sometimes reverse such determinations based on a revised medical necessity determination made after submission of the claim. Such a process creates unacceptable confusion and financial risk among enrollees and providers that properly submit a request for prior authorization and then act in reliance on the MAO's prior authorization of the service. Instead, the MAO's prior authorization should be treated as a binding determination upon which the provider and enrollee should be able to rely for coverage and payment purposes.

In addition, the FAH thanks CMS for its acknowledgement that CMS rules concerning the timeframes for pre-service organization determinations under 42 C.F.R. sections 422.568 and 422.572 are applicable to prior authorization requests. The FAH emphasizes that these regulations properly require that the plan make organization determinations "as expeditiously as the enrollee's health condition requires." As a result, a plan may be obligated to make a determination on a request for prior authorization in fewer than 72 hours where necessary based on the enrollee's condition. See 42 C.F.R. § 422.572(a).

The FAH appreciates the opportunity to comment on the draft Call Letter. We look forward to continued partnership with CMS as we strive for a continuously improving health care system. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to be "A. M. ...". The signature is fluid and cursive, with a large initial letter 'A' and a long horizontal stroke extending to the right.



Charles N. Kahn III
President & CEO

January 16, 2018

Electronically Submitted on www.regulations.gov

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

Re: Notice of Proposed Rulemaking 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 Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Many of our members contract with Medicare Advantage Organizations (MAOs) to provide services to Medicare Part C beneficiaries. We believe that it is important for the Centers for Medicare & Medicaid Services (CMS) to consider the views of direct providers of patient care to these beneficiaries in order to structure the Part C program to best serve beneficiary interests.

To that end, we are pleased to provide CMS with our views in response to the above-referenced notice of proposed rulemaking (Proposed Rule), which was published in the Federal Register on November 28, 2017 (82 F.R. 56336). We would be eager to meet CMS staff to discuss our concerns further and to answer any questions you might have regarding hospital operations and the care our members provide to Medicare beneficiaries.

I. Flexibility for MAOs to Vary Benefit Design Can Result in Unreasonable Cost-Sharing Burdens for Beneficiaries and Leave Providers with More Uncompensated Care (II.A.2, 4, 5)

The Proposed Rule sets forth several policies that would provide MAOs with greater flexibility to configure beneficiary cost-sharing responsibilities. For example, the Proposed Rule would reinterpret an existing regulatory requirement that an MAO offer its plans “with uniform benefits and level of cost-sharing throughout the plan’s service area”¹ to allow a Medicare Advantage (MA) plan to offer enrollees reduced cost-sharing for certain services. Relatedly, the Proposed Rule announces that CMS intends to consider specific factors and sources of information in establishing the mandatory and voluntary maximum out-of-pocket (MOOP) limits.

We commend the agency’s goal of ensuring MA plans are designed to address beneficiaries’ needs and manage their health. We are concerned, however, that MAOs may conflate this admirable goal with the goal of cutting their own costs, and we urge you to exercise caution in affording MAOs flexibility in benefit designs. Drawing from our members’ experience providing care directly to beneficiaries, we have found that “innovative” plan designs can and do undermine CMS’s goals by increasing beneficiary confusion and imposing unreasonable burdens on beneficiaries and costs on providers of care.

High cost-sharing can discourage beneficiaries from receiving necessary care and burden them with unreasonable costs. It is important to keep in mind that this population is financially vulnerable; in 2013, for example, about 36 percent of Medicare Advantage enrollees had incomes under \$20,000.² Cost-sharing responsibilities are particularly burdensome for this population and may cause them to forego care.

Targeted reductions in cost-sharing in the manner described in the Proposed Rule can eliminate financial barriers to care and enable beneficiaries to better manage their conditions. For example, the Proposed Rule suggests that under the new interpretation of 42 C.F.R. section 422.100(d), an MAO could “offer diabetic enrollees zero cost-sharing for endocrinologist visits.” We would welcome such efforts: for patients with chronic conditions, reduced cost-sharing for necessary services can make the difference between managing the condition and avoiding an acute episode, or causing difficult choices that delay care and encourage an acute episode. Managing conditions in this way can improve patients’ overall health, eliminating the need for future interventions and reducing overall spending. But we are concerned that MAOs may seek to offset reductions in cost-sharing for certain services by increasing cost-sharing for other services. Such offsets should be unnecessary if MAOs are properly configuring cost-sharing to best manage beneficiaries’ care to reduce the need for higher-cost services through prevention of acute episodes. **We urge you to clarify that your interpretation of the uniformity requirement would only allow MAOs to reduce their enrollees’ cost-sharing obligations and that such reductions cannot form the basis for any increase in cost-sharing for other services.**

¹ 42 C.F.R. section 422.100(d).

² CMS: 2013 Characteristics and Perceptions of the Medicare Population (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html>).

We also urge you to exercise caution in allowing MAOs to shift costs to enrollees in an effort to manage utilization. Two examples illustrate how these strategies are simply inappropriate for Medicare beneficiaries.

First, there is an incorrect belief that emergency departments are routinely overutilized by patients as a replacement for primary care. Whether in response to this belief or to other concerns, CMS allowed increased enrollee cost-sharing obligations for emergency visits up to the limit set out in the annual call letter last year.³ But the concern that emergency departments are overused by Medicare beneficiaries is simply misplaced: when Medicare beneficiaries visit the emergency department, the outcome is typically an outpatient observation stay or admission for an inpatient stay. Fully 96 percent of Medicare beneficiaries report having a usual source of care, and 87 percent of Medicare Advantage enrollees reported that they could “always” or “usually” make a timely appointment for routine care.⁴ With that in mind, we would be troubled by any efforts to discourage emergency department visits among Medicare beneficiaries through increased cost-sharing or coverage denials.⁵

Second, we have previously commented that some MAOs inappropriately reclassify inpatient hospital stays as outpatient “observation” stays. Though MAOs may describe this as an effort to discourage unnecessary inpatient stays and manage costs, whether a patient should be admitted to the hospital is a clinical decision and not one that the patient is in any position to influence. As we have described before in our comments on the Advance Notices of Methodological Changes and Draft Call Letters for CYs 2017 and 2018, MAOs often reclassify hospital stays as outpatient observation stays even when the patient was admitted based on an attending physician’s written orders that meet nationally-recognized clinical management criteria for inpatient admission status. MAOs may impose greater cost-sharing on outpatient services than on inpatient services. By reclassifying an inpatient stay as “observation status,” even after an enrollee has already been discharged from the hospital, an MAO can shift more costs to the enrollee and ultimately bring about an overall payment rate to the hospital that is significantly below the cost of care provided to the beneficiary. Given how frequently MAOs change the status of claims from inpatient to observation, MAOs are routinely putting enrollees at financial risk by deploying these cost-cutting tactics.

In many cases, these cost-sharing obligations are simply too burdensome for enrollees, and hospitals are left with unpaid bills. Our members have anecdotally reported that for every \$100 that an MA plan increases beneficiary inpatient copayments, a hospital is left with an additional 1 percent of their expected net revenue as bad debt from enrollees in that plan. Unlike original Medicare, MAOs are not specifically required by regulation to reimburse providers for their uncollected beneficiary cost share (i.e., copayments, co-insurance, etc.), with narrow exceptions in the context of certain dual-eligible beneficiaries. This occurs despite the fact that costs for Medicare bad debt are built into the capitation rates the Medicare program pays to

³ According to the Final CY 2018 Call Letter, this amount is \$100 for plans that adopt the voluntary MOOP and \$80 for plans that adopt the mandatory MOOP. 2018 Final Call Letter at p. 125 (April 3, 2017), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf>.

⁴ Kaiser Family Foundation analyses of the 2011 Medicare Current Beneficiary Survey (MCBS) Access to Care File and the 2012 Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

⁵ We also encourage you to consider whether increased cost-sharing for emergency department visits might be discriminatory in violation of 42 C.F.R. section 422.100(f).

MAOs. And because CMS does not require MAOs by regulation to reimburse providers for the bad debts of their enrollees, many hospitals, especially those in smaller systems and individual facilities, have been unable to negotiate such reimbursement from plans. Thus, hospitals are regularly seeking payment from patients, and reasonable efforts to collect these cost-sharing amounts are often unsuccessful. From 2014 to 2016, the amount of cost-sharing that some of our member hospitals could not collect from MA plan enrollees grew from 40 percent to 45 percent.

This is only exacerbated when MAOs are given greater flexibility regarding their plans' cost-sharing configurations. Because an MAO sees no increased exposure from shifting costs to the enrollee, it has no incentive to evaluate or consider the affordability of its enrollees' cost share or to minimize its enrollees' exposure to collections activity.

As we have described, emergency services and patient status, that is observation versus inpatient hospital stays, are inappropriate targets for MAOs' cost-cutting strategies, and efforts to manage utilization by shifting costs for these services to enrollees and providers are simply misguided. **We therefore strongly encourage you to limit MAOs' ability to impose higher cost-sharing for emergency services and observation care.** If CMS is going to allow MAO flexibility in assessing cost-sharing by enrollees,⁶ including for those MA plans that adopt the lower, voluntary MOOP, **CMS should ensure those costs are not shifted to providers by amending its regulations to specifically require that MAOs reimburse providers for the uncollected debt of their enrollees.** After all, MAOs are in a much better position than providers to collect cost-sharing from enrollees, as they are the creators of the plan's benefit design.

II. Eliminating the "Meaningful Difference" Requirement Will Lead to Increased Beneficiary Confusion (II.A.6)

Starting with the 2019 contract year, CMS proposes to eliminate the requirements that plans offered by the same MAO in an area be meaningfully different with regard to key plan characteristics. CMS's stated goal of this proposal is to "improve competition, innovation, available benefit offerings, and provide beneficiaries with affordable plans that are tailored for their unique health care needs and financial situation."⁷

The FAH believes this proposal is more likely to lead to increased beneficiary confusion rather than improved competition and benefit offerings. Medicare beneficiaries choosing MA already have a plethora of options for their health care coverage. Data released by CMS in the fall of 2017 touted lower MA average monthly premiums and record-breaking MA enrollment in 2018, with more than one-third of Medicare enrollees (34 percent) expected to be in an MA plan in 2018. CMS also noted continued strong access to MA, with 99 percent of Medicare enrollees with access to an MA plan, and more than 85 percent of Medicare enrollees with access to ten or

⁶ The FAH also notes CMS's request for comment on whether to include the use of MA encounter data in determining annual cost-sharing limits on Part A and B services to prevent discriminatory benefit design (42 C.F.R. section 422.100(f)(6)). It is currently not possible to comment on the appropriateness of using encounter data in this context when the data is not available for providers and other stakeholders to analyze.

⁷ 82 F.R. 56363 (November 28, 2017).

(footnote continued)

more MA plans.⁸ And, in the proposed rule, CMS states that there were 18 beneficiary-weighted average plans per county in 2017.⁹

Reports from the Medicare Rights Center¹⁰ and the Center on Aging at American Institutes for Research¹¹ note that the existing options within the Medicare program are often overwhelming for beneficiaries. CMS acknowledged such research studies in the proposed rule.¹² These are the concerns that led to CMS implementing the meaningful difference requirement in the first place, with the goal of improving beneficiaries' ability to select the best plan for their health care needs. Given that: the meaningful differences requirement has helped alleviate some of that confusion; beneficiaries have maintained strong access to MAOs (*i.e.*, an average of 18 plans per county) after implementation of the policy; and the policy adds very little administrative requirements per plan (about two hours per plan),¹³ it is unclear what purpose is served by removing the meaningful differences requirement.

CMS also cites concerns with administering the meaningful difference requirement should the Agency finalize its proposals related to flexible benefit options under the proposed rule. **Should CMS finalize those proposals, the FAH suggests that the meaningful difference standard not be abandoned, but rather be adapted to consider the more flexible benefit options CMS develops under the proposed rule.** While the FAH has concerns, further detailed elsewhere in this letter, that the flexibility in benefit designs proposed by these rules could lead to greater consumer confusion, consumers should at least be informed when two plans offered by the same MAO represent only nominal differences in terms of premiums, cost sharing, benefits, and networks. Given continued MA enrollment growth and an average of 18 options per county, it is not clear that consumers currently demand or need more choices. Also, even if more choices are offered, the FAH would suggest that the meaningful difference standard could be adapted to differentiate between real and illusory choices.

⁸ CMS Press Release: Medicare Offers More Health Coverage Choices and Decreased Premiums in 2018 (September 29, 2017), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-09-29.html>.

⁹ 82 F.R. 56363 (November 28, 2017).

¹⁰ Medicare Rights Center, *Medicare Trends and Recommendations: An Analysis of 2015 Call Data from the Medicare Rights Center's National Helpline* (March 2017), <https://www.medicarerights.org/2015-medicare-trends>. The analysis found that 23 percent of calls to the Medicare Rights Center's helpline in 2015 were regarding Medicare enrollment or disenrollment.

¹¹ Center on Aging at American Institutes for Research, *Medicare Complexity Taxes Counseling Resources Available to Beneficiaries* (October 2016) <http://www.air.org/system/files/downloads/report/Medicare-Complexity-Taxes-Counseling-Resources-October-2016-rev.pdf>. The brief cites research from 2011 and 2014 stating that, "Many beneficiaries do not choose the highest value plans – those offering the highest quality with the lowest cost – and they avoid switching plans because they fear that care may be disrupted, costs may be higher, or that they will need to learn a whole new set of rules and requirements."

¹² 82 F.R. 56363 (November 28, 2017).

¹³ 82 F.R. 56481 (November 28, 2017).

III. CMS Should Explore Opportunities to Improve the MA Quality Rating System (II.A.11)

MA Star Ratings System Could Benefit from Well-Designed Physician and Hospital Survey Tool and Measures

The FAH supports inclusion of survey measures of physician experiences into the Star Ratings System, so long as the survey tool is mindful of the burden surveys place on the physician's time and resources. The FAH also supports including survey measures of hospital experiences and encourages CMS to utilize a survey tool that would allow hospitals to provide such feedback as well. Hospitals, like physicians, interact with health plans daily and communicate continually with plans about beneficiaries ongoing care needs both within the hospital and in preparing for care after discharge from the hospital. **As noted above, such a survey tool should balance the administrative burden on the physician and/or hospital against the benefit survey-based measures provide to beneficiaries when selecting MA plans. The FAH stands ready to work with CMS on designing and implementing a survey tool that strikes this balance.**

Opportunities to Improve Measures – Incorrect Patient Status Undermines the Accuracy of the Star Ratings Program

The accuracy of Star Ratings can be impacted by changing patient status from inpatient to observation. Readmission rates reported to Medicare are clearly reduced as a consequence of such reclassifications. We have expressed these concerns in prior year comment letters, and CMS seems to be aware of these concerns, as indicated in the Medicare Advantage 2018 Final Call Letter:

“NCQA is exploring several revisions to the HEDIS Plan All Cause Readmission measure based on feedback they have received from the field and stakeholders. These revisions may impact the definition of the denominator, numerator and risk adjustment model for data collected in 2018. The specific revisions they are exploring include 1) *Inclusion of observation stays in the denominator and numerator....* [Emphasis added.]”¹⁴

The FAH agrees that including outpatient observation stays for MAOs in the numerator and denominator of an All Cause Readmission Measure helps to discourage improper patient classification. **We encourage CMS to include the All Cause Plan Readmissions from the Star Rating measures for CY 2019 and to include observation stays for MAOs in the numerator and denominator.**

Opportunities to Improve Measures – CMS Should Promote Network Adequacy Through the Star Ratings Program

The FAH has previously expressed concern that an MAO's apparent compliance with network adequacy standards may obscure issues with actual network adequacy and the scope of

¹⁴ 2018 Final Call Letter at p. 107 (April 3, 2017), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2018.pdf>.

represented provider options to enrollees within the network, if the MAO uses downstream organizations to provide administrative and health care services to beneficiaries. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees' de facto provider network.

Unfortunately, network adequacy looks at the whole network a plan identifies, not to the sub-network to which many enrollees are relegated. These “networks within a network” are often far narrower than the provider network depicted in the provider directory or the Health Service Delivery (HSD) tables on which CMS based its approval of an MAO, thus creating a more narrow network as the beneficiary moves through the healthcare continuum. Enrollees may have selected a particular MAO plan on the basis of its provider network, only to realize later that a downstream organization will discourage enrollees from accessing particular providers. This is especially problematic when a hospital is identified as in-network in the provider directory, but the physicians affiliated with the hospital, while in the main network, are not a part of the physician or provider group to which the downstream organization directs enrollees. Moreover, the downstream organization's sub-network may not meet the network adequacy standards to which the MAO is subject.

While we encourage CMS to implement audit protocols that identify and review these downstream organizations, **we also suggest the inclusion of a standard in the Star Ratings Program to promote the adequacy and stability of an MAO's network.** Specifically, CMS should design a measure to ensure that beneficiaries are aware of the historical problems that any MAO has had both with the initial adequacy of its networks and with the changes an MAO has made during the course of a year that affect its networks.

Opportunities to Improve Measures – CMS Should Not Incorporate Dismissals in its “Timely Decision about Appeals” Measure

CMS uses as a measure for purposes of the Star Rating system, the effectiveness of an MAO in resolving beneficiary appeals of MAO determinations. The current measure, Reviewing Appeals Decisions/Appeals Upheld measures (Part C & D), focuses only on merits decisions. The timeliness aspect of the measure for purposes of IRE review changed its time horizon in CY 2017 from April 1, to May 1. At page 109 of the 2018 Final Call Letter, CMS indicates it will consider modifying the measure for CY 2019 to include appeal dismissals and withdrawals of appeals.

While we express no opinion on counting the withdrawal of an appeal for purposes of the measure, as it may reflect a merits-based resolution of an appeal, we oppose any future change to include dismissals in the measure for two reasons. First, the measure is designed to improve the beneficiary experience with the appeals process. That experience is not improved by encouraging plans not to reach the merits of the beneficiary appeal through a dismissal. Second, simply including dismissals as a positive factor in the measure creates an incentive within an MAO to increase the opportunities to enter dismissals, for example, by imposing procedural obstacles to a beneficiary briefing the merits of her appeal. As an association of providers, we have been

exposed over many years to the creation of roadblocks to merits decisions in an administrative setting, because the appeal body is being evaluated on managing its docket. Beneficiaries generally do not have the level of legal experience necessary to confront such roadblocks to a merits-based resolution of a dispute. **While we understand CMS’s desire to reevaluate and improve measures across all of the Star Ratings programs, we hope that CMS will take into consideration the concerns raised above, as well as those raised “by the majority of respondents [that] do not agree with adding withdrawn and dismissed appeals to the Part C appeals measures.”**¹⁵

IV. Eliminating the Mandatory Use of CMS-Developed Compliance Training Will Maximize Effective Training for Employees, Eliminate Confusion, and Reduce Unnecessary Provider Burden (II.B.2)

Under current regulations, compliance programs for MA and Part D organizations must include training and education between the compliance officer and the sponsoring organization’s employees, senior administrators, governing body members, as well as their first-tier, downstream and related entities (FDRs). CMS is proposing to eliminate the mandatory use of CMS-developed training for compliance purposes, and replace it with a general requirement for each MA organization to have such a program. Specifically, FDRs, including hospitals, would no longer be included as needing such training and education.

CMS discussed in the proposed rule that, when it first required a single federal training program (developed by CMS), it hoped the program would reduce the burden for plans and FDRs of being subjected to too many repetitive and overlapping training requirements for each sponsor with which they had a relationship. CMS noted in the proposed rule that, as a practical matter, the problem has persisted, and FDRs are still being subjected to multiple sponsors’ specific training programs and have the additional burden of taking CMS training and reporting completion back to the sponsor or sponsors with which they contract. Further, CMS explains that since implementation of the mandatory CMS-developed training has not achieved the intended efficiencies, the Agency is proposing to delete the provisions requiring use of the CMS-developed training. CMS also notes that it does not generally interfere in private contractual matters between sponsoring organizations and their FDRs, and because CMS continues to audit sponsors’ compliance programs including their monitoring, auditing, and oversight of FDRs, this requirement is no longer necessary.

The FAH strongly supports this proposal and commends CMS for taking steps to relieve this significant and unnecessary regulatory burden on hospitals. Compliance training is a critical component of health care operations, and hospitals have focused concerted efforts over many years to ensure that their employees receive high value, interactive training that effectively engages them and creates measurable impact in employee behavior consistent with the desired outcomes of the training protocols. Hospitals and other FDRs have long satisfied the compliance training requirement, and many other aspects of program integrity training, using their own internal programs.

¹⁵ 2018 Final Call Letter at p. 183 (April 3, 2017), <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf>.

Requiring FDRs to train employees for some aspects of program integrity using an internal program, while using the CMS training module for compliance or code of conduct training, has been administratively burdensome and confusing for employees. Further, the related attestation requirements also are burdensome as various MAOs require different attestations, which is particularly problematic for hospitals and large hospital systems that train and attest for up to hundreds of thousands of employees each year.

We also note that though the CMS-developed general compliance training content is intended to be purposefully generic to be relevant to various health care entities, in practice, it contains terms of art and other phrases (references to agents and brokers, for example) that may be inapplicable to certain health care entities and their employees. This creates undue confusion for employees and places an administrative burden on compliance staff who must field questions and provide explanations about matters that are not relevant to their business.

CMS's proposal to eliminate the mandatory use of the CMS-developed training program will address the above concerns and permit hospitals to administer their own comprehensive and personalized compliance training programs that are very specific to the compliance protocols in that particular hospital or hospital system. This includes devoting valuable resources to produce highly engaging and relevant Code of Conduct training information about a hospital's Ethics Line and reporting processes, as well as the hospital's commitment to creating a culture of non-retaliation. Training programs that are developed uniquely for a particular hospital or hospital system will ensure that employees receive effective, clear and high-quality compliance training.

We appreciate that since implementation of the CMS-developed training program, the Agency listened to the concerns of FDRs and had permitted some flexibility regarding the requirement. **However, eliminating mandatory use of the CMS-developed training altogether, as now proposed by CMS, will maximize the impact of the existing high value, interactive and effective training programs that hospitals currently administer to employees, while relieving hospitals of administrative burden and employee confusion associated with use of the current generic, one-size-fits-all approach. Therefore, we offer our strong support for this proposal.**

V. **Minimum Enrollment Requirements and Regular Monitoring of MAOs' Financial Health is Critical to Ensuring Beneficiaries Do Not Experience Disruptions in Care (II.B.3)**

MA plans are generally required to maintain adequate enrollment levels. Under 42 C.F.R. section 514, however, CMS can waive these requirements for up to three years while monitoring the MAO's financial and administrative capacity and ability to manage to risk, as well as its marketing and enrollment efforts, on a year-to-year basis. The Proposed Rule would eliminate this annual evaluation and allow CMS to grant a three-year waiver of the minimum enrollment requirement. This waiver would only be available to contract applicants, *not* to existing MAOs.

When an MAO has low enrollment numbers, its financial stability may fluctuate dramatically over weeks or months. By reviewing a waiver request annually, CMS can ensure that an MAO is not experiencing financial hardship that may cause it to fail in the middle of a

plan year, potentially disrupting enrollee access to care and inevitably causing significant confusion. **We encourage CMS to retain its existing policy of reviewing waiver requests on an annual basis.**

VI. Marketing Requirements Should Be Carefully Crafted to Allow Providers to Communicate with their Patients (II.B.5)

We appreciate CMS’s efforts to clarify the scope of communications that are considered “marketing materials” and are subject to various restrictions. In particular, we support the proposal at 42 C.F.R. section 422.2260 to exclude specific types of communications from the definition of “marketing materials,” including materials that “mention benefits or cost-sharing, but do not meet the definition of marketing in this section,” which specifies that marketing materials must be “intended to draw a beneficiary’s attention to a MA plan or plans” and to “influence a beneficiary’s decision-making process when making a MA plan selection or influence a beneficiary’s decision to stay enrolled in a plan.”

We read proposed 42 C.F.R. section 422.2260 to allow providers that serve MA beneficiaries to communicate directly with those patients regarding their care, and those communications would not be considered “marketing materials” within the new definition. **We therefore respectfully request that you exclude from the definition of “marketing materials” any communications from providers or MAOs to their patients regarding their care, including communications regarding cost-sharing responsibilities or listing the plans in which a provider participates.** CMS does not generally require providers to seek CMS’s approval for communications with patients who are enrolled in traditional Medicare. As long as the provider-patient or MAO-patient communication does not serve to “influence a beneficiary’s decision-making process when making a MA plan selection or influence a beneficiary’s decision to stay enrolled in a plan,”¹⁶ then we see no reason why such communications regarding cost-sharing obligations should be subject to CMS’s review simply because the patient receives Medicare benefits through an MAO.

VII. Creation of a “Preclusion List” to Define the Set of Providers That Cannot Serve MA Plan Enrollees is not as Effective as Requiring Medicare Enrollment (II.B.11)

As described in the Proposed Rule, in 2017, CMS finalized a rule under which providers must be enrolled in traditional Medicare by 2019 in order to serve MA plan enrollees. The Proposed Rule indicates that CMS has received feedback from providers that it is overly burdensome, and perhaps duplicative, to require providers to undergo health plan credentialing and to be enrolled in traditional Medicare. The Proposed Rule acknowledges, however, that “Medicare enrollment, in conjunction with MA credentialing, is the most thorough means of confirming a provider’s compliance with Medicare requirements and of verifying the provider’s qualifications to furnish services and items.”¹⁷

We agree with this statement, and we urge CMS to maintain the requirement that providers enroll in traditional Medicare rather than adopting the “Preclusion List” system.

¹⁶ 42 C.F.R. section 422.2260 (proposed).

¹⁷ 82 F.R 56448 (November 28, 2017).

While the Proposed Rule describes the Preclusion List as an effort to reduce the burden on providers, it strikes us as more inefficient to maintain two separate systems – a “Preclusion List” and the traditional Medicare enrollment system – than to simply require all providers that seek to serve any Medicare beneficiaries to enroll in traditional Medicare. It seems particularly onerous on CMS and providers alike in light of the fact that, according to the Proposed Rule, nearly half of providers who serve MA enrollees are already enrolled in traditional Medicare.

We continue to support the now-finalized rule at 42 C.F.R. section 422.222 requiring providers to enroll in traditional Medicare in order to serve MA plan enrollees, which ensures that *all* Medicare beneficiaries are served by providers that satisfy CMS’s rigorous criteria. The preamble to that final rule explained the requirement as follows:

We believe that MA organization enrollees should have the same protections against potentially unqualified or fraudulent providers and suppliers as those afforded to beneficiaries under the fee-for-service (FFS) and Part D programs. Indeed, Medicare beneficiaries and enrollees, the Medicare Trust Funds, and the program at large, are at risk when providers and suppliers that have not been adequately screened, furnish, order, certify, or prescribe Medicare services and items and receive Medicare payments.... Requiring enrollment allows us to have proper oversight of providers and suppliers, making it more difficult for these types of providers and suppliers to enroll in Medicare and remain enrolled in Medicare. Furthermore, it allows us to remove a enrolled provider or supplier that does not comply with our rules across Medicare (Part A, Part B, MA, and Part D).¹⁸

We believe that requiring Medicare enrollment of all providers that serve Medicare beneficiaries is the most effective way to protect all Medicare beneficiaries. Moreover, removing the requirement that providers enroll in traditional Medicare in order to serve MA plan enrollees would eliminate a powerful incentive for providers that serve MA enrollees to enroll in traditional Medicare. This is an effective tool for ensuring that all Medicare beneficiaries have widespread access to care, and we see no reason to abandon it.

With these concerns in mind, we urge you to retain the current Medicare enrollment requirement. **However, if CMS adopts the proposal to create a Preclusion List, we urge you to make clear that any provider that is currently enrolled in traditional Medicare could not be placed on the Preclusion List.** This guarantee would not apply to any providers that are revoked from Medicare or under a reenrollment bar; rather, it would simply establish that participation in traditional Medicare is sufficient for a provider to serve MA plan enrollees.

VIII. Greater Transparency in MAO Medical Record Requests Would Reduce Provider Burden – Comment Solicitation (II.B.13)

For several years, hospital providers and affiliated physicians have experienced very burdensome requests for medical records connected with a twice-yearly CMS imposed deadline on MAOs to provide risk adjustment data. CMS establishes the deadlines each year

¹⁸ 81 F.R. 80447 (November 15, 2016).

approximately ten weeks in advance. Once the deadlines are published, providers receive a flood of requests for medical records, typically in February and September, no more than 30 days before the deadline. These requests are separate and apart from the more limited, and typically more specific, requests for medical records pursuant to RADV audits.

We appreciate CMS's longstanding recognition that the transmission of risk adjustment data for this purpose is governed by the agreements negotiated between MAOs and providers, as reflected in 42 C.F.R. section 423.310(d).¹⁹ To the extent CMS seeks to alleviate unnecessary burden on providers that provide risk adjustment data to MAOs pursuant to those agreements, hospitals continue to encourage CMS to require that MAOs furnish providers with a copy of any CMS request to the MAO that supports a request of medical records from that provider. This would provide for greater transparency as to the appropriate scope and extent of CMS's need for supporting medical records and clarify for providers what medical records are necessary for CMS audit purposes versus medical records that are being requested to support enhanced risk adjustment scores. Our member hospitals spend hundreds of hours addressing MAO requests for medical records that are overly broad and general. For example, many MAOs ask for all records in a given date range for their covered beneficiaries, regardless of whether the medical records have any potential impact on the given patient's risk scores. Ensuring MAOs provide context for their record requests would allow providers to respond more efficiently.

IX. Reducing Medical Loss Ratio Requirements Will Limit CMS's Oversight Ability (II.C.1)

The FAH urges CMS to ensure robust plan auditing to assure MAOs are meeting their Medical Loss Ratio (MLR) requirements. In the proposed rule, CMS proposes to dramatically reduce MAOs' minimum MLR reporting requirements. **CMS has an obligation to monitor and accurately measure MLR for Part C plans, and the FAH encourages continued oversight to confirm that an MAO's MLR reflects a complete and accurate snapshot of claims actually paid in the most recent periods possible.** We are skeptical, given the level of services denials and patient status disputes that our members have experienced in the last several years, that the MAOs are satisfying MLR ratios if they are calculated on a claims paid basis. The FAH believes that the reduced data collection requirements proposed by CMS will only exacerbate this problem as limited data in turn limits CMS's ability to fulfill its oversight obligations.

X. Physician Groups That Bear Risk Under a Physician Incentive Plan Need Adequate Stop-Loss Insurance Coverage to Mitigate Any Perverse Incentives to Withhold Care (II.C.5)

CMS has long recognized the need for balance in Physician Incentive Plans (PIPs). In the final rule adopting changes to the PIP regulations in 1996, for example, CMS noted the importance of incentivizing physicians and physician groups to manage utilization not only to "prevent unnecessary spending, but also to reduce the risk of unnecessary and intrusive procedures." At the same time, however, CMS recognized the need to "ensure that all medically

¹⁹ See, e.g., 73 F.R. 48652 (Aug. 19, 2008).

necessary services are furnished both to protect patient health and to avoid the need for more costly care later.” 61 F.R. 13432.

These concerns remain valid, and the PIP program’s stop-loss coverage requirements are integral to ensuring that financial concerns and cost sensitivity never overtake clinical considerations. With that in mind, we urge you to exercise caution in changing the level and nature of stop-loss insurance coverage that physicians and physician groups must maintain in order to take on “substantial financial risk” within the meaning of the rule. **We support the proposal to retain the existing standard for identifying “substantial financial risk” under 42 C.F.R. section 422.208(d)(2).** To the extent CMS adopts a methodology by which it would modify the level of coverage required on a regular basis without engaging in further rulemaking, we would appreciate the opportunity to comment on those changes, and we therefore support the proposal in paragraph (f)(2)(iv) to publish the table in a guidance document, such as the annual rate announcement.

The FAH appreciates the opportunity to comment on the Proposed Rule. We look forward to continued partnership with CMS as we strive for a continuously improving health care system. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,





Charles N. Kahn III
President & CEO

March 3, 2017

Electronically Submitted to AdvanceNotice2018@CMS.HHS.Gov

Cynthia G. Tudor, Ph.D.
Acting Director, Center for Medicare
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore MD. 21244

Re: Advance Notice of Methodological Changes for Calendar Year (“CY”) 2018 for Medicare Advantage (“MA”) Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter

Dear Acting Director Tudor:

The Federation of American Hospitals (“FAH”) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Many of our members contract with Medicare Advantage Organizations (“MAOs”) to provide services to Medicare Part C beneficiaries. We believe that the views of direct providers of patient care to these beneficiaries is important for the Centers for Medicare and Medicaid Services (“CMS”) to consider in structuring the Part C program to best serve beneficiary interests.

We are pleased to provide CMS with our views in response to the *Advance Notice of Methodological Changes for Calendar Year 2018 for Medicare Advantage, Part C, and Part D Payment Policies and the 2018 Call Letter* (“Call Letter”). In particular, the FAH is pleased that

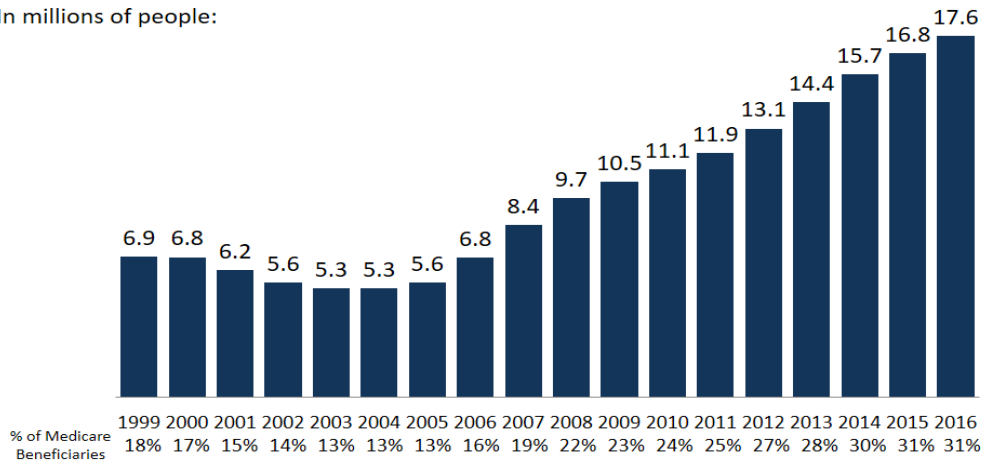
CMS is proposing an increase in MAOs’ baseline payment rates for 2018.¹ The development and adoption of adequate payment policies is critical for ensuring MAO enrollees’ access to quality health care services, and CMS’s proposed base rate helps achieve that goal. Below we discuss additional provisions in the Call Letter that we believe also will promote enrollee access to quality medical care, including adequate provider networks offered to MAO enrollees.

I. The Growth of the Medicare Part C Program is Unprecedented and Compels Robust CMS Oversight of Program Policies and Plans

The Kaiser Family Foundation reports that private health plan enrollment in Medicare has grown dramatically, more than tripling from 5.3 million beneficiaries in 2006 to 17.6 million enrollees in 2016, which is almost one in three people on Medicare. In 2016, Medicare Advantage constituted 31 percent of total Medicare enrollees, as compared to 13 percent in 2005. Current monthly enrollment data from CMS indicates that enrollment as of February 2017 stands at 19.6 million people, of the more than 58 million Medicare eligible population, or almost 34 percent of the eligible population. In fact, Medicare Advantage may outstrip the size of original Medicare within the next decade, and CBO projects that about 41 percent of Medicare beneficiaries will be enrolled in Medicare Advantage in 2026.

Total Medicare Private Health Plan Enrollment, 1999-2016

In millions of people:



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

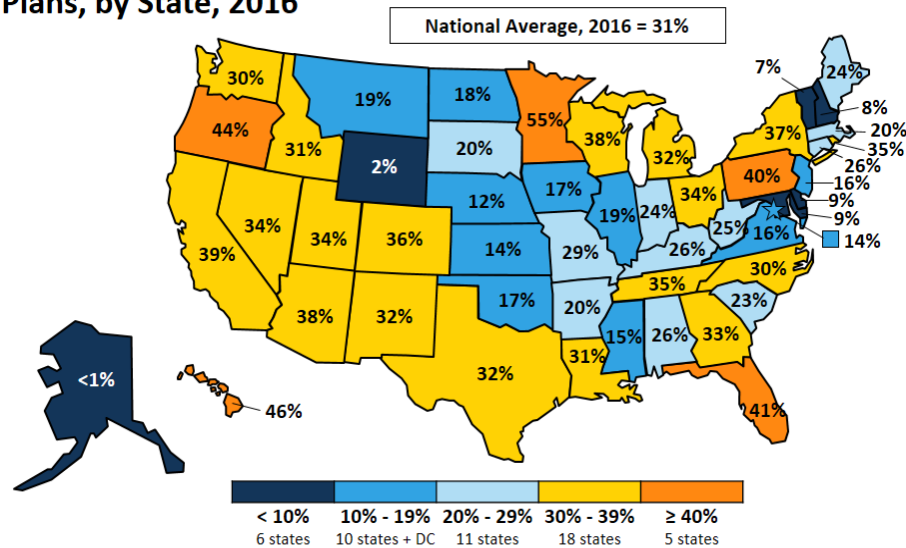
SOURCE: Authors’ analysis of CMS Medicare Advantage enrollment files, 2008-2016, and MPR, “Tracking Medicare Health and Prescription Drug Plans Monthly Report,” 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.



¹ Under the Call Letter, baseline Medicare Advantage payment rates for 2018 will rise by 0.25 percent on average. See CMS Fact Sheet, *2018 Medicare Advantage and Part D Advance Notice and Draft Call Letter* (Feb. 1, 2017).

While Medicare Advantage enrollees in 2016 represented more than 31 percent of all Medicare beneficiaries, in several large states Medicare Advantage enrollment significantly exceeds the national average:

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2016

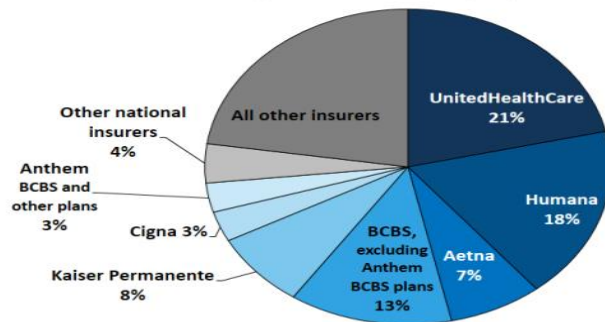


NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2016.



And as we noted last year, Medicare Part C's primary three contractors now represent more than half of all beneficiaries.

Medicare Advantage Enrollment, by Firm or Affiliate, 2016



Total Medicare Advantage Enrollment, 2016 = 17.6 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and excludes Anthem BCBS plans. Anthem includes BCBS plans, which comprise 2% of all enrollment (approximately 410,000 enrollees), and other plans, which comprise about 1% of all enrollment (about 149,000 enrollees). Other national insurers includes about 692,800 enrollees across the following firms: Wellcare, Centene, and Universal American. Percentages may not sum to 100% due to rounding.
SOURCE: Authors' analysis of CMS Enrollment files, 2016.



Given these trends, major policy decisions affect not just health plans, but also beneficiaries and providers. **Therefore, program policies and their impact on stakeholders should be given adequate focus and robust oversight by CMS, with opportunity for ongoing stakeholder feedback, as well as appropriate notice and comment on policy proposals.** Further, while we appreciate that CMS, in compliance with the *Securing Fairness In Regulatory Timing Act of 2015*, Pub. L. No. 114-106 Section 2, has provided a 30-day comment period for the draft Call Letter, **we respectfully request, for the CY 2019 process and subsequent years, that CMS allow more time for beneficiaries and other stakeholders to consider these important matters before public comment is due.** The Administrative Procedure Act considers 60-days notice before comment as adequate for this purpose.

II. The Misuse of Medical Necessity Determinations to Reclassify Inpatient Stays as “Observation Status,” Has a Wide Range of Adverse Impacts on the MA Population and the Accuracy of CMS Information Used to Assess MAOs (Attachment VI: 2018 Call Letter p. 106)

Through comments we provided in 2016 and 2015, in response to the Advance Notice of Methodological Changes and Draft Call Letters for calendar years 2017 and 2016, we highlighted our concerns about MAO patient status determinations. Our member health systems and hospitals are reporting that billed hospital inpatient stays, with written attending physician orders for inpatient admission status that meet nationally recognized clinical management criteria, are being reclassified at ever-increasing rates to outpatient observation stays by the MAOs either through retrospective remittance advice denials or during the stay by MAO-employed or contracted hospitalists, medical directors and/or case management departments.² In addition, at-risk physician groups and/or management service organizations (“MSOs”) that are participating in downstream full risk arrangements with MAOs are acting in a similar manner regarding their physician orders for observation status.

Many MAOs also have failed to adopt the Medicare Inpatient Only list of procedures reflecting those that should always be performed in an inpatient hospital setting. CMS created and revisits the list annually to promote quality outcomes for Medicare patients by ensuring care is provided in the right clinical setting. This effort should not vary depending on whether a Medicare beneficiary participates in traditional Medicare or Medicare Advantage. Below we address those above concerns again in light of the OIG’s new Work Plan targeted to evaluate the impact of capitated payment arrangements on denied services.³

² In markets where MAOs have risk arrangements with organized physician groups, delegated medical groups or downstream management service organizations (collectively, “downstream organizations”), these relationships often involve sub-capitation contracts that shift financial risk where some or all of the Part A and Part B premium is funded to the downstream organization. Those downstream organizations substantially over-utilize outpatient observation status due to the financial incentives inherent in their risk arrangements with MAOs.

³ See OIG Work Plan 2017 at p. 28 (“Capitated payment systems, such as those used by CMS to pay MA plans, may create financial incentives for plans to underserve beneficiaries. We will examine national trends and oversight by CMS of denied care within MA. We will determine the extent to which services were denied, appealed, and overturned in MA from 2013 to 2015. We will also compare rates of denials, appeals, and overturns across MA plans and evaluate CMS’s efforts to monitor and prevent inappropriate denial of care in MA.”)

A. MAOs are Treating Inpatient Stays as Observation Services at Increasing Rates

The vehicle for this wholesale reclassification of patient status as observation rather than inpatient, has varied based on either: (1) a selective application of the Medicare “two-midnight rule” that was intended to provide clarity about inpatient or outpatient status, rather than arbitrarily reduce the overall number of inpatient hospital stays; or (2) Milliman Care Guidelines modified opaquely by MAOs so that providers have no predictability in assessing patient status. The sense of our membership is that since the two-midnight rule was adopted, the number of inpatient stays reclassified by MAOs as “outpatient observation status” has continued to increase in the MA population as compared to the Medicare fee-for-service (“FFS”) population. The potential explanation for these increases in observation status in the MA population may be explained in part in some counties by premium risk shifting by MAOs to physician groups for the provision of services and care, incentivizing such sub-capitated groups and potentially affecting decisions on patient status. An inordinate number of observation stays are very long stays, in excess of three days. Our members have observed these trends for several years, and are concerned that the increases in observation status use are now appearing in markets where there is no significant level of sub-capitation. Challenges to denied inpatient status through the appeal process are somewhat successful even at the first level of appeal with plans, but such appeals should be unnecessary as many denials of inpatient status through appeal should not be occurring.

With the introduction of the Medicare Outpatient Observation Notice (“MOON”) this March, along with the high level of long stay observation status in the MA population, increased confusion to enrollees is inevitable. Implicit in the MOON notice are the presumptions of the two-midnight rule, that if a physician believes the stay is expected to cross two midnights, an admission order should be written. But that is clearly not occurring through MAO physicians’ orders, based upon our members’ experience. In fact, if an MAO physician and/or hospitalist writes an order for an inpatient stay before an enrollee has received observation services for more than 24 hours, then prior to discharge changes that order to replace the inpatient admission with an order for observation status, the MOON may not be required to be delivered to the enrollee. This will be particularly problematic for patients that experience services under Medicare FFS before transitioning to MA. And over time, patients will move back and forth between Medicare FFS and MA, creating even more confusion.

The use of observation status also could be problematic when an MAO requires an enrollee to have a prior qualifying three-day or even one-day inpatient hospital stay for skilled nursing facility (SNF”) coverage, like original Medicare. Indeed, the two-midnight rule was designed in part to reduce confusion among beneficiaries regarding inpatient status and allow a beneficiary to predict whether he or she would be eligible for SNF care subsequent to a hospital stay. When applied in the MA setting, the rule should have the same effect. It is certainly confusing for a beneficiary to understand that after spending many days in a hospital bed, he or she has not satisfied a hospital stay requirement for a SNF stay if the MAO has not waived that condition to SNF coverage. It is even more problematic if the patient is in the SNF when the MAO decides, post-hospital discharge, to change a hospital’s claim for an inpatient stay to observation status. See section 10.2.1 of Chapter 4 of the Medicare Managed Care Manual.

We also are concerned that under many prevailing agreements between MAOs and hospitals, a hospital is permitted to bill patients for an inpatient stay if the claim is ultimately denied by the MAO, when the hospital has provided the patient with appropriate notice of their financial responsibility if their MAO does not reimburse the hospital for services and care provided. Given the significant frequency with which these changes of status from inpatient to observation are occurring, it is inevitable that some hospitals will provide such advance notice of potential non-coverage to beneficiaries. MAOs should not be allowed to shift financial risk to enrollees in this fashion.

B. Impact on Star Ratings Through Incorrect Patient Status

The accuracy of Star Ratings can be impacted by changing patient status from inpatient to observation. Readmission rates reported to Medicare are clearly reduced as a consequence of such reclassifications. CMS seems to be aware of these concerns, perhaps because we have expressed them in prior year comments to the call letter, and indicates in this year's Call Letter at page 106 as follows:

NCQA is exploring several revisions to the HEDIS Plan All Cause Readmission measure based on feedback they have received from the field and stakeholders. These revisions may impact the definition of the denominator, numerator and risk adjustment model for data collected in 2018. The specific revisions they are exploring include 1) *Inclusion of observation stays in the denominator and numerator* [Emphasis added.]

We agree that including outpatient observation stays for MAOs in the numerator and denominator of an All Cause Readmission Measure helps as a disincentive to improper patient classification. We are concerned however that CMS has removed All Cause Plan Readmissions from the Star Rating measures for CY 2018. See 2018 Call Letter at p. 88 n. 15. We understand that CMS is considering adjusting the measure and support the adjustment, but believe that such adjustments should occur in CY 2018, rather than putting the measure on hold for a year.

We encourage CMS to review the level and scope of observation status in the MA population. This is consistent with the 2017 OIG Work Plan at page 28. We believe such a review would support: (1) adopting a transparent and uniform standard for the definition of an inpatient stay, and (2) prevent the adoption of financial incentives that impact decisions about patient status. The failure to take these steps creates confusion for beneficiaries, jeopardizes good clinical judgment, and puts both beneficiaries and providers at financial risk. Such risks are increased as Medicare Part C continues to grow to a larger portion of the Medicare program.

III. MAOs Applying Readmission Penalties Twice To Providers

As CMS is aware, MAOs make use of CMS reimbursement methodology and its constituent parts to determine reimbursement rates to providers for a variety of services. CMS integrates several factors into its determination of reimbursement rates for inpatient services in the CMS PC Pricer, including whether a hospital has experienced excessive readmissions relative to a standard established under the Hospital Readmissions Reduction Program (the

“HRRP”). An analog of the CMS PC Pricer through purchased software is used by MAO plans to make payments to contracted hospital providers for inpatient hospital services.

The HRRP has succeeded in lowering the readmission rate – a recent ASPE study published in the New England Journal of Medicine reports that readmissions have dropped significantly overall, and hospital inpatient care under traditional Medicare is not simply being converted to outpatient stays. The incentives created by the HRRP have successfully encouraged hospitals to improve quality of care and their communications to post-acute providers, positively impacting readmission statistics.

The HRRP, as designed, does not result in the denial of coverage for a readmission. Rather it imposes a financial penalty for excessive readmissions on every admission. MAO plans not only use that penalty through the analog of the CMS PC Pricer to reduce payments to hospitals, but they are denying patient readmissions post discharge. This is occurring in some instances whether the readmission was related or unrelated to the prior admission. Our hospital members report that the level of such denials for readmissions have risen dramatically. MAOs are running claim edits to determine whether a prior admission had occurred within thirty days of a current admission, and denying payment for the current admission without any investigation as to the medical necessity for the current admission. Thus, MAOs apply the HRRP reduction, but do not follow the HRRP policy. In this regard, the MAOs generate a significant financial shift by penalizing hospitals twice. Because MAOs are not following the HRRP, we request that CMS provide guidance to MAOs to either follow their own MAO readmission policies that hospitals will either accept or dispute and eliminate the HRRP penalties from their payment calculation through their analog PC Pricer, or follow HRRP and its related policies concerning readmissions and cease denials of all-cause readmissions.

We raised this concern for our members in our comments to the CY 2017 Call Letter. Unfortunately, those comments were not addressed in the final CY 2017 Call Letter. We strongly encourage CMS to take these steps quickly to restore the appropriate payment level to providers under Medicare Part C. MAOs should not be allowed to apply multiple and inconsistent penalties to hospitals. **To preserve the integrity of the HRRP, we urge CMS to provide the requested guidance immediately.**

IV. The Provider Network Adequacy Audit Protocols Should Evaluate Network Adequacy at the Sub-Network Level

We welcome CMS’s continued focus on provider network adequacy. CMS can reinforce one of its major themes under the 2018 Call Letter, improving beneficiary protections, by ensuring that beneficiaries have accurate lists of the providers available to them both at the time they choose a plan and when they need to choose a provider. We also support the efforts of CMS to make network differences “both transparent to beneficiaries and consistent throughout the plan year.” *See* 2018 Call Letter at p. 114. Beneficiaries certainly receive less than they expect when there are material changes to an MAO’s network of providers during the plan year, or if they cannot access the identified network of providers after they have enrolled. Our members have witnessed firsthand during the last several years the confusion that enrollees often experience when navigating provider networks and the challenges they can face when their

access to care is restricted. CMS's own "Online Provider Directory Report," released January 13, 2017, documents many of the inaccuracies in MAO directories and the inability of beneficiaries to get appointments with many MAO providers. We encourage CMS to target these problems in audits of MAO provider networks to ensure that enrollees can access the benefits to which they are entitled.

In our comments to the 2016 and 2017 Draft Call Letters, we expressed concern that an MAO's apparent compliance with network adequacy standards may obscure issues with actual network adequacy and the scope of represented provider options to enrollees within the network, if the MAO uses downstream organizations to provide administrative and health care services to beneficiaries. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees' de facto provider network.

Unfortunately, network adequacy looks at the whole network a plan identifies, not to the sub-network to which many enrollees are relegated. These "networks within a network" are often far narrower than the provider network depicted in the provider directory or the Health Service Delivery ("HSD") tables on which CMS based its approval of an MAO, thus creating a more narrow network as the beneficiary moves through the healthcare continuum. Enrollees may have selected a particular MAO plan on the basis of its provider network, only to realize later that a downstream organization will discourage enrollees from accessing particular providers. This is especially problematic when a hospital is identified as in-network in the provider directory, but the physicians affiliated with the hospital, while in the main network, are not a part of the physician or provider group to which the downstream organization directs enrollees. Moreover, the downstream organization's sub-network may not meet the network adequacy standards to which the MAO is subject. We encourage CMS to implement audit protocols that identify and review these downstream organizations to ensure that enrollees have adequate access to care.

To that end, we encourage CMS to adopt specific requirements for MAO provider directories and use the audit protocols to ensure that these directories accurately depict the true scope of the provider network. In particular, we believe that MAO provider directories should include information regarding in-network physicians' medical groups and institutional affiliations. This level of detail would allow CMS to identify and address the incongruities created by the use of downstream organizations while allowing beneficiaries to make informed plan selections.

V. The Provider Network Adequacy Audit Protocols Should Evaluate Network Adequacy for Post-Acute Care

As noted above, the fact of a provider's identification in a network directory does not necessarily mean the provider truly is available. Our MA patients also experience the situation where a patient stay no longer meets the standards of care for inpatient services, but there are no medically appropriate post-acute settings available for discharge. This occurs because the MAO has no additional financial cost to extend a patient's hospital length-of-stay under the MS-DRG

system, but would have additional cost if they transferred the patient to the appropriate post-acute provider of care. Patients have a right under the Medicare Act to be treated in an appropriate environment, and this includes a discharge from the inpatient hospital setting when appropriate. **Therefore, we urge CMS to consider for purposes of network adequacy that MAOs demonstrate meaningful access, including a review of availability of listed post-acute providers that are accepting MA patients. We also urge an audit of MAO practices associated with approving timely discharges to an appropriate post-acute care setting.**

Further, current CMS network adequacy standards do not include inpatient rehabilitation facilities (“IRFs”) as a provider type that requires a specific number or threshold for the provider network and many MAOs have extremely high denial rates for IRF services. To the extent that post-acute care services are available, these factors result in MAOs providing rehabilitation services almost exclusively in SNFs, which we do not believe meets the requirement that MA plans offer “equal” benefits as are provided under traditional FFS Medicare. **We urge CMS to ensure that IRF coverage is equally available to MAO enrollees as is available to FFS beneficiaries, and specifically CMS should consider requiring MAOs to report denial rates by provider type.**

VI. High Maximum Out-of-Pocket (“MOOP”) Limits and Enrollee Cost-Sharing Obligations Can Have Negative Consequences for Providers (Attachment VI:2018 Call Letter, Section II Part C, p. 116-118)

MAOs have employed a variety of strategies to reduce costs, many of which involve passing on costs to beneficiaries. Unlike original Medicare, MAOs are not specifically required by regulation to reimburse providers for their uncollected beneficiary cost-share (*e.g.*, copayments, co-insurance), with narrow exceptions in the context of certain dual-eligible beneficiaries. MAOs generally require providers to seek payment from patients, and reasonable efforts to collect these cost-sharing amounts are often unsuccessful. The MAO sees no increased exposure from shifting the burden to the enrollee, so they have no incentive to evaluate or consider the affordability or collectability of their enrollees’ cost-share. In 2014 alone, some of our member hospitals were only able to collect 60 percent of plan enrollee cost-sharing.

Concurrent with the decreasing ability to collect cost-sharing, MOOP limits for enrollees continue to rise: from 2011 to 2016, the average MOOP for an enrollee in an MA plan has increased from \$4,313 to \$5,181. *See* CMS Landscape Files for 2015-2016 (representing an almost \$167 increase between 2015 and 2016). Additionally, increasing MAO flexibility in how it allocates the MOOP between inpatient and outpatient services has several serious consequences for beneficiaries. When MA plans allocate more of the MOOP to outpatient services, which appears to be the trend, it discourages Part C beneficiaries from using outpatient services when they might otherwise choose to do so. It also prompts MAO plans to change the status of an inpatient admission to an outpatient stay (as discussed on Section I above), which may cost the beneficiary more in cost-sharing liability than an inpatient service.

It is our experience that many enrollees simply do not understand their cost-sharing obligations. Because MAOs maintain ongoing relationships with their enrollees, providers often seek to collaborate with MAOs to clarify these responsibilities and address enrollees’ debt.

Pursuant to Medicare Advantage marketing requirements, MAOs seek approval from CMS before engaging in outreach and communication efforts that target enrollees. Our hospital members continue to request that CMS give MAOs more flexibility to correspond directly with enrollees on providers' behalf regarding their outstanding cost sharing obligations. Given the absence of a requirement from CMS that MAOs pay providers uncollected member responsibility at the federal reimbursement rate, for which they are clearly funded in their monthly premium, our members would expect CMS to allow hospitals to partner with the MAOs to communicate with the enrollee to make strides in understanding their cost-sharing obligations and thereby reduce bad debt exposure. The MAO explanation of benefits alone is simply not an effective mechanism to facilitate enrollee engagement. **While we understand that CMS is wary of communications to enrollees that may be deceptive or misleading, we hope that CMS will permit future requests for MAO enrollee communications that serve simply to clarify existing cost-share obligations to our members.**

Without the ability to engage MAOs and enrollees in efforts to collect cost-sharing obligations, providers are left with growing amounts of unpaid member responsibility. If enrollees are given even greater cost-sharing responsibilities, providers will simply face even larger unpaid bills. If CMS adopts this proposal, CMS should require MAOs to reimburse providers for uncollected member responsibility at the then current federal reimbursement rate. This would place the burden for uncollected member responsibility where it should lie, with the MAO itself given that such costs are included in their capitation payments. **We applaud CMS efforts to reduce or eliminate cost-sharing flexibility in specific service categories for voluntary MOOP plans, and we urge CMS to consider leaving the voluntary and mandatory MOOPs at their current levels.**

VII. CMS Should Not Incorporate Dismissals in its “Timely Decision About Appeals” Measure (2018 Call Letter, p. 108)

CMS uses as a measure for purposes of the Star Rating system, the effectiveness of an MAO in resolving beneficiary appeals of MAO determinations. The current measure, Reviewing Appeals Decisions/Appeals Upheld measures (Part C & D), focuses only on merits decisions. The timeliness aspect of the measure for purposes of IRE review changed its time horizon in CY 2017 from April 1, to May 1. At page 108 of the 2018 Call Letter, CMS indicates it is again considering modifying the measure for CY 2019 to include appeal dismissals and withdrawals of appeals, apparently in addition to merits decisions.

While we express no opinion on counting the withdrawal of an appeal for purposes of the measure, as it may reflect a merits-based resolution of an appeal, we oppose the proposed change to include dismissals in the measure for two reasons. First, the measure is designed to improve the beneficiary experience with the appeal process. That experience is not improved by encouraging plans not to reach the merits of the beneficiary appeal through a dismissal. Second, simply including dismissals as a positive factor in the measure creates an incentive within an MAO to increase the opportunities to enter dismissals, for example, by imposing procedural obstacles to a beneficiary briefing the merits of its appeal and causing the MAO to confront the veracity of its initial decision adverse to the beneficiary. As an association of providers, we have been exposed over many years to the creation of roadblocks to merits decisions in an

administrative setting, because the appeal body is being evaluated on managing its docket. Beneficiaries generally do not have the level of legal experience necessary to confront such roadblocks to a merits-based resolution of a dispute.

VIII. Medical Loss Ratio

We support CMS efforts to monitor and accurately measure Medical Loss Ratio (“MLR”) for Part C plans and would encourage continuing oversight to confirm that an MAO’s MLR reflect a complete and accurate snapshot of claims actually paid in the most recent periods possible. We are skeptical, given the level of services denials and patient status disputes that our members have experienced in the last several years, that the MAOs are satisfying MLR ratios if they are calculated on a claims paid basis.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. [unclear]", written in a cursive style.