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The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

***Re: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4190-P]***

Dear Administrator Verma:

Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. 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.

The FAH is pleased to provide CMS with our views in response to the above-referenced *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule* (Proposed Rule).

**Service Category Cost Sharing Limits for Medicare Parts A and B Services (42 C.F.R. §§ 422.100 and 422.113)**

The FAH applauds CMS’s proposal to codify service-specific cost-sharing limits that were previously announced through the annual call letter and to provide greater transparency as to the process CMS uses to establish these limits. In particular, we appreciate CMS’s attention to the category of emergency services, a category that places a unique burden on Medicare beneficiaries. We agree with CMS that “it can be difficult for enrollees to differentiate emergency services from post-stabilization services,” and we support the proposal to create a single cost-sharing limit for both emergency and post-stabilization services.

We are concerned, however, that CMS has proposed to increase the cost sharing limits in this category, proposing to allow an MA plan with a lower, voluntary maximum out-of-pocket limit (MOOP) to impose \$150 in cost sharing for emergency and post-stabilization services. While the cost-sharing limits in various categories have increased year by year, such increases can be particularly harmful to beneficiaries in the emergency services context. Due to the age and vulnerability of the Medicare population, visits to the emergency department are necessary and not substitutes for primary care. Increasing cost share limits (and by extension, permitting increased cost share amounts) can make it unaffordable for many Medicare beneficiaries to receive this necessary care. Thus, we urge CMS *not* to increase cost share limits for emergency services and post-stabilization services, since doing so may prevent many Medicare beneficiaries from receiving needed services and further burden hospitals with uncollectable bad debts.

Ultimately, many Medicare beneficiaries will simply be unable to afford the cost share. The traditional Medicare program accounts for this reality by reimbursing providers for uncollected cost shares, such as copayments and co-insurance. These payments of uncollected cost shares (*i.e.*, bad debt) are also built into the capitated payments that MAOs receive from CMS. MAOs are not, however, required to pass along those payments to providers. Although it may be suggested that this is a matter for MAOs and providers to resolve in their private agreements, it is unclear why providers shouldn’t be reimbursed for uncollected cost-share amounts simply because the patient is enrolled in an MA plan instead of traditional Medicare. Moreover, most MAOs enjoy considerable bargaining power over their network providers – particularly as the payer market has consolidated nationwide – and it is unrealistic to expect that an MAO would agree to pass on these payments to providers. ***We therefore urge CMS to lower the cost-sharing limits for emergency and post-stabilization services and to require MAOs to reimburse providers for uncollected cost share.***

**Network Adequacy (§§ 417.416 and 422.116)**

The FAH supports CMS’s decision to codify its longstanding approach to measuring and evaluating MAOs’ network adequacy. We believe this is an essential component of protecting beneficiaries’ access to care, and we appreciate CMS’s efforts to enhance transparency around how it oversees MA plans’ network adequacy. We offer a few observations regarding proposed exceptions to or variations of the default network adequacy standards.

***Rural Providers.*** We are concerned that the relaxed access standard for rural counties proposed in § 422.116(d)(4)(i) would threaten access to care for too many Medicare beneficiaries. Presently, the exception request process allows MAOs that face challenges satisfying the network adequacy standards to demonstrate that they “provide access that is

consistent with or better than the original Medicare pattern of care for a given county and specialty type.”<sup>1</sup> The FAH recognizes that MAOs serving rural counties sometimes face challenges satisfying the network adequacy standards. However, we believe the existing exception request process provides CMS with the opportunity to appropriately evaluate any exception request, thus reducing the risk that beneficiaries’ access to care will be unnecessarily compromised. We see no reason why CMS should not simply continue to consider and grant exceptions through the existing process.

***Telehealth.*** The FAH has long supported the appropriate expansion of telehealth as a modality capable of providing access to timely, high-quality care for beneficiaries, particularly in rural and underserved areas, and we applaud the flexibility CMS has provided during the novel coronavirus (COVID-19) pandemic to ensure beneficiaries maintain the ability to access care in unique circumstances. We urge CMS, however, to ensure that beneficiaries continue to have access to in-person care and to respect beneficiaries’ freedom to choose between remote and in-person services under section 1852(m)(4) of the Social Security Act and 42 C.F.R. section 422.135. We are concerned that CMS’s proposal to provide a ten-percentage point “credit” towards satisfaction of certain access standards where an MA plan contracts with telehealth providers of a particular specialty type may not be appropriate in all circumstances. We therefore urge CMS to take a more tailored approach to evaluating network adequacy and the use of telehealth providers by a particular MAO that takes into account community patterns of care.

***Certificate of Need.*** The FAH strongly disagrees with the proposal to give a ten-percentage point “credit” towards satisfaction of certain access standards when the MAO operates in a state with certificate of need (CON) laws in effect. In support of this proposal, CMS notes that “studies suggest that the removal of [CON] laws that serve as a barrier to entry into the market lead to greater access to providers and a redistribution of health care services to higher quality providers.” Even if “CON laws adversely affect access in states and counties where they are in effect,” as CMS observes, this does not mean that MA enrollees in those states should not be guaranteed the same access to care that other Medicare beneficiaries enjoy. A “credit” towards satisfaction of the access standards may be appropriate where an MAO has actually provided access to care through a substitute, as in the case of telehealth. But the proposal to do so in all states with CON laws or “other state imposed anti-competitive restrictions” is not appropriate. To the extent that CON laws may pose real challenges in terms of network adequacy, we urge CMS to look to *other* policy solutions to address these issues, rather than diluting network adequacy standards across the board for MAOs in these states.

### **Medical Loss Ratio (MLR) (42 C.F.R. §§ 422.2420, 422.2440, and 423.2440)**

***The FAH is opposed to the proposed Medicare MLR rule change expanding the definition of incurred claims to include payments that are made to non-providers.*** Incurred claims are currently properly restricted to payments for claims for clinical services (*i.e.*, direct claims paid to providers for covered services), and claims paid to non-providers for other covered services are better incorporated into the MLR calculation insofar as such payments

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<sup>1</sup> Medicare Advantage Network Adequacy Criteria Guidance, § 5 (p. 17) (available at [https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA\\_Network\\_Adequacy\\_Criteria\\_Guidance\\_Document\\_1-10-17.pdf](https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf)).

(footnote continued)

qualify as quality payments under existing criteria. This process is consistent with the purpose of the Medicare MLR requirement, which includes helping to “ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans.”<sup>2</sup>

The Medicare MLR requirement was adopted as part of the Affordable Care Act (ACA),<sup>3</sup> and while the Medicare MLR provision does not define the term “medical loss ratio,” the ACA separately requires that the MLR for commercial plans be computed based on the percentage of premium revenue expended on “reimbursement for clinical services provided to enrollees under such coverage” and “activities that improve health care quality.”<sup>4</sup> As CMS has implemented the Medicare MLR requirement under 42 U.S.C. § 1395w-27(e)(4), it has properly taken the “general approach of using the commercial MLR rules as a reference point.”<sup>5</sup> In fact, the Medicare MLR rule only departs from the commercial MLR rule to “the extent necessary and appropriate given the Medicare context.”<sup>6</sup> The Proposed Rule, however, does not identify any reason that the Medicare context makes it necessary and appropriate to depart from the requirement in the commercial MLR rule that incurred claims be paid to providers for covered services. Commercial providers are experienced with benefits similar to the supplemental benefits at issue in the Proposed Rule, and under the commercial MLR rule, payments to non-providers associated with these kinds of benefits are only included in the numerator if they qualify as quality improvement activities. Deviating from this approach in the Medicare MLR rule is not necessary or appropriate because the Medicare context does not meaningfully differ from the commercial context with respect to the benefits at issue.

### **Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (§ 422.514)**

The FAH applauds CMS’s proposal to address the spread of D-SNP “look-alikes.” We share the concerns raised by CMS regarding the proliferation of these plans, which create significant beneficiary confusion and undermine efforts by CMS and the states to improve coordination of care for dually-eligible beneficiaries and to simplify communications to dually-eligible beneficiaries regarding their cost-sharing obligations and their benefits. ***We strongly support CMS’s proposal not to enter into or renew a contract for a D-SNP look-alike in a state where there is a D-SNP or similar plan.***

### **Risk Adjustment Claim Encounter Submissions**

The FAH urges CMS to consider a modification to the Part C Risk Adjustment Program to ensure that risk adjustment payments are made based on data that more accurately reflect the additional expenditures made by MAOs based on members’ health status. ***In particular, the FAH supports limiting MA encounter data to data derived exclusively from paid claims or, in the case of a provider that accepts capitation, provider encounter data.*** The risk adjustment program is designed to “account[] for variations in per capita *costs* based on health status.”<sup>7</sup> At

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<sup>2</sup> Proposed Rule, 85 Fed. Reg. 9002 at 9066 (Feb. 18, 2020).

<sup>3</sup> The ACA collectively refers to the *Patient Protection and Affordable Care Act* (Pub. L. 111-148) and the *Health Care and Education Reconciliation Act* (Pub. L. 111-152). The Medicare MLR requirement is found in section 1103 of the *Health Care and Education Reconciliation Act*, which amended 42 U.S.C. § 1395w-27(e)(4).

<sup>4</sup> 42 U.S.C. § 300gg-18.

<sup>5</sup> 78 Fed. Reg. 31284 at 31285 (May 23, 2013).

<sup>6</sup> *Id.* at 31290.

<sup>7</sup> 42 U.S.C. § 1395x-23(a)(3)(A) (emphasis added).

present, we understand that MAOs include MA encounter data from unpaid, denied and underpaid claims. Such claims do not reflect cost incurred by the MAO but actually reflect uncompensated costs of care incurred by providers not reimbursed by MAO's. This is particularly true because MAOs deny claims at significantly higher rates than commercial insurance carriers and self-funded group health plans. Limiting the MA risk adjustment data in this way would not place an undue burden on MAOs because the current timelines for submission of this data allows adequate time for the prompt payment of claims prior to the initial data submission deadline, and certainly before the final risk adjustment data submission deadline the following year.

### **Authorizations, Denials, Downcoding, and Reclassifications**

The use of various pre-payment and post-payment “tools” by MA plans is proliferating, with a negative impact on provider payment for services. While some of these tools are meant to ensure program integrity, the concerns detailed below highlight that they often go beyond the legitimate scope of program integrity efforts, and instead, result in delay or denial of payments. A 2018 Department of Health & Human Services (HHS) Office of Inspector General report highlighted concerns with MA service and payment denials. The OIG report stated, “MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits.”<sup>8</sup> The OIG recommended that CMS reduce the incidence of inappropriate denials by: enhancing oversight of MA contracts and taking corrective action; addressing persistent problems regarding inappropriate denials and insufficient denial letters; and providing enrollees with easy-to-understand and easily accessible information about serious MA plan violations. The FAH was pleased to see that CMS concurred with these recommendations and urges the Agency to implement them swiftly. The FAH further urges CMS to consider the following additional opportunities to support the access of MA beneficiaries to needed care and the payment to providers for such care.

***Two Midnight Rule.*** As we have shared in previous comment letters, there has been and continues to be a significant trend among MAOs of denying coverage and authorizations for inpatient admissions ordered by physicians and reclassifying them as outpatient observation stays instead. MAOs use a variety of standards to determine whether a particular hospital stay meets their criteria for an inpatient admission (sometimes through remote means), even though determining patient status is a clinical decision that should be made by the medical professional treating the patient. ***To address this issue, as we have suggested in the past, CMS should require MAOs to use the two-midnight rule in determining patient status. This is the same standard used by CMS for physicians to determine if a particular hospital stay should be covered as an inpatient admission and this standard is equally appropriate for MA beneficiaries.***

***Medicare Benefit Determination and Payment Rules.*** Some plans use proprietary non-CMS-endorsed standards to determine coverage for inpatient procedures and inpatient rehabilitation hospital (IRF) coverage. Additionally, the Medicare Inpatient-Only (IPO) list, which is the single, definitive source of guidance as to which procedures must be performed in an inpatient setting in order to be reimbursable by Medicare, is not utilized by some plans. Similarly, many MA plans do not apply CMS's fee-for-service IRF coverage guidelines, instead

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<sup>8</sup> *Id.* at pg. 17.

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using proprietary standards that direct enrollees to less intensive care settings than they need and to which they are entitled.<sup>9</sup> The use of these proprietary standards creates confusion and administrative challenges for beneficiaries and providers and results in misalignment between the treatment of Medicare beneficiaries under the fee-for-service program and those in an MA plan. ***The FAH urges CMS to ensure that MA plans are following Medicare benefit determination and payment rules.***

***Authorizations.*** Our members routinely report delays and inconsistencies with authorization processes for both emergency and elective admissions across MA plans. Some of the more common issues with authorizations include:

- Lack of transparency and clarity regarding the guidelines plans use to evaluate authorization requests;
- Delays in plans approving requests;
- Varying authorization and documentation rules across payers and their different products;
- Use of reference numbers that are not authorizations for services and care;
- Inability to rely on prior authorization approvals;
- Delays obtaining prior authorization approval for post-acute care, resulting in patients spending more time than necessary in an inpatient setting;
- Delays in access to critical post-acute care and rehabilitation services.
- Limiting peer-to-peer reviews to only permit the attending physician (whose scheduled is filled with patient care activities that do not align with also supporting the authorization process) to discuss the provider authorization requests with the plan or only providing a limited time period (*e.g.*, a few hours) in which to have that discussion.

In conclusion, when plans deny the authorization requests, providers struggle to understand why (*e.g.*, based on what guidelines) the request was denied. Sometimes this discontinuity can be addressed without a more formal appeal, but in other instances the provider must enter the extended appeals process. Even when providers make it through the authorization process and receive an approval, they are increasingly finding that some plans do not honor that approval at the time of payment. Plan enrollees and the providers who care for them must be able to rely on authorization determinations.

***Appeal Rights.*** Given the challenges described above with authorizations, denials, downcoding and reclassifications, providers (and by extension beneficiaries) are further harmed due to their inability to seek a CMS review. Specifically, the appeal rights for in-network providers are covered by provider participation agreements, and are not eligible for appeal to CMS. The appeals processes in participation agreements are complex, cumbersome, not standard across plans, often not automated, and require significant administrative resources and staffing for health care providers.

***The FAH strongly urges the Agency to address the concerns described above. As part of those efforts, the FAH encourages CMS to examine the Improving Seniors' Timely Access to Care Act of 2019 (H.R. 3107), which would: create an electronic prior authorization program; require MA plans to report to CMS their use of prior authorization and approval/denial rates; require plans to adhere to evidence-based guidelines; and require timely prior authorization***

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<sup>9</sup> See MMCM, ch. 4 § 10.2. MA enrollees are entitled to – and MAOs must provide – coverage of “all Original Medicare-covered services,” which includes IRF services covered under fee-for-service Part A.

determinations, to determine actions the Agency can take administratively to improve the current prior authorization process.

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The FAH appreciates the opportunity to comment on this 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,

A handwritten signature in black ink, appearing to read "Andrew M. ...". The signature is fluid and cursive, with a large initial "A" and a long horizontal stroke at the end.