



Charles N. Kahn III
President & CEO

December 21, 2018

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

Re: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 [CMS-2018-4185-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.

We are pleased to provide CMS with our views in response to the above-referenced *Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, published on October 31, 2018.

I.A.1. Requirements for Medicare Advantage Plans Offering Additional Telehealth Benefits

The FAH has long-believed in the benefits of telehealth to enable access to timely, high-quality care for beneficiaries, particularly in rural and underserved areas. As such, the FAH supports CMS' implementation of provisions of the *Bipartisan Budget Act of 2018* allowing Medicare Advantage (MA) plans to offer "additional telehealth benefits" and treat them as basic benefits for the purpose of calculating bids starting with plan year 2020.

While the expansion of these benefits for Medicare beneficiaries in MA plans will positively impact their health care experience, these same benefits are not available to fee-for-service Medicare beneficiaries. This bifurcation between fee-for-service and MA beneficiaries is unfortunate and should be rectified by expanding access to telehealth services for fee-for-service beneficiaries.

The FAH was pleased that, in the CY 2019 Physician Fee Schedule (PFS), CMS recognized the evolving state of physician services, noting that many of these services are being performed via telecommunications technology. The FAH also appreciated CMS' acknowledgement that technology and its uses have evolved in the many years since the Medicare telehealth services statutory provision was enacted, and we supported CMS' expansion of payment for communication technology-based services in the CY 2019 PFS Final Rule. More reforms, however, are needed to ensure access to telehealth services.

In the CY 2018 PFS Proposed Rule, CMS solicited comments on how the Agency could further expand the use of telehealth services for Medicare beneficiaries. We noted then that current Medicare coverage and payment rules for telehealth services create challenges for many providers seeking to improve access to and coordination of patient care through these technologies. The FAH believes that reforming the coverage and payment rules for telehealth and remote monitoring technologies will lead to improved access for beneficiaries in both rural and urban areas to primary as well as specialty and subspecialty care. By substituting video consultations for in-person visits, the telehealth benefit could also lead to reduced costs for the Medicare program and reduced burden on beneficiaries.

In order to promote care coordination for beneficiaries with multiple chronic conditions, we suggest that Medicare coverage and payment for telehealth should be expanded more broadly. Specifically, CMS should simplify the process of approving services for Medicare telehealth coverage by approving all Medicare-covered services for telehealth unless services are determined inappropriate for the benefit on a case-by-case basis. The current process for determining which services provided via telehealth are eligible for Medicare reimbursement is outdated and has resulted in Medicare beneficiaries not having access to appropriate telehealth services. Additionally, medical and behavioral health services that can be appropriately delivered via telehealth technology should be reimbursed by Medicare, Medicaid, private insurance, and other payers at the same level as when those services are delivered in person.

II.A.2. Dual Eligible Special Needs Plans (D-SNPs)

We appreciate CMS’s attention to D-SNPs, which play a critical role in serving dual-eligible beneficiaries. In considering how benefits for dual-eligible beneficiaries are structured, it is important to remember that the burden of MA enrollees’ unpaid cost-sharing obligations is disproportionately borne by providers, not MAOs. For beneficiaries enrolled in original Medicare, providers are generally entitled to some reimbursement for uncollected beneficiary cost share, including copayments and co-insurance. But the same is not true in the MA setting, where those costs are built into the capitation payments that CMS pays to MAOs. MAOs are not required to pass on these payments to providers, and providers are left to negotiate with the MAO to determine whether the provider will be compensated for any uncollected cost sharing. The reality is that most MAOs enjoy outsized bargaining power in negotiations with providers. If a hospital is unable to negotiate such reimbursement from an MAO as a result, the MAO simply enjoys a windfall in the form of bad debt payments that it does not pass on to providers.

This picture is further complicated when the beneficiary is a full or partial dual eligible. For example, when a beneficiary is a qualified Medicare beneficiary (QMB), the state Medicaid program is responsible for paying the QMB’s cost sharing; under federal law, however, a state Medicaid program can limit its coverage of QMBs’ cost-sharing to the extent the combined payment exceeds Medicaid rates. 42 U.S.C. § 1396a(n). In response, many states have adopted a “lesser-of” rule and set their payment rate below what Medicare would pay. As a result, providers often collect nothing on these crossover claims. Because the “lesser-of” rule is a matter of state policy, MAOs are fully aware that their contracted providers will collect nothing from the state on these particular claims.

We urge CMS to consider how D-SNPs should be designed to minimize cost-sharing obligations that are ultimately unpaid and to consider a more holistic approach to coverage for dually eligible beneficiaries that does not simply transfer cost-sharing liability to providers while providing a windfall to MAOs in the form of bad debt payments. In particular, CMS should ensure MAOs reimburse contracted providers for their enrollees’ bad debt and, in the case of certain dual-eligibles, for cost-sharing amounts that are not paid by state Medicaid programs.

II.B. 1. Medicare Advantage and Part D Prescription Drug Plan Quality Rating System

We enthusiastically support the adoption of National Committee for Quality Assurance’s (NCQA) modified Plan All-Cause Readmission (ACR) measure, which considers “observation” stays in conjunction with inpatient admissions in calculating discharges and readmissions for 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* Attachment A – FAH March 5, 2018 comment letter). These recategorizations by the MAO result in: 1) hospital payment rates that are less than the cost of care provided; 2) beneficiary confusion regarding cost-sharing; and 3) misstated performance under the current quality measure specifications.

Integrating outpatient observation stays in the numerator and denominator will improve the accuracy of the Plan All-Cause Readmissions measure, and we strongly support this change.

Other Recommendations to Improve the Medicare Advantage Program

The FAH supports efforts to improve the Medicare Advantage program for enrollees and offers additional recommendations for improvements below and attached. (*See Attachment A*).

Provider Directories and Network Adequacy (Attachment A, pgs. 7-9)

The FAH appreciates CMS' reminder to MAOs earlier this year that inaccurate provider directories could lead to enforcement actions and was pleased to see some compliance actions against a number of MAOs. The FAH encourages CMS to continue these enforcement actions to ensure beneficiaries have accurate information when selecting plans and providers.

The FAH continues to remain concerned, however, about MAOs' lack of compliance with network adequacy requirements, particularly "networks within a network" that 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. The FAH recommends CMS address these concerns by: 1) implementing audit protocols to identify and review downstream organizations and take appropriate enforcement actions; 2) requiring that MAOs demonstrate meaningful access; 3) auditing MAO practices associated with approving timely discharges to an appropriate post-acute care setting; and 4) including a standard in the Star Ratings Program to promote the adequacy and stability of an MAO's network.

Prior Authorization (Attachment A, pg. 10)

The FAH continues to urge CMS to ensure that enrollees and providers can rely on MAO prior authorizations. Specifically, 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. This would help curtail the practice of MAOs reversing their prior authorization determinations after submission of the claim for services that were already provided.

Outpatient Observation Status (Attachment A, pgs. 6-7)

The FAH has previously expressed concerns that some MAOs inappropriately reclassify inpatient hospital stays as outpatient "observation" stays. 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. The FAH recommends that CMS require MAOs to apply the fee-for-service Two-Midnight Rule when reviewing inpatient admissions vs. observation stays.

Inpatient-Only Criteria

The Medicare Inpatient-Only (IPO) list 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. Some MAOs use divergent standards, which creates confusion and administrative challenges for our members. The FAH urges CMS to require MAOs to follow the IPO list.

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,

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



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 read "A. M. ...". The signature is stylized and somewhat cursive, with a large initial letter 'A' and a long horizontal stroke extending to the right.