Federation of American Hospitals®

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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 Center[10] and the Center on Aging at American Institutes for Research[11] 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.

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[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/MedicareAdvtgSpecRateStats/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 <u>all</u> 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. <u>Greater Transparency in MAO Medical Record Requests Would Reduce Provider Burden – Comment Solicitation (II.B.13)</u>

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,