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Electronically Submitted to PartCDcomments@cms.hhs.gov

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

Re: 2017 Transformation Ideas – Response to Request for Information in the 2018 Rate Announcement and Call Letter

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 the views of direct providers of patient care to these beneficiaries is important for the Centers for Medicare and Medicaid Services (“CMS”) to consider in structuring the Part C program to best serve beneficiary interests.

We are pleased to provide CMS with our views in response to the *Request for Information in the 2018 Rate Announcement and Call Letter*.

I. The Growth of the Medicare Part C Program is Unprecedented and Compels Adequate Time for Beneficiaries and Other Stakeholders to Comment on Policy Proposals

As we noted in our response to the *Advance Notice of Methodological Changes for Calendar Year 2018 for Medicare Advantage, Part C, and Part D Payment Policies and the 2018 Call Letter* (“Call Letter”), the Kaiser Family Foundation reports that private health plan enrollment in Medicare has grown dramatically, more than tripling from 5.3 million beneficiaries in 2006 to 17.6 million enrollees in 2016, which is almost one in three people on Medicare. In 2016, Medicare Advantage constituted 31 percent of total Medicare enrollees, as compared to 13 percent in 2005. Current monthly enrollment data from CMS indicates that enrollment as of February 2017 stands at 19.6 million people, of the more than 58 million Medicare eligible population, or almost 34 percent of the eligible population. In fact, Medicare Advantage may outstrip the size of original Medicare within the next decade, and CBO projects that about 41 percent of Medicare beneficiaries will be enrolled in Medicare Advantage in 2026.

While Medicare Advantage enrollees in 2016 represented more than 31 percent of all Medicare beneficiaries, in several large states Medicare Advantage enrollment significantly exceeds the national average. For example, enrollment in Oregon, Florida, Pennsylvania, Minnesota, and Hawaii exceeds 40 percent. And, Medicare Part C’s primary three contractors – UnitedHealthcare (21 percent), Humana (18 percent), and Blue Cross Blue Shield (13 percent, excluding Anthem BCBS plans) – now represent more than half of all beneficiaries.

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

II. MAOs Applying Readmission Penalties Twice To Providers

As CMS is aware, MAOs make use of CMS reimbursement methodology and its constituent parts to determine reimbursement rates to providers for a variety of services. CMS integrates several factors into its determination of reimbursement rates for inpatient services in the CMS PC Pricer, including whether a hospital has experienced excessive readmissions relative to a standard established under the Hospital Readmissions Reduction Program (the “HRRP”). An analog of the CMS PC Pricer through purchased software is used by MAO plans to make payments to contracted hospital providers for inpatient hospital services.

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

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

We raised this concern for our members in our comments to the CY 2017 and CY 2018 Call Letters. Unfortunately, those comments were not addressed. We strongly encourage CMS to take these steps quickly to restore the appropriate payment level to providers under Medicare Part C. MAOs should not be allowed to apply multiple and inconsistent penalties to hospitals. **To preserve the integrity of the HRRP, we urge CMS to provide the requested guidance immediately.**

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

CMS can reinforce one of its major themes under the final 2018 Call Letter, improving beneficiary protections, by ensuring that beneficiaries have accurate lists of the providers available to them both at the time they choose a plan and when they need to choose a provider. We also support the efforts of CMS to make network differences “both transparent to beneficiaries and consistent throughout the plan year.” *See* 2018 final Call Letter at p. 116. Beneficiaries certainly receive less coverage than they expect when there are material changes to an MAO’s network of providers during the plan year, or if they cannot access the identified network of providers after they have enrolled. Our members have witnessed firsthand during the last several years the confusion that enrollees often experience when navigating provider networks and the challenges they can face when their access to care is restricted. CMS’s own “Online Provider Directory Report,” released January 13, 2017, documents many of the inaccuracies in MAO directories and the inability of beneficiaries to get appointments with many MAO providers. **We encourage CMS to target these problems in audits of MAO provider**

networks to ensure that enrollees can access the benefits to which they are entitled. We also suggest the inclusion of a standard in the Star Rating System to promote the adequacy and stability of an MAO’s network.¹

In our comments to the 2016, 2017, and 2018 Draft Call Letters, we expressed concern that an MAO’s apparent compliance with network adequacy standards may obscure issues with actual network adequacy and the scope of represented provider options to enrollees within the network, if the MAO uses downstream organizations to provide administrative and health care services to beneficiaries. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees’ de facto provider network.

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

In the 2018 final Call Letter, we were pleased to see that, over the next year, CMS “will consider additional ways to measure differences in provider networks in our overall review of meaningful difference” and hopes “to issue subregulatory guidance...as soon as possible.” See 2018 final Call Letter at p. 116. As CMS works to develop guidance, **we encourage CMS to adopt specific requirements for MAO provider directories and use the audit protocols to ensure that these directories accurately depict the true scope of the provider network.** In particular, we believe that MAO provider directories should include information regarding in-network physicians’ medical groups and institutional affiliations. This level of detail would allow CMS to identify and address the incongruities created by the use of downstream organizations while allowing beneficiaries to make informed plan selections.

¹ We request as part of future consideration of the Star Rating system that CMS 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 the stability of its networks.

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

As noted above, the fact of a provider's identification in a network directory does not necessarily mean the provider truly is available. Our MA patients also experience the situation where a patient stay no longer meets the standards of care for inpatient services, but there are no medically appropriate post-acute settings available for discharge. This occurs because the MAO has no additional financial cost to extend a patient's hospital length-of-stay under the MS-DRG system, but would have additional cost if they transferred the patient to the appropriate post-acute provider of care. Patients have a right under the Medicare Act to be treated in an appropriate environment, and this includes a discharge from the inpatient hospital setting when appropriate. **Therefore, we urge CMS to consider for purposes of network adequacy that MAOs demonstrate meaningful access, including a review of availability of listed post-acute providers that are accepting MA patients. We also urge an audit of MAO practices associated with approving timely discharges to an appropriate post-acute care setting.**

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

V. Provider Contract Terminations – Ensuring Network Adequacy, Timely Notification, and Transparency

In recent years, significant mid-year changes to MAO provider networks prompted CMS to reexamine its guidance on provider contract terminations in order to protect beneficiaries from patient access limitations that follow these MAO mid-year interventions. We applaud CMS' attention to this area. For example, we appreciate that, as of CY 2015, MAOs must notify CMS at least 90 days in advance of "significant" no cause provider terminations and "demonstrate continued compliance with applicable network access requirements." *See* 2015 final Call Letter p. 103. However, we encourage CMS to take greater steps to ensure adequate notice and transparency for beneficiaries and providers regarding MAO provider contract terminations.

For example, **CMS should require that MAOs be transparent regarding the specific metrics that formed the basis to terminate a provider**, thus allowing the provider to thoroughly understand the reason for termination, and allowing for an appeal and possible cure over a specified timeframe. The MAOs' notices to all providers identifying the basis for termination also should be transmitted to CMS as part of the information CMS currently collects from MAOs during the provider contract termination process.

Additionally, after an MAO terminates a provider contract, it is unclear whether the MAO continues to meet network adequacy standards. This information is currently not made available to the public, which can lead to confusion for beneficiaries and their providers when, for example, a major physician practice is suddenly terminated from the network. **After an MAO provider contract termination, we urge CMS to reevaluate network adequacy and make public that information. At a minimum, CMS should reevaluate network adequacy and provide that information in response to requests from health care providers and beneficiaries.**

Further, when considering the potential impact of significant changes in a network on beneficiaries and the MAO's ability to actually deliver the benefits to which it attests in the submission of its plan benefit package(s), **we urge CMS to take steps to implement beneficiary protections.** Significant terminations – even those that continue to meet CMS Health Service Delivery (“HSD”) and benefit requirements – are always going to be accompanied by disruption. Thus, the proposals discussed below are essential to ensure that beneficiaries can make informed decisions based on up-to-date information that affects their access to care, while ensuring that providers can exercise their appeal rights as well.

In the 2015 final Call Letter (*see* p. 105), CMS notes that as a “best practice,” MAOs “should provide enrollees more than the 30 days advance notice” of the termination of a provider. We agree that the current 30 day standard is inadequate. **We encourage CMS to undertake notice and comment rulemaking and propose a longer – no less than 60 day – notice to beneficiaries** so that they can exercise their choices, including a right to revert to traditional Medicare or to select another MAO plan.

In the same final Call Letter (*see* p. 107), CMS also noted that requiring MAOs to provide more than 60 days prior notice to providers “would give providers sufficient time to exercise their appeal rights.” We agree that 60 days prior notice is inadequate, and share CMS’ concerns that beneficiaries can receive notices of terminations that are still being appealed by the provider. **We encourage CMS to undertake notice and comment rulemaking and propose more than 60 days advance notice to providers** so they can exercise their appeal rights and avoid beneficiary confusion.

Also in the 2015 final Call Letter (*see* p. 105), CMS agreed that “Limiting MAOs’ ability to make network changes during the AEP and/or requiring enrollee notification prior to the AEP would be a viable way to provide enrollees with some level of certainty regarding the provider network for a contract year.” We agree that CMS should institute a blackout period where an MAO could not provide notice right before the Annual Enrollment Period (“AEP”), and this blackout period should extend through the beginning of the new membership year. A plan that suddenly announces a “significant” change in network during the AEP must have known of such change when submitting its bid(s) and attesting to their completeness. To announce its decision in the midst of the AEP is not only confusing to beneficiaries, and unfair to providers who serve those beneficiaries, but also to other plans may experience risk selection issues as a result. **We encourage CMS to undertake rulemaking and propose that, but for exceptional circumstances, plans be prohibited from undertaking notice to providers of terminations during certain periods.**

Finally, significant terminations create disruption to beneficiaries and their expectations about the scope of their benefits and access to care. To protect those beneficiaries, **CMS should undertake notice and comment rulemaking to require MAOs to maintain the current beneficiary cost sharing for the out-of-network providers during a transition period.**

VI. High Maximum Out-of-Pocket (“MOOP”) Limits and Enrollee Cost-Sharing Obligations Can Have Negative Consequences for Providers (2018 final Call Letter, p. 120)

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

Concurrent with the decreasing ability to collect cost-sharing, MOOP limits for enrollees continue to rise: from 2011 to 2016, the average MOOP for an enrollee in an MA plan has increased from \$4,313 to \$5,181. *See* CMS Landscape Files for 2015-2016 (representing an almost \$167 increase between 2015 and 2016). Additionally, increasing MAO flexibility in how it allocates the MOOP between inpatient and outpatient services has several serious consequences for beneficiaries. When MA plans allocate more of the MOOP to outpatient services, which appears to be the trend, it discourages Part C beneficiaries from using outpatient services when they might otherwise choose to do so. **We applaud CMS efforts to reduce or eliminate cost-sharing flexibility in specific service categories for voluntary MOOP plans, and we urge CMS to consider leaving the CY 2019 voluntary and mandatory MOOPs at their current levels.**

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

CMS will permit future requests for MAO enrollee communications that serve simply to clarify existing cost-sharing obligations to our members.

Without the ability to engage MAOs and enrollees in efforts to collect cost-sharing obligations, providers are left with growing amounts of unpaid member responsibility. If enrollees are given even greater cost-sharing responsibilities, providers will simply face even larger unpaid bills, despite reasonable efforts to collect these cost-sharing amounts. Unlike original Medicare, in the Part C context, CMS has not required plans to reimburse providers for their uncollected beneficiary copayments despite that such bad debts are factored into the cost structure of Part C capitation rates and plans are responsible for their benefit designs, including the allocation of cost sharing for any given service level.²

In addition to permitting MAO enrollee communications to clarify existing cost-sharing obligations, **CMS should update its regulations to require MAOs to reimburse providers for uncollected member responsibility at the then current federal reimbursement rate.** This process seems the most equitable given that MAOs' capitation rates compensate them for bad debt expense and they already collect monthly premiums from their members. Such a process also is consistent with the dual-eligible beneficiary Financial Alignment Demonstration and thus has precedent. To do otherwise causes a windfall to plans that incur no bad debt cost, but retain capitation payments that account for that cost.

VII. CMS Should Not Incorporate Dismissals in its “Timely Decision About Appeals” Measure (2018 final Call Letter, p. 109)

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 appeal process. That experience is not improved by encouraging plans not to reach the merits of the beneficiary appeal through a dismissal. Second, simply including dismissals as a positive factor in the measure creates an incentive within an MAO to increase the opportunities to enter dismissals, for example, by imposing procedural obstacles to a beneficiary briefing the merits of its appeal and causing the MAO to confront the veracity of its initial decision adverse to the beneficiary. As an association of providers, we have been exposed

² Managed care plans designed for dually eligible patients (those covered by both Medicare and Medicaid) participating in the Financial Alignment Demonstration are required to pay providers their full contracted rate to account for that fact that a bad debt component has been built into the capitation rate. Financial Alignment Demonstration Capitated Model Medicare Rate Methodology, Integrated Care Resource Center (November 1, 2013 PowerPoint), page 5, col. H.

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' 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."** See 2018 final Call Letter at p. 183.

VIII. Continuing Oversight of Medical Loss Ratios

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

IX. Creating a Pathway for Medicare Advantage Risk Under MACRA

We support efforts by CMS to provide a pathway for MA plans and their clinicians to participate in the Alternative Payment Model ("APM") Incentive Program under the Quality Payment Program, as established by the *Medicare Access and CHIP Reauthorization Act of 2015* ("MACRA"). As more beneficiaries choose to enroll in MA plans, their care should be aligned on the shared goals with that of beneficiaries in APMs outside of MA plans. **Clinicians serving these MA plan beneficiaries should be able to count their patients towards the Qualifying APM Participant ("QP") status thresholds.**

Sincerely,

A handwritten signature in black ink, appearing to read "Virginia", written over a horizontal line.