Federation of American Hospitals®

Charles N. Kahn III
President and CEO

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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) 2022 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II [CMS-2020-0093]

Dear Director Kouzoukas:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Many of our members contract with Medicare Advantage Organizations (MAOs) to provide services to Medicare Part C beneficiaries. We believe that it is important for the Centers for Medicare & Medicaid Services (CMS) to consider the views of direct providers of patient care to these beneficiaries in order to structure the Part C program to best serve beneficiary interests.

The FAH is pleased to provide CMS with our views in response to the above-referenced Advance Notice of Methodological Changes for Calendar Year (CY) 2022 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies, Part II, published on October 30, 2020 (the Advance Notice).

Potential New Measure Concepts – Provider Directory Accuracy (Part C)

The FAH strongly encourages CMS to develop a new Star Ratings measure on provider directory accuracy. As CMS has previously acknowledged, Medicare beneficiaries depend on provider network information to make informed enrollment decisions and to access covered services. The regulatory requirement that an MA organization maintain an application programming interface (API) that provides access to a "complete and accurate" provider directory (42 C.F.R. § 422.120(b)) assists in expanding access to this critical information, but there continues to be significant variability in the completeness and accuracy of provider directory information. Inclusion of a new measure on provider directory accuracy in the Star Rating system will incentivize MAOs to further improve their provider directories so that beneficiaries can access accurate and actionable information. In addition, this measure will alert beneficiaries to plans with less complete or accurate directories.

In developing this measure, we urge CMS to give particular focus to the disclosure of critical network-within-a-network information, which is often deficient or omitted from provider directories. MAOs often contract with independent practice associations (IPAs) or other provider organizations on a capitated basis to provide and arrange for care for a discrete set of a plan's enrollees. This practice effectively creates a "sub-network" within the MAO's broader provider network, and each enrolled beneficiary will be largely limited to hospitals, specialists, and other providers within the particular sub-network to which s/he is assigned. Where the provider directory fails to disclose the existence of sub-networks and provide information on each provider's sub-network participation, the provider directory is incomplete and also inaccurate because it erroneously suggests that each enrollee has access to a wider range of providers than is actually available under the plan's policies. Beneficiaries depend on accurate provider directories to make informed enrollment decisions, and accurate information on the presence and composition of sub-networks is essential for that purpose. ***We therefore strongly encourage CMS to measure the extent to which plans provide complete and accurate information concerning the existence and provider composition of any network-within-a-network as part of any Star Rating measure on provider directory accuracy.***

Inappropriate Denial of Inpatient Stays and Observation Stays

The use of various pre-payment and post-payment "tools" by MA plans is proliferating, eroding beneficiary coverage and placing providers at financial risk for non-payment of covered services. While some of these tools are meant to ensure program integrity, the FAH is concerned about the trend toward aggressive MAO strategies that go beyond the legitimate scope of program integrity efforts, and instead, result in the improper delay or denial of payments.[1]

As we have shared in previous comment letters, MAOs have engaged in a growing trend of denying coverage and authorizations for inpatient admissions ordered by physicians and

[1] These concerns are reflected in a 2018 report from the Department of Health & Human Services (HHS) Office of Inspector General. *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf (noting that "MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits" and recommending, *inter alia*, addressing persistent problems regarding inappropriate denials).

reclassifying them as outpatient observation stays, which artificially improves MAOs performance on the Plan All-Cause Readmission measure. We were pleased, then, to see CMS's announcement in the CY2020 Call Letter that it would modify this measure to appropriately capture observation stays like inpatient admissions. The FAH supported this policy change because it removes an incentive for an MAO to reclassify inpatient admissions as outpatient stays.

In the aftermath of this change, however, MAOs have not only continued the trend of inappropriate denials of inpatient admissions, but they are also increasingly refusing to pay any amount (even the negotiated rate for observation services) for inpatient care that would unequivocally qualify for Part A coverage under CMS's two-midnight rule. In other words, MAOs are increasingly shifting from downcoding and reclassifying inpatient care to denying payment for hospital services altogether. We are concerned that this may be rewarded under the Star Ratings system because, by denying payment for observation care as well, the MAO can reduce the total number of hospital stays reflected in the readmissions measure. This practice undermines the integrity of the Star Ratings system, which relies by necessity on payment data, even though that information does not necessarily reflect whether medically necessary care was actually provided to a beneficiary pursuant to a physician's orders.

In order to correct this imbalance, we urge CMS to direct MAOs to use CMS-endorsed standards for determining coverage. For example, the two-midnight rule, which is used by CMS to determine if a particular hospital stay should be covered as an inpatient admission, should be applied in the MA context as well. Beneficiaries and providers alike would benefit from consistent policies and coverage guidelines. ***The FAH urges CMS to ensure that MA plans are following Medicare benefit determination and payment rules.***

Beneficiary Cost-Sharing Obligations

We look forward to a forthcoming rule setting service-specific cost-sharing limits for services covered under Medicare Parts A and B. While we recognize that these limits are the subject of a rulemaking process separate from this Advance Notice, we write to remind CMS that any time greater cost-sharing obligations are imposed on beneficiaries, this imposes a significant burden on beneficiaries and providers alike. As we have shared in previous comments, a significant portion of MA enrollees' cost-sharing obligations are left unpaid, creating financial risk for providers. Under traditional Medicare, providers are generally reimbursed for uncollected beneficiary deductible and copayment amounts. To the extent MAOs have the flexibility to shift the cost of care to enrollees, we believe MAOs should also be required to reimburse providers for unpaid cost-sharing obligations. It is unclear why MAOs should not be obligated to make providers whole in these circumstances, particularly when the costs for Medicare bad debt are built into the capitation rates the Medicare program pays to MAOs. As the share of Medicare beneficiaries enrolled in MA plans rises with each passing year, and as CMS provides MAOs greater flexibility to increase cost-sharing amounts in specific service categories, providers are being forced to take on more and more of this financial risk. ***With that in mind, we urge CMS to require MAOs to reimburse providers for uncollected beneficiary cost share amounts.***

Risk Adjustment Claim Encounter Submissions

The FAH urges CMS to consider a modification to the Part C Risk Adjustment Program to ensure that risk adjustment payments are made based on data that more accurately reflect the additional expenditures made by MAOs based on members' health status. ***In particular, the FAH supports limiting MA encounter data to data derived exclusively from paid claims or, in the case of a provider that accepts capitation, provider encounter data.*** The risk adjustment program is designed to "account[] for variations in per capita costs based on health status."[2] At present, we understand that MAOs include MA encounter data from unpaid, denied, and underpaid claims. Such claims do not reflect cost incurred by the MAO; rather they reflect uncompensated costs of care incurred by providers not reimbursed by MAOs. This is particularly true because MAOs deny claims at significantly higher rates than commercial insurance carriers and self-funded group health plans. Limiting the MA risk adjustment data in this way would not place an undue burden on MAOs because the current timelines for submission of this data allows adequate time for the prompt payment of claims prior to the initial data submission deadline, and certainly before the final risk adjustment data submission deadline the following year.

Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes

The FAH applauds CMS's decision in its June 2, 2020 Final Rule (CMS-2020-0010-0663) to reduce the spread of D-SNP "look-alikes" by restricting contracts with D-SNP look-alikes in states where there is a D-SNP or similar plan. We share the concerns raised by CMS in the proposed and final rules regarding the proliferation of these plans, which create significant beneficiary confusion and undermine efforts by CMS and the states to improve coordination of care for dually-eligible beneficiaries and to simplify communications to dually-eligible beneficiaries regarding their cost-sharing obligations and their benefits. We are pleased that CMS is addressing this issue.

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The FAH appreciates the opportunity to comment on the Advance Notice. If you have any questions or wish to speak further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,

[2] 42 U.S.C. § 1395w-23(a)(3)(A) (emphasis added).