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Electronically Submitted to AdvanceNotice2018@CMS.HHS.Gov

Cynthia G. Tudor, Ph.D.
Acting Director, Center for Medicare
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore MD. 21244

Re: Advance Notice of Methodological Changes for Calendar Year ("CY") 2018 for Medicare Advantage ("MA") Capitation Rates, Part C and Part D Payment Policies and 2018 Call Letter

Dear Acting Director Tudor:

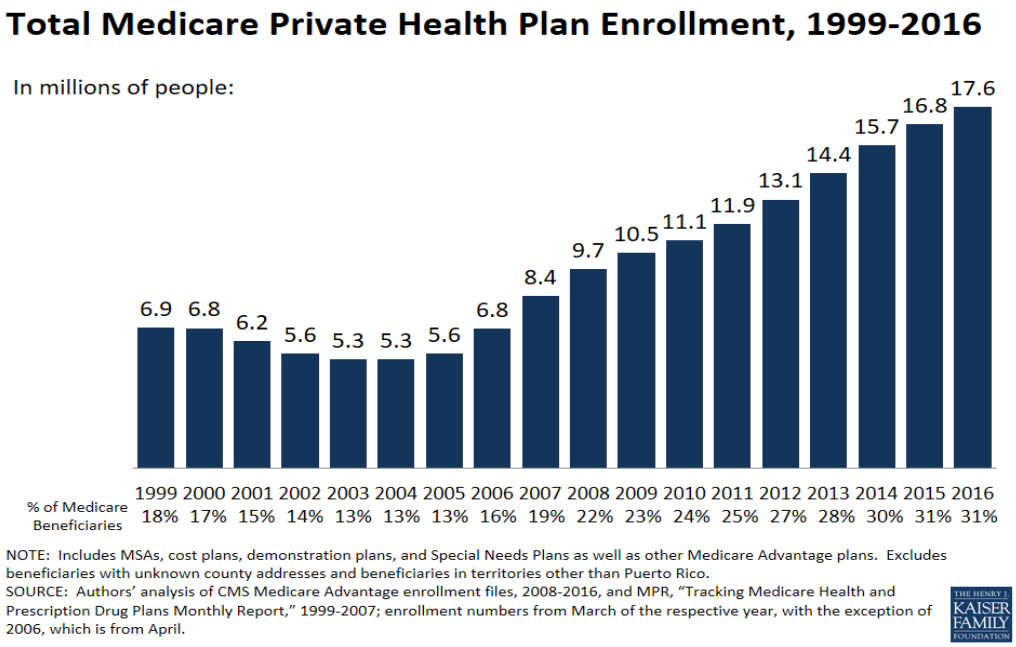
The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well 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 *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"). In particular, the FAH is pleased that

CMS is proposing an increase in MAOs' baseline payment rates for 2018.[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. Below we discuss additional provisions in the Call Letter that we believe also will promote enrollee access to quality medical care, including adequate provider networks offered to MAO enrollees.

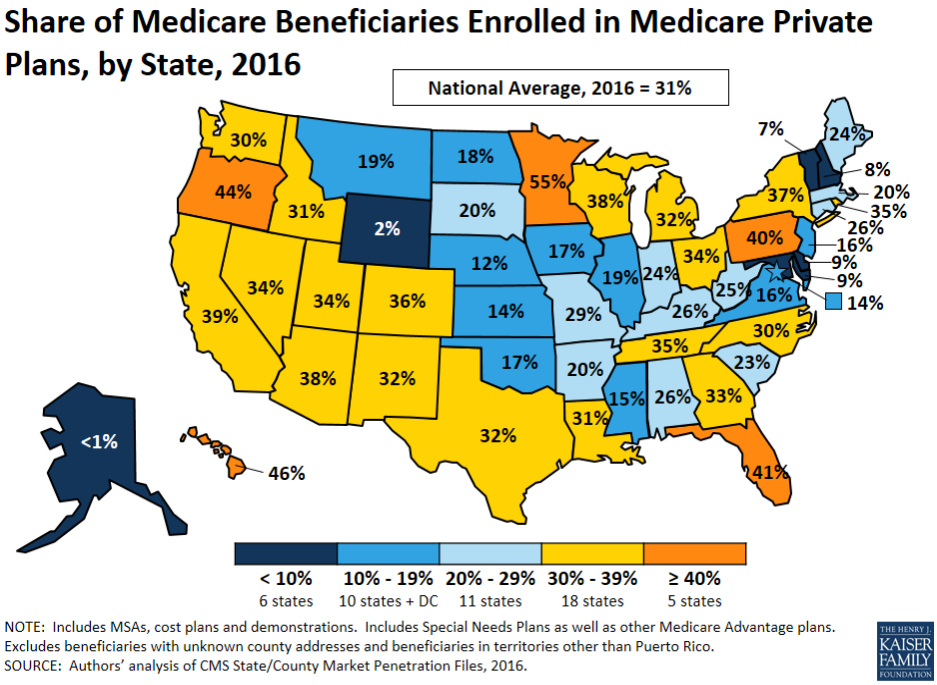
I. The Growth of the Medicare Part C Program is Unprecedented and Compels Robust CMS Oversight of Program Policies and Plans

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.



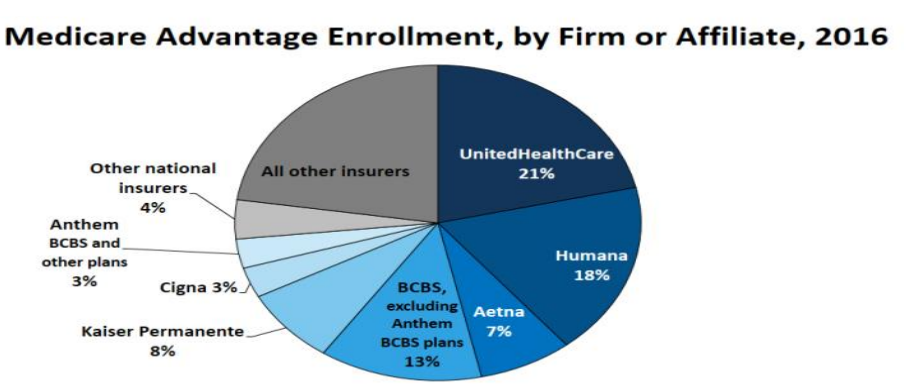
[1] Under the Call Letter, baseline Medicare Advantage payment rates for 2018 will rise by 0.25 percent on average. See CMS Fact Sheet, *2018 Medicare Advantage and Part D Advance Notice and Draft Call Letter* (Feb. 1, 2017).

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:



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2016.

And as we noted last year, Medicare Part C's primary three contractors now represent more than half of all beneficiaries.



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and excludes Anthem BCBS plans. Anthem includes BCBS plans, which comprise 2% of all enrollment (approximately 410,000 enrollees), and other plans, which comprise about 1% of all enrollment (about 149,000 enrollees). Other national insurers includes about 692,800 enrollees across the following firms: Wellcare, Centene, and Universal American. Percentages may not sum to 100% due to rounding.
SOURCE: Authors'analysis of CMS Enrollment files, 2016.

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.** Further, 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.** The Administrative Procedure Act considers 60-days notice before comment as adequate for this purpose.

II. The Misuse of Medical Necessity Determinations to Reclassify Inpatient Stays as "Observation Status," Has a Wide Range of Adverse Impacts on the MA Population and the Accuracy of CMS Information Used to Assess MAOs (Attachment VI: 2018 Call Letter p. 106)

Through comments we provided in 2016 and 2015, in response to the Advance Notice of Methodological Changes and Draft Call Letters for calendar years 2017 and 2016, we highlighted our concerns about MAO patient status determinations. Our member health systems and hospitals are reporting that billed hospital inpatient stays, with written attending physician orders for inpatient admission status that meet nationally recognized clinical management criteria, are being reclassified at ever-increasing rates to outpatient observation stays by the MAOs either through retrospective remittance advice denials or during the stay by MAO-employed or contracted hospitalists, medical directors and/or case management departments.[2] In addition, at-risk physician groups and/or management service organizations ("MSOs") that are participating in downstream full risk arrangements with MAOs are acting in a similar manner regarding their physician orders for observation status.

Many MAOs also have failed to adopt the Medicare Inpatient Only list of procedures reflecting those that should always be performed in an inpatient hospital setting. CMS created and revisits the list annually to promote quality outcomes for Medicare patients by ensuring care is provided in the right clinical setting. This effort should not vary depending on whether a Medicare beneficiary participates in traditional Medicare or Medicare Advantage. Below we address those above concerns again in light of the OIG's new Work Plan targeted to evaluate the impact of capitated payment arrangements on denied services.[3]

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[2] In markets where MAOs have risk arrangements with organized physician groups, delegated medical groups or downstream management service organizations (collectively, "downstream organizations"), these relationships often involve sub-capitation contracts that shift financial risk where some or all of the Part A and Part B premium is funded to the downstream organization. Those downstream organizations substantially over-utilize outpatient observation status due to the financial incentives inherent in their risk arrangements with MAOs.

[3] See OIG Work Plan 2017 at p. 28 ("Capitated payment systems, such as those used by CMS to pay MA plans, may create financial incentives for plans to underserve beneficiaries. We will examine national trends and oversight by CMS of denied care within MA. We will determine the extent to which services were denied, appealed, and overturned in MA from 2013 to 2015. We will also compare rates of denials, appeals, and overturns across MA plans and evaluate CMS's efforts to monitor and prevent inappropriate denial of care in MA.")

A. MAOs are Treating Inpatient Stays as Observation Services at Increasing Rates

The vehicle for this wholesale reclassification of patient status as observation rather than inpatient, has varied based on either: (1) a selective application of the Medicare "two-midnight rule" that was intended to provide clarity about inpatient or outpatient status, rather than arbitrarily reduce the overall number of inpatient hospital stays; or (2) Milliman Care Guidelines modified opaquely by MAOs so that providers have no predictability in assessing patient status. The sense of our membership is that since the two-midnight rule was adopted, the number of inpatient stays reclassified by MAOs as "outpatient observation status" has continued to increase in the MA population as compared to the Medicare fee-for-service ("FFS") population. The potential explanation for these increases in observation status in the MA population may be explained in part in some counties by premium risk shifting by MAOs to physician groups for the provision of services and care, incentivizing such sub-capitated groups and potentially affecting decisions on patient status. An inordinate number of observation stays are very long stays, in excess of three days. Our members have observed these trends for several years, and are concerned that the increases in observation status use are now appearing in markets where there is no significant level of sub-capitation. Challenges to denied inpatient status through the appeal process are somewhat successful even at the first level of appeal with plans, but such appeals should be unnecessary as many denials of inpatient status through appeal should not be occurring.

With the introduction of the Medicare Outpatient Observation Notice ("MOON") this March, along with the high level of long stay observation status in the MA population, increased confusion to enrollees is inevitable. Implicit in the MOON notice are the presumptions of the two-midnight rule, that if a physician believes the stay is expected to cross two midnights, an admission order should be written. But that is clearly not occurring through MAO physicians' orders, based upon our members' experience. In fact, if an MAO physician and/or hospitalist writes an order for an inpatient stay before an enrollee has received observation services for more than 24 hours, then prior to discharge changes that order to replace the inpatient admission with an order for observation status, the MOON may not be required to be delivered to the enrollee. This will be particularly problematic for patients that experience services under Medicare FFS before transitioning to MA. And over time, patients will move back and forth between Medicare FFS and MA, creating even more confusion.

The use of observation status also could be problematic when an MAO requires an enrollee to have a prior qualifying three-day or even one-day inpatient hospital stay for skilled nursing facility (SNF") coverage, like original Medicare. Indeed, the two-midnight rule was designed in part to reduce confusion among beneficiaries regarding inpatient status and allow a beneficiary to predict whether he or she would be eligible for SNF care subsequent to a hospital stay. When applied in the MA setting, the rule should have the same effect. It is certainly confusing for a beneficiary to understand that after spending many days in a hospital bed, he or she has not satisfied a hospital stay requirement for a SNF stay if the MAO has not waived that condition to SNF coverage. It is even more problematic if the patient is in the SNF when the MAO decides, post-hospital discharge, to change a hospital's claim for an inpatient stay to observation status. See section 10.2.1 of Chapter 4 of the Medicare Managed Care Manual.

We also are concerned that under many prevailing agreements between MAOs and hospitals, a hospital is permitted to bill patients for an inpatient stay if the claim is ultimately denied by the MAO, when the hospital has provided the patient with appropriate notice of their financial responsibility if their MAO does not reimburse the hospital for services and care provided. Given the significant frequency with which these changes of status from inpatient to observation are occurring, it is inevitable that some hospitals will provide such advance notice of potential non-coverage to beneficiaries. MAOs should not be allowed to shift financial risk to enrollees in this fashion.

B. Impact on Star Ratings Through Incorrect Patient Status

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. CMS seems to be aware of these concerns, perhaps because we have expressed them in prior year comments to the call letter, and indicates in this year's Call Letter at page 106 as follows:

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.]

We agree that including outpatient observation stays for MAOs in the numerator and denominator of an All Cause Readmission Measure helps as a disincentivize to improper patient classification. We are concerned however that CMS has removed All Cause Plan Readmissions from the Star Rating measures for CY 2018. *See* 2018 Call Letter at p. 88 n. 15. We understand that CMS is considering adjusting the measure and support the adjustment, but believe that such adjustments should occur in CY 2018, rather than putting the measure on hold for a year.

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We encourage CMS to review the level and scope of observation status in the MA population. This is consistent with the 2017 OIG Work Plan at page 28. We believe such a review would support: (1) adopting a transparent and uniform standard for the definition of an inpatient stay, and (2) prevent the adoption of financial incentives that impact decisions about patient status. The failure to take these steps creates confusion for beneficiaries, jeopardizes good clinical judgment, and puts both beneficiaries and providers at financial risk. Such risks are increased as Medicare Part C continues to grow to a larger portion of the Medicare program.

III. 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 Call Letter. Unfortunately, those comments were not addressed in the final CY 2017 Call Letter. 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.**

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

We welcome CMS's continued focus on provider network adequacy. CMS can reinforce one of its major themes under the 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 Call Letter at p. 114. Beneficiaries certainly receive less 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.

In our comments to the 2016 and 2017 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.

To that end, 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.

V. 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.**

VI. High Maximum Out-of-Pocket ("MOOP") Limits and Enrollee Cost-Sharing Obligations Can Have Negative Consequences for Providers (Attachment VI:2018 Call Letter, Section II Part C, p. 116-118)

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. It also prompts MAO plans to change the status of an inpatient admission to an outpatient stay (as discussed on Section I above), which may cost the beneficiary more in cost-sharing liability than an inpatient service.

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-share 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. If CMS adopts this proposal, CMS should require MAOs to reimburse providers for uncollected member responsibility at the then current federal reimbursement rate. This would place the burden for uncollected member responsibility where it should lie, with the MAO itself given that such costs are included in their capitation payments. **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 voluntary and mandatory MOOPs at their current levels.**

VII. CMS Should Not Incorporate Dismissals in its "Timely Decision About Appeals" Measure (2018 Call Letter, p. 108)

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 108 of the 2018 Call Letter, CMS indicates it is again considering modifying the measure for CY 2019 to include appeal dismissals and withdrawals of appeals, apparently in addition to merits decisions.

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 the proposed 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 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.

VIII. Medical Loss Ratio

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.

Sincerely,