Federation of American Hospitals®

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August 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Information on Medicare Advantage (CMS–4203–NC)

Dear Administrator Brooks-LaSure,

The Federation of American Hospitals (FAH) is the national representative of more than 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 areas across 46 states, plus Washington, DC and Puerto Rico. Our members include 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.

We are writing in response to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on the Medicare Advantage (MA) program. The FAH has previously expressed concerns about the need for CMS to take steps to protect Medicare beneficiaries that receive access to Medicare coverage through MA and address program abuses by Medicare Advantage organizations (MAOs). This RFI is an important step, and we urge CMS to quickly layout plans to address major shortcomings in MAO oversight and ensure that beneficiaries in the program have improved access to care.

The Office of the Inspector General (OIG) in its recent report, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About

Beneficiary Access to Medically Necessary Care" (hereinafter, "OIG Report")[1] outlined how MAOs systemically apply problematic operating policies, procedures and protocols that inappropriately deny and delay care that Medicare beneficiaries are entitled to receive. We urge CMS to exercise its broad oversight authority over MAOs to ensure beneficiaries maintain adequate and improved access to their entitled benefits in the medically appropriate healthcare service setting.

As part of this RFI on ways to strengthen the MA program, CMS is seeking input for improvements in five key areas that align with CMS' vision:

- Advance Health Equity
- Expand Access: Coverage and Care
- Drive Innovation to Promote Person-Centered Care
- Support Affordability and Sustainability
- Engage Partners

This letter addresses these five areas and offers recommendations to improve access and care for MA enrollees. We applaud CMS' effort as the agency begins to scrutinize actions by MAOs to ensure MA enrollees are receiving appropriate care.

Section 1: Advance Health Equity

There is growing evidence that MA enrollees experience significant disparities in access to high-quality and necessary care compared to traditional Medicare fee-for-service (FFS) beneficiaries. These disparities in access and quality are amplified due to the differences in the demographic distributions between the MA and FFS programs. The MA program has a significant population of racial and/or ethnic minority and dual eligible enrollees. Racial and ethnic minority beneficiaries make up a much higher proportion of the MA program than FFS. In 2019, the percentage of racial and ethnic minorities enrolled in MA was 32 percent, compared to 21 percent in traditional Medicare.[2] This means that when MA plans limit enrollee access to high-quality care, these practices could increase disparities in care.

Disparities in access to care under the MA program include networks with limited access to high-quality hospitals, receiving lower-quality end-of-life care and lower-quality nursing home care, and greater dissatisfaction with out-of-pocket costs compared to beneficiaries in FFS. Overall, MA enrollees are more likely than traditional Medicare enrollees to be admitted to average-quality hospitals than high- or low- quality hospitals, suggesting that MA plans may be

[1] Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI-09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[2] Murphy-Barron, et al. (2020). Comparing the Demographics of Enrollees in Medicare Advantage and Fee-For-Service Medicare. Milliman Report. https://bettermedicarealliance.org/publication/comparing-the-demographics-of-enrollees-in-medicare-advantage-and-fee-for-service-medicare/.

steering their enrollees to specific hospitals for nonemergent hospitalizations.[3] When looking at end-of-life care received by both MA and FFS beneficiaries, family and friends of beneficiaries enrolled in MA at the time of death or prior to hospice were more likely to report that care was not excellent and that they were not kept informed compared to traditional FFS.[4] MA enrollees also reported greater dissatisfaction with out-of-pocket expenses at 25.51 percentage points higher than traditional Medicare enrollees.[5] Most notably, an OIG report recently found that MAOs denied or delayed care and payments that met applicable coverage and billing rules under FFS.[6] The report found that 13 percent of MA prior authorization requests met Medicare coverage rules and 18 percent of denied requests met coverage and billing rules. These findings offer overwhelming evidence that the direct and indirect actions MA plans take to cut costs and restrict networks, and the resulting disparities in MA beneficiary access to necessary care, may have inequitable impact due to the larger proportion of minority and dually eligible MA enrollees.

As the MA program continues to grow, racial and ethnic minorities, as well as other disadvantaged populations, are entering the program at significantly higher rates than their Caucasian counterparts.[7] While there are many beneficial aspects intrinsic to the MA program, more data must be collected to determine the extent to which its pitfalls may be disproportionately affecting minorities and disadvantaged populations. If significantly more racial/minorities and/or dually eligible beneficiaries continue to enroll in the MA program at higher rates than Caucasian and non-dual eligible enrollees, they will continue to experience delayed care or be denied medically necessary care that they would otherwise receive under FFS. Therefore, the direct or indirect actions that MA plans are taking to delay and/or limit enrollee access to necessary care cannot go unaddressed.

MA plans often offer attractive benefits to disadvantaged Medicare beneficiaries who struggle to afford supplemental services such as Medicare Part D, dental, club memberships, or other similar benefits. Some MA plans also offer wraparound services that address social determinants of health by providing benefits such as meals for patients after a hospital stay. Plans should be commended for these types of policies. However, severely-ill or injured patients who need access to medical and hospital services may find these additional benefits do not outweigh the access problems they encounter due to limited provider networks and overly aggressive utilization control practices.

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[3] Meyers, D. J., Trivedi, A. N., Mor, V., & Rahman, M. (2020). Comparison of the Quality of Hospitals That Admit Medicare Advantage Patients vs Traditional Medicare Patients. JAMA network open, 3(1). https://doi.org/10.1001/jamanetworkopen.2019.19310.

[4] Ankuda, C. K., Kelley, A. S., Morrison, R. S., Freedman, V. A., & Teno, J. M. (2020). Family and Friend Perceptions of Quality of End-of-Life Care in Medicare Advantage vs Traditional Medicare. JAMA network open, 3(10). https://doi.org/10.1001/jamanetworkopen.2020.20345.

[5] Park, Sungchul. (2022). Effect of Medicare Advantage on health care use and care dissatisfaction in mental illness. Health Services Research, 57(4). https://doi.org/10.1111/1475-6773.13945.

[6] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

[7] Meyers, D. J., Mor, V., Rahman, M., & Trivedi, A. N. (2021). Growth In Medicare Advantage Greatest Among Black And Hispanic Enrollees. Health affairs (Project Hope), 40(6), 945–950. https://doi.org/10.1377/hlthaff.2021.00118

As part of CMS' efforts to provide guidance to MAOs regarding the appropriate use of MAO clinical criteria for medical necessity reviews and utilization management, **the FAH urges CMS to clarify that MAOs, their downstream risk providers and their contracted hospitalists must provide their beneficiaries with inpatient coverage and providers with inpatient reimbursement when (1) appropriate under Medicare's Two-Midnight Rule; and (2) beneficiaries undergo procedures on the inpatient-only (IPO) list.** These two Medicare FFS clinical standards should be applied consistently to all MA enrollees since the Medicare Advantage program and the Medicare FFS program serve the same demographic population and these beneficiaries are entitled to the same benefits as required by 42 C.F.R. § 422.100. Requiring MA plans to use these policies will protect patients enrolled in MA and afford them the same protections that FFS beneficiaries are guaranteed. Again, while *all* MA enrollees are put at greater risk by these MA policies that inappropriately push patients out of hospitals (or inadequately reimburse hospitals for providing the appropriate level of care), due to the demographic differences between MA and FFS populations, these policies may inadvertently create disparities in care for the MA program's most at risk beneficiaries.

Excessive use of unique prior authorization criteria and limited networks also are likely creating disparities and may be even more challenging to identify because when MAOs deny care, there are no encounter data or claims to highlight the trends. Our members have noted that disabled patients that need inpatient medical rehabilitation facility (IRF) services, as well as inpatient mental health and substance abuse services, are at particular risk.

CMS is also seeking information on MA plans' use of algorithms to identify enrollees with special care needs or vulnerabilities. We are not aware of special programs such as these. However, the FAH has significant concerns about MA plans that rely heavily on algorithms that lead to prior authorization and claims payment denials – often after the care has been provided. The use of these algorithms likely has the opposite impact that CMS would hope to achieve in addressing care disparities. To the extent these algorithms are based on historic biases, appropriate patient care could be in jeopardy. We have heard concerns especially related to IRF care and inpatient care for substance abuse. **We urge CMS to require that utilization management tools and the logic for proprietary algorithms be made public to patients and providers.**

The growing research on potential disparities in care and access to care for the sick and more diverse populations covered under MA highlight the need for more oversight and exploration on direct and indirect MA policies and practices that may be creating disparities in care – especially when compared to beneficiaries in traditional FFS. **The FAH urges CMS to expand data collection, public reporting, and research on care disparities that may be affecting diverse populations, either directly or indirectly, due to MAO policies and practices.**

Section 2: Expand Access: Coverage and Care

CMS is seeking comments on ways to strengthen beneficiary access to health services for enrollees in MA. The RFI's "Expanding Access: Coverage and Care" section seeks input on ways to improve the tools and information for beneficiaries to choose an MA plan that best

meets their anticipated needs; increase mental and substance use access; the role of telehealth in improving MA enrollee access to care; the best ways to ensure network adequacy and communicate network changes; and the impact of utilization management programs used and ways to ensure that the programs do not prevent or delay appropriate care. These are important issues for CMS to consider and we appreciate CMS' focus and attention to engage with patient and provider stakeholders to improve enrollee access to high quality and timely care.

Aggressive utilization control practices are a problem that the FAH and other stakeholders have raised with CMS for several years. But it is not just patients and providers raising concerns. The OIG Report[8] highlighted that MAOs systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees.

The OIG Report also identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA enrollees, as previously discussed. Specifically:

- *Improper prior authorization denials*. The OIG found that thirteen percent (13%) of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.

- *Improper denials for lack of documentation*. The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.

- *Improper payment request denials*. The OIG found that eighteen percent (18%) of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, and deploy inappropriate pre- and post-payment denial policies, and even deny claims for previously authorized services. These activities are often carried out by way of MAOs' downstream at-risk physicians and contracted hospitalists. All of these activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.[9]

Giving beneficiaries a better picture of the utilization control practices used by MA plans, along with other plan details, during the enrollment process could go a long way to educating enrollees of the potential access challenges they may face – especially if they have a known

[8] Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General ("OIG"), OEI-09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[9] For further detail, see Federation of American Hospitals, "Re: Needed Improvements to Medicare Advantage Organization Practices," September 1, 2021 (the "September 1 Letter"), attached hereto.

medical condition. **The FAH recommends that MA marketing materials outlining plan benefits include a list of services that require prior authorization or pre-certification, the rate at which those services are approved, and the average length of time for approvals.** This important information could provide invaluable details to enrollees and their families as they weigh their coverage options in MA plans and traditional FFS. This information is also a good counterbalance to oversimplified messages about "free" MA services excluded from FFS coverage (such as gym memberships or other supplemental services) that appear generous but that are often obsolete when a patient is very ill and needs extensive health care services.

From a network adequacy perspective, MA enrollee access to services and care is often more limited than it would appear in an MAO's Health Service Delivery ("HSD") submission or provider directory that a beneficiary reviewed and relied upon during their open enrollment decision making process to choose an MAO. MAOs often use downstream organizations which direct care to a far narrower provider network, rendering network access to certain providers illusory. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups and their sub-capitation arrangements create a financial incentive to direct care to a particular provider or group, creating a de facto provider network at the downstream organization level that is far more limited than the MAO's advertised network. **The FAH continues to recommend that CMS take action to foster MAO network transparency to protect MA enrollees' access to care by implementing audit protocols to identify and review the adequacy of downstream organizations' provider networks and taking appropriate network enforcement actions for noncompliance with network adequacy standards. In addition, the FAH urges CMS to incorporate network adequacy into the Star Ratings Program.**

Network adequacy is particularly a problem in post-acute care. MA enrollees routinely experience inappropriate delays in discharge from the inpatient hospital setting due to MAOs' lack of (1) an adequate post-acute network and (2) post-acute providers in MAOs' networks willing to accept beneficiary discharges. When a patient is ready for transfer from an acute-care setting to a post-acute environment (including Long Term Care Hospitals (LTCHs), IRFs, and skilled nursing facilities ("SNFs")), the most appropriate course is the prompt and safe transfer of the beneficiary so s/he may begin to receive post-acute care (e.g., rehabilitation) in the most suitable environment. MAOs, however, often are financially incentivized to prolong beneficiaries' hospital stays (often paid at a case rate such as the MS-DRG system) rather than incurring the additional cost of post-acute provider stays, and may delay discharges based on the lack of available or willing post-acute providers. In addition, MAO's post-acute networks often do not include an adequate number of post-acute facilities to ensure that the appropriate facility is available and post-acute care is not delayed or disrupted. This has been a particularly acute problem during the COVID-19 public health emergency (PHE) when hospitals often have been desperate to discharge patients quickly to open up beds for waiting COVID-19 patients. **The FAH recommends that CMS require MAOs to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in MA beneficiary inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities.**

The OIG Report highlighted the many harmful practices that arise from MAOs' adoption of prior authorization and use of inappropriate clinical criteria, and the FAH urges CMS to protect beneficiaries by ensuring MAOs adhere to critical Medicare coverage rules, as discussed above. For example, instead of consistently and transparently authorizing and paying for inpatient services when an MAO beneficiary receives hospital services that span two or more midnights from the first day of patient presentation to the hospital (Two-Midnight Rule), many MAOs use a variety of standards (including unique standards they develop and promulgate on their own) to determine whether a particular hospital stay meets their criteria for an inpatient admission. MAOs deny authorizations for inpatient admissions ordered by physicians and reclassify them as outpatient observation stays with troubling frequency, often using non-transparent, remote means of assessing medical necessity and overriding the treating medical professional's clinical decision. In addition, our members report that MAOs create financial incentives for contracted physicians to change the admission status before discharge and reduce the MAO's payment obligation to hospitals for services and care. Furthermore, members have reported MAO denials of inpatient coverage for procedures included on the Medicare IPO list, which is the single definitive source of guidance as to which procedures must for patient safety reasons be performed in an inpatient setting to be covered by Medicare. These practices are not appropriate utilization review activities; instead, they dilute the benefits provided to MA beneficiaries and undermine the benchmarking process used to fund MA coverage and ensure actuarial equivalence. ***The FAH, therefore, reiterates our recommendation that CMS require MAOs and their contracted physicians—including their employed group physicians, downstream at-risk physicians and their hospitalists—follow the Two-Midnight Rule in determining patient status and the medical necessity of an inpatient admission and provide inpatient coverage and payment for each procedure on Medicare's IPO list.*** The consistent application of these requirements across the Medicare program would protect patients and promote transparency in and fiscal oversight of the MA program.

MAO clinical criteria and review practices may particularly burden beneficiary access to specific types of care, and the FAH supports the OIG's recommendation that CMS undertake targeted audits of particular service types that have a history of inappropriate denials. For example, some MAO plans use proprietary, non-CMS-endorsed standards to determine coverage for IRF services. These standards may direct beneficiaries to less intensive care settings, delaying or denying MA beneficiary access to the intensive, comprehensive, IRF-level care indicated by their condition and reducing access to their entitled benefits. The use of these proprietary standards creates confusion and administrative challenges for beneficiaries and providers and results in an inappropriate misalignment between the treatment of Medicare beneficiaries under the FFS program and those in an MA plan. The OIG's report identified a number of cases in which the MAO improperly denied a request for prior authorization of IRF services. ***The FAH therefore urges CMS to (i) issue new guidance to ensure MAOs do not use more restrictive clinical criteria or request unnecessary documentation, and (ii) undertake targeted audits focusing on IRF and other specific service types that have a history of inappropriate denials.***

In order to protect MA beneficiaries, the FAH urges CMS to exercise its broad MAO oversight authority and ensure beneficiary access to their entitled benefits by addressing MAO authorization and payment denials of care that meets Medicare coverage rules. As the OIG observed:

> ***Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers.*** *Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Further, beneficiaries enrolled in Medicare Advantage may not be aware that there may be greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.*[10]

Finally, MA providers' appeal rights are typically governed by their agreements with MAOs. MAOs' appeals processes are complex, cumbersome, not standard across plans, often not automated, and require significant administrative resources and staffing for health care providers. Additionally, MAO patient portals or websites should include "point and click" options for patients to appeal prior authorization denials for services and items. Ensuring that patients and providers have an easy way to quickly appeal denials of service will improve patient access and minimize excessively strict approval criteria.

Section 3: Drive Innovation to Promote Person-Centered Care

While MAOs and providers do engage in innovative risk-based payment and delivery models, these relationships can be more challenging to establish with multiple MA plans in various markets, with smaller patient populations, and greater reliance on FFS rates as a starting point for payment. However, models that build off CMMI models and programs, where infrastructure can be expanded to MA populations offer some options and flexibility. Some plans are more sophisticated in their ability to develop and maintain innovative programs, and hospitals look for opportunities to work with plans to improve patient care, program efficiencies, and care quality.

Section 4: Support Affordability and Sustainability

The FAH understands MAOs currently include MA encounter data from denied (in part or in full), pended, and underpaid claims in their risk adjustment data submissions to CMS, resulting in increased risk adjustment payments that do not reflect the costs incurred by the MAO. This behavior is inconsistent with the purposes of the Part C Risk Adjustment Program and inflates Medicare spending without any corresponding beneficiary benefit. **The FAH urges CMS to limit MA encounter data for the Risk Adjustment Program to data derived from fully paid claims or, in the case of a provider that accepts capitation, provider encounter data.**

Further, MAOs often hire private contractors on a contingency fee basis to conduct a variety of audits on a pre-payment or post-payment claims basis. These audit types include (1) charge audits, where the contractors inappropriately remove Medicare covered charges from claims; (2) MS-DRG audits, where the contractors use proprietary software to downgrade the

[10] OIG Letter at 20 (emphasis added).

underlying diagnoses necessary to support a DRG by inappropriately removing or re-bundling billed ICD-10 codes; and (3) medical record audits, where the contractors question the accuracy of physician documentation regarding the beneficiary's health and associated comorbidities that support the underlying diagnosis and medical necessity. These audits often are undertaken without any clinical basis and regularly fail to include an adequate explanation for the contractor's conclusions. Through this process, remote third-party contractors overrule the professional opinion of the treating professionals, despite often lacking the relevant clinical training or expertise. MAOs' delegation to these contractors frequently creates confusion due to poor communication between MAOs and their contractors. These issues are exacerbated due to convoluted appeal processes. While the FAH acknowledges that MAOs are obligated to conduct reasonable audits, we are concerned that contingency fee audits conducted by MAOs' contractors are improperly motivated by financial incentives, fueling a "bounty hunter" mentality, and inappropriately burdening providers caring for MA beneficiaries. CMS acted several years ago to curb these types of unfair practices under the Medicare FFS recovery audit contractor (RAC) program and should exercise similar oversight of these practices under the MA program.

Section 5: Engage Partners

CMS is requesting comments on ways to improve the gap in information for patients, plans and providers. Quality information is a critical component in selecting a provider or hospital and is also important when beneficiaries are selecting an MA plan. In addition to our recommendations on policy improvements to protect patients in MA, **we urge CMS to consider further refinements to its MAO oversight by developing new quality metrics for MAO operations that could be included in the Star Ratings Program**. New quality measures should be developed to rate and report on patient access problems related to appeals and denial overturn rates for prior authorization, appeals and overturn rates for payment denials, network adequacy, and service delays. The FAH is currently developing a new MA quality measure concept on Level 1 Appeals to highlight overturn rates for health plans. This measure would supplement the current measures evaluating Level 2 Appeals. We believe such measures would promote competition on these critical access-oriented dimensions of MA plan quality, rewarding and incentivizing better MAO behavior and providing beneficiaries with critical information on the potential for excessive plan denials for service.

CMS has the statutory authority to address these and other abusive MAO practices as part of its broad oversight authority over MAOs. If CMS were to implement some of our recommended changes through regulation, we believe it would facilitate improved engagement between plans and providers. And, as explained further below, such oversight would not implicate the non-interference clause contained in section 1854(a)(6)(B)(iii) of the Social Security Act or compromise its goals.

The Social Security Act provides CMS wide latitude to address MAO behavior, and the non-interference prohibitions expressly enumerated in the statute would *not* preclude CMS from taking action regarding MAOs' inappropriate use of clinical criteria to deny or alter care delivery settings, improper actions limiting provider networks, or other abusive measures that inappropriately limit beneficiary access to care and burden providers.

The non-interference clause contains two discrete, narrowly-drawn prohibitions. First, CMS cannot mandate an MAO contract with a specific provider. Second, CMS cannot mandate that an MAO implement a particular price structure within a provider contract. The text of the non-interference clause reads as follows:

> *In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not [1] require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this subchapter or [2] require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.*[11]

Beyond these two express prohibitions, CMS retains its broad regulatory authority – and responsibility – to ensure beneficiaries receive the Medicare benefits to which they are entitled.

The plain text of the non-interference clause has not been expanded by regulation or judicial precedent. To date, we have only identified limited CMS discussion of section 1854(a)(6)(B)(iii) in the context of mandated payment model adjustments for MAOs, which would plainly violate the statute's directive that CMS not "require a particular price structure for payment under" a provider agreement.[12] Along similar lines, CMS recently concluded that a commenter's suggestion that CMS require "payment by the MA organization of certain amounts to a contracted provider" is "within the scope of" actions precluded by the non-interference clause.[13]

The larger context of the MA statutory scheme and legislative history confirm the non-interference clause is a narrowly tailored, targeted provision designed to foster competition rather than to place MAO conduct beyond CMS' regulatory reach. Ever since the Medicare and Medicaid programs were enacted in 1965, CMS has been charged with providing a broad swath of Americans with access to essential quality and affordable health care. The MA program incorporates private, CMS-contracted plans in the Medicare program with the objective of expanding beneficiary choice while leveraging plan competition to improve quality and reduce program costs. The MA non-interference clause and the Part D non-interference clause, are designed to preserve that competition by preventing CMS from setting MA rates or mandating

[11] Social Security Act § 1854(a)(6)(B)(iii).

[12] *See* CMS, "Report to Congress: Alternative Payment Models & Medicare Advantage" (July 16, 2019), https://www.cms.gov/medicare/medicare-advantage/plan-payment/downloads/report-to-congress-apms-and-medicare-advantage.pdf; *See also* Centers for Medicare & Medicaid Services (CMS), "Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs" (May 1, 2013), https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/PaymentReductions.pdf

[13] Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards, 87 Fed. Reg. 22,290, 22,380 (April 14, 2022).

contracting with any particular provider.[14] The legislative history reflects a particular desire to preserve price-based competition among MA plans by prohibiting CMS from setting rates.[15]

Expanded CMS oversight over the abusive MAO practices described in our September 1, 2021 Letter and in this letter would not implicate the non-interference clause or compromise its goals. Indeed, the law is clear that Medicare beneficiaries who enroll in MA plans are entitled to the same benefits, at a minimum, that they would receive if they were enrolled in original Medicare.[16] To that end, CMS retains the authority to ensure MAOs satisfy minimum benefit requirements. By implementing the recommendations we have offered, CMS would ensure MAOs comply with their basic statutory obligation to provide beneficiaries access to timely, adequate, and appropriate care. Such a regulatory response would *promote* meaningful competition between MAOs on the dimensions of quality, value and care delivery while also protecting beneficiaries and promoting improved partnership with providers.

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The FAH appreciates the opportunity to offer these insights. We are committed to working with you to ensure America's seniors in MA plans have improved access and better care. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

[14] In 2003, section 1854(a)(6)(B)(iii) was amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, § 222, 117 Stat 2066, to extend its requirements to Medicare Prescription Drug Plans, and a corresponding provision was included in the Part D statute at 1860D-11(i).

[15] *See* 149 Cong. Rec. S15670-03, S15691, describing legislators' goals in incorporating the non-interference clause with respect to Part D plans: *"*They said: We believe in competition. . . . Let the private sector negotiate their incentives for the insurers to get lower costs out of the pharmaceuticals. . . . Let that mechanism work. Don't have the head of CMS, the Medicare Director in Washington, DC, dictate prices for everybody. *Let us not set those prices in the Senate.* Let us let the marketplace work to squeeze cost and get efficiency out of the system" (emphasis added).

See also 149 Cong. Rec. S15670-03, S15761, "The competition in this bill achieves significant 'bang for the buck' because it relies on drug plans to negotiate discounts. CBO says the private insurance model has a cost management factor of 25 percent-the effect of price discounts, rebates, utilization controls, and other tools that a PDP might use to control spending. By relying on the bargaining power of drug plans, this bill will drive down the costs of prescription drugs."

See also Congressional Budget Office, Letter to the Honorable William H. Frist, MD (January 23, 2004), https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4986/fristletter.pdf, "CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree."

[16] *See* S.S.A. §1852(1)(A), "[E]ach Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original [M]edicare fee-for-service program option".