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January 16, 2018

Seema Verma

Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

7500 Security Boulevard

Baltimore, MD 21244

Submitted electronically via the Federal Rulemaking Portal:

<http://www.regulations.gov>

RE: CMS-4182-P: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

Dear Administrator Verma:

The Healthcare Association of New York State (HANYYS), on behalf of our member non-profit and public hospitals, nursing homes, home health agencies, and other healthcare providers, welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule outlining 2019 contract year policy and technical changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit (Part D) programs, published in the *Federal Register* on November 28, 2017. CMS' comprehensive rule looks to support innovation in MA and Part D products through improvements in quality, accessibility, and affordability to better meet the needs of Medicare beneficiaries.

HANYYS is supportive of CMS' goal to promote improvements and innovation in the MA program. The MA program is an important source of coverage for approximately one-third of Medicare beneficiaries.

While HANYYS supports CMS providing MA plans with greater flexibility to innovate, we continue to urge CMS to address the fundamental uncertainty about the extent to which MA plans are able to behave inconsistently with traditional Medicare policy, both in terms of coverage and payment. Given the growth of the MA program, we urge CMS to provide clarity on the following fundamental questions:

- Do MA plans have the ability to deviate significantly from fundamental Medicare coverage and payment policy?

- If plans do substantially deviate from payment and coverage policy, does CMS view these deviations as within its regulatory authority to correct, or must providers be prepared to dispute these behaviors solely in private contract disputes?

We believe that Medicare beneficiaries and providers will be well served if CMS has authority to oversee the deviations described above. With the growing proliferation of different Medicare products, including private fee-for-service plans, CMS should be prepared to oversee rules around prompt payment, utilization review, and other related payment policy issues for MA plans.

HANYS appreciates the opportunity to provide comments to the agency and asks that CMS consider our detailed comments below on its proposed policy changes around greater flexibility in plan benefit design, beneficiary cost sharing and beneficiary enrollment, and plan medical loss ratio requirements. In addition, HANYS supports the comments submitted by the American Hospital Association.

Flexibility in MA Premium Uniformity Requirements

The Medicare statute requires MA plans to offer their plans “at a uniform premium, with uniform benefits and level of cost sharing throughout the plan’s service area.” Historically, CMS has interpreted the statute as requiring MA plans to offer all beneficiaries access to the same benefits at the same level of cost sharing. In this rule, CMS is providing notice of a change to its prior interpretation of the statute. CMS is now saying the statute permits MA plans to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for beneficiaries that meet specific medical criteria, provided that similarly situated beneficiaries are treated the same. However, CMS does note that the new flexibility would still prohibit MA plans from denying, limiting, or conditioning the coverage or provision of a service or benefit based on health status-related factors. This increased flexibility would be available to plans for the 2019 plan year.

HANYS is concerned as to how the change in policy may impact beneficiaries without special conditions. Beneficiaries already encounter barriers to care due to copays and cost-sharing requirements. If MA plans impose higher cost-sharing on a portion of the beneficiaries to offset reductions in cost-sharing for others, this will result in significant adverse financial and treatment implications.

HANYS urges CMS to institute safeguards to ensure that beneficiaries who are considered healthier members of the population are not inappropriately harmed by modifications to the MA cost-sharing and uniformity requirements. Consideration must be given to supporting individuals at high risk, managing individuals with rising risk, and sustaining individuals at low risk.

Maximum Out-of-Pocket (MOOP) and Cost-Sharing Limits:

CMS proposes to modify existing regulations under which the agency establishes the MOOP limits, and annual cost-sharing limits on Parts A and B services to prevent discriminatory benefit

design. The MOOP limits and cost-sharing limits are based on Medicare fee-for-service (FFS) data and reflect a combination of patient utilization scenarios and length of stays or services used by average to sicker patients. The existing methodology for setting MOOP limits creates limits for local and regional MA plans that vary from year to year, requiring CMS to exercise discretion to annually stabilize the limits.

Currently, all MA plans must establish limits on beneficiary out-of-pocket cost sharing for Parts A and B services that do not exceed the annual limits established by CMS. These limits are intended to help ensure that enrollment by individuals who use higher-than-average levels of healthcare services are not discouraged from enrollment. MA plans that adopt a lower, voluntary MOOP are given greater flexibility in their cost-sharing requirements.

CMS intends to use Medicare FFS data to establish annual MOOP limits and proposes to increase the voluntary MOOP limit by increasing the number of service categories that have higher cost sharing in return for offering a lower MOOP. CMS' goal under the proposed rule is to establish future MOOP limits based on the most relevant or available data, or combination of data, to maintain benefit stability over time and reflect beneficiaries' healthcare costs in the MA program.

CMS will monitor for potential discrimination if a plan is targeting cost-sharing reductions and additional supplemental benefits for a large number of disease conditions, while excluding other higher-cost conditions. **HANYS strongly supports agency efforts to prevent and take action against any plan discrimination.**

Meaningful Differences in MA Bid Submissions and Bid Review

CMS proposes to eliminate the “meaningfully different” standard that MA organizations must meet if they offer multiple MA plans in the same county. Currently, CMS requires MA plans that offer multiple products in an area to have meaningful differences with respect to key characteristics such as premiums, cost-sharing, or offered benefits. Each year, CMS promulgates meaningful difference evaluation standards to determine substantial differences in benefit packages. For contract year (CY) 2019, CMS proposes to eliminate this requirement to allow plans to innovate and improve plan options for beneficiaries.

As CMS notes in the rule, the principal concern with eliminating the “meaningfully different” standard is increased beneficiary confusion regarding plan options. In certain markets, the elimination of this standard is likely to increase the number of plan options available to beneficiaries.

HANYS is concerned that the limited benefits plans would achieve through removal of this standard does not outweigh the risk of beneficiary confusion, particularly in light of the proposed changes to the uniformity requirements that will give plans more flexibility around benefits and cost-sharing. If CMS moves forward with this proposal, HANYS urges the agency to engage stakeholders, particularly beneficiaries and beneficiary advocacy groups, before enacting it to explore better tools and resources to improve the beneficiary's experience when choosing a health plan.

Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage and Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually-Eligible Beneficiaries

Individuals who have been enrolled in a non-Medicare health plan, such as a Medicaid managed care plan or a commercial plan, can be enrolled in an MA plan run by the same plan when those individuals first become eligible for Medicare. This process is known as the seamless enrollment process and is automatic unless the beneficiary enrolls in FFS Medicare or a different MA plan. CMS suspended approval of new requests to use seamless enrollment in November 2016 to reevaluate its policies. In addition, CMS can passively enroll beneficiaries in a new MA plan if the contract for their current plan is being terminated in the middle of a plan year, or if there is potential harm to beneficiaries.

CMS proposes to resume using the seamless enrollment process, but only for plans that offer both Medicaid managed care plans and MA Dual Eligible Special Need Plans (D-SNPs). Plans would be able to automatically enroll beneficiaries of the Medicaid plan in the affiliated D-SNP when they become eligible for Medicare. CMS is also proposing to expand the use of passive enrollment to include dual eligibles who face an involuntary disruption in their Medicare or Medicaid coverage to promote integrated care and continuity of care.

Taken as a whole, these changes could create an improved seamless enrollment process that protects more vulnerable beneficiaries from losing their continuity of coverage. However, meaningful beneficiary communication will be key to successful implementation of these initiatives. **HANYS strongly recommends that CMS ensures beneficiaries receive adequate notice of any change in enrollment and that mechanisms exist for beneficiaries or their advocates to get timely answers to their questions regarding the seamless enrollment process. It is essential that the required notice include all key information necessary for the beneficiary to make an informed decision.**

Reducing the Burden of the Medicare Part C and D Medical Loss Ratio (MLR) Requirements

MA plans and Part D sponsors are required to report their MLRs, which reflect how much of a plan's total revenue is spent on claims for medical services, medications, and certain other qualifying expenses, such as quality improvement activities (QIAs). CMS may impose penalties on MA and Part D plans for failure to have an MLR of at least 85%. The current MA MLR rules are based on commercial MLR rules, which do not count fraud prevention activities as QIA.

CMS proposes to allow MA and Part D plans to include in the numerator of their MLR the amount of claim payments recovered through fraud reduction efforts that do not exceed fraud reduction expenses. CMS is also proposing to expand the definition of QIAs to include all fraud reduction activities, including fraud prevention, detection, and recovery. This change would increase the MLR numerator, making it easier for plans to meet the 85% standard.

HANYS believes that the MLR standard is an important tool for CMS to hold plans accountable for how their premium dollars are spent. **HANYS urges CMS to drop its proposal to allow fraud activities to be included in the MLR numerator.**

Communication/Marketing Materials and Activities

CMS prohibits MA plans from distributing marketing materials and applications forms to individuals eligible for MA plans unless the document has been submitted to CMS at least 45 days (10 for certain materials) for approval prior to use. The agency is proposing to narrow the definition of marketing materials to focus on materials that are most likely to lead to an enrollment decision. CMS will continue to require those materials be submitted to and approved by CMS, but would develop less stringent requirements for communications materials that are excluded from the revised definition of marketing materials—for example, materials that do not include information about the plan’s benefit structure or cost-sharing.

HANYS strongly recommends that CMS ensure these new communications materials do not lead to beneficiary confusion and inappropriate marketing attempts by MA plans.

Reducing Provider Burden—Comment Solicitation

CMS is exploring ways to reduce the burden on providers arising from requests by MA plans for medical record documentation, particularly in connection with MA program requirements. The agency is interested in stakeholder feedback on the nature and the extent of this burden of producing medical record documentation.

HANYS has consistently heard from member hospitals that MA plans often request hundreds or thousands of charts with a very short and unreasonable turnaround time for purposes of collecting codes for risk adjustment. Audits are overly broad in terms of information requested. For example, plans will regularly request “all records and notes” for all patients seen by the provider for a date range that can span up to an entire year or longer. The audit’s timeframe, request volume, and response time is often not supported by the contractual agreement, or the contract is silent. When the provider pushes back, the MA plan states that the audit is necessary to comply with CMS MA risk-adjustments requirements.

To reduce provider burden and establish a more efficient process for medical record documentation requirements from MA plans, **HANYS recommends the following:**

- **Limit medical record requests to a statistically valid random sample of the provider’s patients for specific items and services over a limited timeframe.** Rather than permit MA plans to issue broad medical record documentation requests covering all items and services for all MA beneficiaries treated by the provider for a significantly long period of time, HANYS recommends that medical record documentation requests be limited in scope.
- **In cases of individual patient medical record documentation requests, require MA plans to clearly define the items and services requested and limit the timeframe**

for most cases. In certain instances, MA plans may request all medical records for a given patient covering an entire year or some other excessively lengthy timeframe. Rather than permitting MA plans to issue these extensive requests covering such long periods, CMS should limit the timeframe.

- **Create a mechanism for CMS to address medical record documentation requests, payment, coverage, and other operational issues between providers and MA plans.** CMS has not provided clear guidance, and as a result MA plans currently do not follow the same processes for provider medical record documentation requests, thereby increasing the complexity and difficulty for providers to meet these requests as described above. This lack of uniformity, and in some cases, conflict between MA plans' interpretation and actual CMS requirements poses significant operational and financial challenges for providers.

HANYS appreciates the opportunity to provide feedback on the proposed rule. If you have questions regarding our comments, please contact me at (518) 431-7730 or jgold@hanys.org or Stefanie Pawluk, Director, Insurance and Managed Care at (518) 431-7827 or spawluk@hanys.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey A. Gold".

Jeffrey Gold
Senior Vice President, Managed Care and Special Counsel