



**Date** 1.16.18

Demetrios Kouzoukas  
Principal Deputy  
Administrator for  
Medicare and Director,  
Center for Medicare

Centers for Medicare &  
Medicaid Services  
Department of Health  
and Human Services  
Attention: CMS-4182-P  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Director Kouzoukas,

On behalf of Change Healthcare, I would like to submit comments on CMS-4182-P, the proposed Medicare Advantage (MA) rule released on November 16.

Working alongside its customers and partners, Change Healthcare leverages its software and analytics, network solutions and technology-enabled services to help them improve efficiency, reduce costs, and more effectively manage complex workflows.

### **Medical loss ratio (MLR) and fraud prevention**

Change Healthcare develops and licenses its claims code auditing software product, ClaimsXten™, to both commercial health plans and public programs. Change Healthcare's claims code auditing products help assure that provider claims are paid accurately and appropriately in an automated manner. They are currently utilized by over 300 private companies as well as state Medicaid programs. The ClaimsXten software is licensed annually and has a high rate of renewal among clients. The routine renewal of this product attests to the value delivered to MA plans by identifying and correcting improperly coded medical claims submitted by providers.

While ClaimsXten is utilized to review accuracy of coded medical claims, it is important to note that the product does not provide recommendations for payment. Payment decisions are based upon the MA plan's policies encompassing eligibility, medical policy, and provider contract terms, among other factors. Typically, Change Healthcare's clients adopt and/or modify the clinical edits within its claims code auditing product to reflect their organization's medical, billing, and coding policies. A MA plan determines whether it will utilize a clinical edit based upon its

own policies.

The rules and logic in Change Healthcare's automated claims code auditing solution have been thoroughly reviewed by medical practitioners for consistency with established standards. The edit development process utilizes many different independent expert sources, including the American Medical Association's Common Procedure Terminology (CPT), CMS's Medicare payment rules, and medical specialty guidelines, to ensure the integrity of the product. Change Healthcare also utilizes providers and other healthcare professionals as consultants to review clinical edits for their appropriateness and consistency before they are incorporated into its products.

**Change Healthcare applauds CMS's intent to focus on fraud reduction activities in the MA and Part D programs by including these activities in the MLR as proposed in section II (C) (1) (b) (1) of the rule. Change Healthcare believes this proposal is an important and appropriate step toward ensuring that premium dollars are spent effectively and that taxpayer resources are protected from mismanagement. In addition to supporting these changes in the regulations, Change Healthcare urges CMS to include health information technology (IT) and claims code auditing solutions specifically in the list of allowable expenses. Finally, for ease of administration, Change Healthcare recommends that CMS consider extending these same changes to the regulations that govern the commercial and Medicaid markets.**

According to public data, fraudulent claims accounted for \$41 billion in improper payments in Medicare fee-for-service (FFS),<sup>1</sup> and \$16.2 billion or 10 percent of all MA payments in fiscal year (FY) 2016.<sup>2</sup> This consistently high cost of fraud to taxpayers, in addition to the size and complexity of the program, has led the Government Accountability Office (GAO) to label Medicare as a "high-risk program" with regards to fraud vulnerability.<sup>3</sup> Despite this well-documented risk, the current regulatory framework does not sufficiently incentivize MA and Part D plans to invest in a robust fraud prevention and reduction program. Instead, as the proposed rule opines, "[the regulations encourage] MA organizations and Part D sponsors to invest in tracking down and recouping amounts that have already been paid, rather than in preventing payment of fraudulent claims" before they occur."

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<sup>1</sup> US Government Accountability Office. Report to Congressional Addresses. CMS Needs to Fully Align its Antifraud Efforts with the Fraud Risk Framework. Dec. 2017. Available: <http://www.gao.gov/assets/690/688748.pdf>.

<sup>2</sup> Shulte, F. Fraud and Billing Mistakes Cost Medicare – and Taxpayers – Tens of Billions Last Year. The Center for Public Integrity. July 19, 2017.

<sup>3</sup> US GAO Report, Dec. 2017 at page 2.

In response, CMS proposes to remove “fraud prevention activities” from the list of excluded expenses in the MLR calculation to the list of valid Quality Improving Activities (QIA) for the purposes of calculating the MLR numerator. It further proposes to rename the category “fraud reduction activities” and include under that definition activities designed to prevent fraud, detect fraud, and recover fraudulent payments. This approach is consistent with the GAO’s Fraud Risk Framework recommending that federal government agencies, including CMS, engage in prevention and “early detection” of fraud rather than leaning toward a “pay and chase” strategy inherent to a post-hoc review of claims that have already been paid.<sup>4</sup> For this reason and others that CMS presents in the proposed rule, Change Healthcare agrees that these are appropriate steps to take in MA at this time and would suggest further that CMS consider similar changes in the Medicaid and commercial market regulations in the future.

The proposed rule requests feedback regarding which activities should be included in the revised definition of fraud reduction activities. As a healthcare technology company that helps improve efficiency and outcomes in the healthcare system and delivers important insights to its customers to reduce fraud, Change Healthcare requests CMS to ensure that health IT geared toward fraud reduction, including control of incorrect coding, be included as an allowable expenditure. Change Healthcare’s products help MA plans to root out fraud daily, whether its cause is related to coding errors, inefficiencies due to excessive ordering, improper billing or intentional fraud. Change Healthcare accomplishes this by providing best-in-class software solutions that help MA plans to make medical necessity determinations, review and process accurate claims, and recover fraudulent payments in a timely manner.

An example of these products which can control improper payment of provider claims is the claims code auditing solution, ClaimsXten, which is utilized by MA plans to not only edit professional claims, but also to produce analytics reports that help to identify outlier providers who show a tendency to code their claims in a manner that is not aligned with that of their peers. Utilizing this solution, MA plans can prevent these payments before they occur, thus saving the cost of a post-adjudication review and recovery of the fraudulent payment. It also allows MA plans to communicate with their outlier providers about proper coding practices to reduce the risk of fraud in the future. Additionally, Change Healthcare’s analytics reports provide MA plans with tools to reward providers that show a propensity toward responsible coding.

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<sup>4</sup> US GAO Report, Dec. 2017 at page 15.

**Change Healthcare encourages CMS to ensure health IT is an allowable expenditure under this rule and that it specifically include activities such as claims code auditing, pre-pay coding, physician-profiling, and audit/recovery operations as fraud reduction activities.**

The proposed rule further requests input regarding the current list of exclusions to QIA and whether they should apply to fraud reduction activities. Change Healthcare believes that some of the QIA exclusions are applicable to fraud prevention activities, while others may not be as relevant. Change Healthcare believes that the definition of "fraud reduction activities" should be sufficiently broad so as not to exclude health IT. With this in place, the current list of exclusions could remain largely the same.

For example, Change Healthcare's claims code auditing products perform within a MA plan's claims adjudication system, but are decidedly separate and distinct from these systems. Despite this difference, CMS could interpret the current regulatory exclusion for "establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health IT that are designed primarily or solely to improve claims payment capabilities" to include claims code auditing solutions because Change Healthcare's products help to improve payment capabilities, while also helping to prevent fraudulent payments.<sup>5</sup> **Change Healthcare requests that CMS make the distinction between the two functions by removing the reference to products "that are designed primarily or solely to improve claims payment capabilities."** This would retain the exclusion for costs related to claims adjudication systems, while also allowing those products that operate within the systems to continue to root out fraud.

### **Reducing provider burden from medical record requests**

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

Change Healthcare works closely with MA plans to ensure that they obtain accurate risk scores for their beneficiaries and supports policies that strengthen risk adjustment programs. Change Healthcare's services begin with proprietary technology and expertise to assist MA plans in converting their source data and managing errors to facilitate timely and accurate submission to the Risk

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<sup>5</sup> § 422.2430(b)(5).

Adjustment Processing System (RAPS) and Encounter Data System (EDS). Change Healthcare adds proprietary technology and analytics that are utilized by MA plans to evaluate the documented health status of their beneficiaries, identifying gaps between health status, provider documentation and reported quality scores and risk scores.

Change Healthcare also partners with MA plans in several unique ways to meet their Healthcare Effectiveness Data and Information Set (HEDIS®), Star ratings and other quality reporting needs to better manage beneficiaries' overall care. Change Healthcare's HEDIS.com software and industry-leading expertise enable MA plans with full command over the management of their HEDIS and quality measure reporting and workflow processes. Change Healthcare solutions feature a full, web-based, end-to-end approach for all quality and clinical outcomes reporting.

Change Healthcare is acutely aware of the burden placed upon provider offices by requests for medical records. Because providers see beneficiaries from various MA plans and with different types of coverage, their office resources place significant focus on being paid correctly for their services. Change Healthcare believes providers have a significant burden to respond to medical record requests multiple times annually for every MA plan with whom they provide services. This burden is compounded with requests for medical records related to commercial and Medicaid plan risk adjustment, Star ratings, and health plan payment integrity programs.

Due to CMS MA risk adjustment, payment methodology, Star ratings programs, and payment integrity programs, the requests for medical records in the MA market will not be declining. Based upon Change Healthcare's experience, MA plans seek, on average, 1.18 charts per beneficiary and have expanded the dates of service of these requests from 12 months to 18-24 months. Combined with commercial and Medicaid plan risk adjustment and a shortened HEDIS season, providers are repeatedly contacted for much larger volumes of charts throughout the year. Additionally, beneficiary charts are larger in size, primarily due to how electronic health records (EHRs) embed additional information into a medical record for a single encounter, which may not be relevant or usable for risk adjustment and quality programs. While a medical encounter may have been recorded on a single-page subjective, objective, assessment, and plan (SOAP) note in the past, an EHR may produce a 15-page encounter record.

Though electronic standards and processes could ease requests for medical record retrieval, the human aspect can still make the process difficult. Since CMS risk adjustment and quality measures are based upon what is documented in the medical record, the need for MA plans to request medical

records will continue. These requests will also likely increase due to the need to obtain medical records for the Medicaid and commercial markets.

Providers have responded to these requests in many ways, including:

- Declining to provide the medical records due to insufficient time or resources. Change Healthcare's experience finds that approximately 15 percent of medical record requests are ignored by provider offices.
- Setting limits on how many medical records they are willing to retrieve per request.
- Charging a fee to access the medical records or passing on copying costs. Change Healthcare's experience finds that, on average, approximately 25 percent of charts provided include a copying fee; fees average approximately \$25 per medical record.
- Making the medical records available only through a third-party vendor, which also requires a fee.

MA plans are attempting to reduce these burdens on providers in many ways, including:

- Combining their requests for medical records to meet risk adjustment and quality needs so that the request to a provider office is only made once annually.
- Paying EHR vendors to obtain medical records electronically without requesting them from the provider directly or impacting the provider's resources.
- Focusing more on prospective risk adjustment activities to reduce the number of medical records that are requested for retrospective chart review.
- Investing in provider education and documentation improvement initiatives that aim to proactively address incomplete and inaccurate documentation.
- Deploying technology to integrate risk and care gap alerts in the EHR so that the providers can address these directly within their workflow and reduce the need to request medical records for beneficiaries where these have been addressed.

The request for medical records is directly related to the number of risk score and quality gaps that beneficiaries have; thus, the volume of medical records requested from providers increases with increased beneficiary risk score and quality gaps. If a beneficiary has seen multiple providers for the year that is being measured, it is likely that the MA plan will request medical records from multiple providers for the same beneficiary.

As a healthcare technology company, Change Healthcare continuously works with its clients and partners to solve challenging healthcare industry issues. The application of technology has the potential to bridge the information gap that exists in providing quality and efficient care at a lower cost. There are multiple endeavors where Change Healthcare is actively trying to close this gap, and all involve accessing information on the desktops that the provider office utilizes in its daily workflow. Some of these endeavors include:

- EHR integration: Providers review and enter information into their EHR systems daily; it is the one place they are certain to see information about a beneficiary's chronic conditions that they need to be aware of and address during the beneficiary's visit. Change Healthcare has developed an integrated solution with a leading EHR vendor and is actively pursuing opportunities to integrate with other EHR systems to display risk score gaps and quality gaps to the provider at the point of care and within the provider workflow. The provider is alerted of chronic conditions that have not yet been reported by any provider in the current calendar year and is given the opportunity to confirm the condition, mark it as no longer existing or invalid, or to enter a different condition that the beneficiary has. This is especially helpful as the medical diagnosis depends upon the ability of beneficiaries to recall and report their medical history, and research indicates patient recall is typically flawed and incomplete.<sup>6</sup> MA plans benefit by receiving the information that they need much sooner and the alerts may also cause providers to assess, diagnose, and treat conditions that they were unaware of because they were reported by other providers the beneficiary has seen. This will lead to improved quality of care and reduce the burden of requesting medical records for these beneficiaries because the MA plan knows that the providers have been made aware of the beneficiary's chronic conditions. Additionally, the MA plan has appropriate information for risk adjustment and quality measurement purposes.
- Electronic Data Interchange (EDI) Messaging: Change Healthcare's Intelligent Healthcare Network™ interconnects thousands of government and private payers, medical and dental providers, pharmacies, and laboratories. This presents the opportunity to message provider offices with important information that requires their attention as they submit claims through the EDI gateway to be adjudicated by the MA plan. This messaging may include information about chronic conditions a beneficiary has that has subsequently been observed by the provider. In some of these cases, the claim that was submitted does not contain diagnosis

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<sup>6</sup> Cohen, Gillian & Java, Rosalind. (1995). Memory for medical history: Accuracy of recall. *Applied Cognitive Psychology - APPL COGNITIVE PSYCHOL.* 9. 273-288. 10.1002/acp.2350090402.

codes to indicate that the beneficiary still has the condition or that the provider diagnosed it or is aware of it. The messaging requests that the provider office or the medical biller review the beneficiary's chart to check if the chronic condition was documented during the visit, and if so to add the chronic diagnosis code to the submitted claim. Provider offices that cooperate and are willing to respond to the messaging will lessen the burden of medical record requests because the beneficiary's risk score gaps have been closed. While some auditing would be necessary to ensure provider compliance, based upon early experience and conservative calculations, Change Healthcare believes it can reduce the need for medical record requests by approximately 20 percent.

These are just two instances where Change Healthcare is working with its partners to improve the flow of information among treating providers and to close the gap of information and potential gaps in care that may adversely impact a beneficiary. Change Healthcare is actively pursuing other opportunities where technology can impact and improve health outcomes. These types of products, with greater adoption, provider engagement and participation, and industry support, will reduce the burden of medical record requests to provider offices, while addressing the underlying root causes of these requests and ensuring that MA plans and CMS have improved access to data and make better decisions that improve the quality of care delivered to the beneficiary and his/her health outcomes.

In response to specific questions in this section of the proposed rule, please refer to Attachment A.

### **Star ratings and the Categorical Adjustment Index (CAI)**

Over the past few years, CMS has been addressing issues regarding the ability of MA plans to achieve quality-based bonus payments if they have a significant amount of dual eligibles. CMS proposes to codify the calculation and use of the reward factor and the CAI in §§ 422.166(f)(2) and 423.186(f)(2), while it considers other alternatives for the future. **Change Healthcare urges CMS to develop a long-term solution that addresses the socio-economic challenges faced by MA low-income beneficiaries.**

Change Healthcare identifies MA low-income beneficiaries who may benefit from dual enrollment and acts as an authorized representative to assist them in applying to the appropriate state Medicaid agency. Change Healthcare annually assists to enroll approximately 44,000 MA low-income beneficiaries in a dual eligible program and has cumulatively helped save these beneficiaries over \$2.5 billion in Part B premiums. In addition to Medicaid, Change Healthcare helps identify and enroll



MA low-income beneficiaries into the Part D Low-Income Subsidy (LIS). In addition to Medicaid and LIS, Change Healthcare helps guide health plans' low-income enrollees through Community Link™, an extensive database of more than 15,000 public and privately-sponsored community programs to which they may qualify. Change Healthcare helps plans' low-income enrollees secure approximately \$150 million in financial benefits through Community Link annually.

The strongest evidence of the positive impact of Change Healthcare's assistance to MA low-income beneficiaries is plan tenure. While the average period of MA plan enrollment is approximately three years, Change Healthcare finds that those it helps enroll into Medicaid as a dual eligible remain with their MA plan an additional 18 months. Similarly, Change Healthcare finds that those it helps enroll into a community-based program remain with the MA plan an additional 9 months. Thus, MA low-income beneficiaries stay more loyal to their plan when their socio-economic challenges are addressed. Additionally, Change Healthcare finds that MA low-income beneficiaries express more satisfaction with their plan through a multitude of surveys that impact the plan's quality-based bonus payments when their socio-economic challenges are addressed.

Change Healthcare strongly urges CMS to incentivize MA plans and providers to meet the socio-economic challenges of their low-income beneficiaries through quality measures, program incentives or value-based care programs. Change Healthcare's experience has shown that its interventions with these beneficiaries have been linked to higher quality care, improved health, and lower costs.

Continuing its work to assess the impact of addressing socio-economic challenges, Change Healthcare is beginning to assess a new tool called the Patient Activation Measure (PAM).<sup>7</sup> The PAM is a survey that assesses an individual's knowledge, skill, and confidence for managing his/her health and health care. Scores are aggregated into four categories; higher categories have been shown to indicate improved control of chronic conditions with improved health levels and lower costs of care. Change Healthcare will be conducting a study utilizing the PAM among select MA plan clients and their beneficiaries who have received enrollment assistance into programs that address their socio-economic challenges.

Change Healthcare possesses over 15 years of experience in meeting the socio-economic challenges for millions of MA low-income beneficiaries. Change Healthcare welcomes the

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<sup>7</sup> Hibbard, Judith H., et al. "Development of the Patient Activation Measure (PAM): Conceptualizing and measuring activation in patients and consumers." *Health services research* 39.4p1 (2004): 1005-1026.

opportunity to collaborate with CMS to improve the lives of these vulnerable beneficiaries.

### **Flexibility in the MA uniformity requirements**

Change Healthcare supports CMS's proposal to allow MA plans to offer targeted supplemental benefits to medically vulnerable enrollees. By tailoring benefits to the beneficiary's health condition, MA plans will be able to improve care delivery, promote wellness, and achieve cost savings for the Medicare program. These benefits will also encourage beneficiaries to be more engaged and compliant with their care.

Additionally, Change Healthcare asks CMS to provide MA plans with flexibility to determine the criteria for offering tailored benefits. Rather than offering the same benefits to all beneficiaries with the same diagnosis, MA plans should be able to tailor the benefits based upon factors such as the beneficiary's state of health and level of disease severity. CMS should also enable MA plans to address social determinants of health by offering non-medical social services to beneficiaries, including transportation to medical appointments, access to healthy foods, and safe housing.

### **Other comments on Star ratings**

CMS proposes specific rules to govern the addition, updating of, and removal of quality measures and to apply these rules to the measures proposed in this rulemaking. Change Healthcare supports these rules as it provides more structure to the Star ratings program and allows MA plans with more clarity to provide better quality care for their beneficiaries.

### **MA risk adjustment**

While not specifically addressed in this proposed rule, Change Healthcare would like to commend CMS for providing more opportunities in 2017 for MA plans and vendors to ask detailed questions during the regular CMS risk adjustment webinars and through the risk adjustment e-mail listserver. Without timely, specific answers, MA plans and vendors face uncertainty complying with CMS relevant guidance, which can result in plan bid submissions that contain higher rates for their beneficiaries to account for this uncertainty. Change Healthcare encourages CMS to continue providing these forums in the future.

## Conclusion

Change Healthcare appreciates the opportunity to comment on CMS-4182-P. Please contact me or Tim Jones, Director of Public Policy & Advocacy, ([tim.jones@allegrohealth.com](mailto:tim.jones@allegrohealth.com)) if you have any questions or would like to arrange a follow-up meeting to discuss any of these issues in further detail.

Sincerely,

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## **Attachment A: Change Healthcare responses to specific medical record documentation questions**

In the proposed Medicare Advantage (MA) rule released on November 16 (CMS-4182-P), CMS notes that, to address concerns from providers about burdensome requests from MA plans for their beneficiaries' medical record documentation, it is soliciting comment from stakeholders to more fully understand the issue and for ideas to accomplish reductions in provider burden. In response to specific questions about the nature and extent of medical record requests in the proposed rule, Change Healthcare submits these comments.

**Reasoning behind the request sent by the MA plan to the provider:** MA plans request medical records to ensure the completeness and accuracy of the diagnosis coding for risk adjustment as well as to abstract information for quality and HEDIS measures. Additionally, the information is utilized for provider education. Since the MA risk scores require conditions to be well-documented in the medical record and the MA plan may be audited to ensure this documentation, they have an obligation to request medical records both for internal audit purposes as well as to check for missing diagnosis codes that were not submitted on the claim since it is well-known that provider submission of chronic diagnosis codes on claims data is sometimes inaccurate and often incomplete.

The payment model of CPT codes, as well as the history of the present illness (HPI) or chief complaint (CC), drive the diagnoses submitted on the claim. This is also a determining factor for medical record requests and reviews to document codes because the chronic conditions are often not submitted on the claim for the encounter. Further, given CMS 5010 diagnosis code processing limits (837p (12 Dx)/837i (25 Dx)), it is common for diagnosis codes to be truncated during the billing process and not be included in the claim. **Change Healthcare urges CMS to lead updates to these file standards so that they are more supportive of complete documentation.**

**Amount of time afforded to providers to respond to such requests:** It is common that the MA plan is working to complete medical record review in time for a CMS sweeps period. As a result, the request for medical records and completion of the reviews are required within a fixed period (approximately 8-12 weeks). Thus, the provider would be expected to respond to the request for medical records within a few weeks. If that time expanded, the MA plan's ability to complete the medical record review would be impacted to submit RAPS or EDS diagnosis codes before the sweeps submission deadline.

Additional challenges for providers to respond timely include the timing of MA sweeps and record requests, which occur primarily during the Thanksgiving and Christmas holiday seasons. In addition, there tends to be an increase in care during the winter due to flu season, which places an even higher burden on providers. Though Change Healthcare offers bulk uploads, fax, mail, EHR offsite and field reviewer (FR) onsite retrieval to reduce the burden, some providers still decline to comply with requests for medical records. Change Healthcare's experience finds that, on average, approximately 15 percent of requests for medical record requests are ignored.

**Frequency of requests for providers to submit medical records:** The frequency of requests is dictated by the CMS sweeps calendar and whether the MA plan performs chart projects for September, March, and January sweeps separately or combined. Most MA plans will perform medical record review for at least two of the sweeps deadlines; a significant portion of those medical record requests could occur at the same provider offices. Additionally, there could be a separate request for medical records during HEDIS season as most MA plans utilize a quality team that works separate from its risk adjustment team.

**Volume of medical records in each request:** The volume of medical records in each request is highly variable based upon the MA plan's risk adjustment goals, resources, and activities. The volume is also dependent upon the number of MA beneficiaries for each plan at a provider's office. Thus, it is likely that provider offices that serve a significant number of MA beneficiaries for a plan will have a high number of requests for medical records (possibly dozens or even hundreds of charts). While it is understood that this request is a burden for provider offices to comply, MA plans have few alternatives for requesting these records based upon MA risk adjustment, quality/HEDIS requirements, and payment methodology.

**Method of collection and submission of medical records:** MA plans may utilize their own resources or more commonly enlist the services of a chart retrieval company to gain access to the medical record. Other companies centralize provider records and require a fee payment to gain medical record access. Some providers are also charging fees for access to their medical records. Change Healthcare's experience finds that, on average, approximately 25 percent of providers charge \$25 for each medical record.

Medical records can be retrieved by scanning paper charts where the provider office has collected them from their files in a stack or give supervised access to the EHR vendor to retrieve the beneficiary charts for the appropriate date ranges. Some EHR vendors can create an electronic file of requested

medical records for a fee. Medical records are typically stored, transmitted, and accessed electronically via secure File Transfer Protocol (FTP) as digital images (most commonly PDF) or electronically formatted extracts.

**How narrowly or broadly the requests are framed (for example, whether the request is for a single visit, a specific condition, and for what timeframe):** Medical records retrieved for risk adjustment typically span 12-18 months of service and/or are based upon the beneficiary's eligibility date range with the MA plan. CMS guidance to allow medical record review and reporting of diagnosis codes in cases where the beneficiary may have been enrolled with a different MA plan may widen the scope beyond the beneficiary's eligibility date range. Similarly, for quality and HEDIS abstraction, the request includes the calendar year or the beneficiary's eligibility date range.

For MA risk adjustment data validation (RADV) audits, while there may be specific dates of service that are requested based upon claims data, the entire year or beneficiary's eligibility date range is typically requested and reviewed rather than specific dates of service since RADV allows for support of additional Hierarchical Condition Categories (HCCs) based upon the medical record that may not have been submitted on claims.

**Extent to which requests are made pursuant to a CMS-conducted RADV audit, other CMS activities, or for other purposes (please specify what the other purposes are):** The medical record requests pursuant to a CMS-conducted RADV audit represent a small fraction of the total number of medical record requests an MA plan would make in any given year. Most of the medical record requests are for risk adjustment or quality/HEDIS compliance. The MA plan may also perform some internal audits of medical records where anomalies in diagnosis coding or evaluation & management (E&M) coding is seen from a provider office as compared to a provider's peers.

**Considerations that may be unique to solo providers:** Solo providers are unlikely to have the staff needed to support a significant number of medical record requests. If they service multiple payers across multiple lines of business, the likelihood that they will receive medical record requests for a portion of their portfolio is high. As a result, they would have difficulty responding to these requests both due to the volume and the short timeframe by which the medical records are required.

**Impact on burden due to increased adoption of EHR systems:** While the adoption of EHR systems has greatly reduced the amount of medical records that are paper-based charts, little has been accomplished to ease access to those charts. This is partly due to the number of EHR systems that are

incompatible and have difficulty sharing information, even accounting for electronic standards across the industry. Additionally, when considering patient privacy and security concerns, as well as the manual nature of the retrieval process (logging into the EHR and printing out or exporting the desired medical records), there is significant burden to obtain medical records. As a result, provider office staff is required to be involved in most of these cases to give access or retrieve the medical records for the requestor.

In response to specific questions about the nature and extent of requests related to medical record attestations in the proposed rule, Change Healthcare submits these comments.

**Reasoning behind the attestation request:** Based upon Change Healthcare's experience, most of the attestation requests made are attributed to charts with signature deficiencies; this can occur in approximately 35 percent of all records. Change Healthcare notes relevant RADV guidance, "If a physician or outpatient record is missing a provider's signature and/or credentials, consider using the CMS-Generated Attestation that was provided with your data. CMS will only consider CMS-Generated Attestations for RADV."<sup>8</sup>

Change Healthcare helps MA plans identify signature or chronic condition documentation deficiencies by appending unique exception codes to diagnoses that have deficiencies requiring clarification from the provider or attestation. Examples include, but are not limited to, signature deficiencies, incomplete dates, and missing credentials. MA plans can also utilize this data to educate providers.

**Amount of time afforded to providers to respond to such requests:** Due to the nature of CMS sweep periods, the provider usually has a few weeks to respond to the medical record requests before it impacts the chart coding operations or before it is beyond the submission deadline.

**Frequency of requests for providers to sign attestations:** The frequency is 2-3 times annually per MA plan to account for risk adjustment and HEDIS. If the provider is enrolled in multiple MA plan networks, the overall frequency would be much higher based upon the number of MA plans requesting medical records.

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<sup>8</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Checklist.pdf>

**Volume of requests:** The volume for each provider is variable based upon the size of his/her practice and the number of patients enrolled in MA plans.

**Level and duration for which attestations are requested (for example, for each medical record, for all medical records for a beneficiary for a particular date of service or for a particular year):** Normally, all medical records for a beneficiary for a particular year are requested.

**Whether there is reduced burden associated with electronic signatures:** Electronic signatures do reduce the burden compared to requiring physical signatures.