January 16, 2018

To the Centers for Medicare & Medicaid Services (CMS),

L.A. Care is pleased to have the opportunity to comment on the proposed CY 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 Programs. L.A. Care is largely supportive of the changes outlined in the proposed rule. L.A. Care is requesting further clarification on the topics listed below and has also provided feedback in response to CMS’ request for information regarding Section 13. Reducing Provider Burden.

**B. Improving the CMS Customer Experience**

**Section 2. Reducing the Burden of the Compliance Program Training Requirements**

L.A. Care strongly supports the reduction of compliance training requirements related to first-tier, downstream and related entities (FDRs).

**Section 5. Revisions to Parts 422 and 423, Subpart V, Communication/Marketing Materials and Activities**

L.A. Care supports the move to redefine marketing materials and communication materials and the shift to using electronic delivery of required materials as opposed to requiring hard copy mailings. We would like to request further clarification on how this would or would not impact the required use of model materials. L.A. Care would also recommend that CMS release the new or changing guidance for marketing and communication materials late 2018 or early 2019. This will ensure enough time has been given to organizations to appropriately plan, develop, design, approve and translate materials for the 2020 marketing and enrollment season.

**Section 11. Preclusion List – Part C/ Medicare Advantage Cost Plan and PACE**

L.A. Care supports the idea of a Part C preclusion list but would like additional information on how the list’s information would be shared with health plans. L.A. Care would also like clarity surrounding whether beneficiary notices would be required if the beneficiary’s provider ended up on the preclusion list shortly after the beneficiary had been assigned or received care from the provider. Additionally, if a beneficiary notice is required, would distribution of the notice be the responsibility of the health plan or CMS?

**Section 12. Removal of Quality Improvement Project for Medicare Advantage Organizations**

L.A. Care strongly supports the removal of having to submit and report on duplicative Quality Improvement Projects.

**Section 13. Reducing Provider Burden Request for Information**

Provider abrasion due to medical chart retrieval is a problem. While our plan does request a significant number of charts for risk adjustment for Medicare/CMS, the abrasion is more the result from the totality of requests across multiple regulators, sub-regulators, lines of business (MA, Commercial, Medicaid) and for multiple functions (risk adjustment, HEDIS, Quality, payment integrity, care management, etc.). It is clear that the solution to reducing provider burden should not be just a CMS focused approach but one that requires re-engineering across the regulator and plan level to coordinate all chart retrieval activities.

At L.A. Care we have centralized most of the chart retrieval requests through an existing department and developed a workgroup with all departments that have chart retrieval needs. This cross functional, coordinated effort has on average reduced the number of times we are at provider offices for chart retrieval in half. Moreover we have been communicating the change in our approach to contracted provider groups. The prospect of change is welcomed news and helps to positively differentiate our plan from others.

The coordination of chart retrieval requires ongoing planning meetings with the departments who have large volume retrieval needs, coordination of schedules, retrieval target lists, and what data needs to be collected.  Generally we request all copies of the chart be made for broad dates of service (all encounters that are 18 to 24 months old).   This provides the opportunity to extract data for multiple functional requirements (e.g. Risk Adjustable Dx or key HEDIS measures) and be of value for any other department that has use for medical chart review.  Clear identification of what data needs to be extracted for each member is decided up front and communicated with the retrieval and coding vendor.

Secondarily, many of the larger provider groups/IPAs have already centralized their own retrieval activities (hard copies or via EMRs). Establishing relationships with the departments at these groups not only reduces the need to directly involve the provider office but makes the retrieval of charts for multiple members across multiple providers quicker, less expensive, and more effective.

Finally, to fully leverage the retrieval efforts and mitigate repeat retrieval requests, the plan has a sophisticated file management system that can curate all the images of charts being retrieved by any/all departments. Departments and staff can then first turn to the library of charts for any future or ad hoc needs to see if the charts for the member have already been retrieved.

If the medical records are not in the repository of charts, we will work with a chart retrieval organization to close any remaining gaps.

The benefits of this cross-functional coordination are:

* Significant reduction in provider abrasion
* Real savings on vendor costs associated with coordinated retrieval requests and operational savings associated with centralizing the internal management of all requests
* Increased enterprise wide information awareness and availability with a file management tools curating all the retrieved charts

In closing, L.A. Care would like to thank you again for allowing us the opportunity to comment on the proposed changes and we look forward to reviewing and implementing the final policy changes.

Sincerely,

L.A. Care Health Plan