American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4069-P
PO Box 8018
Baltimore, MD 21244-8018

BY EMAIL

RE: Proposed Rule Establishing the Medicare Advantage Program (69 *Federal Register* 46866), August 3, 2004

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems, and our 31,000 individual members, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule to establish the Medicare Advantage (MA) program. As dictated by Title II of the "Medicare Modernization Act of 2003" (MMA), the new MA program will replace the Medicare+Choice program in offering private plan alternatives to elderly and disabled patients enrolled in Medicare's traditional fee-for-service program.

Our comments below address several points of the proposed regulation that reflect a disquieting trend in how private plan options are made available to Medicare beneficiaries. Specifically, we are concerned about a continued relaxation of the federal standards governing MA plan operations coupled with widening preemption of state requirements normally applied to private health plans. Increasingly, hospitals and other providers are left in a regulatory "no-man's land" with little or no means available to address issues of inappropriate health plan actions.

Subpart C – Benefits and Beneficiary Protections

Requirements Relating to Basic Benefits**.** The MMA requires that MA regional preferred-provider organization (PPO) plans set catastrophic limits on beneficiary out-of-pocket expenditures for basic benefits – those services normally covered by traditional Medicare: one limit for in-network benefits alone and another for the combined total of in-network and out-of-network basic benefits. We support the CMS proposal to make MA regional plans responsible

for tracking these beneficiary out-of-pocket limits and for notifying members when they have been met. This information would help hospitals collect the proper out-of-pocket amounts from beneficiaries and minimize the need for refunds, while streamlining hospital reimbursement for providing covered services. **AHA recommends that MA plans be required to supply this information to health care providers and/or hospitals when the plan is notified that an MA plan member has presented for services.**

Access to Services**.** In an effort to ensure adequate beneficiary access to in-network cost-sharing levels, the CMS proposed rule includes a provision that would enable MA regional plans to meet access standards by designating "essential hospitals" with which the plans have failed to contract, but which are necessary to provide adequate medical access in large geographic — particularly rural — areas. CMS has also proposed that the required "robustness" of a regional plan's network of contracted providers be related to the difference between in-network and out-of-network cost-sharing levels. We have several concerns about this provision.

First, CMS states in the preamble to the proposed rule (page 46883) that the MA organization "must also provide assurances that it will make payment to the hospital for inpatient hospital services in an amount not less than the amount that would be payable under section 1886 of the Act." **AHA recommends that CMS clarify that this payment amount would not be limited to the diagnosis-related group (DRG) payment, but would also include any adjustments for payments related to indirect medical education (IME), disproportionate share hospital (DSH), and new technology**.

Second, the provision for "additional" payment made directly by CMS to hospitals using the Federal Hospital Insurance Trust Fund needs clarification. CMS states that payment would be the "sum of the difference between the amount that would have been paid to the hospital under section 1886 of the Act and the amount of payment that would have been paid for those services under fee-for-service Medicare had the essential hospital been a critical access hospital." Although the designated "essential hospital" must demonstrate that MA payment would be less than the hospital's cost of providing services to MA regional plan enrollees, it is unclear whether the additional payment would (1) reimburse the essential hospital at the full Medicare fee-for-service (FFS) rate, (2) fully reimburse the essential hospital for its costs, which may be an amount greater than the Medicare FFS payment rate, or (3) reimburse at cost plus 1 percent — the amount generally paid to critical access hospitals (CAHs). **AHA recommends that CMS clarify this provision to provide the additional payment necessary to make up the difference between the full amount that would have been paid to hospitals under section 1886 and, if greater, its cost or, in the case of a CAH, the amount otherwise payable under Title 18.**

Third, it is unclear whether CAHs qualify for designation as "essential hospitals" under the proposed rule. Section 422.112(c)(1) states that an essential hospital is considered a general acute care hospital as defined in section 1886(d) of the Act. This would effectively exclude CAHs, which are defined in section 1820 of the Act. However, CAHs are among the best examples of "essential hospitals" because they are located in isolated, rural communities, they often require a higher payment than standard DRG amounts, and they are specifically mentioned

in the CMS proposed rule with respect to the supplemental payment provision described earlier. **AHA recommends that CMS stipulate that CAHs are eligible for designation as essential hospitals under this provision and for supplemental CMS payments in addition to MA plan payments.**

According to the proposed rule, MA regional plans must make a good faith effort to contract with essential hospitals in order to take advantage of the flexibility of the access standard. In the preamble to the proposed rule (page 46883), CMS asks for input on how to ensure that a MA plan has met this condition and how to ensure that supplemental payments to essential providers remain within the $25 million budgeted for 2006 and future budgetary restrictions. We believe that a primary indicator of a plan's good faith effort is its willingness to engage in contract negotiations. When plans present a standard contract in a "take it or leave it" context, providers have no opportunity to address their concerns, including payment amounts and operational issues, such as claims processing, utilization review, and administrative requirements. CMS has proposed further reductions to federal and state requirements governing MA plan operations that would likely yield more lopsided standard contracts in which providers will need to negotiate changes. By enabling MA plans to avoid contract negotiations, a greater number of designated essential hospitals will draw from the limited supplemental payment budget to account for costs that should have been addressed earlier in the contracts. **AHA recommends that CMS clarify that MA plans must be willing to negotiate contract terms with providers in order to meet the test of having made a good faith effort to enter into a contract.**

Subpart I – Compliance with State Law and Preemption by Federal Law
Section 422.402 of the proposed rule explains that the standards established in the regulation would supersede state law or regulation with the exception of state licensing laws or state laws related to plan solvency. This broad interpretation of the preemption of state law and the failure to impose federal standards regarding critical elements of MA plan operations would create the regulatory "no-man's land" that we referred to at the beginning of this letter. Although an effective contracting process could address concerns related to plan operations, the CMS proposal, as it currently reads, does not ensure good faith contract negotiations. Without adequate federal or state governing standards or fairly negotiated contracts, providers will have few means to ensure prompt payment or acquire access to external review of inappropriate denials of coverage or payment. Although CMS attempts to address the prompt payment issue, it includes no substantive standard except for non-contracting providers. It appears CMS intends to rely on the contracting process to govern MA plan-provider relations and remove the basic state regulatory parameters that govern proper conduct in the private plan market. **AHA recommends that CMS either narrow its interpretation of how state law may be preempted or expand its own requirements for plan-provider contracting to include basic provider protections, such as prompt payment.**

Subpart M – Grievances, Organization Determination and Appeals
Advance Beneficiary Notices in the MA Program. Open access managed care arrangements will allow for greater flexibility and choice for beneficiaries in accessing care. It is unclear, however, whether the enrollee will understand that certain services might not be authorized by the MA plan or covered by Medicare. In addition, some enrollees may wish to access services

from a particular network provider, regardless of whether the plan would cover the care. This would result in a lack of payment to providers, should the plan eventually deny approval for the care. In the proposed rule's preamble, CMS asked whether to permit or require network and non-network providers to furnish a type of advance beneficiary notice when managed care enrollees access non-Medicare covered services. Hospitals should not be held responsible for being aware of each and every local coverage determination from each and every MA plan, nor should they be responsible for informing members about the details of an unfamiliar coverage determination. MA plans must manage and maintain this information because it will become increasingly complex as plans utilize local medical review policies from outside an individual provider's area. **AHA recommends that CMS require MA plans – not providers – to inform its members about non-covered services.**

The AHA appreciates the opportunity to comment on the proposed rule. If you have any questions, please contact me or Donald May, AHA's vice president for policy, at (202) 626-2356 or via e-mail at dmay@aha.org).

Sincerely,

Rick Pollack
Executive Vice President