



**American Hospital  
Association**

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March 6, 2014

Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS Draft 2015 Medicare Advantage Call Letter Released Feb. 21, 2014 with the Advance Notice of Methodologic Changes for Calendar 2015 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Draft Medicare Advantage (MA) 2015 Call Letter to Medicare Advantage Organizations as Attachment VI to the subject Advance Notice. The draft call letter presents several operational and technical modifications to the requirements for health plan bids to offer 2015 plans under the Medicare Advantage program. As such, the letter addresses several areas of importance to hospitals, including provider contract terminations and greater transparency with respect to cost sharing variations.

**The AHA believes it is important to ensure that MA enrollees have access to a selection of high-quality providers in or near to their communities, while not inhibiting care coordination and the growth of integrated care systems. The AHA also believes that Medicare beneficiaries should be able to rely on the information available about an MA plan when they select that plan.**

Our detailed comments follow by corresponding subsection of the letter.



## SECTION II – PART C POLICY UPDATE

### **Subsection A. Increasing Transparency for Beneficiary Part C Cost Sharing for Inpatient Stays (page 108)**

As indicated in this subsection, CMS has been reviewing alternative cost-sharing structures adopted by some MA plans and whether beneficiaries understand how MA plans calculate cost sharing when those structures differ from original Medicare, especially for inpatient services. CMS has found that there is substantial confusion among beneficiaries in this regard. The alternative cost sharing example given is when an MA enrollee is transferred from an inpatient acute hospital to an inpatient rehabilitation hospital and the inpatient rehabilitation stay is treated as a new admission with another hospital first day deductible and per diem cost sharing. In contrast, under original Medicare, beneficiaries pay only one inpatient hospital deductible during a benefit period, even if the beneficiary is transferred from one inpatient hospital type to another or has multiple stays, for any reason, during the benefit period. The out-of-pocket financial implications of these two cost-sharing approaches can be significantly different. **The AHA supports CMS’s proposed interim approach of increasing beneficiary awareness by requiring clearer, plain language descriptions of alternative cost-sharing structures in plan comparison information. We also support the continued evaluation of alternative cost-sharing structures, whether some approaches pose excessively high inpatient cost sharing, and whether the issue warrants regulatory changes to protect beneficiaries.**

### **Subsection C. Provider Contract Termination Guidance (page 115)**

The AHA applauds CMS for addressing a variety of issues related to MA plan network changes. The selection of a physician is a very personal decision and, once established, that relationship often becomes integral to that beneficiary’s health, his or her ability to adopt critical self-management techniques for chronic conditions, and success in adhering to complex treatment protocols in the face of a significant acute condition. Those relationships should be protected as much as possible. Minor network fluctuations can occur throughout the plan year for a variety of reasons, including provider retirements or relocation. We recognize the MA plan’s responsibility to offer a network of providers that meets network adequacy and attains the highest possible quality ratings under the Stars program. However, we also believe that significant network changes, resulting in the disruption of numerous patient-provider relationships, should be made before the start of a subsequent election period and with ample notification to beneficiaries. **We recommend that CMS adopt a primary principle in addressing provider terminations – that is, that beneficiaries not be required to change established relationships with their physician(s), hospitals or other providers when their MA plan makes significant network changes after the point at which enrollees are locked into the plan.** This can include requiring plans to cover the terminated provider as in-network for the remainder of the plan year. Another way to protect beneficiaries from significant mid-year network changes is to allow them to “vote with their feet” and select another plan. **The AHA recommends granting a Special Election Period (SEP) to**

**those beneficiaries whose Part C plans have significant changes in their provider networks following the start of AEP in a given year.**

**CMS Guidance Related to MAO Network Changes.** CMS points to significant mid-year changes to Medicare Advantage Organization (MAO) provider networks this year as the reason to consider augmenting its current guidance regarding such changes. MAOs currently have considerable discretion to select the providers with whom to contract to build effective networks. They also are able to make changes to these networks at any time during the contract year, as long as they continue to furnish all Medicare-covered services in a non-discriminatory manner, meet established access and availability standards and timely notice requirements, and ensure continuity of care for enrollees. **The AHA urges CMS to adopt additional guidance regarding significant mid-year changes to MAO provider networks.**

CMS goes on to indicate that it considers significant changes to provider networks as those that go beyond individual or limited provider terminations that occur during the routine course of plan operations, and has asked for comment on whether a more specific and uniform definition of “significant” should be adopted. **The AHA believes that criteria should be applied in judging whether a proposed provider network is “significant,” but cautions against the adoption of a uniform or overly specific definition.** Plan size, geography and type (such as insurer-based or integrated provider system-based) will impact the significance of provider network changes. Potential criteria offered in the draft include percent of total enrollees affected, number/percent /type of physicians being terminated, hospitals included in termination, etc. Other criteria that could be used are whether the contemplated network reductions would disproportionately affect certain types of care (such as cancer care), types of beneficiaries (such as those with serious or chronic conditions), or types of providers (such as academic medical centers or hospital-based practices). CMS also should consider if an MAO’s network changes eliminate the facilities at which network practitioners have privileges or vice versa.

**Notifying CMS of Significant Terminations.** CMS proposes new procedures to enable greater oversight when MAOs are planning provider network changes. The procedures focus on MAOs notifying their CMS Regional Office Account Managers (AM) no less than 90 days before a planned significant termination of providers in their networks. This time would be used to ensure that the MAO would continue to meet access and network standards, as well as provide adequate notice to providers and enrollees. CMS also asks whether it should use the rulemaking process to broaden its authority to limit MAOs’ ability to terminate provider contracts without cause at any time during the year.

**The AHA supports the proposed 90-day notification to CMS about planned significant changes to MAO provider networks. We also urge CMS to proceed with regulatory changes regarding significant provider contract terminations during the AEP or subsequent plan year. We do not believe such limitations would pose an**

unreasonable barrier to MAO development of effective provider networks, since MAOs contract with CMS on a year-by-year basis. Medicare beneficiaries should be able to rely on the provider network participation information available to them during the AEP.

**Notifying Enrollees of Significant Terminations.** CMS is planning to strengthen current health plan responsibilities to notify enrollees of network changes in its Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) materials, which are provided to all enrollees each fall.

**The AHA supports strengthened enrollee notification, but with modifications to CMS's proposal.** Specifically, we urge CMS to change the proposed language for the notice that puts network changes all in the context of "providers leaving the plan," suggesting that all changes are at the initiation of the providers. Network changes are the result of action by either the plan or the provider, or in many cases involve both parties simultaneously, so the notice should use neutral language. Also, the notice underscores that enrollees should select another provider. As stated earlier, when significant mid-year changes occur, we believe enrollees in MA plans should not be compelled to give up established relationships with providers who were part of the MAO's provider network when they selected and enrolled in the plan. They should have the option to switch to another plan (not just one offered by the same MAO) or be allowed to continue to receive services from their established providers until the end of the plan year with in-network cost sharing. These options should be clear and not subject to the plan's concurrence or require that the enrollee file an appeal to use them.

**Contracted Provider Notification and Right of Appeal.** The AHA supports CMS's plan to provide more than 60 days' notice to providers of a contract termination. We agree that it is preferable to provide sufficient time for both the notice and completion of any provider appeals before affected enrollees are notified of any change.

Thank you for your consideration of our comments. We look forward to working with you and your staff on subsequent MA rule making. If you have any questions, please contact Jeff Goldman, vice president of coverage policy, at (202) 626-4639 or [jgoldman@aha.org](mailto:jgoldman@aha.org) or Ellen Pryga, director of policy, at (202) 626-2667 or [epryga@aha.org](mailto:epryga@aha.org).

Sincerely,

/s/

Linda E. Fishman  
Senior Vice President, Public Policy Analysis & Development