December 8, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: CMS-4085-P; Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs

Dear Acting Administrator Frizzera:

On behalf of the American Medical Association, the Medical Group Management Association, and the undersigned state and national medical organizations, we are submitting comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule, *Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs [CMS–4085–P; RIN 0938–AP77]*. In particular, we strongly urge CMS to finalize its proposed policy change for "Compliance Programs Under Parts C and D" and generally support other provisions of the proposed policy and technical changes that strengthen beneficiary protections.

Compliance Training Requirements

Current CMS regulations pertaining to Medicare Advantage (MA) organizations' first tier, downstream, and related entities have led many MA plans to issue notices to the physicians in their networks requiring that they annually obtain certification in Medicare fraud, waste and abuse compliance policies. As CMS notes, this requirement is entirely unnecessary as physicians already must certify when they enroll in Medicare that they will not present or cause to present a false claim to Medicare. Requiring an additional fraud, waste and abuse certification imposes an additional unnecessary burden on physicians.

As CMS also notes in its proposed rule, physicians and group practices may contract with dozens of MA plans, each of which is currently requiring that its network physicians take an educational course in fraud, waste and abuse compliance. The result is that the same educational requirement, which has already been met by every physician who has a Medicare provider number, is being duplicated many times over. The undersigned organizations and our members view these requirements as substantially increasing the "hassle factor" for physicians whose patients are enrolled in MA plans.

CMS proposes to modify the fraud training requirement to state that physicians and other providers who have met this requirement through enrollment into the Medicare program are deemed to have met this training and education requirement. **The undersigned organizations strongly support this change and urge CMS to finalize this proposed policy.**

We continue to have strong concerns, however, about the requirement from many MA plans that physicians complete the fraud, waste and abuse training prior to December 31, 2009. We urge the agency to take immediate action to clarify that physicians who have enrolled in the Medicare program need not comply with this deadline.

Risk Adjustment Data Validation

An area that has posed serious problems for physicians who have contracts with MA plans or accept patients in MA private fee-for-service plans is the burden on physician practices associated with audits by MA plans. Physician offices have made numerous complaints about extremely burdensome audits of their patients' charts that are conducted by or on behalf of MA plans. In many cases, the correspondence that is sent to physician offices, often by third parties with whom the practice does not have any contract, implies that the chart reviews are mandated by CMS for risk adjustment data validation. Given the very small percentage of charts that are actually included in CMS-required risk validation audits, it appears that the great majority of the chart reviews that are the subject of these complaints may actually be self-initiated by the plans with the aim of increasing the payments they receive from CMS. The correspondence is misleading in this respect.

Often, MA plans or their agents demand that a large number of charts be made available to auditors. Reportedly, plans regularly do not offer to compensate practices for the resources required to pull these charts and then re-file them, nor for any needed photocopying, although some have offered to reimburse for photocopying in response to requests. As CMS contemplates increasing its oversight of MA plans, we urge the agency to take into account the potential impacts of more aggressive program integrity efforts on the medical practices that provide care to MA plan subscribers. At a minimum, office staff time required to pull, review, copy, and re-file medical records should be compensated. Methods should be employed to ensure that physicians can identify the entity that is requesting information, the reasons for the request and for any deadline provided for responding to the request, and that the same practices are not required either to comply with repeated audit demands from one plan or with demands from a multitude of plans within the same timeframe.

That physician practices have been overwhelmed by the volume of audit requests from MA plans may be one reason that plans have experienced difficulties with documentation that are now prompting CMS to provide an avenue for appealing audit findings. If MA plan audits were more targeted and focused on the CMS risk adjustment data validation process rather than fishing expeditions to identify opportunities for higher coding, they might get better compliance.

In addition to the foregoing, there are a number of policies outlined in the proposed rule that would improve the current Medicare prescription drug and Medicare Advantage programs for beneficiaries and physicians.

Material Differences in Plans and Uniform Marketing Format

We agree that many beneficiaries (as well as their advocates and representatives) have found the rapid proliferation of Medicare prescription drug and MA plans bewildering. This is exacerbated

when plans are not sufficiently different from each other and the marketing materials difficult to compare across plans. This adds not only to beneficiary confusion, but confusion for everyone involved in helping or providing health care services to beneficiaries. We support the agency's proposed requirement that to an extent a sponsor has multiple plan offerings, those offerings must be sufficiently different in order to provide beneficiaries meaningful options. In addition, we also support the agency's proposed rule to require sponsors to use standardized "templates" in their beneficiary communication materials (for example, the Annual Notice of Changes (ANOC) and the Evidence of Coverage (EOC) notices), so that beneficiaries, physicians, and other individuals who assist beneficiaries are able to understand how the beneficiary's current benefits and cost-sharing requirements will be changing and more easily compare their current plan with other plan options. Physicians and their staff are often on the front lines of deciphering these changes and explaining them to their Medicare patients.

Maximum Allowable Out-of-Pocket and Cost Sharing

We strongly support the proposal to establish a standard and mandatory cap on member cost sharing for all local MA plan types in order to ensure plans are not discriminatory and beneficiaries are protected from unreasonable financial costs regardless of which MA plan they enroll. In the context of MA benefits and qualified prescription drug coverage, we also support the proposal to establish cost sharing thresholds for individual services above which cost sharing may be viewed as discriminatory. Once again, this will provide beneficiaries with the ability to make meaningful and informed decisions while at the same time structuring the MA and Part D programs to provide the health services and prescription drugs that the plans have contracted to provide. This ensures that beneficiaries will have access to health care and medication when they have the greatest need for both.

Thank for your consideration of our comments.

Sincerely,

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Osteopathic Internists

American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Medical Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Missouri State Medical Association
Montana Medical Association

Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society