Illinois Health and Hospital Association

April 6, 2020

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: CMS-4190-P, Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) thanks you for this opportunity to formally comment on the proposed rule establishing policy and technical changes to the Medicare Advantage (MA) program for contract years 2021 and 2022. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its unwavering pursuit of better beneficiary access to high-quality and cost-effective healthcare services. IHA shares these goals. To that end, we present CMS with a few concerns regarding the proposed changes to network adequacy requirements for MA plans.

MA is a growing source of Medicare coverage in Illinois, with the percentage of Illinois Medicare beneficiaries enrolled in MA plans more than doubling over the past decade. As of 2018, the most recent year of data available, MA enrollment among Illinois Medicare beneficiaries was approximately 22%. Further, the current administration has expressly supported and pushed MA enrollment as the preferred coverage option for Medicare beneficiaries, stating in an Oct. 3, 2019 Executive Order that the Secretary of the U.S. Department of Health and Human Services "shall propose a regulation to provide beneficiaries with improved access to providers and plans by adjusting network adequacy requirements for MA plans to account for: (a) the competitiveness of the health market in the States in which such plans operate, including whether those States maintain certificate-of-need laws or other anti-competitive restrictions on health access."

We appreciate CMS' consideration of MA network adequacy requirements, particularly because Kaiser Family Foundation (KFF) research shows 35% of MA enrollees are enrolled in plans with narrow networks. In comparing KFF's network analysis with the

National Conference of State Legislatures' classification of states by the presence of Certificate of Need (CON) laws, there is no clear relationship between narrow networks and CON laws. In other words, narrow networks are not exclusive to CON states, as one might assume from the evidence presented in the proposed rule. Further, a wealth of evidence indicates most MA insurers already pay providers at or near the traditional Medicare fee-for-service (FFS) provider payment amounts, suggesting that CON laws do not result in higher average costs for MA organizations (Berenson et al. 2015; Pelech 2018; Trish et al. 2017).

We acknowledge the evidence regarding the impact of CON laws on cost and patient access is mixed. However, if we accept CMS' basic argument that Medicare beneficiaries and MA plans in CON states experience higher prices and lower patient access, we question CMS' proposal to further constrict MA provider networks through a 10 percentage point credit. By allowing MA plans to decrease the percentage of beneficiaries that must have access to provider specialties, in accordance with published time and distance standards, CMS will allow MA plans to further restrict beneficiary access in areas they purport already experience a shortage of available provider options.

Further, making this credit available *in addition to* the proposed telehealth credit of 10 percentage points could lower MA network adequacy requirements from 90% to 70% of a plan's Medicare enrollees being within published time and distance standards for certain provider types. The proposed telehealth credit would be applicable to provider specialties including dermatology, psychiatry, neurology, otolaryngology, and cardiology, all of which are consistently among the most searched for specialties across the country. In other words, if finalized, this proposed rule would allow MA plans to include even fewer of the most in-demand specialists in their networks than they do today, further restricting access for beneficiaries that are already likely experiencing restrictive provider networks regardless of CON laws.

MA plans, by design, already have more limited networks of physicians and other providers compared to Medicare FFS. If the administration is earnest in their desire to "provide beneficiaries with improved access to providers and plans by adjusting network adequacy requirements for MA plans," then it should propose policies that require MA plans to mirror Medicare FFS, not provide loopholes by which MA organizations can legally continue their narrow network practices.

Thus, we urge CMS to reconsider both network adequacy proposals. Instead of 10 percentage point concessions for telehealth network supplements and plans operating in CON law states, CMS should rigorously review provider distribution by specialty. In counties where published provider-to-beneficiary ratios cannot feasibly be met, CMS should take the time and expend the resources required to create customized time and distance standards for MA organizations. Finally, we suggest the administration pursue more impactful provider recruitment strategies, building of programs such as the Health Resources and Services Administration's Health

Provider Shortage Area (HPSA) tuition-reimbursement program and the Conrad State 30 program. These popular, bipartisan programs work to bring more providers to areas that experience access issues, and will more meaningfully impact the wellbeing Medicare beneficiaries, regardless of whether they are MA or FFS enrollees.

Ms. Verma, thank you again for the opportunity to comment.

Sincerely,

A.J. Wilhelmi
President & CEO