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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; Program Integrity; Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule [CMS-9957-P]

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid (CMS) proposal entitled, *Patient Protection and Affordable Care Act; Program Integrity; Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule* [CMS-9957-P].

As a threshold matter, we urge CMS to reevaluate its program integrity proposals for qualified health plan (QHP) issuers to ensure that they do not create additional, unintended burdens for physician practices. While many of CMS' proposals do not place direct requirements on physicians, we are concerned that the proposed program integrity and oversight requirements for QHP issuers—particularly those relating to risk adjustment and maintenance of records—will result in QHP issuer demand for documentation, paperwork, and audits of physician practices. This has been a continual problem in the Medicare Advantage (MA) program. We have received numerous reports regarding self-initiated MA plan audits of physician practices for purposes of risk adjustment validation, and have engaged with CMS many times to resolve the issues and problems resulting from such activity. **To avoid these issues upfront in the context of QHP issuer oversight, we strongly urge CMS to make clear in its final rule that QHP issuers may not independently audit physician practices for purposes of compliance with CMS' proposed oversight requirements.**

Standards for Downstream and Delegated Entities

CMS proposes that all agreements among a QHP issuer's delegated and downstream entities, including entities that directly provide health care services, be required to specify: 1) delegated activities, reporting responsibilities, and remedies for noncompliance; 2) mandatory compliance with all applicable laws and regulations relating to the QHP issuer's obligations under 45 CFR 156.340(a); 3) permission for the Secretary, the Office of Inspector General (OIG), or their designees to audit or

inspect the entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations under 45 CFR 156.340(a) for 10 years from the final date of the agreement period; and 4) these provisions after October 1, 2013 for all new agreements and by January 1, 2014 for all existing agreements. **We strongly urge CMS to rescind these proposals, which would unduly burden physician practices and negatively affect access to care.**

In particular, the requirement that a physician practice which contracts with a QHP issuer give permission for the Secretary, the OIG, or their designees to audit or inspect the practice's books, contracts, computers, or other electronic records, including medical records and documentation, for 10 years following the final date of the agreement period is unreasonable and should be omitted from the final rule. While physicians who participate in the Medicare program are already subject to HHS audits and document requests, those requirements are narrowly tailored in many instances, and often include some due process safeguards. The broad authority conferred in CMS' proposal would expose both Medicare-participating and non-participating physicians to unfettered access by HHS to their records for 10 years after the end of the contract period, a time period that significantly exceeds other Medicare "look back" periods. To ensure that this oversight function does not lead to excessive administrative burden for physicians and discourage contracting with QHP issuers, we urge CMS to omit this requirement.

We also strongly caution CMS against modeling its regulatory requirements on the MA program, as those oversight policies have caused numerous unintended problems for physicians. In 2005, CMS promulgated regulations for MA plans that required certain contract terms to ensure CMS oversight over MA plans and downstream entities, similar to those proposed in this rule. Since those regulations were issued, MA plans have conducted fishing expeditions to identify opportunities to inflate their risk adjustment scores, rather than to ensure MA plans' compliance with program integrity oversight requirements. We have received numerous reports from physician offices that they have received correspondence, often from third parties, implying that these risk adjustment audits are required by CMS. Given the very small percentage of charts that are actually included in the CMS-required risk validation audits, it appears that the majority of chart reviews are self-initiated by MA plans with the aim of increasing the payments they receive from CMS. In addition, we are now seeing cases where the MA plan requests documentation for purposes of risk adjustment, and then uses that same information to recoup or deny payment for services billed.

Through the course of such audits, 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 QHP issuers and QHPs, we urge CMS to take into account the potential impacts of more aggressive program integrity efforts on the medical practices that provide care to QHP enrollees. 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 any deadline provided for responding to the request. In addition, the same practices should not be required to comply with repeated audit demands from one plan, or with demands from a multitude of plans within the same timeframe.

We are also concerned that CMS' proposed language at 45 CFR 156.340, which requires a QHP issuer to ensure compliance of downstream and delegated entities with certain oversight regulations, may give rise to QHP issuer initiated compliance training requirements. This was also an issue in the context of MA plans, where CMS originally required such compliance training, and then revoked this requirement when the Agency concluded that it was unfair to require physicians to comply with the compliance training of multiple MA plans. **To avoid this situation in the context of QHP issuers, we urge CMS to explicitly make clear in the final rule that QHPs cannot independently require physician compliance training.**

We urge CMS to review its proposals regarding downstream and delegated entities and to omit or narrowly tailor its proposed regulation to ensure that physician contracting with QHP issuers does not prove unduly burdensome for physicians or encourage independent QHP issuer auditing of physician practices.

Improper Plan Assignment and Application of Cost-Sharing Reductions

We strongly agree with CMS' proposal in 45 C.F.R. 156.410 to hold providers and enrollees harmless if the QHP issuer does not provide the appropriate cost-sharing reductions to an enrollee or enrollment in the appropriate QHP. Under the proposed provisions in this section, the QHP issuer may not seek reimbursement from an enrollee or the applicable physician for improper cost-sharing reductions and improper assignment of an individual to a QHP. We agree with CMS that because the QHP issuer is responsible for ensuring the enrollment of an enrollee in the appropriate plan and for ensuring the cost-sharing reduction is provided appropriately, the QHP issuer should not be able to recoup overpayments of cost-sharing reductions that resulted from the QHP issuer's own errors.

Thank you for considering our comments. If you have any questions concerning this letter, please contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

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