However, under the **Policy**, CMS is essentially waiving MAO coverage of services rendered by contracted providers. Essentially, Medicare Advantage is reduced to Humana-coverage, UHC-coverage, Aetna-coverage, etc., allowing MAOs to be more restrictive than Original Medicare and more restrictive than non-contracted Medicare Advantage coverage.

If, regardless of medical necessity, an MAO decides not to reimburse a contracted provider for services, the provider is left with almost no recourse to enforce that payment (as contracted providers lose their IRE appeal rights via the contract). If CMS cannot (or more accurately, chooses not to) enforce regulations that require payment to contracted providers, then MAOs are not required to provide coverage of:

- Basic benefits (**422.101**)
- Supplemental benefits (**422.102**)
- Emergency care (**422.113(b)**)
- Post-stabilization care (**422.113(c)**)
- Skilled nursing facilities (**422.133**)

Each of the above-listed areas involves services for which coverage is required under the Medicare Advantage program. However, under the **Policy**, it appears that MAOs would not be required to provide coverage if the provider is contracted.

Furthermore, federal law and CMS regulations require MAOs to not be more restrictive in their Medicare coverage of services than Original Medicare. However, the **Policy** directly contradicts that by allowing MAOs to make up their own rules for coverage of services rendered by contracted providers.

In effect, the **Policy** reduces Medicare Advantage coverage to mean that beneficiaries are not required to pay for the services provided to them and MAOs have the sole discretion as to whether or not to pay contracted providers for basic benefits or Medicare-covered services, regardless of medical necessity. The message the **Policy** sends to emergency safety net providers is that CMS only cares that the beneficiary isn't charged for the costs of services, and CMS has no regard for the strain that providers undergo to try and preserve beneficiary access to care. This is not a sustainable policy for the future of Medicare Advantage.

As you may be aware, there is a growing trend of emergency safety net providers who are choosing not to accept any Medicare Advantage patients due to the heavily burdensome requirements imposed by Medicare Advantage plans, essentially limiting the access that beneficiaries have to necessary services and care.

Here are a few links to articles which further emphasize the impact on beneficiary access to care:

- https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012
- https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-

right.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=0462A6042034F2T

- https://www.healthleadersmedia.com/finance/why-more-organizations-are-terminating-medicare-advantage-contracts

The issues illuminated in these articles demonstrate that not only are beneficiaries being impacted by the growing rejection of Medicare Advantage, but also that MAOs are failing in their responsibilities to provide adequate access to and coverage of care.

II. THE POLICY CONTRADICTS THE FEDERAL PREEMPTION PREMISE.

The **Policy** has been communicated as "*CMS will neither interpret, guide, nor enforce contract clauses governing payment in a private contract*." However, CMS is not being asked to enforce a private contract's payment provision, but rather CMS is being asked to enforce federal regulations and Medicare contract provisions that obligate payment. As stated above, most MAOs provide coverage through payment. If MAOs are not required to provide payment for services, then they are not required to provide coverage.

Previously, CMS cited **Section 1854(a)(6)(B)(iii) of the Social Security Act** as the basis for the **Policy**, stating:

> *Section 1854(a)(6)(B)(iii) of the Social Security Act (the Act), commonly known as the "non-interference clause," prohibits CMS from **requiring an organization to contract with a particular health care provider** or to **use a particular price structure for payment under such a contract**. As a result, CMS is generally not involved in **pricing or contract discussions and disputes** between MAOs and the providers participating in their plan networks.*

However, **Section 1854(a)(6)(B)(iii) of the Social Security Act** states:

> *(iii) Noninterference.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.*

As you know, the contract between CMS and the MAO does not determine payment amounts, require a particular price structure, or require MAOs to contract with particular providers. It simply tells the MAOs what they have to provide. Specifically, basic benefits and access to benefits in Subpart C. Furthermore, nothing we have brought to CMS involves a pricing or contracting dispute, simply the non-payment for plan-directed emergency and post-stabilization services for which the MAO is financially responsible under federal law and regulations.

Thus, CMS is overapplying this law as a basis for its **Policy**, while invalidating its own contract with MAOs and undermining the entire Medicare Advantage program. If you disagree, please provide the legislative intent [redacted]

Essentially, the **Policy** places a private contract above the Medicare contract, which is inconsistent with federal preemption provisions found in the federal law and CMS regulations. Both the Medicare Managed Care Manual, Chapter 10 §30 and 42 CFR §422.402 indicate that federal law should preempt state law, except when it comes to licensing requirements. Yet this **Policy** allows a state law contract to preempt the Medicare contract.

The Medicare contract is the foundation of Medicare Advantage. MAOs are only permitted to offer Medicare Advantage plans pursuant to their contract with Medicare. However, if the **Policy** limits CMS' ability to enforce clearly defined provisions of the Medicare contract, then this **Policy** severely undercuts Medicare Advantage itself. Instead of providing federal funding for Medicare Advantage coverage, CMS is providing federal funding for "MAO coverage" under the guise of Medicare Advantage.

III. THE POLICY CONTRADICTS PUBLICLY AVAILABLE CMS POLICY UPON WHICH PROVIDERS RELY.

The Medicare Managed Care Manual is a CMS document that outlines the rules for Medicare Advantage, which aligns closely with **42 CFR §422**. However, the Manual is not identical, indicating that CMS intended for specific changes and interpretations to apply.

For example, **42 CFR 422.504(a)(15)** identifies addressing and resolving CTM complaints as a material element of the contract between CMS and MAOs, yet the Manual in **Chapter 11, §100.1** does not list complaint resolution at all, let alone as a material element. While this office may not agree with that omission, it clearly demonstrates that the Manual is intended to define Medicare Advantage rules more specifically than federal. Therefore, it is accurate to say that the Manual reflects CMS/HHS policy for Medicare Advantage.

However, nowhere in the Manual does the **Policy** appear, written or implied. **Chapter 4, §20.5.2** states (echoing **422.113(c)(2)(i)** verbatim):

> *The MAO is financially responsible for post-stabilization care services obtained within or outside the MAO that:*
> • *Are pre-approved by a plan provider or other MAO representative;*
> [Note: the term plan provider is defined in **Chapter 4, § 20.3** as "*a plan provider - a provider with whom the MAO has a written contract to furnish plan covered services to its enrollees*…"]

Thus, it appears that part of CMS policy states that an MAO is financially responsible for services pre-approved by a plan provider, but another part of CMS policy states that it won't enforce that financial responsibility established by its own policy.

While a discussion of regulations specifically intended to protect contracted providers will occur in Part 4 of this letter, it is important to include the fact that CMS does have the authority to exclude contracted providers from regulations. In **Chapter 13, §50.1 of the Manual**, CMS affirmatively states "*Contracted providers (including subcontracted entities) do not have appeal rights under the provisions discussed in this guidance*."

Throughout the Manual, there are regulations that CMS indicates certain distinctions between how the rules are to be applied for in-network or contracted providers versus out-of-network or non-contracted providers.

However, regarding **Ch. 4 §20.1-20.5**, CMS does not distinguish between contracted providers and non-contracted providers for the financial responsibility applied to emergency and post-stabilization care. Regardless of the fact that financial responsibility for services pre-approved by a plan provider is affirmatively stated, CMS does not affirmatively or impliedly indicate that the financial responsibility for emergency services does not apply for emergency services provided by a contracted provider, nor that the 1-hour timeframe for response to notification does not apply for contracted providers. CMS could have made these distinctions and chose not to.

Moreover, our own investigation revealed that this **Policy** was communicated to plans as early as May 1, 2013 (*Note: this office could find no evidence that this was publicly communicated to providers*). However, the Manual has been updated at least twice since 2013 and CMS has declined to include the **Policy** and its application in the Manual, either affirmatively or impliedly.

The inconsistency in policy and enforcement is disingenuous and counterintuitive. To have publicly available policy that says an MAO is financially responsible for certain services (without an affirmative or implied exclusion for contracted providers) while also having a largely unknown policy that says CMS will not enforce its own policy is misleading and borderline fraudulent.

Furthermore, if an emergency safety net provider relies on the publicly released Medicare rules in deciding whether to contract with an MAO, then CMS is inducing false reliance. Given that the "non-interference" policy is not widely dispersed nor easily accessible, most providers are likely unaware of this **Policy**. Thus, they are being told by CMS that certain rules exist which obligate the MAO's financial responsibility and require payment, while CMS determines that it will not enforce those rules if they are contracted, despite no publicly available indication of this policy.

IV. THE POLICY FAILS TO ACCOUNT FOR MEDICARE ADVANTAGE RULES SPECIFICALLY INTENDED FOR CONTRACTED PROVIDERS.

As you know, Medicare Advantage is a federal program, governed by four key federal authorities: Title 42, the Medicare Managed Care Manual, CMS rules and guidance, and HHS audit findings and recommendations. The four authorities work in concert with one another to protect Medicare beneficiaries and ensure a fair and just healthcare system.

Each of these four authorities has established or discussed plan-directed care in some form or fashion. Each of them supports the premise that contracted providers act on behalf of the plan and the plan is responsible for said action:

42 CFR §422.113 states –

> **The MA organization -(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative.**

As we have stated, this is also directly reflected in the Manual as well [See Ch. 4, §20.5.2]. Thus, both Title 42 and the Manual affirmatively state that a plan provider ("*a provider with whom the MAO has a written contract to furnish plan covered services to its enrollees"*) can authorize post-stabilization services for an MAO enrollee and the **MAO** is financially responsible for those services. Furthermore, this section establishes that the financial responsibility is the MAOs, not the providers.

Medicare Managed Care Manual Ch.4, §160 states –

> **CMS considers a contracted provider an agent of the MAO offering the plan.**

§160 goes on to discuss beneficiary protections related to plan-directed care, but ultimately establishes that the MAO is liable for the actions of a contracted provider.

On September 4, 2023, the published CMS CDAG/ODAG guidance stated –

> **"The provision of an item or service by a contract provider constitutes a favorable organization determination."**

As you may know, the provision or denial of authorization for services is an organization determination. If the provision of services constitutes a favorable organization determination and a plan provider can pre-approve its own services, then the rational conclusion is that a plan provider can authorize its own services simply by providing them.

And finally, Inspector General Grimm's **Report in Brief, April 2022, OEI-09-18-00260** stated –

> **In most cases, a beneficiary needs prior authorization to receive care from a noncontracted provider. However, the skilled nursing facility was an in-network facility. This qualified the claim as "plan-directed care," and therefore no prior authorization was required.**

This again established that the provision of services by an in-network (or contracted) facility qualifies as plan-directed care and no authorization is required.

Thus, federal law, CMS policy, CMS commentary, and HHS guidance all support plan-directed care and all establish that MAOs are financially responsible for services authorized by plan providers/contracted providers/in-network facilities. Yet contracted providers still see denials in violation of Medicare Advantage rules and guidance as a result of the **Policy**.

The **Policy** allows MAOs to continue to improperly withhold federal funds from their contracted providers, by restricting CMS from its obligation to enforce federal law and its own policies and regulations.

As stated previously, the **Policy** creates a contradiction where one policy states the rule and another policy essentially invalidates the rule by preventing enforcement.

V. CONCLUSION

Deputy Mazumdar, you stated that you did not have a basis to challenge the "non-interference" policy. However, each of the above arguments alone is a reasonable basis to challenge the policy; taken together, it seems unconscionable that this policy should continue as it is.

To decline to enforce statutory, regulatory, and Medicare contractual payment provisions for MAOs essentially allows Medicare Advantage Organizations to contract out of their Medicare Advantage obligations. It allows MAOs to deny emergency services without establishing that a prudent layperson standard was not met. It allows MAOs to deny post-stabilization services without responding to notification prior to discharge, even though federal law and CMS regulation state that the plan is financially responsible if it fails to respond within 1 hour. It allows MAOs to withhold federal funds owed for plan-directed care and services, in violation of rules and guidance specifically intended to require the release of such funds. It allows MAOs to dictate what is and isn't covered arbitrarily, without regard for Medicare rules.

The longer CMS employs this **Policy** and refuses to enforce payment provisions, the greater the impact will eventually be on beneficiaries. We are already seeing providers exiting MAO networks, which reduces the options that beneficiaries have for in-network care. We are already seeing hospitals declining to accept any Medicare Advantage patients, forcing beneficiaries to travel to extreme lengths for care. We are already seeing hospitals go bankrupt as a result of non-payment, which again reduces beneficiary access to care.

For Medicare Advantage to survive, this **Policy** must change. A policy invalidating the rules that govern the Medicare Advantage program undermines the integrity of the MA program and CMS' authority.

We hope that you will consider these challenges and review the impact of this policy.

Respectfully,

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