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January 16, 2018

The Honorable Eric D. Hargan, Acting HHS Secretary
The Honorable Seema Verma, CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: File Code CMS-4182-P

Dear Acting Secretary Hargan and Administrator Verma:

On behalf of the National Health Care Anti-Fraud Association (NHCAA), I am writing in response to the proposed rule published in the November 28, 2017 issue of the *Federal Register* with file code CMS-4182-P, titled “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program.”

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. We are unique among associations in that we are a private-public partnership—our members comprise the nation’s most prominent health insurance plans as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

NHCAA’s mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission is the same regardless of whether a patient has private health coverage

through an employer or as an individual, or is a beneficiary of Medicare, Medicaid, or any other public program.

On a national level, fraud infects and undermines our nation's health care system and is a drain on finite resources. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more annually. It is a serious and costly problem that affects every patient and every taxpayer. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm — unfortunate and insidious effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and certainly it is not victimless.

It is from this perspective that NHCAA offers its comments. This proposed rule addresses a range of topics relating to the Medicare program. Our comments are limited to those provisions that impact health care anti-fraud efforts, most notably the changes the Centers for Medicare & Medicaid Services (CMS) plans to make to the calculation and reporting of medical loss ratio (MLR) by Medicare Advantage (Part C) plans and Prescription Drug Benefit Program (Part D) sponsors. NHCAA strongly supports these proposed changes. Our specific comments follow.

Section 2718 of the Patient Protection & Affordable Care Act (ACA) established, by statute, medical loss ratio minimums for commercial health insurers requiring large group market insurers to expend at least 85% of annual premium revenue on a combination of reimbursement for medical services and “activities that improve health care quality.”

In the nearly eight years since the ACA's enactment, throughout the rulemaking process, and as MLR requirements have been expanded beyond the commercial market to include Medicare Parts C & D and

Medicaid managed care, NHCAA has consistently argued that the anti-fraud efforts of health insurers are unequivocally “activities that improve health care quality.”

Despite NHCAA’s position, the MLR rules currently in place for commercial health insurers, Medicare Part C plans, Part D sponsors and Medicaid managed care plans, while making some allowance for claims payment recoveries in incurred claims, specifically exclude “fraud prevention activities” from the list of quality improvement activities. Nevertheless, NHCAA continues to believe that insurer activities devoted to anti-fraud efforts—regardless of whether they are categorized as recoveries, savings, detection or prevention—are activities that improve health care quality and therefore should be acknowledged as such for the MLR calculation.

NHCAA strongly supports the changes that CMS proposes to the MLR calculation and the reporting of the calculation for Medicare Advantage and Medicare Part D and asks that these changes be made final. NHCAA specifically supports CMS’s plan to alter the rules for Medicare Parts C & D plans regarding fraud reduction activities by:

- (1) Removing the current exclusion of fraud prevention activities from the definition of quality improvement activities (QIA);
- (2) Expanding the definition of QIA to include all fraud reduction activities, including fraud prevention, fraud detection, and fraud recovery; and
- (3) No longer including in incurred claims the amount of claims payments recovered through fraud reduction efforts, up to the amount of fraud reduction expenses.

CMS also asks for comments on whether fraud reduction activities should be included in quality improvement activities as proposed, or whether CMS should create a separate MLR numerator category

for fraud reduction activities. NHCAA believes that fraud reduction activities should be included in QIA as proposed.

We note with enthusiasm some of the insights CMS offers in explanation of its changes to MLR in the proposed rule, including:

“We are proposing these changes to the Medicare MLR rules because we believe that limiting or excluding amounts invested in fraud reduction undermines the federal government's efforts to combat fraud in the Medicare program, and reduces the potential savings to the government, taxpayers, and beneficiaries that robust fraud prevention efforts in the MA and Part D programs can provide. Fraud prevention activities can improve patient safety, deter the use of medically unnecessary services, and can lead to higher levels of health care quality, which is part of the reason why we require such activities as a condition of participation in the MA and Part D programs.”

“We are concerned that the current rules could create a disincentive to invest in fraud reduction activities, which is only partly mitigated by the current adjustment to incurred claims for amounts recovered as a result of fraud reduction activities, up to the amount of fraud reduction expenses. We believe that it is particularly important that MA organizations and Part D sponsors invest in fraud reduction activities as the Medicare trust funds are used to finance the MA and Part D programs. We believe that including the full amount of expenses for fraud reduction activities as QIA will provide additional incentive to encourage MA organizations and Part D sponsors to develop innovative and more effective ways to detect and deter fraud.”

“Because [the] adjustment to incurred claims is only available to the extent that an MA organization or Part D sponsor recovers paid fraudulent claims, it encourages MA organizations and Part D sponsors to invest in tracking down and recouping amounts that have already been paid, rather than in preventing payment of fraudulent claims ... all expenditures for fraud reduction activities would be included in the MLR numerator as QIA ... As a result, MA organizations and Part D sponsors will no longer have an incentive to use contract revenue to pursue recovery of paid fraudulent claims instead of investing in fraud prevention. We believe that effective fraud reduction strategies will include efforts to prevent payment of fraudulent claims, and we believe that the proposed inclusion of all fraud reduction activities as QIA in the MLR numerator will strengthen the incentive to engage in these vital activities.”

These CMS comments encapsulate many of the same arguments NHCAA has consistently made since the enactment of the ACA regarding the quality-affirming aspects of fraud reduction activities routinely implemented by health plans. Anti-fraud activities improve health care quality; for that reason alone, anti-

fraud investments—including those directed at prevention, detection and recovery efforts—should be included on the quality side of the MLR equation.

The Federal government has consistently recognized the pernicious effects health care fraud has on quality. For example, a 2007 U.S. Department of Health & Human Services, Office of Inspector General report titled “Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors”¹ includes Section IV, titled “The Government’s Role in Enforcing Health Care Quality.” Beginning on page 7, column three examines health care fraud from a quality perspective. The report identifies “[t]he predominant criminal and civil fraud theories” as “medically unnecessary services and ‘failure of care,’” and explains that, “When medically unnecessary services are provided, the patient is unnecessarily exposed to risks of a medical procedure[.]” The report goes on to provide examples of criminal and civil court cases involving providers that failed to properly investigate medically unnecessary procedures.

Regarding the second fraud theory, “failure of care,” the report again provides examples, including one where a rehabilitation center “entered into a \$1.9 million civil False Claims Act settlement to resolve allegations that it provided worthless services to patients, resulting from systemic understaffing at the facility, where deficient services and abuse caused six patient deaths.” Other examples of how health care fraud has resulted in patient harm are not only sobering but sadly very numerous. Clearly, health care fraud has an adverse impact on patient safety and health care quality.

¹ U.S. Department of Health & Human Services, Office of Inspector General, and American Health Lawyers Association. (2007). Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors. Washington, D.C.
<http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>

NHCAA believes that, in this proposed rule, CMS has articulated a keen understanding of the motives and incentives that prompt Medicare Advantage organizations and Part D sponsors to engage in fraud reduction activities. We believe many of these same motivations and incentives influence insurers in the private insurance market and in Medicaid managed care plans as well.

NHCAA agrees with CMS that the MLR rules currently in place for Medicare Parts C & D can serve as a disincentive to plans from investing in cutting-edge fraud solutions such as predictive modeling and data analytics. As such, NHCAA encourages CMS to extend the same methodology it proposes for Medicare to Medicaid managed care plans as well. In addition, NHCAA urges the Department of Health & Human Services (HHS) to make similar adjustments to the rules it put in place regarding MLR for commercial health insurers following the enactment of the Affordable Care Act.

NHCAA also agrees with CMS's proposal to reduce the burden that MLR reporting requirements have created for Medicare Parts C & D. We acknowledge CMS's point that this action aligns with the January 30, 2017, Presidential Executive Order on Reducing Regulation and Controlling Regulatory Costs.

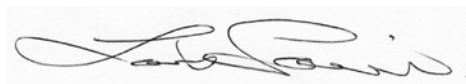
The proposed rule would significantly reduce the current reporting burden to require only the minimum amount of information needed for MLR reporting by organizations with contracts to offer Medicare benefits. Under the proposed rule, MLR reporting requirements would be limited to the following data fields:

- Organization name;
- Contract number;
- Adjusted MLR (which would be populated as "Not Applicable" or "N/A" for non-credible contracts); and
- Remittance amount.

This significant reduction in data reporting does not alter CMS's authority to conduct audit reviews. And Medicare Advantage organizations and Part D sponsors would continue to be required to retain documentation supporting the MLR figure reported and to make available any information needed to determine whether the data and amounts submitted with respect to the Medicare MLR are accurate and valid. With these safeguards in place, NHCAA strongly supports CMS's planned changes to MLR reporting for Medicare Part C plans and Part D sponsors.

On behalf of the National Health Care Anti-Fraud Association, thank you for this opportunity to comment on CMS's proposed rule relating to Medicare and the significant changes CMS proposes to the medical loss ratio calculation and its reporting under Medicare Advantage and Medicare Part D. We are available for any questions that you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Louis Saccoccio", is centered on a light gray rectangular background.

Louis Saccoccio
Chief Executive Officer