AMERICA'S PHYSICIAN GROUPS

February 13, 2023

Chiquita Brooks LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via: https://www.regulations.gov/commenton/CMS-2022-0163-0001

Re: 2024 Medicare Advantage and Part D Proposed Rule CMS-4201-P

Dear Administrator Brooks LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) proposed rule for the Medicare Advantage and Part D programs. We welcome the agency's openness to stakeholder input and ongoing commitment to improving health care for all Americans.

Below, (I) APG will first provide a brief description of our organization, followed by (II) a brief summary of CMS's proposal, and then (III) our comments and recommendations. Together they reflect the voice of our membership and our commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, person-centered health care.

Although this letter and its content pertain to the 2024 Medicare Advantage and Part D Proposed Rule, APG's member groups note that many of the positive effects of the rule could be eclipsed by other changes that CMS proposed in its more recent Advance Notice. For example, a potentially increased Star Rating for serving Medicare beneficiaries with greater social risk factors, as per the Proposed Rule, would have little to no effect if the risk adjustment system significantly reduces payments for the clinical conditions that disproportionately affect disadvantaged enrollees, as per the Advance Notice. As our members complete their analyses of the Advance Notice's impact on their enrollees, APG looks forward to providing CMS with greater insight on the potential effects of those changes on MA plans, provider groups, and enrollees.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value and that engage in the full spectrum of alternative payment models and Medicare Advantage

(MA). Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis.

Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide. APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians). These professionals in turn provide care for nearly 90 million patients.

II. CMS' Proposed Rule

In its Proposed Rule, CMS proposes the following:

- Clarifications and revisions to the regulations governing when and how Medicare Advantage (MA) plans develop and use coverage criteria, utilization management, and prior authorization policies;
- Changes to the Medicare quality program, including adding a health equity index (HEI) reward and reducing the weight of patient experience and access measures;
- Clarification of a current requirement for MA plans to provide culturally competent care by expanding the list of populations affected, requiring MA organizations to offer digital health education to enrollees, and requiring MA organizations to include providers' cultural and linguistic capabilities in provider directories; and
- Policies to strengthen network adequacy requirements to provide behavioral health services.

III. Summary of APG's Recommendations

- **Any restrictions that CMS implements for the use of prior authorization should explicitly allow prior authorization to be used to alert patients to coverage and cost-sharing differences for in-network and out-of-network providers and facilities.**
- **For new MA plan enrollees, CMS should opt for a 30-day transition period. If longer transition periods are needed for certain situations, such as scheduled surgeries, these should be clearly delineated.**
- **Any transition period rules that CMS adopts for new MA plan enrollees should include exceptions that allow the use of prior authorization when employing this approach would improve the quality of care.**
- **CMS should issue guidance on handoffs among MA plans when Medicare beneficiaries disenroll from one plan and move to another. Such handoffs would ensure that MA plans and providers communicate effectively about enrollees' care plans and courses of treatment.**
- **CMS should provide greater clarity about, or an exception to, the proposed requirement that utilization management guidelines be based on current widely used treatment guidelines or clinical literature in the case of novel therapeutics that lack these sources.**
- **CMS should retain the existing Star Ratings reward factor in conjunction with a new health equity index until the methodology for identifying beneficiaries affected by social risk factors is fully developed.**
- **CMS should allow providers in delegated arrangements with MA plans more ability to provide expanded benefits, including additional supplemental ones, that are expressly tailored to the needs of individual marginalized patients.**
- **CMS should provide any culturally competent care materials that the agency develops for the fee-for-service program as examples for MA plans to use or adapt for their providers and enrollees.**

- **CMS should develop and provide education for all Medicare beneficiaries in the use of telehealth to improve access to medically necessary covered telehealth benefits.**
- **CMS should permit MA plans to contract with and reimburse any behavioral health care providers licensed in the states in which MA plans operate or credentialed or certified by a national organization to provide any covered behavioral health care services to MA enrollees.**

IV. APG's Detailed Comments and Recommendations

Utilization Management and Prior Authorization

In its Proposed Rule, CMS proposes clarifications and revisions to the regulations governing when and how Medicare Advantage (MA) plans develop and use coverage criteria and utilization management policies to ensure that MA enrollees receive the same access to medically necessary care they would receive in traditional Medicare. CMS proposes that:

1. Prior authorization policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.

2. Approval granted through prior authorization must be valid for the duration of the approved course of treatment. Plans must provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan.

3. MA plans must comply with National Coverage Decisions (NCDs), Local Coverage Determinations (LCDs), and general coverage and benefit conditions included in Traditional Medicare statutes.

4. MA plans cannot deny coverage of a Medicare-covered item or service based on internal, proprietary, or external clinical criteria.

5. When there are no applicable coverage criteria in Medicare statutes, regulations, NCDs, or LCDs, MA plans may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available.

6. MA plans must establish a Utilization Management Committee to review all utilization management, including prior authorization, policies annually.

For item #5 above, CMS proposes to replace the existing requirement that practice and utilization management guidelines be based on reasonable medical evidence or a consensus of health care professionals in the particular field with a requirement that utilization management guidelines be based on current widely used treatment guidelines or clinical literature. CMS also proposes a new requirement that in creating these internal policies, MA plans must provide (1) a publicly accessible summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations; (2) a list of the sources of such evidence; and (3) an explanation of the rationale that supports the adoption of the coverage criteria used to make a medical necessity determination. The agency noted its belief that the public posting of the summary of evidence used to develop a plan's internal coverage criteria would require minimal time and estimated a total of 16 hours of work over the course of a year.

APG appreciates the steps that CMS proposes to address potential confusion about the application of prior authorization and other utilization management tools. APG notes that the proposed language for the first item in

CMS' proposal overlooks an essential function of prior authorization, which is to ensure that patients are aware of the implications of their choice of provider or place of service. Plans use prior authorization not only to notify enrollees when a service is not covered, but also to alert them to the possibility that switching a planned procedure to an in-network provider or location would ensure compliance with coverage requirements or reduce cost-sharing. This use of prior authorization can be of tremendous benefit to enrollees that they may find well worth the extra step and time by helping them to avoid coverage denials or higher cost sharing.

Any restrictions that CMS implements for the use of prior authorization should explicitly allow prior authorization to be used to alert patients to coverage and cost-sharing differences for in-network and out-of-network providers and facilities.

APG strongly urges CMS to reconsider the proposal regarding 90-day transition periods. The draft language is excessive and overly broad and would have significant implications not only for MA plans' financial performance, but also for their ability to effectively coordinate enrollees' care.

Specifically, CMS proposes that:

> *MA organizations offering coordinated care plans must have, as part of their arrangements with contracted providers, policies for using prior authorization that provide for a minimum 90-day transition period for any ongoing course(s) of treatment when an enrollee has enrolled in an MA coordinated care plan after starting a course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider. This includes enrollees who are new to an MA coordinated care plan having either been enrolled in a different MA plan with the same or different parent organization, or an enrollee in Traditional Medicare and joining an MA coordinated care plan, and beneficiaries new to Medicare and enrolling in an MA coordinated care plan. The MA organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days.*

As written, this proposal would allow the continuation of all courses of treatment, including those that do not fit patients' new coordinated care plans and that may not be in their best interests. This fact could significantly delay the patient's new provider and MA plan from transitioning to an updated care plan and course of treatment. Patients' quality of care would be far better served by ensuring that the previous and new providers and MA plans communicate about and understand any existing care plans and courses of treatments.

In addition, CMS's proposal offers no provisions or guidance as to how MA plans should handle handoffs when a Medicare beneficiary disenrolls and enrolls instead in a different MA plan. The net effect of CMS's proposal would thus be to delay care transitions without improving the quality of those transitions.

As a result, APG proposes the following changes in CMS's proposal:

1. **For new MA plan enrollees, CMS should opt for a 30-day transition period. If longer transition periods are needed for certain situations, such as scheduled surgeries, these should be clearly delineated.**
2. **Any transition period rules that CMS adopts for new MA plan enrollees should include exceptions that allow the use of prior authorization when the approach would improve the quality of care.**
3. **CMS should issue guidance on handoffs among MA plans when Medicare beneficiaries disenroll from one plan and move to another. Such handoffs would ensure that MA plans and providers communicate effectively about enrollees' care plans and courses of treatment.**

APG also requests clarification regarding CMS's proposal to replace the existing requirement that practice and utilization management guidelines be based on reasonable medical evidence or a consensus of health care professionals in the particular field. CMS proposes instead a requirement that utilization management guidelines

be based on current widely used treatment guidelines or clinical literature. However, health care is an ever-expanding field with novel therapeutics and other complex treatments introduced on a frequent basis, often before clinical literature and treatment guidelines have time to catch up with the evolving science and incorporate it. The language of CMS's proposal appears to overlook this well-recognized time lag in the medical literature. MA plans would benefit from greater clarity around the development and application of practice and utilization management guidelines for novel therapeutics that lack established treatment guidelines or clinical literature.

As a result, APG also asks that CMS provide greater clarity about, or an exception to, the proposed requirement that utilization management guidelines be based on current widely used treatment guidelines or clinical literature in the case of novel therapeutics that lack these sources.

APG also has concerns about CMS's proposal to require MA plans to provide a publicly accessible summary of evidence that was considered during the development of the internal coverage criteria, including a list of evidence sources and an explanation of the rationale that supports the adoption. Although the goal of fostering greater transparency to patients, providers, and others is laudable, it seems highly unlikely that a publicly posted document prepared in 16 hours or less, and that summarizes all of an MA plan's internal coverage criteria developed during the year, would be sufficiently reader-friendly or helpful for beneficiaries or clinicians. If CMS's goal is to increase transparency without unduly increasing administrative burden, then APG suggests that CMS modify this proposal or provider greater clarity to MA plans about what types of documentation would satisfy these requirements.

Star Ratings Quality Program

CMS proposes changes to the Medicare Star Ratings quality program to encourage MA and Part D plans to improve care for enrollees with certain social risk factors. These changes include adding a health equity index (HEI) reward as a replacement for the current reward factor. CMS also proposes to reduce the weight of patient experience/complaints and access measures by half to further align with other CMS quality programs and the current CMS Quality Strategy. In addition, CMS proposes to remove guardrails (bi-directional caps that restrict upward and downward movement of a measure's cut points compared to the prior year) when determining measure-specific-thresholds for non-Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; modify the Improvement Measure hold harmless policy; include an additional rule for the removal of Star Ratings measures; and remove the 60 percent rule that is part of the adjustment for extreme and uncontrollable circumstances.

APG applauds CMS's proposal to add an HEI reward to the Star Ratings program and encourages CMS to create consistency in how equity is measured, incentivized, and rewarded across MA and all Medicare alternative payment model programs. This perspective is consistent with APG's longstanding advocacy on behalf of standardized measures across MA, the Medicare Shared Savings Program, the dual-eligible population, and other types of alternative payment models.

However, APG is concerned that the HEI as proposed will be implemented with an initial methodology for identifying beneficiaries with specified social risk factors (SRFs) that CMS says it will modify over time. CMS proposes to consider identifying people with SRFs as those receiving the low-income subsidy (LIS) in Part D or those dually eligible for Medicare and Medicaid. Although LIS and dual eligibility are two important characteristics for identifying people with increased SRFs, they do not capture the full array of disadvantaged Medicare beneficiaries. Limiting identification of SRFs to LIS and dual eligibility will exclude other beneficiaries whose health equity should also be advanced and effectively penalize or under-reward MA plans that invest in improving care for these other at-risk populations. Maintaining the existing reward factor while the new HEI is rolled out and

improved would ensure that the benefits that are going into programs to advance health equity and address social determinants of health are not compromised.

APG thus proposes that CMS should retain the existing Star Ratings reward factor in conjunction with a new health equity index until the methodology for identifying beneficiaries affected by social risk factors is fully developed.

Furthermore, as APG noted in our response to the MA request for information (RFI), APG members believe that CMS can do even more to encourage approaches that will advance health equity. Specifically, CMS should allow more ability to providers operating in delegated arrangements with MA plans to provide expanded benefits (including additional supplemental ones) that are expressly tailored to the needs of individual marginalized patients. The chief medical officer of one APG member cites one example of the need: a poor Black patient with cancer who, under the current supplemental benefit structure, may be allowed only ten rides per year, but who may require far more. CMS could allow greater flexibility so that decisions to expand or change some benefits could be made at the provider rather than plan level, since patients' physicians have visibility into individuals' medical and social needs that health plans cannot capture from coding and claims.

APG thus proposes that CMS should allow providers in delegated arrangements with MA plans more ability to provide expanded benefits, including additional supplemental ones, that are expressly tailored to the needs of individual marginalized patients.

APG supports CMS' proposal to reduce the weight of patient experience and access measures to further align with other CMS quality programs and the current CMS Quality Strategy that promotes quality outcomes. APG also notes that there is still a greater share of process measures compared to outcome measures and encourages CMS to move as expeditiously as possible to adopt more outcome measures.

Health Equity and Cultural Competence

CMS proposes clarification of a current requirement for MA plans to provide culturally competent care by expanding the list of populations to whom MA organizations must provide services in a culturally competent manner. CMS proposes to expand the list of populations to include people with these characteristics:

- Limited English proficiency or reading skills;
- Ethnic, cultural, racial, or religious minorities;
- Disabilities;
- Identification as lesbian, gay, bisexual, transgender, nonbinary, intersex, or other sexual or gender orientation or origination;
- Living in rural, urban, or other areas with high levels of deprivation; or
- Otherwise adversely affected by persistent poverty or inequality.

CMS also proposes to improve MA enrollees' access to medically necessary covered telehealth benefit by requiring MA organizations to develop and maintain procedures to offer education and training in the use of telehealth and other digital health tools. In addition, CMS proposes requiring MA organizations to include providers' cultural and linguistic capabilities in provider directories, and that MA organizations address health disparities as part of existing requirements to develop and maintain quality improvement programs.

APG strongly supports CMS' goal of ensuring that all Medicare beneficiaries receive culturally competent care. APG's member groups find that value-based care arrangements offer them the flexibility to provide person-centered care to the diverse array of Medicare beneficiaries that meets each patient's clinical, social, and cultural needs. APG requests clarification about how CMS plans to implement and monitor this requirement. For example,

given the extensive list of different groups of people that CMS included in the proposed rule, it would be administratively burdensome to require plans to develop materials or training targeted specifically to each of these groups. If CMS intends to require that any written materials be developed or modified to fulfill the expectations of the culturally competent services list, APG requests that CMS provide any culturally competent care materials that the agency develops for the fee-for-service program as examples for MA plans to use or adapt for their providers and enrollees.

APG thus proposes that CMS provide any culturally competent care materials that the agency develops for the fee-for-service program as examples for MA plans to use or adapt for their providers and enrollees.

APG supports CMS' goal of ensuring that Medicare beneficiaries are equipped to access health care via telehealth and agrees that telehealth can be less accessible to those who lack the means to use the medium effectively and thus exacerbate existing disparities. Given that this reality is shared across all of Medicare, we encourage CMS to develop and provide digital health education to all Medicare beneficiaries to improve access to medically necessary covered telehealth benefits. MA plans and other groups could then use these resources as examples to provide similar education services for their enrollees.

APG thus proposes that CMS develop and provide education for all Medicare beneficiaries in the use of telehealth to improve access to medically necessary covered telehealth benefits.

APG supports CMS' proposal to require MA plans to include in provider directories "each provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office." As noted in APG's response to CMS' proposal to create a National Provider Directory, providing accurate descriptive information about all providers—such as their ability to accept new patients, their participation in various health plans, and their languages spoken—would greatly enhance all Americans' ability to select their providers, especially those who are disadvantaged.

Behavioral Health Services

CMS proposes policies to strengthen network adequacy requirements and reaffirm MA organizations' responsibilities to provide behavioral health services. Specifically, CMS proposes to undertake the following:

- Add Clinical Psychologists, Licensed Clinical Social Workers, and Prescribers of Medication for Opioid Use Disorder as specialty types for which CMS sets specific minimum standards and on which it evaluates MA networks, and make these specialty types eligible for the existing 10 percentage point telehealth credit;
- Amend general access to services standards to explicitly include behavioral health services;
- Codify standards for appointment wait times for both primary care and behavioral health services;
- Clarify that emergency medical services that must not be subject to prior authorization include behavioral health services to evaluate and stabilize an emergency medical condition;
- Require that MA organizations notify enrollees when the enrollee's behavioral health or primary care provider(s) are dropped midyear from networks; and
- Require MA organizations to establish care coordination programs, including coordination of community, social, and behavioral health services to help move towards parity between behavioral health and physical health services and advance whole-person care.

APG commends CMS for the agency's ongoing efforts to address the behavioral health access crisis and to integrate physical and behavioral health services. CMS has also recently expanded the types of behavioral health

care providers that can be reimbursed directly under the Medicare Physician Fee Schedule to include licensed professional counselors and licensed marriage and family therapists. CMS should continue to seek additional opportunities to improve Medicare beneficiaries' access to behavioral health providers by expanding the types of providers that can be reimbursed.

There is a unique opportunity presented by MA to facilitate the task of addressing Medicare reimbursement of different types of behavioral health care providers. CMS could permit MA plans to contract with any behavioral health care provider licensed in the states the MA plan operates in to provide services to their enrollees. For example, Ochsner Health refers patients in need of tobacco cessation services to counselors who do not qualify as a type of provider eligible for direct reimbursement under the Medicare Physician Fee Schedule. This limitation forces Ochsner Health to pay for this service without Medicare financial support. This exclusion limits MA plans and provider groups from fully coordinating and managing patient care in an environment with a provider workforce shortage.

APG thus proposes that CMS permit MA plans to contract with and reimburse any behavioral health care providers licensed in the states the MA plan operates in or credentialed or certified by a national organization to provide any covered behavioral health care services to their enrollees.

V. Conclusion

Given the value of the MA program to an ever-growing share of Medicare beneficiaries, especially those who are disadvantaged, APG welcomes CMS' efforts to improve enrollees' experience with MA. Continuing to refine expectations for utilization management, quality measurement, health equity advancement, and access to behavioral health care are goals that APG members are eager to help support.

As noted above, although this letter and its content pertain to the 2024 Medicare Advantage and Part D Proposed Rule, APG's member groups note that many of the positive effects of the rule could be eclipsed by other changes that CMS proposed in its more recent Advance Notice. For example, a potentially increased Star Rating for serving Medicare beneficiaries with greater social risk factors, as per the Proposed Rule, would have little to no effect if the risk adjustment system significantly reduces payments for the clinical conditions that disproportionately affect disadvantaged enrollees, as per the Advance Notice. As our members complete their analyses of the Advance Notice's impact on their enrollees, APG looks forward to providing CMS with greater insight on the potential effects of those changes on MA plans, provider groups, and enrollees.

Sincerely,

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