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March 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS–4192–P. Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule outlining Medicare Advantage (MA) and prescription drug benefit policies for contract year 2023, published in the *Federal Register* on January 12, 2022 (87 Fed. Reg. 1842).

The AMA supports the steps that CMS is taking in this proposed rule to improve network adequacy requirements for MA plans and urges that this proposal be finalized. We appreciate CMS' efforts to provide better integration for patients who are dually eligible for Medicare and Medicaid and support the revised maximum out-of-pocket limit policy for these patients, which is intended to improve their access to physician services. We support having health plans address patients' social needs that are linked to their health outcomes and recommend that special needs plans be accountable for connecting patients to needed support services. The AMA advocates that diagnoses coded for audio-only telehealth encounters be included in the risk-adjusted payment models used in the MA program. The AMA welcomes the proposed changes for third party marketing and communications requirements to help patients obtain the plan that best suits their individual needs, and supports ensuring that all pharmacy price concessions, including retroactive direct and indirect remuneration fees, are included in the definition of "negotiated price." The remainder of this letter provides more detailed comments on the policies included in this 2023 proposed rule. In addition, this letter contains detailed information and recommendations in response to the CMS requests for information pertaining to prior authorization for hospital transfers and building behavioral health specialties within MA networks.

MA Network Adequacy Rules (§ 422.116)

In an effort to provide an adequate network of providers to deliver care to MA enrollees, CMS is proposing to require that MA plan applicants demonstrate they have a sufficient network of contracted providers to care for beneficiaries before CMS will approve an application for a new or expanded MA plan. Due to proposed changes in the timing of the network adequacy reviews, CMS is also proposing to allow a 10-percentage point credit toward the percentage of beneficiaries residing within published time and distance standards for new or expanding service area applicants. Once the coverage year starts

(January 1), the 10-percentage point credit would no longer apply and plans would need to meet full compliance. **The AMA strongly supports CMS' proposal with regards to strengthening MA network adequacy rules by requiring that MA plan applicants demonstrate they have a sufficient network of contracted providers to care for beneficiaries before CMS will approve an application for a new or expanded MA plan. The AMA urges that CMS finalize this proposal.**

Traditional Medicare allows seniors to access any physician or hospital that accepts Medicare patients, but MA access is limited to physicians and hospitals within plan networks. More than one in three MA enrollees are in a narrow physician network, which can be defined as less than 30 percent of physicians in the county participating in the plan. Another 43 percent of enrollees are in medium networks, defined as 30 to 69 percent of physicians in the county participating.[1] On average, MA networks include less than half of all physicians in a given county. This is a critical issue because in 2021, more than 26 million people were enrolled in a MA plan, accounting for 42 percent of the total Medicare population, and $343 billion (or 46 percent) of total federal Medicare spending (net of premiums).[2]

Narrow network plans have become increasingly common in private health insurance markets, including MA. Generally, such plans offer enrollees a narrow set of physicians and hospitals in a geographic area in exchange for lower premiums.[3] Narrow networks give insurers greater leverage to negotiate physician payment rates and to select those providers that the insurer believes deliver the highest quality of care.[4] However, MA plans state that, because they already pay providers at or near Medicare fee schedule rates, negotiating lower payment rates is not a significant consideration.[5] Instead, they achieve lower total costs by focusing on utilization.

The AMA and other physician groups have raised concerns that narrow physician networks create challenges for patients seeking care and pose potential patient protection issues. Specifically, a narrow network might have shortages of specific specialties, and plans may purposefully understaff specialties to avoid attracting enrollees with expensive pre-existing conditions like cancer and mental illness.[6] Access to psychiatrists is more restricted than other specialties. On average, only 23 percent of psychiatrists in a county participate in MA plans, and 36 percent of plans include less than 10 percent of psychiatrists in their county.[7] Limited access to specialists extends beyond psychiatry to cardiothoracic surgeons, neurosurgeons, radiation oncologists, and others.

While the AMA appreciates CMS' continued focus on strengthening its application standards and oversight, we also reiterate our 2019 recommendations that CMS consider adopting a suite of policy proposals to enhance network directory accuracy, network adequacy, network stability, and communication with patients about MA plans' physician networks. The AMA also recommends that CMS establish an external advisory group to obtain ongoing input regarding MA plan network issues.

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[1] https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/.
[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/#:~:text=In%202021%2C%20more%20than%2026,spending%20(net%20of%20premiums).
[3] https://www.urban.org/sites/default/files/publication/99414/why_do_medicare_advantage_plans_have_narrow_networks.pdf.
[4] https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf.
[5] https://www.urban.org/sites/default/files/publication/99414/why_do_medicare_advantage_plans_have_narrow_networks.pdf.
[6] https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf.
[7] https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/.

These earlier recommendations are summarized below:

Ensure MA Network Directory Accuracy

- Require MA plans to submit accurate physician directories to CMS every year prior to Medicare open enrollment and whenever there is a significant change in the physicians included in the network.
- Conduct accuracy reviews on network directories more frequently for plans that have had deficiencies.
- Publicly report the most recent accuracy scores on Medicare Plan Finder (MPF).
- Establish penalties for failure to maintain complete, accurate and updated directories.

Ensure that Network Adequacy Standards Provide Sufficient Patient Access

- Require plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year.
- Analyze the extent to which networks maintain or disrupt teams of physicians and hospitals that work together.

Make Lists of Network Physicians More Easily Accessible

- Require plans to submit lists of network physicians to CMS annually and whenever changes occur and post the lists on the MPF website.
- Link the physician lists to a website that would allow patients to first find a physician and then find which health plans contract with that physician.
- Simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on the MPF website.

Improve Network Stability

- Measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on MPF.
- Ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan.

Finally, the AMA encourages CMS to seek regular input from in-network physicians regarding network policies by creating a network adequacy task force that includes patients and other stakeholders in addition to physicians.

Dual-Eligible Special Needs Plans (D-SNPs)

The AMA appreciates CMS' continued attention to the experiences of individuals dually eligible for Medicare and Medicaid and the need to better align and integrate benefits for these enrollees. The AMA recognizes that without proper integration, care for dually eligible individuals can be fragmented, poorly

coordinated and difficult for patients to navigate, and that suboptimal care coordination can in turn compromise patient care and increase overall program spending.

Although AMA policy does not speak specifically to D-SNPs, we maintain that the same protections we advocate for all MA plans, including network adequacy requirements, should apply similarly to D-SNPs. Additionally, the AMA believes that integrated care plans should meet certain criteria intended to help improve the care quality and life quality of dually eligible individuals. Accordingly, we believe that coverage of medical, behavioral health, and long-term services and supports should be aligned and that integrated care should be grounded in the diversity of dually eligible enrollees. We further support integrated care that is tailored to individuals' needs and preferences, prioritizes care coordination, simplifies eligibility and enrollment processes, minimizes administrative burdens, and honors enrollee choice of plan and physician. Finally, educational materials should be easy to read and emphasize that the ability to opt in or out of integrated care resides solely with the enrollee.

Attainment of the Maximum Out-of-Pocket (MOOP) Limit (§§ 422.100 and 422.101)

CMS proposes to revise the regulations governing MOOP limits for MA plans to require that costs accrued under the plan benefit package are counted towards the MOOP limit. The accrued costs that will now be counted towards the MOOP limit would include cost-sharing paid by secondary or supplemental insurance such as Medicaid as well as cost-sharing that remains unpaid due to either limits on Medicaid liability for Medicare cost-sharing or cost-sharing protections for patients dually eligible for Medicaid and Medicare. **The AMA strongly supports the MOOP proposal and recommends that it be finalized.**

The AMA has long-standing concerns about federal policies that limit payment of Medicare cost-sharing amounts on behalf of patients dually eligible for Medicare and Medicaid. Although the current policy proposal would not raise Medicaid cost-sharing payments on behalf of dually eligible patients to the full Medicare rates, it would improve equity under the MOOP limit for dually eligible MA enrollees compared to those enrolled in Medicare alone. Currently, MA enrollees who have Medicare alone are treated as having reached the MOOP limit once they have accrued cost-sharing under the MA plan benefit whether or not they have actually paid all of the cost-sharing. The CMS proposal would treat patients enrolled in both Medicaid and MA the same as those who are only enrolled in MA for purposes of applying the MOOP limit. The intent of the revised policy is to improve access to physician services by requiring MA plans to pay their full rate on behalf of dually eligible patients who have reached the MOOP limit, just as they do now for patients with Medicare alone, thus making it more financially sustainable for physicians to provide treatment for dually eligible patients.

Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments (HRAs) (§ 422.101)

CMS proposes to require that all SNPs (chronic condition special needs plans, D–SNPs, and institutional special needs plans) include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their HRAs. The AMA supports CMS' recognition of the importance of this issue, and we agree that health plans can play a critical role in addressing the social needs of patients. Health plans are best suited to collect this information and have the necessary resources to connect beneficiaries to social support services. The AMA supports the initial set of factors (food, housing, and transportation) as they are clearly linked to impacting an individual's health outcomes. **We recommend that CMS consider further staging the implementation of all these factors as it is important that the data collected and reported be standardized and align with the work of the**

Health Level 7 Gravity Project. Only food insecurity has been finalized and housing instability and transportation remain as drafts, and housing quality should be considered in addition to instability. Because sharing of these data across providers and settings will be integral to ensuring that physicians, practices, health plans and others are coordinating efforts, we believe that data standards that enable interoperability are imperative and measurement efforts should remain in sync with those activities.

However, we do not believe CMS' proposed requirement on SNPs goes far enough as it does not hold SNPs accountable to ensure beneficiaries are connected to the necessary support services. The proposal only requires that the results from the initial and annual HRAs be addressed in the individualized care plan. To truly address the issue(s), there must be some level of accountability placed on MA plans. MA plans are provided additional reimbursement for higher acuity patients, and this will just result in MA plans claiming they have sicker beneficiaries to justify higher reimbursement without a clear connection to an outcome. Therefore, **we recommend CMS hold the SNPs accountable for ensuring beneficiaries are connected to support services. Otherwise, we are not addressing the root cause of the problem(s) and not truly addressing the issue when it comes to tackling social risk factors.**

Therefore, as CMS begins to tackle addressing social risk factors within its various programs through adoption and requiring providers and health plans to capture beneficiary status as it relates to topics such as housing instability, food security, access to transportation, etc., there needs to be a clear level of understanding of who is responsible for connecting a patient to services and navigating the various resources at the local level. Otherwise, we run the risk of the questions and quality measures related to social risk status not leading to improvements in patients' outcomes in the absence of any resources or tools available to beneficiaries. We have the potential of doing more harm than good by frequently asking patients their social risk status but not addressing the issue.

We do not agree with the proposal to specify the questions in sub-regulatory guidance. This information should be standardized across plans and Medicare programs to ensure the screening tools health plans are utilizing to capture this information are validated and uniformly adopted across plans, regardless of SNP, MA, Health Exchange plan or Medicaid. In addition, further details are needed on what may satisfy as an intervention, as these activities or referrals should be widely available within a region or community and demonstrated to be effective in meeting the individual's needs. We are aware of organizations like the National Committee for Quality Assurance (NCQA) developing a measure addressing social needs using standardized screening tools and urge CMS to review the work of NCQA to ensure the SNP questions and acceptable interventions on this topic are standardized with the SNP requirement. We are also aware of a proposal put forward for a similar quality measure for use in the Merit-Based Incentive Payment System (MIPS) for physicians and Inpatient Quality Reporting (IQR) program for hospitals. Lack of standardization will lead to no true level of accountability which could in turn lead to lack of coordination in connecting beneficiaries to services as well as inconsistency and inability to assess improvements across programs.

Audio-Only Encounters and Risk Adjustment

The AMA advocates that diagnoses coded for audio-only telehealth encounters be included in the risk adjusted payment models used in the MA program. CMS has assigned a high priority to improving equity in the delivery of health care services. Audio-only services need to be available to ensure equitable coverage for patients who need access to telecommunication services but who do not have access to two-way audio-visual technology. For example, according to the most recent progress report from the Federal Communications Commission, Tribal lands continue to face significant obstacles to broadband deployment. Likewise, an October 2020 article in Government Technology reported that

less than half the population in the parts of Alabama defined as the "Black Belt" have internet access, and two of these Alabama counties have no internet access at all. Marginalized urban communities have also been excluded from broadband service and need to rely on audio-only visits, because even when cities have broadband, many residents of these communities do not have access to it in their homes. A June 2020 report of the National Digital Inclusion Alliance describes data showing that the U.S. has more than three times as many urban as rural households living without home broadband of any kind.

Broadband and audio-visual telehealth services are clearly not accessible by all Medicare patients. The experience physicians have had providing patient care through audio-only visits demonstrates that they do not diminish quality relative to audio-visual visits and, because some patients are more comfortable speaking with their physicians without video and the quality of telephone service may be better than they can obtain over the internet for audio-visual services, some patients report better health care experiences with telephone than audio-visual visits.

Audio-only visits can effectively contribute to diagnosis and treatment for patients with chronic conditions, including diabetes, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and irritable bowel disease or Crohn's. Physicians can discuss patients' symptoms and behaviors, including understanding not only quantitative measures such as glucose readings but discussing what patients are typically eating, the amount of pain, and how they feel. For patients with equipment that permits remote monitoring, physicians can listen to their lungs and heart over the phone and get their weight and blood pressure readings. Cancer patients can be followed up over the phone to monitor how they are tolerating therapy. It is important that the information provided during audio-only visits be included in MA risk adjustment models.

Marketing and Communications Requirements on MA and Part D Plans to Assist Their Enrollees (§§ 422.2260 and 423.2260, 422.2267 and 423.2267, 422.2274, and 423.2274)

Required Materials and Content

MA plans must issue and reissue (as appropriate) member identification cards that enrollees may use to access covered services under the plan. Likewise, a Part D plan sponsor must issue a card or other type of technology that its enrollees may use to access negotiated prices for covered Part D drugs. The new rule would codify existing guidance for ID card requirements under §§ 422.2267(e)(30) and 423.2267(e)(32). Additionally, a disclaimer would be added alerting beneficiaries that the preferred costs may not be available at the pharmacy they use and provide information to these beneficiaries about how to access the list of pharmacies offering prescription drugs at a preferred cost in the beneficiary's area. The AMA supports programs whose purpose is to contain the rising costs of prescription drugs and encourages prescription drug price and cost transparency. Accordingly, the AMA believes that the dissemination of information to beneficiaries addressing the cost-sharing advantages of accessing network pharmacies is a step in the right direction. In addition, there should be improved transparency surrounding prescription drug costs including rebate and discount information, financial incentive information, pharmacy and therapeutics (P&T) committee information, and formulary information including information concerning whether certain drugs are preferred over others and patient cost-sharing responsibilities with this information being made available to patients and to prescribers at the point-of-care in electronic health records. To support these standards the AMA encourages efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing electronic health records, and empowering physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. Therefore, the AMA applauds CMS for

streamlining the codification of member identification cards and ID card standards and supports providing additional information to beneficiaries concerning which pharmacies offer prescription drugs at a preferred cost.

Website Requirements

Existing regulations require plans to have an internet website and include requirements regarding posted content. CMS is proposing to add the requirement that plans post instructions about how to appoint a representative and include a link to a downloadable version of the CMS Appointment of Representative Form, as well as enrollment instructions and forms. The AMA sees no problem with this change and supports ensuring that the appointment form is available online and easily accessible.

Multi-Language Insert

The multi-language insert (MLI) is a standardized document that informs the reader that interpreter services are available in the 15 most common non-English languages in the United States. The MLI guidance in the MMG also requires plans to include the required statement in any language that meets the five percent threshold but is not already included on the MLI. As such, CMS is proposing to require that beneficiaries be informed of the free interpreter services that are available for the 15 most common non-English languages in the United States and any language that meets the 5 percent threshold. If OCR were in the future to finalize broader or more robust requirements associated with interpreter services than what CMS is proposing and plans adopted those broader or more robust OCR requirements, CMS will consider plans compliant with the MLI requirements. The AMA believes that language assistance should be provided and that it should be culturally sensitive and competent. Moreover, the AMA believes that language interpretive services should be a covered benefit for all health plans since health plans are in a superior position to pass on the cost of these federally mandated services as a business expense and that federal funding for medical interpretive services should be provided so that the cost of providing interpretative services does not fall upon physicians in private practice. As such, the AMA is supportive of this additional multi-language insert so long as the financial cost of the insert and the translation services does not place any additional financial burdens on physicians in private practice.

Third-Party Marketing Organizations

There has been a significant increase in marketing related complaints from beneficiaries directly attributed to the activities of third-party marketing organizations (TPMOs). Therefore, CMS is proposing additional regulatory oversight mechanisms to protect Medicare beneficiaries from confusing and potentially misleading activities. These mechanisms include a standardized, prominently displayed, and enforceable disclaimer. Furthermore, the mechanisms would include additional oversight of plans that do business with a TPMO, either directly or indirectly through an FDR, require TPMOs to disclose to the plan any subcontracted relationships used for marketing, lead generation, and enrollment, and additional clarification for beneficiaries regarding lead generating activities. The AMA supports cost-conscious, informed market-based decision-making in health care and believes that managed health care plans should meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices. The AMA encourages using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans. **As such, the AMA applauds CMS for the proposed changes and supports the**

greater patient protections that will be in place while still allowing the patient to obtain the plan that is best for their individual needs.

Quality Rating System (§ 422.166)

The AMA supports the CMS decision as outlined in the Health Plan Management System memorandum issued on August 5, 2021 ("Medicare Health Outcomes Survey (HOS) Outcome Measures Moved to Display for 2022 and 2023 Star Ratings"), to suppress and not calculate for use within Star Ratings two HOS outcome measures (Improving or Maintaining Physical Health and Improving or Maintaining Mental Health) for the 2020 and 2021 follow-up measurement periods. The two measures involve clinical action, and given the ongoing pandemic it is inappropriate to measure plans on the measures.

Furthermore, while the pandemic is ongoing it is inappropriate to hold plans accountable for the *Effectiveness of Care* measures as they are really targeting clinical quality, which is a physician or facility issue—and therefore physicians and facilities have the data. The AMA has repeatedly highlighted to CMS the need for the Star Ratings program to focus more on compliance and communication, as opposed to measures that rely on physician action. For health plans to increase their Healthcare Effectiveness Data and Information Set (HEDIS) scores and earn greater incentives from CMS, plans are requiring practices as part of their clinical data submission requirements to submit data on all patient lab results and tests and the plans state it is due to the Star Ratings HEDIS requirements. Many of the measures, particularly the HEDIS Effectiveness of Care measures, have more to do with physician quality than assessment of a health plan. Therefore, the data demands plans are still placing on physician practices is another administrative demand when physicians are facing dramatic staffing shortages due to the pandemic, especially in light of the recent surge due to the omicron COVID-19 variant.

Pharmacy Price Concessions (§ 423.100)

The AMA has long supported meaningful efforts to reduce prescription drug prices, lower patient out-of-pocket prescription drug costs and increase drug pricing transparency. We are pleased to see CMS taking action on this front and support the agency's proposal to ensure that all pharmacy price concessions, including retroactive direct and indirect remuneration fees ("DIR fees"), are included in the definition of "negotiated price." The proposed change to the definition of "negotiated price" is significant, as the negotiated price in Part D is the cornerstone that determines beneficiary cost-sharing at the point of sale, as well as health plan and government liabilities.

The collection of DIR fees well after the sale of a prescription drug to a patient has long created needless uncertainty for pharmacies and has resulted in higher than necessary out-of-pocket costs for patients, while benefiting Part D plan administrators and pharmacy benefit managers. Ensuring that all pharmacy concessions, including DIR fees, are included in the definition of "negotiated price" at the point-of-sale provides much needed pricing transparency for pharmacies, allowing them to appropriately capture the full picture of their ultimate reimbursement for a drug upfront, as well as plan for the future without facing unknown fees or clawbacks well after the fact. While larger chain and retail pharmacies are likely well equipped to handle potential uncertainty, smaller independent and community pharmacies, including practice-based pharmacies, are not well situated to deal with uncertainty regarding reimbursement and continuously absorb unexpected financial losses. Additional transparency and certainty around DIR fees will help these smaller pharmacies continue to serve patients, particularly those in underserved areas without ready access to a large chain pharmacy.

Additionally, appropriately considering the DIR fees at the point-of-sale should ultimately result in lower out-of-pocket costs for patients. The proposed change of the definition of "negotiated price" to include all pharmacy price concessions, including DIR fees, at the point-of-sale should serve to lower the price on which beneficiary cost-sharing is based, resulting in lower overall drug costs for patients. While AMA policy strongly supports this proposed change, we do caution that changes to beneficiary cost-sharing can result in plan administrators raising plan premiums in response to incurring increasing liability.

Request for Information: Prior Authorization for Hospital Transfers to Post-Acute Care Settings During a Public Health Emergency

The AMA greatly appreciates CMS' commitment to ensuring that hospitals, post-acute care facilities (including long-term care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities), physicians, and MA organizations have the tools necessary to provide access to appropriate care to patients without unnecessary delay during a public health emergency (PHE). We supported CMS' guidance addressing permissible flexibilities for MA organizations during the PHE to help ensure MA enrollees, and the health care systems that serve them, avoid delays and disruptions in care. We also agree with CMS that delays or disruptions in care within the MA program can have a ripple effect and negatively impact the timely provision of appropriate care to non-MA patients. Similarly, we agree that payers offering flexibilities during periods of increased hospitalizations can support health care organizations' management of resources.

New AMA survey findings show that more than one-third (34 percent) of physicians reported that prior authorization (PA) led to a serious adverse event, such as hospitalization, disability, or even death, for a patient in their care. Also, more than nine in 10 physicians (93 percent) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82 percent) said patients abandon treatment due to authorization struggles with health insurers. The findings of the AMA survey illustrate a critical need to streamline prior authorization requirements to minimize delays or disruptions in care delivery. Health plans agreed to make a series of improvements to the prior authorization process several years ago, but despite harmful consequences of delayed or disrupted care, most health plans are not making meaningful progress on reforms. **We urge CMS to continue to advance policies to reduce these alarming rates of prior authorization interference in patient care.**

Moreover, state medical societies are reporting to the AMA that physician practices are increasingly unable to fully staff their offices due to the health impacts of COVID-19 on their employees. Given that 40 percent of physicians employ staff specifically to manage prior authorizations, CMS must consider the resulting delays in patient care that come from practices' inability to fulfill the administrative requirements that come with running a practice during a PHE. Practices may wind up reducing hours of availability or not providing certain services. **While physicians are available to provide clinical services, the absence of staff to manage the massive volume and administrative burden of prior authorization requests severely limits patient access to care during a time when the country is facing a massive public health crisis.** While many businesses and companies are facing similar workforce issues right now, they have potentially other ways to continue functioning. Physicians cannot ignore administrative requirements because they will not be paid, and patients will not be covered.

CMS seeks feedback on "the impact of MA organizations' prior authorization requirements for patient transfer on a hospital's ability to effectively manage resources and provide appropriate and timely care during a PHE" and provided specific topics for feedback, to which we respond below:

- *The overall impact of both the relaxation and reinstatement of prior authorization requirements for patient transfer by MA organizations on the provision of appropriate patient care in hospital systems.*

Beginning in April 2020, many major payers—including Aetna, Anthem, Health Care Services Corp., Cigna, Humana, and United Healthcare—instituted waivers temporarily suspending or relaxing a host of PA requirements for their MA lines of business in light of the PHE. These temporary policy changes included a relaxation of PA requirements for post-acute care, impacting patient transfers from acute care. Notably, several plans completely suspended PA requirements for admissions to in-network post-acute care facilities including SNF, IRF, and LTAC, requiring only notification and length of stay reviews. Some waived PA requirements for all transfers to lower levels of care and for discharges to home health. As a complement, some plans also waived inpatient stay requirements for certain transfers—for example, suspending a 21-day inpatient requirement for transfers to LTAC. At least one plan waived PA and instated a temporary notification-only requirement for all admissions to acute care facilities. Plans also made changes to PA policies beyond relaxing requirements for patient transfers during the PHE: several payers waived PA for COVID-19-related diagnostic radiology or durable medical equipment critical for treating COVID-19, and most extended the duration of approved PAs for non-COVID-19 related outpatient services, for example from 90 to 180 days.

Physicians' feedback suggests that these PA policy relaxations during the COVID-19 pandemic had limited reach and minimal lasting impact, attributable both to the policies' short and intermittent duration and to a lack of transparency in PA requirements. Health plans neglected to implement consistent policies through the duration of the PHE. Despite surges in COVID-19 hospitalizations, many plans reinstated pre-PHE PA requirements for patient transfers in early summer 2020, and virtually all plans reported that the policies were reinstated by January 2021, with a few plans reinstating temporary waivers only as a delayed response to the Omicron surge in early 2022. In the absence of waivers, transfers from acute inpatient settings to lower levels of care were subject to PA for most of the PHE. These PA requirements for post-acute care interrupted the appropriate movement of patients between acute-care hospitals and post-acute settings, contributing to bed shortages while determinations were being made and preventing some patients from receiving timely care in acute inpatient settings during the height of the pandemic. This would have been preventable had health plans implemented waivers for the duration of the PHE, instead of taking a reactive approach that could never keep pace with the rapid epidemiological changes of the COVID-19 pandemic. **As such, we urge CMS to require that any relaxation or suspension of PA policies apply consistently throughout the duration of a PHE.**

Communication and transparency issues further disrupted the effectiveness of PA policy changes made during the PHE. In a 2020 AMA survey of 1,000 practicing physicians, 52 percent of providers reported that payers had never offered relief from prior authorization requirements at all—a figure which points to lapses in communication of PA policy changes between health plans and providers. Complicating this, every health plan implemented unique policy modifications, resulting in a patchwork of highly variable and constantly changing policies that were virtually impossible for inundated providers to track during the PHE. **To minimize care delays and ensure patients and providers feel the maximum intended impact of PA policy relaxations, there should be as much uniformity as possible in PA requirements across payers, and health plans should ensure transparency and clearly communicate to providers any prior authorization requirements and program changes.**

- *Wait times for receiving a response from an MA organization about the authorization of a patient transfer.*

Wait times for PA vary dramatically depending on the service, drug, or treatment at hand; the administrative and clinical documentation requirements of the payer; determinations around medical necessity; and more. Plans often limit responses to PA requests to business hours and days without regard to the fact that patients' need for medical care does not exist solely from 9 a.m. – 5 p.m., Monday – Friday. All insurance companies and benefit managers that require PA should have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. This is particularly critical for patient transfers, when unavailability of health plan staff to approve an authorization could delay a patient receiving appropriate rehabilitative care—and delay opening a precious hospital inpatient bed for another patient—for more than 72 hours over a holiday weekend.

Additionally, several states have begun implementing prior authorization response time requirements that are based on calendar days and/or hours as opposed to business days for these very reasons. For example, in Maine a response must be provided in the lesser of 72 hours or 2 business days, and in Kentucky, a decision on urgent care must be provided in 24 hours.

- *Information pertaining to industry guidelines that are used to inform prior authorization, including the extent to which such guidelines are evidence-based, the degree of transparency that exists for such guidelines, and the extent to which such guidelines are standardized.*

The AMA urges CMS to regulate MA plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and MA patients, including admission to inpatient rehabilitation facilities. Proprietary criteria must not be allowed to supersede the professional judgment of the patient's physician when determining Medicare and MA patient eligibility for procedures and admissions.

- *With respect to MA organizations, the denial rates and associated burden, including rates at which denials are upheld and overturned, for prior authorizations for patient transfer from hospitals to post-acute care facilities.*

Given MA organizations' weak record on making appropriate PA determinations, the AMA harbors significant concerns regarding the validity of MA organizations' PA decisions on patient transfers to post-acute care, particularly on initial denials. As shown by a 2018 HHS OIG report (Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials), MA plan denials are overturned as much as 75 percent of the time when challenged. Specifically, the OIG review of prior authorization denials between 2014 and 2016 found that more than 116,800 PA requests were denied and eventually overturned on appeal for drugs/services to which the patient was entitled. These alarming figures suggest that MA organizations have likely made inappropriate first-round denials in authorization for patient transfers—preventing patients from accessing necessary post-acute care, as well as jeopardizing the care of other patients awaiting hospital inpatient beds.

Many states (e.g., GA, TX, AR, IL, DE) have enacted legislation to require health plans to post data related to approvals or denials of initial prior authorization requests; reasons for denial; whether appealed; whether approved or denied on appeal; time between submission and response, etc. The AMA believes this information should be publicly available for all plans and products.

- *Any consequences of delayed patient transfer from hospitals to post-acute care facilities.*

When prior authorization requirements cause delays in patient transfers, patients whose health depends on services provided in post-acute settings must go without appropriate care, slowing their recovery. For example, a delayed transfer to a rehabilitative facility may mean that a patient waits days to begin vital physical and occupational therapy services, limiting their mobility, independence, and perhaps even ultimate clinical outcome. **Meanwhile, when patients who belong in a lower level of care occupy acute inpatient beds longer than necessary, it becomes difficult for hospitals to find space for new arrivals who require acute inpatient care—delayed patient transfers contribute to bed shortages and harm incoming acute care patients who may be left in the emergency room with nowhere to go.** Keeping patients in an acute inpatient setting who appropriately belong in post-acute care also drains valuable staff and supply resources for acute care hospitals.

- *Recommendations for how CMS can accommodate hospital systems that face capacity issues through policy changes in the MA program.*

Under the current exceptional situation brought on by the COVID-19 crisis and to ensure that physician time is reserved for patient care and not fulfilling administrative requirements, **we support a temporary suspension of all PA requirements for new medical services (including procedures, admissions to acute and nonacute care settings, and durable medical equipment) and prescription drugs through the duration of a declared PHE.** To ensure patient access to care, AMA also supports an extension of all existing PA approvals through the duration of a PHE.

The AMA continues to advocate for a reduction in the overall volume of health plans' PA requirements. As such, and to ensure patients' timely access to appropriate post-acute care, **we urge that prior authorization requirements for admissions to post-acute care settings be waived permanently, beyond the duration of the PHE.** We maintain that even after a PHE, eliminating PA requirements for these transfers supports high-quality, clinically appropriate care and protects acute care access for all members of a community. Ensuring timely transfers to post-acute care allows a patient to receive the vital rehabilitative services needed to support a prompt, successful recovery. Moreover, removing PA for these transfers supports the overall health and wellness of an entire community by opening up vital hospital inpatient beds to patients needing this acute level of care.

- *Examples of any contrast in a state's policies for payers (for example, Medicaid managed care) with respect to prior authorizations for patient transfer that do not pertain to MA organizations, and the effects of such policies on hospitals systems' ability to effectively manage resources.*

During the PHE, nearly every state suspended prior authorization requirements under their Medicaid fee-for-service programs using waiver authority, recognizing both the resulting delays in care that prior authorization requirements impose on patients and the administrative burden that prior authorization places on already struggling physician practices and overwhelmed hospitals. Additionally, in some states, prior authorization requirements were suspended under Medicaid Managed Care and many states removed some requirements through regulation, legislation, or executive orders in state-regulated commercial plans. Policymakers in several other states urged health plans to minimize the impact of prior authorization as a barrier to treatment, including testing and treatment of COVID-19.

More broadly, state legislatures have taken action over the last several years to reform the prior authorization process to decrease care delays and administrative burdens. Examples of these reforms can be found here and many are based on the Prior Authorization and Utilization Management Reform Principles and the Consensus Statement on Improving the Prior Authorization Process. It is imperative

that all payers, including MA plans, begin adopting these types of reforms that are aimed at judicious use of prior authorization and streamlining of the process, to ensure patients have timely access to care and to reduce administrative waste in the health care system.

Request for Information: Building Behavioral Health Specialties Within MA Networks

The AMA urges CMS to ensure that all MA provider networks include adequate access to physicians and other health professionals and organizations offering behavioral health care, including access to those who offer evidence-based treatment for opioid use disorder (OUD) and other substance use disorders (SUD). This includes timely, affordable access to addiction medicine and psychiatry physicians who provide buprenorphine in-office for the treatment of OUD as well as Opioid Treatment Programs (OTP).

Quantitative network adequacy standards are critical to ensuring MA networks meet the needs of beneficiaries and the AMA continues to appreciate the enforcement of such measurements on MA plans. However, we do have concerns with relaxation of time and distance standards in 2020 by CMS and hope the agency will take steps to ensure access for all enrollees. Additionally, the AMA supports the use of additional quantified standards such as wait times as an added measurement of network adequacy. In fact, the AMA views wait time requirements as a necessary complement to the time and distance standard to ensure true access to timely care. Often a network practice or OTP may be conveniently located but not be accepting new patients or have appointments available in the timeframe needed given their patient load. Or a network may not have a sufficient number or type of in-network mental health, OUD or SUD providers. We agree with the Legal Action Center that "federal and state regulators must do more to establish and enforce quantitative metrics for network adequacy, monitor carrier performance, protect consumers who cannot access network providers for covered services, and identify and address the underlying causes of limited provider networks."

The AMA encourages CMS to consider additional measurement and data to gain a more comprehensive understanding of the adequacy of MA networks, such as:

- Minimum full-time specialist-to-enrollee ratios by specialty, including facility-based health care professionals and minimum full-time primary care physician-to-enrollee ratios;
- Geographic accessibility of primary care physicians, specialists, facility-based health care professionals, hospitals, urgent care, and others;
- The hours of operation of medical practices and other organizations in the network;
- Capacity to accept new patients; and
- The ability of the network to meet the needs of enrollees, which may include low-income persons and adults with serious, chronic, or complex health conditions or physical or mental disabilities or persons with limited English proficiency.

Additionally, the AMA encourages CMS to require reporting of network changes to regulators that may render the network inadequate for certain services, along with the actions that the MA plan is taking to correct the inadequacies and ensure access to care for enrollees.

Specific to increasing access to behavioral health, OUD and SUD care, there are widespread disparities in network utilization that need to be addressed. A 2019 study by accounting firm Milliman found there are widespread disparities across multiple areas, including:

- Out-of-network utilization for behavioral health inpatient care was 5.2 times more likely compared to medical/surgical providers—an 85 percent increase from 2013-2017;
- In-network payment rates for primary care visits were 24 percent higher than for behavioral health visits in 2017;
- Out-of-network utilization rates for SUD office visits were 9.5 times higher than primary care medical/surgical visits in 2017; an increase from 5.7 times in 2013; and
- A behavioral health office visit for a child was more than 10 times more likely to be out-of-network in 2017 compared to a primary care office visit—more than twice the disparity seen for adults.[8]

With respect to the provision of medications to treat opioid use disorder (MOUD), we urge CMS to require MA plans to report the number of physicians and other health care professionals who are authorized to provide MOUD and who are in-network and accepting new patients. Differentiation must be made for physicians providing buprenorphine in-office and SUD care provided at OTPs (commonly associated with methadone). This is an important data point because buprenorphine can be obtained at a pharmacy and a 3-month prescription is not uncommon, whereas patients in an OTP often must go to the physical location of the OTP every day. If there is not an adequate number of OTPs within a reasonable time or distance, that greatly hinders access to an evidence-based treatment option. Additionally, we encourage CMS to require MA plans to report on the number of patients receiving MOUD, including the type of MOUD, and whether that care is being provided by in-network or out-of-network physicians and other health professionals, to help determine adequacy of the network. Colorado has taken an innovative approach to do this that we believe could be a strong model for CMS' consideration.[9]

Another state-based innovative model that has increased access to MOUD, reduced hospital utilization and improved care for thousands is the Virginia Department of Medical Assistance Services Addiction and Recovery Treatment Services (ARTS) program. This effort, which began approximately five years ago, removed barriers such as prior authorization to begin buprenorphine in-office and increased payment for OUD and SUD care. Not surprisingly, these actions were instrumental in greatly increasing in-network availability of OUD and SUD treatment in Virginia.

CMS should also ensure that specialties evaluated for network adequacy requirements include outpatient mental health clinics and outpatient SUD treatment. Beneficiaries should have access to a variety of behavioral health facilities at the residential and inpatient levels of care.

In terms of telehealth, the AMA continues to study the changing landscape as it relates to coverage, payment, and access to telehealth, and data suggests that telehealth has and will continue to play an important role in increasing access to quality care, especially for behavioral health care. Telehealth has specifically played an important role during the COVID-19 pandemic in improving access to mental health care and all indications are that this will continue.

Studies suggest that telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities; however, drivers impacting inequitable access to telehealth need to be addressed, including gaps in broadband

[8] https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx).

[9] https://drive.google.com/file/d/1HmPverUgJzABS4p4o7sX32aqm69c-BWr/view.

infrastructure, lack of affordable internet connectivity, lack of access to devices and other necessary technologies, and gaps in digital literacy among patients.

However, telehealth is a modality for delivering care and not a service separate or distinct from care provided via other modalities such as in-person. Clinical requirements may dictate fluid movement between modalities, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. Additionally, patient preferences and situations may change from one appointment to the next and patients should always have the opportunity to access care in-person if they choose. Therefore, telehealth should remain a supplement to, not a replacement for, in-person physician networks.

Moreover, MA plans should allow all contracted physicians to provide care via telehealth. Prior to the pandemic, many insurers established a separate network for telehealth or select telehealth providers which did not always include contracted physicians who provided in-person services. With the increased demand and changing regulatory environment during the pandemic, more physicians have implemented telehealth in their practices and patients are more likely to seek care via telehealth from their regular physician who also provides care in-person. As telehealth has become integrated into physician practices, the perpetuation of separate telehealth networks is no longer justified. In addition, it is confusing for patients and threatens continuity of care and the patient-physician relationship. Therefore, the AMA urges CMS to ensure that telehealth services should not replace in person services for MA network adequacy purposes and to pursue requirements that all contracted physicians in QHPs be permitted to provide services via telehealth to improve access to care.

MA plans may consider additional ways to increase behavioral health provider participation in networks:

- Ensure that payment rates for those who offer behavioral health care are sufficient and meet payment rates for medical or surgical benefits.
- As noted in the above response to the request for information on prior authorization, remove insurance-induced administrative burdens such as PA for behavioral health care.
- Guarantee transparent business practices, reduced denials of medically necessary services, decreased paperwork, rapid credentialing, and streamlined appeals processes.

Thank you for your consideration. If you have any questions regarding this letter, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD