Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

January 5, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Brooks-LaSure,

On behalf of AMGA and its members, I appreciate the opportunity to comment on the "Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs" (CMS-4205-P).

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for over one in three Americans. Our members work diligently to provide innovative, high-quality, patient-centered care in an efficient and cost-effective manner. Many of our member medical groups participate in the Medicare Advantage (MA) program, both under contract with MA plans and via their own sponsored MA plan offerings. For this reason, AMGA is uniquely positioned to comment on various components of the proposed rule, including proposals aiming to advance equitable care access for MA beneficiaries.

AMGA is pleased to offer the following recommendations for your consideration:

Improving Behavioral Health Access: AMGA supports CMS' proposal to include "Outpatient Behavioral Health" in network adequacy reviews. While AMGA supports telehealth, we underscore the critical need to preserve in-person care access in MA plans and urge CMS to monitor the impact of the proposed addition of Outpatient Behavioral Health to the list of specialties eligible for a 10-percentage point credit for telehealth services on beneficiary access to in-person care.

Standards for Supplemental Benefits: AMGA supports CMS' proposal to shift responsibility for determining the effectiveness of Special Supplemental Benefits for the Chronically Ill (SSBCI) to plans. AMGA further supports CMS' proposal to require plans to increase transparency surrounding marketing for SSBCI and to ensure patient education on the availability of supplemental benefits.

Utilization Management and Social Risk Factors: While AMGA appreciates CMS' focus on health equity, we recommend CMS pursue policies to reduce the use of prior authorization, as opposed

to simply reforming it.

Fast-Tracking Beneficiary Appeals: AMGA recommends CMS finalize its proposal to improve the appeals process for MA beneficiaries.

Our detailed comments on these provisions of the proposed rule are below:

Improving Behavioral Health Access

AMGA supports CMS' proposal to add "Outpatient Behavioral Health" to the list of facility types evaluated as part of network adequacy reviews. The addition of this facility specialty, which would encompass opioid treatment providers, marriage and family therapists (MFTs), mental health counselors (MHCs), and other addiction medicine and behavioral health providers, would help increase access to valuable behavioral health services.

Regarding the proposal to add Outpatient Behavioral Health to the list of specialty types eligible for a 10-percentage point credit for telehealth services, AMGA appreciates CMS' acknowledgment of the challenges faced by plans in meeting network requirements, particularly in geographically complex regions, and the agency's commitment to telehealth, as reflected in the Calendar Year (CY) 2024 Physician Fee Schedule final rule. However, AMGA members also recognize the importance of access to in-person care. MA plan networks should reflect this importance, and the impact to in-person behavioral health care access should be evaluated when considering this proposal.

It is imperative to revisit the concerns previously raised by AMGA in response to the CY 2021 Medicare Advantage proposed rule.[1] We urge CMS to closely monitor the effects of this proposal on plan networks, given the paramount importance of beneficiaries' continued access to in-person care.

Standards for Supplemental Benefits

MA plans have the opportunity to provide nonmedical benefits, known as Special Supplemental Benefits for the Chronically Ill (SSBCI), with the expectation that these benefits will either maintain or improve beneficiaries' health or overall function. This proposed rule suggests a shift in responsibility, placing the onus on plans to determine if a specific benefit meets the requisite standard for qualification as an SSBCI, as opposed to expecting CMS to demonstrate if an SSBCI does not meet the "reasonable expectation" standard. Under the proposed rule, plans would need to establish bibliographies of studies or data demonstrating the effectiveness of the SSBCI by the time they submit their bids. Plans would need to make this information available to CMS upon request.

AMGA supports this proposal, aligning with previous recommendations on the SSBCI benefit. In the initial stages of SSBCI implementation, AMGA advocated for an expansive approach, urging collaboration between MA plans and providers to maximize patient access to these expanded benefits. The proposed rule acknowledges the substantial increase in both the number and

[1] AMGA comments on "Calendar Year (CY) 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program; Medicare Prescription Drug Benefit Program (CMS-4190-P)." April 6, 2020

scope of SSBCI offered by MA plans since their introduction. AMGA applauds this trend, noting that plans are now addressing a variety of nonmedical needs that significantly impact beneficiaries' health, and supports CMS' proposal to help ensure that SSBCI improve or maintain beneficiary health.

In addition to these changes, CMS proposes an expansion of requirements governing plan marketing practices. This includes specifying chronic conditions for SSBCI eligibility, indicating additional eligibility criteria, and adhering to updated font size and reading pace requirements in advertisements. AMGA supports this proposal, as well as the proposed requirement to facilitate better decision making and consumer choice by issuing mandatory mid-year notifications outlining unused supplemental benefits. AMGA stands in alignment with CMS in recognizing the importance of clear communication of eligibility criteria and endorsing measures to enhance transparency in plan marketing practices.

Utilization Management and Social Risk Factors

CMS acknowledges the disproportionate impact of prior authorization (PA) on underserved communities and proposes updates to MA plan Utilization Management committees. Specifically, CMS proposes to require that the committees be constructed with a health equity lens, involving, among other things, publicly posting annual health equity analyses of the plan's PA policies and procedures.

While AMGA commends CMS for working to address disparities in healthcare, we argue that reforming the MA plan Utilization Management responsibilities may not effectively address the issue. Our prior comments to CMS emphasized the inequitable impact of PA on care access, and we believe eliminating, rather than reforming, PA would better serve health equity. We reiterate our position as stated in AMGA's February 18, 2023, comment letter to CMS on Medicare Advantage PA:

> "Prior authorizations and restrictive coverage policies remain significant barriers that contribute to inequitable care access, and we believe changes here would closely align with efforts to advance equity."[2]

While AMGA does not object to the proposed committee reforms, we advocate for expedited approvals to alleviate the burden of overly restrictive PA policies on communities and beneficiaries.

Fast-Tracking Beneficiary Appeals

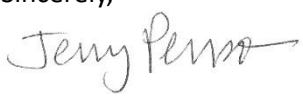
Current regulations limit MA beneficiaries' access to fast-track appeals through Quality Improvement Organizations (QIOs) for service termination decisions via a Notice of Medicare Non-Coverage, unlike those enrolled in traditional Medicare. CMS aims to amend this by mandating that QIOs, rather than MA plans, review untimely fast-track appeals regarding termination of services provided in home health agencies, comprehensive outpatient

[2] AMGA comments on "Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" CMS-4201-P, Feb. 13, 2023

rehabilitation facilities, or skilled nursing facilities. Furthermore, CMS proposes eliminating the provision that currently restricts beneficiaries from appealing service termination decisions when leaving a facility. AMGA supports CMS' initiative, advocating for equal access to the fast-track appeals process for MA beneficiaries.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Senior Director of Regulatory Affairs Darryl Drevna, at 703.833.0033 ext. 339 or ddrevna@amga.org.

Sincerely,



Jerry Penso, MD, MBA
President and Chief Executive Officer