American Association on Health & Disability
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AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

February 12, 2023

Re: Medicare Advantage Proposed Rules; Medicare Part D Prescription Medications Program Proposed Rules – CMS-4201-P

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

Submitted via: www.regulations.gov

Attention: CMS-4201- P

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

People with Chronic Diseases and Disabilities

AAHD is a National Health Council (NHC) member. In its introduction to its submitted comments, the NHC observes: "For people with chronic diseases and disabilities, the decisions made when choosing between traditional Medicare and MA, choosing between specific plans, and when navigating their Medicare or MA plan to access care are particularly important. In addition, Part D is a critical resource for people with chronic conditions and disabilities that rely on its coverage for access to needed therapies, and it is poised to provide even greater benefit in the near future with upcoming changes to create a limit on out-of-pocket expenses." We affirm this basic situation, need, and theme.

Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and 422.116) – Provider Networks

We fully support the NHC recommendations on behavioral health in MA plans. Numerous studies have shown that the provider networks for mental health and substance use disorder specialists are less robust than other specialties. This can leave people with mental health conditions with no other option than to seek care that is out-of-network, often making mental health care unaffordable. Some people will pay overwhelming out-of-pocket costs or take on medical debt, while others will forgo medically necessary mental health treatment. The NHC appreciates that CMS has reaffirmed that MA organizations have responsibilities to provide behavioral health services in ways that assure access. Specifically, we appreciate that CMS proposes:

1. Adding new provider types (clinical social workers, psychologists, and opioid use disorder prescribers) in provider networks and subject to network adequacy standards.
2. Clarifying that behavioral health services can qualify as emergency services, so they are not subject to prior authorization.
3. Extending current requirements to coordinate between community services and behavioral health to close equity gaps.

Consistent with new provisions in the Omnibus Consolidated Appropriations law, AAHD and the Lakeshore Foundation support the advocacy efforts of the Mental Health Liaison Group, workgroup on peer supports, to include Medicare coverage of certified mental health and behavioral health peer specialists in provider networks delivering integrated behavioral health settings.

Additional Network Adequacy Standards

AAHD and the Lakeshore Foundation are members of the Coalition To Preserve Rehabilitation (CPR). We support the CPR recommendations that CMS include IRFs, CORFs, and LTCHs as part of the agency's network adequacy review process for MA plans. Rehabilitation services and settings that provide intensive and specialized rehabilitation services are important components to MA provider networks.

MA Plans and Social Drivers of Health and Equity Quality Measures

AAHD is a member of the National Quality Fourm (NQF) Measure Application Partnership (MAP) Coordinating Committee; the Core Quality Measure Collaborative (CQMC); and National Committee for Quality Assurance (NCQA) national consumer advisory committee. We support the NQF MAP quality measurements submitted to CMS, applied to MA plans and their providers, specifically including:

Facility commitment to health equity
Residents experiencing falls with major injury
Emergency Dept arrival-departure times
Screen; and, Screen positive for social drivers of health
Resolution of at least one health-related social need
Hospital disparity index
Inpatient psychiatric hospital experience of care
Cross-Setting Discharge Function
Primary Care connection to community service providers
Functioning – persons with mental illness and/or SUD
Patient activation gains
Nursing Home staffing turnover

Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137, 422.138, and 422.202)

Members of the Coalition To Preserve Rehabilitation (CPR) include AAHD and the Lakeshore Foundation. We support CPR proposals and perceptions that the CMS proposed rule is an important step forward in beginning to reform the overuse of utilization management, especially prior authorization, in the MA program and reducing the frequency of inappropriately delayed or denied rehabilitative care in a variety of settings.

The CPR submission to CMS refers CMS to: The Department of Health and Human Services Office of the Inspector General (OIG) released a report in 2018 that detailed "widespread and persistent problems" related to denials of care and payment in Medicare Advantage plans. A second OIG report in 2022 found persistent problems with MA plans issuing inappropriate denials of service and payment, including denials of prior authorization requests that met Medicare coverage rules. These barriers to access to care are long-standing, persistent, significant, and require solutions as proposed by the CPR.

We further support the National Health Council observations and recommendations. The rule proposes to increase the transparency of MA plans' utilization management and prior authorization policies. The NHC supports these efforts to ensure that MA enrollees receive the same access to medically necessary care they would receive in Traditional Medicare. While utilization management protocols may be grounded in sound clinical decision-making, such as prior authorization to limit drug-to-drug interactions or prevent overprescribing of potentially addictive medication, the development of such protocols is typically done without much or any patient input, and the rationale for such decisions is not typically made public. As a result, the chronic disease and disability community has become greatly frustrated by the additional burden placed on patients, families, and health care providers. We support oversight and transparency of such practices to inform the patient community as to how decisions are made that have such a direct effect on patients. We appreciate that the rule would do the following:

1. Require the inclusion of current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers when creating internal clinical coverage criteria.
2. Require that the physician or other health care professional used by the MA plan have expertise in the field of medicine that is appropriate for the service be involved before the MA plan can deny coverage.
3. Streamline prior authorization requirements, including adding continuity of care requirements in ongoing care for beneficiaries.
4. Require all MA plans to establish a Utilization Management Committee to review policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines.

MA plans utilization management protocols should be publicly available – available to providers, network providers, and enrollees and potential enrollees.

Continuity of care is a bedrock foundation for the whole person health and wellness of persons with disabilities and chronic health conditions, including behavioral health conditions. The National Quality Forum has recommended to CMS use of several continuity of care quality measures and quality of care measures focused on different kinds of providers sharing care plans. These should be incorporated into the MA requirements.

Medical Necessity Determination Guidelines

The proposed rule codifies existing medical necessity determination guidelines into regulation, including:

1. a provision that MA organizations may not deny coverage for basic benefits based on coverage criteria not found in § 422.101(b) and (c);
2. MA organizations are required to consider whether the item or service is reasonable and necessary under 1862(a)(1);
3. MA organizations must consider an enrollee's medical history; and
4. MA organizations' medical directors must be involved.

We join the CPR in supporting this proposal .

Strengthening Translation and Accessible Format Requirements for Medicare Advantage, Part D, and D-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267)

We support and repeat the NHC submission: The proposed rule requires MA organizations, cost plans, and Part D sponsors to provide materials to enrollees on a *standing basis* in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area. It also requires information in an accessible format using auxiliary aids and services upon receiving a request for the materials or otherwise learning of the enrollee's preferred language and/or need for an accessible format using auxiliary aids and services. The NHC appreciates the focus on language access. This is an important part of making sure that people receive understandable and usable health care information. The NHC particularly appreciates that disability communication access is also a part of all efforts to address language and cultural barriers to care. The standardization of language access requirements will help patients reliably expect what their language access to health information will be.

Medicare Part D Medications – Improving the Low-Income Assistance Program

AAHD and the Lakeshore Foundation have joined 70 organizations, led by the National Council on Aging and the PAN Foundation, submitting comments to CMS on improving the Medicare Part D medications low-income assistance program. We refer CMS to the February 7 coalition letter. The low-income subsidy (LIS) program is a critical safety net that helps cover out-of-pocket costs for prescription drugs. The NCOA led letter provided ideas for cross-Federal agency data collection, analysis, and sharing; educating beneficiaries; educating pharmacists; and creating flexibilities and frequency in notices and updates.

AAHD and the Lakeshore Foundation also endorsed the submission of MAPRx – Medicare Access for Patients Rx. Greater efforts need to be made to assist low income individuals access the Medicare benefits they are entitled to. And, the National Health Council submission also advocates greater support for low income individuals.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

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And
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