January 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS- 4205-P

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Dear Administrator Brooks-LaSure:

The Healthcare Leadership Council (HLC) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to submit comments in response to the Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications proposed rule.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, group purchasing organizations, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC appreciates CMS's efforts through payment and policy proposals to promote health equity as well as healthy competition among Medicare Advantage (MA) and Part D plans. MA continues to grow in popularity and today serves more than 30.8 million people, over half (51 percent) of Medicare beneficiaries.[1] The program appeals to new beneficiaries whose previous employer-sponsored health coverage resembles MA. HLC encourages CMS to finalize

[1] Medicare Advantage in 2023: Enrollment Update and Key Trends, KFF (December 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

proposals that support the continued growth and success of MA and Part D and to consider our recommendations provided below.

Advancing Health Equity

HLC shares CMS's commitment to enhance health equity and further identify and reduce health disparities for all Medicare enrollees. We encourage policies and practices that will address social determinants of health (SDOH) and improve health equity, including eliminating variations in care delivery, addressing diversity challenges in the workforce and clinical trials, investing in data infrastructure to assess disparities, and enhancing interoperability standards. We applaud CMS's Office of Minority Affairs for convening the Annual Health Equity Conference where models of care are highlighted. We also commend CMS for working with the Administration for Community Living (ACL) on strengthening the relationship between health plans and community-based organizations. We believe this is vital to truly addressing SDOH.

Utilization Management

HLC supports CMS's proposal to require that the utilization management (UM) committee include at least one member with expertise in health equity to help ensure MA plans' policies and procedures do not result in disparate impacts on enrollees with social risk factors. We appreciate CMS's effort to advance health equity goals and support the proposed definition of "health equity expertise."

CMS proposes to require MA plan sponsors, beginning in 2025, to annually conduct a health equity analysis of the use of prior authorization to examine the impact of prior authorization on enrollees with three social risk factors: recipients of the low-income subsidy (LIS), who are dually eligible for Medicare and Medicaid, or who have a disability. CMS also seeks feedback regarding additional populations it should consider including in the health equity analysis and alternatives to the July 1, 2025, deadline.

While HLC supports CMS's intention to advance health equity through the proposed health equity analysis requirement of prior authorization analysis requirement, we recommend the following five improvements to the proposal to ensure the new requirement is integrated with the current data flow landscape, avoids unintended adverse consequences, and can have a meaningful impact in addressing SDOH.

- **CMS should require plans to submit the report findings to CMS rather than post it publicly to their websites.** The proposed method to deliver the report, publicly on plan sponsors' websites and in a machine-readable file, would cause unnecessary confusion to providers and beneficiaries who can easily misinterpret publicly available prior authorization metrics. Because providers and enrollees are not consistent across MA plans, it is impossible to compare metrics across plans.
- **CMS should build on current data flows and ensure consistency with the upcoming Health Equity Index (HEI).** We support CMS's health equity goals but are concerned the current proposal lacks attention to efficiency and interoperability. The current proposal would duplicate information that plan sponsors already submit to CMS as well as prior authorization metrics reporting that will soon be required by the upcoming final regulation on Advancing Interoperability and Improving Prior Authorization Processes (RIN 0938-AU87). Rather than create new data flows, we recommend CMS expand current Medicare Part C Reporting Requirements to include the data elements specific to enrollees with the three proposed social risk factors.

- **CMS should allow plans to build new data flows before expanding to additional populations.** CMS is soliciting feedback on extending requirements to populations with additional risk factors. While we support collecting data on additional SDOH in the future, we recommend CMS start smaller and add additional populations in a sustainable manner that advances interoperability and ensures consistency with HEI, so that the data collected can have a meaningful impact. Additionally, CMS should allow plan sponsors at least one year from issuance of the final rule and related reporting specifications to provide adequate time for plan sponsors to compile the new data.
- **CMS should start the timeframe for creating the report at the point where the plan sponsor has all the information necessary to process the request.** Because it is common for medical information to be missing that is needed to make a prior authorization decision, beginning the elapsed time from the submission of the request is not an accurate measure of how long it takes the MA plan to process the request.
- **CMS should require Part D plans as well as MA plans to conduct the health equity analysis.** Keeping in mind the above recommendations to build out this reporting requirement in a sustainable manner, we also recommend CMS consider extending the reporting requirement to Part D plans to achieve consistency towards CMS's health equity goals.

Integrating Duals

HLC supports CMS's goals of promoting meaningful integration of Medicare and Medicaid benefits for dually eligible individuals to improve care coordination and patient outcomes. However, we caution the agency against unwinding state progress to date in an effort to move towards greater integration or implementing overly-burdensome integration requirements for plans, states, and beneficiaries that could ultimately lead to reduced beneficiary choice.

HLC supports proposed changes to the Special Enrollment Periods (SEPs) for duals and other LIS eligible individuals to reduce overall "churn" and promote continuity of care for beneficiaries. However, we recognize some challenges could result from this change to the system. CMS first proposes to replace the current quarterly SEP with a monthly SEP for LIS/dual eligibles to elect a standalone prescription drug plan. We support this proposal as it would likely reduce overall churn and thus improve care coordination. However, we also note that it would limit plans' ability to gain new enrollees and track new membership year-round. HLC is also supportive of CMS's intention to promote integrated enrollment through its proposal to create a new integrated care SEP to allow dual eligibles to elect an integrated Dual Eligible Special Needs Plan (D-SNP) on a monthly basis. We are, however, concerned that this change may negatively impact partial dually eligible individuals (partials). In many states, partials do not qualify for highly integrated dual special needs plans (HIDE-SNPs) or fully integrated dual eligible special needs plans (FIDE SNPs) and thus would not be able to benefit from the new integrated SEP and the resulting increased care coordination.

HLC is highly supportive of several proposals to improve enrollee access and choice. Proposed improvements to the functionality and user experience of the Medicare Plan Finder (MPF) are needed to allow dually eligible MPF users to assess MA plans that cover their full array of Medicare and Medicaid benefits. We encourage CMS to work with impacted D-SNP sponsors to make the Medicaid benefit data collection process and mechanism as smooth as possible. HLC also supports CMS's proposals to limit out-of-network cost sharing for D-SNP preferred provider organizations (PPOs).

HLC appreciates CMS's efforts to ensure plans meet D-SNP requirements to appropriately enhance the health of beneficiaries. We support CMS's proposal to limit non-SNP MA plans with 70 percent or greater dually eligible individuals for contract year (CY) 2025 and to reduce the threshold from 70 percent to 60 percent or greater dually eligible enrollment as a share of total enrollment for CY 2026. HLC recommends that CMS exclude partial dual eligible beneficiaries from the calculation of this threshold and continue to make existing crosswalk exceptions available for members who are dually eligible and transition from a look-alike into a D-SNP.

As CMS continues efforts to improve care coordination among duals, HLC recommends CMS work with states, Congress, and the private sector to improve data consistency and education to beneficiaries. In the current system of care for dual eligibles, beneficiaries can be managed by two distinct and different payers, which are abiding by either state or federal regulations related to care coordination. Oftentimes, this management is duplicative and causes confusion and frustration for the enrollee. There is also a lack of resources and expertise at the state level on Medicare program policies, especially those meant to foster greater integration efforts and D-SNP communications. To address these issues, we recommend CMS offer more educational opportunities to support state partners in understanding requirements and policy changes and require all state Medicaid agencies to have a designated dual eligible subject matter expert.

Lastly, there remain challenges with the exchange of data among health plans, states, and CMS to facilitate both enrollment and care delivery. For example, there is not a consistent use of eligibility categories across states and CMS, which can create issues with continuity of coverage, care coordination, and coordination among the health plan, the state, and beneficiaries. HLC recommends CMS work with Congress, states, and the private sector to identify opportunities for data consistency and information sharing for dual eligible care.

Demonstrating evidence for Special Supplemental Benefits for the Chronically Ill (SSBCI)

HLC supports CMS's goal of ensuring SSBCI truly improve or maintain patients' health. However, we are concerned that CMS's proposal to shift the responsibility from CMS to plans of determining that SSBCI benefits are appropriate and have a reasonable expectation to improve or maintain the health or overall function of chronically ill enrollees will result in fewer SSBCI offerings. The peer reviewed evidence base for the types of benefits provided under SSBCI is nascent and constantly evolving. In some instances, data may not yet be published in literature that conforms to CMS's standards for relevant acceptable evidence. This may lead to plan sponsors offering less innovative and impactful benefits to members. These benefits are essential to addressing SDOH and reducing health disparities.

Expanding Access to Behavioral Healthcare Providers

HLC supports expanded access to and integration of mental health (MH) and substance use disorder (SUD) treatment and supports CMS's proposals towards these goals. HLC is committed to working with CMS on policies to expand the MH/SUD workforce currently experiencing alarming shortages.

We support CMS's proposal to create a new Outpatient Behavioral Health facility-specialty type for network adequacy reviews in order to provide access to the new behavioral health provider types that recently became eligible for Medicare payment under the Consolidated Appropriations Act of 2023. Outpatient Behavioral Health could include marriage and family therapists (MFTs), mental health counselors (MHCs), Opioid Treatment Program (OTP)

providers, Community Mental Health Centers (CMHCs), or other behavioral health and addiction medicine specialists and facilities.

HLC also supports CMS's proposal to add the new Outpatient Behavioral Health facility-specialty type to the list of specialty types that receive a 10-percentage point credit towards the percentage of beneficiaries that reside within published time and distance standards for certain providers when the plan includes one or more telehealth providers of that specialty type that provide additional telehealth benefits. Given the healthcare workforce shortages that are impacting most specialties, HLC recommends that CMS expand the telehealth credit beyond the current list to all behavioral health provider types.

Enhancing Medicare Advantage and Part D Prescription Drugs

Protecting Beneficiaries: Marketing and Agent/Broker Compensation

HLC believes all MA and Part D marketing entities must meet standards to ensure beneficiaries are able to make healthcare choices that best meet their unique needs. While we support CMS's intentions to protect patients' choice and access to information from misaligned incentives, it is important to ensure that changes to compensation and contract terms for agents and brokers do not negatively impact beneficiaries, such as by reducing beneficiary choices. HLC encourages CMS to work with stakeholders towards a solution to meaningfully eliminate bad actors and improve the beneficiary experience. HLC and our member companies have deep expertise in finding innovative solutions to healthcare's toughest challenges.

We also recommend CMS take the following additional steps to mitigate non-compliant marketing by third parties:

- Preserve federal Medicare preemption to ensure consistency in addressing misleading marketing materials across the country,
- Create a consolidated document containing all marketing requirements with examples for stakeholders to reference,
- Revise the process for third party marketing organization (TPMO) material,
- Establish a compliance resolution process for reports of potentially non-compliant marketing materials or tactics, and
- Perform trainings targeted at TPMOs and downstream entities.

Improving Drug Management Programs for Cancer Patients

We support CMS's proposal to expand the definition of "exempted beneficiary" to broaden the category of enrollees considered as being treated for cancer-related pain, to include cancer survivors who continue to suffer from chronic pain. This group often requires long-term pain management, commonly including opioid pain medications, and thus, should be exempted from drug management programs that are intended to pinpoint potential opioid misuse. Additionally, as CMS notes, this proposal is also consistent with the updated 2022 Centers for Disease Control and Prevention Clinical Practice Guideline for Prescribing Opioid for Pain. We also encourage CMS to promote alternatives to opioids that include proven non-pharmacological solutions to pain management, such as therapeutic massage, acupuncture, chiropractic care, physical activity, and changes in eating to include lifestyle medicine.

Thank you for your commitment to the MA and Part D programs. HLC looks forward to working with you on our shared priorities. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President