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February 13, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 4201-P
7500 Security Boulevard
Baltimore, MA 21244

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program (CMS-42010P)

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to submit comments on the proposed rule entitled “Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program” 87 *Fed. Reg.* 79452 (December 27, 2022) issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC’s U.S. membership and expanded its reach to international academic health centers.

The COVID-19 public health emergency (PHE) accelerated the use of telehealth to furnish both medical and behavioral health services to patients in their homes expanding access to care for many. AAMC and its members are committed to advancing health equity through telehealth and support this proposal in recognition of potential inequities due to low digital health literacy. The AAMC recently held a learning series to examine the impact of telehealth on equity and access to care and evolving best practices that are currently in use by health systems to improve digital

health literacy and narrow the digital divide.¹ AAMC members have shared that they have begun to assess patients access to digital tools – both devices and internet access – often by incorporating them into social needs screenings. Further, identifying and engaging community partners to assist with patients’ digital health literacy is vital. The AAMC welcomes the opportunity to partner with CMS and Medicare Advantage Organizations (MAOs) on this important work.

We support proposals to require certain Medicare Advantage Organizations to evaluate beneficiaries’ ability to utilize telecommunications to receive care and to educate patients who may have difficulty using telecommunications. But coverage of telehealth services does not guarantee access. We urge CMS to ensure adequate reimbursement by Medicare Advantage Organizations for services furnished via telehealth.

The AAMC supports the prior authorization proposals included in this proposed rule. The expansion of prior authorization requirements by insurers has led to delays in care and in some cases forced beneficiaries to forego medically necessary care or prescription drugs. Patients are not the only ones to suffer from onerous prior authorization requirements. The administrative burden of prior authorization contributes to physician burnout. We support ways to decrease burden on both the provider and patient and ensure that patients receive medically necessary care.

Lastly, we ask CMS to clarify that the identification of potential overpayments continues to include an adequate investigative period to quantify the impact of the overpayments. This investigative period could take months to fully understand and identify any overpayments. This period should be in addition to the time frame that requires providers remit any overpayments within 60 days of identification, to allow for adequate time to quantify any overpayments.

HEALTH EQUITY IN MEDICARE ADVANTAGE

Digital Health Education for MA Enrollees Using Telehealth. CMS is proposing to require that MAOs offering coordinated care plans² evaluate the digital health literacy of beneficiaries enrolled in their plans and provide digital health education to beneficiaries identified as needing assistance navigating telecommunications. (p. 79484). The AAMC supports this proposal. Based on 2018 data, more than one quarter of Medicare beneficiaries lacked digital access at home. Moreover, some Medicare beneficiaries are unable to use technology for video or even audio visits.³ Requiring MAOs to evaluate beneficiaries’ digital health education is a good first step in assisting beneficiaries are able to access services furnished by telehealth.

¹ See, [Advancing Health Equity Through Telehealth: AAMC Learning Series](#), with recorded webinars from 2022 on (1) strategies to improve telehealth access and equity, (2) promoting equitable specialty access, and (3) leveraging data to drive change in telehealth access equity.

² Examples of coordinated care plans include health maintenance organizations [HMOs], preferred provider organizations, HMO-point of service plans, and special needs plans.

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7400206/>

Finalize Clarifications to Regulatory Language to Ensure Equitable Access to MA Services for All Beneficiaries

CMS proposes to update the regulatory language at 42 CFR § 422.112(a)(8) to clarify, and not change, requirements that MAOs must meet to ensure that all covered benefits are available and accessible to all enrollees. This includes a revision to the regulatory heading to “Ensuring Equitable Access to Medicare Advance (MA) Services” instead of “Cultural considerations,” and listing more examples of underserved populations to which an MA organization must ensure equitable access to services. CMS states clearly that the additional examples of groups proposed for inclusion should not be construed as exhaustive and that “MA organizations must provide all enrollees, without exception, accommodations to equitably access services.”⁴ As CMS discusses in the rule, the various clarifying changes are intended to “reflect the inclusive nature of the protections MA organizations must guarantee for all enrollees” and that language is consistent with the Executive Order 13985 call for ensuring equity across Federal programs.⁵ The AAMC agrees with CMS that these proposed clarifications are meaningful and will help to ensure that federal policy is better oriented toward an equitable opportunity for health care for Medicare beneficiaries who obtain care through MA plans.

CMS also proposes to require MAOs to incorporate into their quality improvement programs one or more activities that reduce disparities in health and health care among their enrollees. (p. 79499). Under the proposal, MAOs’ Quality Improvement (QI) programs would not be limited to activities specific to QI program requirements. The QI programs would be permitted and expected to implement activities tailored to enrollees such as improving communication, developing and using linguistically and culturally appropriate materials for beneficiaries, hiring bilingual staff, community outreach and other similar activities. The Association supports efforts to improve patients’ health and access to medically necessary care through initiatives targeted to meet patients’ needs. We urge CMS to finalize this proposal.

Include the Digital Health Literacy Assessment in the Welcome to Medicare and Medicare Wellness Assessments for Medicare Advantage Beneficiaries

CMS should consider adding this assessment as a screening requirement to the Welcome to Medicare preventive visit that is conducted within the first 12 months of a beneficiary’s enrollment in Part B.⁶ Including this element as part of the Welcome to Medicare preventive visit would capture beneficiaries’ telecommunications abilities upon enrollment and would allow MAOs to identify ways they can support beneficiary’s digital knowledge and access to telehealth services. Thereafter, the screening should be part of the annual Medicare “wellness” visit to annually assess a beneficiary’s digital health literacy.⁷

⁴ 87 Fed. Reg. 79452, at 79480.

⁵ *Ibid.*

⁶ <https://www.medicare.gov/coverage/welcome-to-medicare-preventive-visit>

⁷ <https://www.medicare.gov/coverage/yearly-wellness-visits>

In addition, we recommend that CMS provide framework or model language that MAOs should use to ensure beneficiaries are being properly screened. The proposed rule notes that MAOs will have the flexibility to design their own screening program or procedure. (p. 79484). While we agree there should be some level of flexibility, to properly evaluate whether beneficiaries are being properly screened on their ability to use of digital communications, there should be robust evaluation criteria. Model language would allow CMS to evaluate across MAOs whether they are providing meaningful and culturally appropriate health literacy education and assistance.

The proposed rule states that MAOs would not be required to report this information to CMS. Rather, MAOs would be required to make the information about these programs available to CMS upon request. (p. 79485). CMS should consider requiring annual reporting of this information by MAOs to inform CMS whether beneficiary screening accurately captures and evaluates whether MAOs are meeting this requirement. Further, reporting would show whether an MAO is providing this information in a culturally competent manner, including to individuals with limited English proficiency, limited reading skills, and individuals with diverse cultural and ethnic backgrounds as the proposal requires.

Require MAOs Provide Coverage for Audio-Only Telehealth Visits After the End of the COVID-19 PHE

The COVID-19 PHE has revealed the value of telehealth to maintain continuity of care for many patients. By extending telehealth flexibilities,⁸ Congress acknowledged the value of using telecommunications to provide medically necessary services for patients. The AAMC strongly supports the use of audio-only communication to furnish health care services. During the PHE, coverage and payment for audio-only calls have been critical to ensure access to care for many patients, enabling providers to provide a wide array of services efficiently, effectively, and safely to patients using audio-only technology. CMS should require MAOs to expand telehealth coverage and to include audio-only telecommunications to furnish services, including behavioral and mental health services, to some beneficiaries. CMS should also require MAOs to use a modifier to track the use of audio-only services, similar to the Medicare fee-for-service behavioral health modifier (CPT 93/FQ).

UTILIZATION MANAGEMENT REQUIREMENTS

Utilization management tools are designed to contain spending and prevent patients from receiving low-value items and services. But over the years, insurers have expanded the use of these tools, specifically prior authorization, which has limited patients' access to medically necessary care; created barriers and delays in receiving care; imposed additional burden and stress on providers leading to burnout; and forced some patients to forego needed care or prescription drugs due denials of prior authorization requests. We support proposals included in this proposed rule that seek to decrease onerous prior authorization requirements.

⁸ Consolidated Appropriations Act, 2023, Sec. 4113(b). (P.L. 117-328).

According to Kaiser Family Foundation, in 2021, more than 35 million prior authorization requests were submitted to MAOs on behalf of MA beneficiaries. Of these, more than 2 million prior authorization requests were fully or partially denied. Just 11 percent of prior authorization denials were appealed, but of those a whopping 82 percent resulted in the initial prior authorization denial being fully or partially overturned.⁹ The burden to respond to these denials rests squarely on providers and contributes significantly to burnout. If the beneficiary is required to follow-up on the denial, they often forego care due to the complexities of filing an appeal. We support changes to reduce the number and burden of prior authorizations in MA. To meaningfully exact change to reduce the number of prior authorization requests, we encourage CMS to put in place a system that requires MAOs to submit to CMS the number of prior authorization requests and results (e.g., approval / denial) to allow CMS to accurately track the number of prior authorization requests and denials.

Appropriate Use of Prior Authorization. CMS is clarifying that prior authorization should not be used to deny care. (p. 79504). Prior authorization denials delay needed care or force beneficiaries to forego care or adherence to prescription drug regimens. For example, low-income Medicare beneficiaries may not fill a prescription due to formulary restrictions such as prior authorization and step therapy imposed by the Medicare Part D plan.¹⁰ The proposed rule states that prior authorization should be used to confirm the presence of diagnoses or other medical criteria and to ensure that beneficiaries are receiving medically necessary care. Further, CMS is proposing that approved prior authorization requests for coverage or payment cannot retroactively be denied on the basis of lack of medical necessity. (p. 79716). We urge CMS to finalize this proposal.

Continuity of Care. The proposed rule acknowledges stakeholders' concerns that MA coordinated care plans' prior authorization processes sometimes require enrollees to interrupt ongoing treatment. In response to stakeholders' concerns, CMS is proposing additional continuity of care requirements to help ensure that MAOs provide access to all medically necessary Medicare covered benefits during a course of treatment. (p. 79504). CMS is proposing that prior authorization approvals must be valid for the duration of the entire approved prescribed or ordered course of treatment or service. In addition, CMS is proposing to define a "course of treatment" as a prescribed order or ordered course of treatment for a specific individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider. Further, prior authorization approvals must provide for a minimum 90-day transition period for ongoing course(s) of treatment for a beneficiary newly enrolled in an MA plan or the course of treatment began under the care of an out-of-network provider. MA plans would not be permitted to disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days, even if the patient is receiving care from an out-of-network provider. We support ensuring patients have at least a 90-day transition period for an active course of treatment. However, every patient is different and while CMS is proposing that MAOs would be

⁹ <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>

¹⁰ <https://www.healthaffairs-org.eu1.proxy.openathens.net/doi/10.1377/hlthaff.2021.01742>

prohibited from requiring additional prior authorization requirements for any active course of treatment, even if the services is furnished by an out-of-network provider, MAOs should be required to extend on a case-by-case basis the coverage for some patients receiving care from out-of-network providers after the 90-day period expires and should not impose additional prior authorization requirements.

Annual Review of Utilization Management (UM) Policies by a UM Committee. CMS is proposing that MAOs that have utilization review policies such as prior authorization establish a UM committee lead by the MAOs' medical director. (p. 79505). Under the proposal, beginning January 1, 2024, an MA plan would not be able to use any UM policies for basic or supplemental benefits unless those policies and procedures have been reviewed and approved by the UM committee. UM guidelines would be required to be based on current widely used treatment guidelines or clinical literature. The UM committee would be required to annually review the policies and procedures for all utilization management, including prior authorization, used by the MA plan. Additionally, the UM committee would be required to review, at least annually, UM policies and procedures as necessary to comply with regulations, including removing requirements for UM services and items that no longer warrant UM to remain in compliance with current clinical guidelines. We support these proposals and urge CMS to finalize them.

CMS also seeks comments on whether UM committees should be required to communicate information about practice guidelines and UM policies to providers and, when appropriate, to enrollees. We feel that improved communication channels have the potential to decrease the burden of prior authorization on both patients and providers and we urge CMS to finalize a requirement that MAOs provide meaningful information to providers about their UM policies.

Utilization Management Committee Membership. The proposal would require that the UM committee membership be comprised of a majority of practicing physicians from varying clinical specialties. (p. 79506). The AAMC supports a representative UM committee that understands the prior authorization requirements and the widely used treatment guidelines and clinical literature in order to make accurate determinations of prior authorization requests. At a minimum, we urge CMS to ensure behavioral health expertise is represented on the committee. Finally, if the UM committee does not have specific expertise to properly decide on a prior authorization request, it should be required to seek outside assistance from an entity or entities with expertise in the clinical subject. This will ensure that prior authorization requests are not denied strictly because of the committee's lack of clinical knowledge / experience of the treatment or procedure. The AAMC would welcome the opportunity to work with CMS to identify the types of entities that would be acceptable.

Utilization Management Tools Add to Clinician Burden and Burnout

The American Medical Association surveyed¹¹ more than 1,000 practicing physicians regarding their experience with prior authorization; 88 percent reported that prior authorization interferes with continuity of care. More than 80 percent reported that in the last five years they have seen

¹¹ <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

an increase in the number of prior authorizations for medical services and prescription drugs, with almost 20 percent of prescription drugs requiring prior authorization.

Further, clinicians increasingly cite the use of electronic health records, including prior authorization requests, as a cause of burnout. To meet billing rules the medical record has become bloated, thereby impeding physicians' ability to focus on delivering high quality care. Adding to this burden is the requirement for clinicians to navigate coverage requirements for an array of insurance plans and a lack of standardized transmissions for this information, including the submission of prior authorization requests. We support CMS' proposed changes for Medicare Advantage plans as a way to minimize burden on providers. Also, the Agency should evaluate the process and clinical workflow factors contributing to the burden associated with utilization management tools to see how these factors can be reduced. CMS should evaluate the expanded use of prior authorization in the Medicare fee-for-service program to better understand the impact of prior authorization requirements on patients' timely access to medically necessary care and prescription drugs.

Gold Carding. The proposed rule notes that some MAOs relax or reduce prior authorization requirements for contracted providers that have demonstrated a consistent pattern of compliance with plan policies and procedures for the appropriate utilization of items or services and other evidenced-based criteria that the MA plan deems relevant. CMS believes that the use of gold-carding programs could help alleviate the burden associated with prior authorization. (p. 79507). We support ways to decrease the burden of prior authorization requests on providers and if evidence indicate that gold-carding programs reduce burden, we support expansion and encourage CMS to require MAOs to develop the programs.

However, it is unclear which contracted providers typically receive the gold-carding designation. If gold-carding is primarily used for routine and widely accepted treatments and procedures, then it likely excludes specialized and sub-specialized care that often is tailored specifically to the patient and can be more costly. In other words, tertiary and quaternary institutions and their associated providers who provide specialized care will continue to be unreasonably subjected to prior authorization requirements. Therefore, we ask CMS to investigate further what type of procedures and treatments are typically included in the gold-carding program and publish this information on its website. If it is determined that specialty and sub-specialty care continue to be subjected to a preponderance of prior authorization requests, then MAOs should be required to expand the gold-carding to include other types of care, including specialized care. The AAMC is willing to assist in developing gold-carding for specialists.

REVIEW OF MEDICAL NECESSITY DECISIONS

CMS is proposing to add to the existing requirement that the physician or other appropriate health care professional who conducts the medical necessity review to determine coverage must have expertise in the field of medicine that is appropriate for the item or service being requested before the MAO issues a full or partial denial. (p. 79510). Under the proposal, the physician reviewing the claim would be required to have expertise in the service under review. If the

reviewing physician is not in the same specialty or sub-specialty as the treating physician, the reviewer must have the appropriate level of training and expertise to evaluate the necessity of the requested drug, item or service. This would not require the reviewing physician to be trained in the exact specialty or sub-specialty as the treating physician.

While this may be acceptable for some reviews of medical necessity, AAMC member institutions and their associated providers provide cutting-edge, specialized care that often is unavailable at other institutions. Our concern that it may not be possible to meet this standard if the treatment or service in question is for the specialized and sub-specialized care that often is provided only at teaching hospitals. Therefore, while reviews of certain medical necessity claims for treatments at these facilities and by these providers would necessitate that the reviewing physician have the same level of expertise and training as the treating physician, when that is not possible the reviewing physician should be required to consult with the treating physician and/or a physician trained in the same specialty or sub-specialty to inform their decision making.

MEDICARE PARTS A, B, C AND D OVERPAYMENTS

CMS is proposing to amend existing regulations to Medicare Parts A, B, C, and D regarding the standard for when an “identified” overpayment must be refunded. Currently, the overpayment regulations state, “A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.”¹² A provider is required to refund an overpayment within 60 days of identifying the overpayment. The 60-day time frame begins when the reasonable diligence is completed. This reasonable diligence standard allows an entity to determine the credibility of the potential overpayment and to conduct an internal investigation during which an entity quantifies the overpayment before the 60-day time frame is triggered.

In the proposed rule, CMS suggests replacing the “reasonable diligence” standard with the following standard: “A person has identified an overpayment when the person knowingly receives or retains an overpayment.” (p. 79559). In this case, the term “knowingly” has the same meaning as defined in the False Claims Act. As a result, an overpayment would be “identified” when the entity has actual knowledge of an identified overpayment or acts in reckless disregard or deliberate ignorance of an identified overpayment, and the provider would be required to refund within 60 days of the identified overpayment.

This proposed rule seems to pull back regulatory language that permits quantification of the identified overpayment. In previous rulemaking CMS clarified that “part of the identification is qualifying the amount, which requires a reasonably diligent investigation.”¹³ Therefore, we ask that CMS clarify that providers will continue to have a sufficient opportunity to conduct a

¹² 42 CFR 401.305(a)(2).

¹³ 81 FR 7661

reasonably diligent inquiry into whether a refund obligation exists and to quantify the overpayment before the 60-day time frame begins to run.

AAMC members report that once an overpayment is identified it often takes months to fully investigate and quantify the amount of the overpayment. The process of identifying and quantifying an overpayment is complex and may involve significant data analysis. It would be nearly impossible to thoroughly investigate, quantify, and identify any refund 60 days from learning of a possible issue, especially when multiple payers are involved. We therefore request that CMS make clear that the government still expects reasonable and professional efforts to be undertaken to determine if there is an overpayment and to quantify the amount, even if that process takes additional time to complete. Therefore, the rule should clarify that providers should have adequate time to quantify the overpayment before the 60-day reporting requirement is triggered.

ENHANCEMENTS TO THE MEDICARE ADVANTAGE AND MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAMS

Finalize the Proposal to Add New Behavioral Health Specialists in MA Networks

CMS is proposing to add three new provider types to the list of behavioral health specialists in Medicare Advantage networks. The new specialty types that must be included in MAOs networks to meet the network adequacy requirements include clinical psychology, clinical social work and a category called Prescribers of Medication for Opioid Use Disorder.¹⁴ (p. 79489). The AAMC supports the addition of these behavioral health providers as a requirement for network adequacy. Further, we thank CMS for listening and responding to stakeholders' concerns that patients struggle with accessing behavioral health providers.

However, provider inclusion in a network does not guarantee access. Low reimbursement rates limit access to in-network providers, including behavioral health specialists. Reimbursement rates should reflect the time and resources needed to provide care. CMS should monitor MA beneficiaries' access to all providers, including behavioral health providers, to determine whether low reimbursement rates contribute to poor access. Further, behavioral health specialists included in the network must be accepting new patients. It is not enough to have behavioral health specialists listed on a network. To address access, they also must be accepting new patients.

Finalize Proposal Requiring Access to Out-of-Network Providers for Beneficiaries Enrolled in Coordinated Care Plans

The AAMC supports CMS' efforts to ensure MA beneficiaries have access to medically necessary care by strengthening network adequacy requirements and to clarify that MAOs offering coordinated care plans must arrange and provide coverage for medically necessary care even if care must be provided by an out-of-network provider. CMS is proposing to require

¹⁴ Prescribers of Medication for Opioid Use Disorder includes two specialty types: providers with a waiver under section 303(g)(2) of the Controlled Substances Act and Opioid Treatment Programs (OTPs).

MAOs offering coordinated care plans to also arrange for any medically necessary covered benefit with out-of-network providers. (p. 79493). However, CMS must continue its oversight of MAOs to ensure that they meet the network adequacy requirements to ensure beneficiaries have access to a variety of in-network and, if necessary, out-of-network, providers and facilities that provide primary care, specialty and sub-specialty care and behavioral and mental health care.

Insurers, including MAOs, are replacing robust provider networks with narrower networks claiming that it lowers enrollees' expenses such as premiums and cost sharing. However, narrow networks limit patients access to a select number of providers and hospitals, often decreasing access to hospitals and providers that furnish specialized care. Limiting patients' access to certain providers can be particularly detrimental for patient groups that already suffer from disproportionate levels of disease and death.

Teaching hospitals and their associated physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. However, teaching hospitals and their associated faculty physicians are sometimes excluded from insurer networks. Excluding these institutions and physicians limit patients' access to specialized and sub-specialized care that often is only furnished at teaching hospitals. Ensuring that MA plans have robust provider networks, including teaching hospitals and their associated providers, will safeguard beneficiaries' access to a greater number and type of providers, to meet their health care needs.

CMS is also proposing that beneficiaries receiving medically necessary care furnished by an out-of-network provider or facility should only be responsible for in-network cost sharing. (p. 79493). While the AAMC supports limiting beneficiaries' financial obligation for out-of-network care, out-of-network providers should not be required to accept in-network reimbursement for their services. MAOs should be required to reimburse out-of-network providers at a rate that accurately reflects the services provided.

Finalize Proposal to Extend Time Frames to Notifying Beneficiaries of Provider Contract Terminations

CMS is proposing new requirements for MAOs to provide affected enrollees notice of contracted provider terminations with specific requirements for primary care and behavioral health provider contract terminations. Per the proposed rule, the new requirements are "intended to raise the standards for stability of enrollees' primary care and behavioral health treatments." (p. 79495).

Under current regulations, MAOs can make changes to their networks at any time during the plan year as long as they continue to furnish all Medicare-covered services in a non-discriminatory manner, meeting established access and availability requirements and ensure continuity of care for enrollees. Because CMS feels that provider terminations could impact beneficiaries' access to care and established relationships with providers, CMS requires notification to MA enrollees when a provider network participation contract terminates. (p. 79494). This proposed rule seeks to make sure that the time frame that MA plans must notify beneficiaries of contract terminations is sufficient for beneficiaries to seek care from another provider.

CMS is proposing more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. If finalized, MAOs would be required to inform enrollees who are patients – past or present¹⁵ – of a primary care provider or behavioral health provider whose contract is terminated. Additionally, MAOs would be required to notify enrollees – both in writing and by telephone – at least 45 calendar days before the effective date of the contract termination that involves a primary care or behavioral health provider, which is longer than the 30-day standard that is required for all other specialty types. We suggest CMS require 45 calendar days to notify enrollees of contract terminations for all provider types regardless of specialty. Specialized and sub-specialized care may not be easily available to some patients, and it may take a patient longer to find another provider who can furnish this care.

Results of the Medicare Payment Advisory Commission’s 2022 beneficiary survey revealed that of the 11 percent of beneficiaries who reported looking for a new primary care provider, more than half had trouble finding one. Moreover, more than a third of the 26 percent of beneficiaries looking for a new specialist had trouble finding one. As a result, 18 percent of beneficiaries surveyed reported foregoing care and 4 percent said they couldn’t get an appointment soon enough.¹⁶ The additional 15 days will assist beneficiaries in finding a new provider and not experience a gap in care.

We support the proposals and feel that increasing the notification timeframe will assist impacted beneficiaries in deciding whether to seek care from another provider or continue care even though the provider is no longer part of the MA network. Moreover, provider contract terminations highlight the necessity for MAOs to maintain robust networks of providers and up-to-date provider directories. Provider directories that do not reflect all available providers, specifically identifying those who are accepting new patients, result in some patients without any options to find a new provider.

CMS is soliciting comments on whether a beneficiary negatively impacted by a provider contract termination should be viewed as someone who is experiencing an exceptions condition and therefore is eligible for a special election period (SEP). CMS also seeks comment on whether it should adopt a new SEP for this type of provider contract termination, with explicit standards for when termination of a provider from the network should serve as a basis for SEP eligibility. (p. 79497). We support CMS finalizing a policy that would allow for a new SEP for beneficiaries negatively impacted by provider contract termination, particularly those that cannot find another provider within the network. As noted earlier, narrow networks can limit beneficiaries access to providers; lack of access could be exacerbated secondary to provider contract terminations.

¹⁵ MAOs would be required to notify all current enrollees who have ever been patients of primary care or behavioral health provider or providers leaving their plan’s network, regardless of whether these enrollees currently engage with the providers on a regulatory basis.

¹⁶ Findings from the Medicare Payment Advisory Commission’s 2022 beneficiary survey.

<https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf>

TERMINATION OF SERVICES IN POST-ACUTE CARE

CMS seeks comments in response to stakeholders' concerns that some MAO enrollees are receiving notification of early termination of coverage in post-acute care settings before the beneficiary is healthy enough to return home. Moreover, in some situations the MAO has issued a second termination letter even after the Quality Improvement Organization (QIO) overturned the initial denial of post-acute care after a beneficiary appeal. Denying post-acute care, particularly for patients receiving facility-based care, needlessly imposes additional stress on both patients and families.

We support efforts to ensure that beneficiaries receive the necessary post-acute care in the correct setting. However, MAOs should not be permitted to stop post-acute care without providing the beneficiaries with a time frame or end date of the coverage. MAOs should be required to consult with the treating physician to determine a plan of care that includes discharge from post-acute care. Unfortunately, some beneficiaries discharged early from the post-acute care setting before they are healthy enough to go home decompensate and return to the emergency department sometimes necessitating an inpatient admission to stabilize the patient. This unnecessarily leads to a cycle of being transferred among acute and post-acute settings. Additionally, if a patient returns to the emergency department within 30 days of discharge and requires an inpatient admission, this may negatively impact a hospital's readmission rate. We urge CMS to limit MAOs' ability to deny care without discussing the patient's plan of care with the treating physician. MAOs should not be allowed to retroactively deny post-acute care.

PART C AND PART D MID-YEAR BENEFIT CHANGES

CMS is proposing to prohibit any changes to non-prescription drug benefits, cost sharing, and premiums starting after the MA plans are permitted to begin marketing prospective contract year offerings on October 1 of each year for the following contract year and through the end of the applicable contract year. In other words, beginning for plan year 2024, once marketing for the upcoming plan year begins, MA plans must offer the benefits described in approved bids through the end of the contract year. Plans are prohibited from making changes not included in the approved bid. (p. 79515). The AAMC supports this clarification. Some mid-year benefit changes can negatively impact beneficiaries access to needed care or their ability to afford this care.

EXPANDING ELIGIBILITY FOR LOW-INCOME SUBSIDIES UNDER PART D

CMS proposes to amend the regulations for Medicare beneficiaries who qualify for the Part D low-income subsidy (LIS) in response to the statutory changes to the program under Section 11404 of the Inflation Reduction Act (IRA). The IRA expanded eligibility for the full LIS beginning on or after January 1, 2024, effectively allowing individuals who qualify for the partial subsidy to begin qualifying for the full LIS. The AAMC supports these regulatory amendments as proposed to implement the expansion of the LIS in accordance with the statutory changes to assist qualifying Medicare beneficiaries pay for prescription drugs through assistance to pay for Part D premiums and deductibles and reduced cost sharing. Additionally, we recommend that

CMS commit resources to effectively communicate this change directly with Medicare beneficiaries and with community organizations that assist Medicare beneficiaries with enrollment and accessing their Medicare benefits.

MEDICARE ADVANTAGE AND PART D MARKETING

CMS Should Coordinate with Federal Partners Prior to Finalizing Policy for MA Provider Directories to Identify Providers Approved to Treat Patients with Medications for Opioid Use Disorder (MOUD)

CMS proposes to amend the MA Provider Directory requirements to require organizations to identify providers “who have obtained a waiver under section 303(g)(2) of the Controlled Substances Act from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) to treat patients with MOUD and who are listed on SAMHSA’s Buprenorphine Practitioner List.” The AAMC agrees that this would support the agency’s health equity objectives in part by allowing MA beneficiaries to better identify providers that have specialized training to provide MOUD. However, we ask CMS to clarify how this might interact with state laws on controlled substances and whether such information is also needed to support identification of licensed providers. Additionally, after issuing this proposed rule in December 2022, Congress, through the Consolidated Appropriations Act, 2023, eliminated the waiver requirements for dispensing certain narcotic drugs for maintenance or detoxification treatment¹⁷ and added a training requirement,¹⁸ which in turn might require CMS to revise this proposal after coordination with SAMHSA and the DEA.¹⁹ We ask that CMS clarify in the final rule how this proposal aligns with these new requirements.

¹⁷ See, [Pub. L. No. 117-328](#), Consolidated Appropriations Act, 2023, Sec. 1262 (Dec. 29, 2022), stating “Section 303(g) of the Controlled Substances Act is amended – (1) by striking paragraph (2)[.]”

¹⁸ See, *ibid* at Sec. 1263, adding to Section 303 of the Controlled Substances Act a new subsection (1) entitled “Required Training for Prescribers”

¹⁹ See, SAMHSA’s [Center for Substance Abuse Treatment](#), which states “Congress has taken action in the recent Consolidated Appropriations Act, 2023 that impacts federal requirements for Drug Enforcement Administration (DEA) registrants, including those involved in OUD treatment. SAMHSA and DEA are actively working to develop further guidance related to these changes. Please frequently check this webpage for further updates and guidance.” (Last accessed February 2, 2023).

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We would be happy to work with CMS on any of the comments discussed in this letter or other topics that involve the academic medicine community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at mmullaney@aamc.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Jaffery', with a stylized flourish at the end.

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief, Health Care Affairs

Cc: David Skorton, M.D., AAMC President and Chief Executive Officer
Ivy Baer, JD, MPH, Senior Director and Regulatory Counsel