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Coalition of State Rheumatology Organizations

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May 21, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4207–NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure,

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist. We appreciate the opportunity to provide insights and recommendations in response to CMS's Request for Information on Medicare Advantage (MA) data. Our comments below are supplemental to comments we have also provided through our coalition partner, the Alliance of Specialty Medicine. Taken together, our recommendations would drastically improve the availability of data and information for CMS and beneficiaries.

Beneficiary Access to Care

CSRO remains concerned about the inadequate access to specialty care within MA plans. Current CMS standards lead to insufficient network adequacy, as evidenced in Florida, where one large MA plan terminated more than 2/3 of rheumatologists from their networks for "no cause." In Palm Beach County alone, 32 rheumatologists were terminated, leaving only 9 left to care for patients in the largest county in the state. We appreciate that CMS met with CSRO and the Florida Society of Rheumatology (FSR) to discuss this issue, and at the request of one practice, conducted a network review. CMS shared with the practice that it recognized the number of rheumatologists eliminated was significant, but said the plan still met CMS' network adequacy criteria.

While CMS deems the network "adequate," enrollees continue to report extreme difficultly accessing care, including the medication therapies they have been prescribed. Eliminated practices have attempted to work with plan to restore their "in-network" status – even just temporarily for those patients with the greatest need – to no avail.

This development illustrates why we are deeply concerned that the criteria that CMS uses to determine network adequacy are flawed and must be revised, particularly for rheumatology. To address our concerns and that of our patients enrolled in MA plans, we recommend that CMS adjust physician-to-beneficiary ratio,

as well as its time/distance standards to reflect the actual needs of beneficiaries, particularly in specialties with critical workforce shortages, including rheumatology. We also recommend that CMS implement wait time standards for specialists, including rheumatology, to ensure timely access to care. Recognizing the relationship between network adequacy and provider directories, we recommend that CMS strengthen enforcement of accurate, real-time provider directories and impose penalties for non-compliance. CMS should also consider requiring plans to populate their directories based on the information practices provide to CMS when enrolling in the Provider Enrollment, Chain, and Ownership System (PECOS) system.

Utilization Management

Utilization management practices, including prior authorization and step therapy, delay patient care and pose significant barriers to treatment, particularly in rheumatology where the majority of therapies are subject to these tactics. While we appreciate CMS' recent efforts to address these issues, more needs to be done. For one, CMS must equally apply its prior authorization policies and public reporting requirements to ***all medications*** including those covered under medical (Part B) and pharmacy (Part D) benefits. IN addition, CMS should implement recommendations from the Department of Health and Human Services (HHS) Office of Inspector General (OIG), as outlined below:

- CMS should direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.
- CMS should update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria, and/or examine particular service types.

Finally, CMS must eliminate the 2018 step therapy policy, which creates more delays and barriers to the therapies our patients require.

Marketing

Misleading marketing practices continue to affect beneficiaries, particularly regarding physician access and medication coverage. We see this firsthand in rheumatology, where patients enroll in MA plans only to find that their rheumatologist is not in the network and their medications are not on formulary, which has a detrimental impact on their care and treatment plan. We recommend that CMS provide clarity on the responsibility of MA plans when it comes to the Pre-Enrollment Checklist (PECL), and specifically, require MA plans to detailed information on physician network status and medication formulary coverage in pre-enrollment materials. We also urge CMS to enforce transparent marketing practices, and impose penalties – including termination from the MA program – when MA plans do not follow CMS' requirements.

Quality Measures

You may recall that the CMS' CY 2019 Medicare Advantage and Part D Policy and Technical Changes Proposed Rule solicited feedback about a physician/plan interactions survey, but in the 2020 Advance Notice, CMS reported that "*the vast majority of commenters recommended against a mandatory survey*," citing concerns such as burden, potential for skewed results, and that most plan interactions are with centralized staff. We are concerned that physician organizations were likely unaware of the proposed measure concept and therefore did not comment. CSRO, along with its coalition partner, the Alliance of Specialty Medicine, have urged CMS to reconsider this potential measure concept. Specifically, we urge CMS to adopt a composite measure that relies on a survey of physicians about their interactions with MA plans. Questions should focus on the following:

- **Network adequacy**, including the accuracy of physician directories and physician termination and reinstatement practices;
- **Payment and reimbursement practices**, including the sufficiency of payment rates, the volume of denials and post-payment medical reviews, and other tactics that deny or slow payment after services are rendered;
- **Contract negotiation**, including the process used to negotiate payments to the provider;
- **Utilization management**, including prior authorization practices, step-therapy requirements, non-medical switching of medications, and other administrative barriers that inappropriately diminish or slow beneficiary access to medically necessary diagnostic and therapeutic services and treatment; and,
- **Other administrative burdens**, including referral requirements and the number and type of medical record documentation requests, including those required as part of CMS' Risk Adjustment Data Validation and those required by the plan to establish additional diagnosis for proposes of increasing beneficiary risk scores.

Other Data Needs: Medications

The practice of "white bagging" poses challenges and risks to patient care. We urge CMS to address this issue by improving data collection and transparency by taking the following actions:

- Merge PDE and Part B Claims Data: Enable better identification of white bagging practices.
- Revise PDE Collection Tool: Capture detailed information on provider-administered medications.

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Thank you for considering our feedback on this important issue to our patients enrolled in MA plans. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

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President

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