Alliance of Specialty Medicine

Sound Policy. Quality Care.

March 4, 2022

Meena Seshamani, MD, PhD
Director, Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20201
Submitted electronically via Regulations.gov

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (CMS-2022-0021)

Dear Dr. Seshamani:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians and is deeply committed to improving access to specialty medical care through the advancement of sound health policy. Today, we write in response to the aforementioned advance notice on issues that impact practicing specialty medicine physicians and the Medicare Advantage (MA) and Part D Plan enrollees they serve.

Medicare Advantage Plan Payments

MA plan revenue is anticipated to increase by 7.98 percent from the prior year, not counting the 5 percent Quality Bonus Payments for plans with at least 4 stars. These increases are unconscionable at a time when physicians face an onslaught of reimbursement reductions under the CY 2023 Medicare Physician Fee Schedule due to ongoing budget neutrality adjustments, the Medicare and PAYGO sequesters and other payment policies. Unlike other Medicare payment systems, the payment formula for physicians does not reflect inflation, which will exacerbate these expected pay cuts, especially at this time of historically high inflation.

Moreover, the Alliance has repeatedly urged the agency to address egregious utilization management practices by MA plans, including prior authorizations and step-therapy, as well as rampant "chart audits" under the guise of CMS-mandated Risk Adjustment Data Validation (RADV) reviews. In fact, the American Medical Association (AMA) recently released results from a physician survey on the impact of prior authorization that found more than nine in 10 physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients

abandon treatment due to authorization struggles with health insurers[1]. The widespread use of prior authorization has become a primary tactic by MA plans to manage costs, ultimately overruling physicians' clinical expertise and disrupting patient care.

Furthermore, the use of "chart audits" are driven by the plans to increase their risk scores and seek higher payments from the Medicare program and taxpayers. The strategy is working, judging by the almost 8 percent payment increase for MA plan revenue. However, it adds insult to injury for physicians: many of them face double-digit payment cuts, while they must spend an ever-increasing portion of unreimbursed time fighting MA plans on the very audits by which MA plans increase their own payments. This is a winning formula only for insurance companies. Every other stakeholder in the Medicare program, from beneficiary to taxpayer, experiences higher costs, reduced access to quality care, or both.

We urge CMS to reassess its MA policies and address the challenges we've highlighted, which contribute to significant overpayments and waning quality for seniors.

Quality Rating System

Changes to Existing Star Ratings Measures in 2023 and Future Years

Complaints about the Health/Drug Plan (Part C and D)

In the notice, CMS reviewed MA plan complaints and found that these "primarily originate from beneficiary confusion around misleading marketing materials and/or inadequate training of marketing personnel." As a result, CMS seeks feedback on including additional measures to "hold plans accountable for these issues in the performance measures."

The Alliance strongly supports efforts to tie MA complaints to plan performance. Our practices frequently hear from patients who have inadvertently joined an MA plan without fully understanding the implications of that choice. Anecdotally, this issue occurs more in certain specialties, such as rheumatology, where patients have high ongoing medication needs. In some cases, these individuals believed they were securing supplemental drug coverage, only to find they had given up their Part B benefits for a Medicare Advantage plan they didn't want to join. Indeed, these new enrollees soon learn that their ability to access specialty care and treatment, including medications for their chronic diseases, is severely hindered. In some instances, new enrollees have found that they can no longer see their specialty medicine provider or another similar specialist because MA plans have extremely narrow networks. Some new enrollees have also been forced to switch to a new medication, even if they were stable on their current therapy because the prescribed drug is not "preferred," nor is it even on the plan's formulary.

We hope that CMS's proposal to redefine "negotiated price" may help address the underlying issue of plans artificially lowering premiums to attract beneficiaries. However, ***to ensure beneficiaries are protected from inadvertently enrolling in plans that will not meet their medical needs, we urge CMS to include, in future rulemaking, additional complaints measures in the Stars Ratings.***

[1] See AMA Infographic on 2021 Prior Authorization Survey, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

Potential New Measure Concepts and Methodological Enhancements for Future Years

The Alliance has previously commented on additional quality measure concepts that would improve access and quality, including measures that would transform care and drive quality through value-based initiatives. Specifically, we urged CMS to:

- ***Establish a stars measure that would award points to MA plans that maintain an adequate network of specialty and subspecialty physicians, including those that participate in the Quality Payment Program (QPP).*** As noted above, narrow networks impact enrollee access to high-quality specialty medical care. Specialty and subspecialty physicians continue to be eliminated from MA plans, frequently in the middle of a plan year, leaving enrollees with limited or no access to care for chronic health conditions, such as glaucoma, macular degeneration, rheumatoid arthritis, lupus, and skin cancer, which are best managed by specialists with expertise in those disease areas. When a plan does not have an adequate network of specialty and subspecialty providers, it is impossible for seniors to access the full range of providers and treatments they may need, thus diminishing quality and outcomes. Often, enrollees may not realize they need specialty medical care until after they have enrolled in a plan and new symptoms present or an existing condition worsens. Establishing a measure tied to network adequacy would incentivize MA plans to retain specialty and subspecialty physicians as "in-network" when they can demonstrate their broad contributions to improved quality and resource use, which may be shown through their participation in CMS' QPP, through the Merit-based Incentive Payment System or Advanced Alternative Payment Models.
- ***Establish a stars measure based on a survey of physicians' experiences with MA plans, which could be developed in collaboration with the Alliance and other professional associations.*** Questions should focus on:
    - 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;
    - 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 the number and type of medical record documentation requests.

Other Concerns

CMS previously sought feedback on the nature and extent of medical record documentation requests by MA plans, including ideas to address this burden. As noted earlier, MA plans continue to misrepresent medical record requests to specialty physician practices as CMS-initiated mandatory RADV audits. In reality, these requests are usually plan-initiated and designed to identify additional diagnosis codes, which assist the plans with increasing their "risk scores," thereby increasing their payments from Medicare.

Preparing for these deceptive audits is daunting for already burdened physician practices. More importantly, we are concerned that plans are over-reaching to establish additional diagnoses, which

raises serious concerns about accuracy in Medicare Advantage coded data — an issue that has been raised by the agency and Congressional advisors.[2]

Moreover, the scope and volume of medical record requests are tremendous, with some requests seeking hundreds of records per physician. Furthermore, these requests include untenable submission deadlines, sometimes mere days after the request. Practices that fail to comply have been told their contracted rates will be lowered, or worse, that they may be terminated as in-network providers.

To address these issues, we urge CMS to require MA plans to:

- ***Follow a standardized process for all medical record requests;***
- ***Clearly identify the nature of their medical record request (e.g., RADV, other purpose) and provide written documentation when requests are mandated as part of CMS-initiated audits;***
- ***Provide reasonable deadlines for medical record submissions, as well as a process for extending the submission deadline for extenuating circumstances;***
- ***Limit the number and volume of medical record requests (e.g., no more than once per year and no more than 20 records per physician);***
- ***Allow practices to submit medical records through a secure web-portal, on CD/DVD, or by fax, when possible; and***
- ***Reimburse practices for completing medical record requests at a rate no less than is set under State law.***

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Thank you for considering our feedback as you promulgate rulemaking to address these and related issues. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Association of Neurological Surgeons
American Academy of Otoloaryngology-Head and Neck Surgery
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Plastic Surgeons
American Society of Retina Specialists
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists

[2] See Medicare Payment Advisory Commission March 2021 Report to the Congress, The Medicare Advantage program: Status Report, pp. 374 – 385, https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf