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555 E. Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Phone: 414-918-9825
Email: info@csro.info
Website: www.csro.info

August 30, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4203–NC
P.O. Box 8013
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Requests for Information (RFI) on the Medicare Advantage Program

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.

For CMS to better align Medicare Advantage with the aims discussed in its Vision for Medicare and Strategic Pillars, it must address longstanding issues that harm beneficiaries who enroll in these plans, and burden the providers that care for them. We provide information on those issues in the sections below and urge CMS to take action as part of its initiatives.

Misleading Marketing Materials

In its CY 2023 rulemaking, CMS said it received complaints from beneficiaries about Medicare Advantage plans they had enrolled in, sometimes without their knowledge. CMS noted that the complaints "*primarily originate from beneficiary confusion around misleading marketing materials and/or inadequate training of marketing personnel.*" This does not surprise rheumatology practices considering the "horror stories" we hear on a regular basis.

Our patients, primarily those who are approaching their "Medicare birthday," are frequently the target of grisly marketing campaigns where sales representatives promise a continuation of private health plan benefits once they are Medicare eligible, but later discover access to their physicians and medications are blocked. Our patients have shared with us that plan representatives overstated the extent of the plan's provider network, telling them that their physician is under contract, when in fact the physician is out-of-network. Our patients tell us that plan agents confirm their medications will continue to be covered, only to discover from their physician or pharmacist that the therapy is off formulary, or subject to increased cost-sharing or utilization management tactics, such as step therapy. Some of the most egregious stories are those when an enrollee was unaware, they were being switched, and finds out after their doctor files a claim to traditional Medicare and it is denied.

CMS must hold plans accountable for misleading marketing and false claims. When a plan is found to have engaged in such practices, the plan – not just the marketing agent – should be suspended or barred from Medicare, and face civil monetary penalties.

Equally important, ***CMS must ensure that Medicare Advantage plans are truly offering the same level of access and coverage to their enrollees as beneficiaries in traditional Medicare.*** While the Medicare Advantage industry touts a 94% satisfaction rating[1], we know first-hand that seniors with complex chronic illnesses (such as rheumatoid arthritis) who require a higher level of care by specialty providers and who depend on high-cost therapies to manage their disease, are not well reflected in these surveys. We would be happy to put you in touch with seniors that have faced undue challenges in accessing care because of their plan's restrictions.

Physicians' Experiences with MA Plans

Rheumatologists that do participate in Medicare Advantage face considerable administrative challenges, including utilization management and medical record requests, as well as inadequate payments. Through the Alliance of Specialty Medicine, we have urged CMS to develop a survey of physicians' experiences with Medicare Advantage plans that would focus on these and other challenges. For example, physicians could be queried on 1) payment and reimbursement practices, including sufficiency of payment rates and volume of denials, including those after prior authorization was obtained; 2) challenges with utilization management, including the volume of prior authorizations, how often prior authorizations are overturned or require additional appeal, and the impact of step therapy on clinical care; and 3) medical record documentation requests, including those that are mandated by CMS and those that are aimed at increasing risk scores, the volume of requests received and how they are presented by the plan, the timeline under which records must be submitted, and the fees Medicare Advantage plans pay to practices for their costs, among other questions.

Again, ***we again ask CMS to develop a survey to collect data on physicians' experience with Medicare Advantage plans, to include this survey in the Quality Ratings System (QRS), and to link scores to the quality bonus payments plan can earn.***

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Thank you for considering our comments, and we look forward to working with you as you finalize policies outlined in this proposed rule. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

Madelaine A. Feldman, MD, FACR
President, Coalition of State Rheumatology Organizations

[1] https://bettermedicarealliance.org/wp-content/uploads/2022/01/BMA_Seniors-on-Medicare-Memo_final3.pdf