



August 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

Dear Administrator Brooks-LaSure:

On behalf of the National Health Council (NHC), I am pleased to respond to the Medicare Request for Information (RFI) on the experience of individuals navigating the Medicare and Medicare Advantage (MA) program.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, sustainable health care. Made up of more than 145 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The growth of Medicare Advantage over the last several years means that this RFI is particularly timely. [Forty five percent](#) of Medicare beneficiaries are enrolled in Advantage plans, up from 31 percent in 2016, according to data from the Kaiser Family Foundation. For people with chronic diseases and disabilities, the choices made when choosing between traditional Medicare and MA, choosing between specific plans, and when navigating their Medicare or MA plan to access care are particularly important. The following are our responses to the specific questions in the RFI of most relevance to patients.

What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

One area of focus should be how MA plans can/are using supplemental benefits to address social drivers of health. Utilizing supplemental benefits to address food and housing insecurity and other drivers is one of the potential advantages to the MA model. However, CMS should put mechanisms in place to track and analyze these efforts to efficacy and assure equal access to these types of services across plans.

In addition, it is critical that we ensure all plans are collecting demographic data that is comprehensive and consistent including data on things such as sexual orientation, gender identity, race/ethnicity, disability status, language, veteran status, and social needs (potentially through improved and better-utilized medical billing Z codes that document SDOH data such as housing status, food insecurity, transportation access, etc.). It is important this be done in a way that protects patients' privacy and rights.

What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

Many people with chronic diseases and disabilities utilize brokers to navigate Medicare and MA. The types of information available can vary greatly depending on the source of information. Meanwhile, the federally funded State Health Insurance Assistance Programs (SHIPs) are unbiased resources that are underutilized. We encourage CMS to both assure that brokers have access to and use the information outlined below and work to enhance awareness of SHIPs.

Patient advocacy groups can also be vital partners as they are often on the forefront of developing tools and resources to help patients navigate plan choice. For example, the National Patient Advocate Foundation has developed a [Medicare Plan Guide](#). CMS should continue to work closely with patient groups to support the development of specific resources and to amplify available tools including the CMS plan finder tool.

What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Recognizing that someone living with a chronic disease or disability will potentially need more information when deciding on what Medicare or MA plan they might need is critical to creating a system that is navigable by all. Some of the information that is difficult to get now that will help people make better decisions includes the following:

- Greater access to information about true out-of-pocket costs a patient may face. This should include specifics and dollar amounts or estimates for coinsurance, copays, and other costs;
- More descriptive information about what higher deductibles can mean. For instance, if you have high usage, a low premium/high deductible plan may look enticing, but you may be better off out-of-pocket with a higher premium and lower deductible;
- Information about what moving between MA and traditional Medicare may mean. For instance, if you choose MA and go back to Medicare you may experience issues because you have lost guaranteed issue for Medigap coverage;
- Ability to track specific drugs and providers and implications for cost, not just whether a drug is covered or if it is preferred/non-preferred or not;
- Access to specialists and preferred providers;
- Data or ratings on the plans use of utilization management and step therapy practices; and
- Data specifically on mental and behavioral health coverages and how that aligns with mental health parity policies.

Not only is this information crucial when deciding between Medicare Advantage and traditional Medicare; it is also imperative when deciding between the various offerings in the Medicare Advantage market. This level of information will assure that patients can make informed decisions about their health care coverage.

What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA?

The pandemic created demand for new ways of delivering care. For example, it drove increased utilization of telehealth and provided learnings on how it can be utilized to deliver high-quality, convenient, patient-centered care to many. As we consider the future role of telehealth, it is important that we create a sustainable model – with appropriate patient safeguards – to ensure

telehealth is equitably available when appropriate. Telehealth should be an option for patients and providers, when preferred and clinically appropriate, that does not supplant the availability of in-person care. In addition, payment policies, including cost-sharing requirements, and provider networks must still support access and in-person availability of providers when appropriate.

First, traditional Medicare telehealth policy should ease technology barriers. Telehealth services should be equitably available through easily usable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. The option of audio-only communication is especially important for rural and low-income populations, as many of these patients lack high-speed internet access. However, audio-only care should be held to a standard that assures it is equivalent to telehealth visits. Billing should also reflect the difference between a short phone consultation and an official audio-only telehealth visit.

Second, traditional Medicare telehealth should preserve and promote patient choice. A patient should have the opportunity and flexibility to choose whether they will access care in-person or via telehealth technologies. In addition, patients should have limited out-of-pocket costs for telehealth services and be no more than what they would pay for an in-person visit. Insurers should not incentivize nor disincentivize patients from using one care site over another — the choice should be based on the right care setting for the patient's individual needs.

Finally, traditional Medicare telehealth should remove geographic restrictions, which place a burden on and can limit both patients and providers when evaluating treatment options for optimal care. This includes allowing providers to practice across state lines through telehealth services increasing access to care and improve care coordination for patients, particularly in underserved areas.

What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services?

For people with chronic diseases and disabilities, access to specialty care can be one of the most important elements of their coverage. These providers are often those most difficult to get an appointment with and to access within a reasonable distance. Often, when individuals are shopping for a plan, the first item they check with prospective plans is whether their providers are in network. This may be more challenging for some individuals than others. CMS should continue to explore innovative ways to make specialty care available, including for people with limited mobility or access to providers including people in rural communities or other underserved communities.

In general, the NHC recommends that network adequacy standards for MA plans be more aligned with those for traditional Medicare. We also recommend additional flexibility to accommodate new and innovative delivery models and virtual consultations that can eliminate geographic barriers. Too often, the specialties that are left out of MA network adequacy standards are those that are most important to people with chronic diseases and disabilities. In addition, it can be particularly difficult if changes to networks are made mid-year and someone with a chronic disease or disability made a plan choice based on the availability of a specific specialty close by.

Behavioral health is an area where needs are rapidly increasing, and efforts need to be undertaken to align provider availability with need. CMS should undertake a broad effort to increase availability of behavioral health in underserved areas and through telehealth to meet people where they are with the care they need.

Finally, access to transportation to connect patients to services is vital in supporting network adequacy. All MA programs should review transportation needs of their members and identify interventions they can offer to connect patients to health care and supplemental benefits.

How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

For people with chronic diseases and disabilities, making decisions about plans and based on supplemental benefits can be complex. On one hand, supplemental benefits can be vital in meeting the unique needs of someone with a chronic disease or disability and/or addressing social drivers of health. Often a supplemental benefit may be the draw that entices someone to choose a particular MA plan, but the plan may not be the one that serves them best for their overall health care needs. For instance, someone may choose an MA plan to gain access to hearing aid coverage, but they may lose access to coverage of other needed benefits. Having the information to navigate the balance between supplemental services and access to health care is critical.

Supplemental services are key to addressing social drivers of health. They can be the primary value of an MA plan for a patient. There are also likely access barriers to utilizing supplemental benefits for those that live in areas with limited access to providers and services, or with transportation barriers. In order to assure equity, CMS should undertake efforts to identify geographic and other barriers that limit individuals' access to supplemental benefits.

As mentioned below, true patient engagement is critical in benefit design. This is also true for supplemental benefits. Plans need to be sure they are designing supplemental benefits that will enhance the care a person with a chronic disease or disability receives. Needed supplemental benefits will look different for someone with a chronic disease or disability, and patients should be central in identifying those services to assure they align with their needs and wants.

How do MA plans use utilization management techniques, such as prior authorization? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

While we understand the potential benefit of utilization management in some cases, the chronic disease and disability community has become greatly frustrated by the additional burden placed on patients, families, and health care providers. For instance, studies have shown that formulary restrictions of anti-seizure medications were associated with significant delays in treatment. In some ways, Medicare Advantage plans may be incentivized to overuse utilization management.

While utilization management protocols may be grounded in sound clinical decision-making, such as prior authorization to limit drug-to-drug interactions or prevent overprescribing of potentially addictive medication, the development of such protocols is typically done without much or any patient input, and the rationale for such decisions is not typically made public. We support oversight and transparency of such practices to inform the patient community as to how decisions are made that have such a direct effect on patients.

The NHC urges CMS to consider the following recommendations to lead to more transparent and consistent utilization management processes by reducing the amount of time and resources providers and patients spend navigating the process and promote quicker patient access to needed therapies:

- Ensure that utilization management protocols, including step therapy and prior authorization, are aligned with clinical guidelines as well as peer-reviewed clinical studies when updated guidelines are unavailable;
- Ensure that patients do not have to repeatedly “clear” prior authorization and step-therapy hurdles each year or each time they change plans;
- Retain CMS’ current limitation that step therapy cannot be applied to patients that are stable on their treatments;
- Clarify that MA plans must grant an appeal, authorization, or exceptions request when certain circumstances are met that are in the best interest of the patient and clinically appropriate;
- Ensure that MA plans meet CMS’ [direction](#) to respond to utilization management appeals, prior authorizations, and step therapy exceptions requests within 24 hours for emergencies, and within 72 hours for all other circumstances;
- Require MA plans to get formulary feedback from people with chronic diseases and disabilities and well as clinical experts in geriatrics and care for disabled populations;
- Increase Medicare Advantage (MA) plan accountability for utilization-management tools by reducing opportunities for PBMs to generate a revenue stream for implementing them;
- Ensure that each level of appeal and reconsideration is a meaningful opportunity for the clinician and patient to demonstrate medical necessity; and
- Adopt electronic prior authorization standards for clinicians and plans to use to minimize burden and streamline the process.

What steps could CMS take to enhance the voice of MA enrollees to inform policy development?

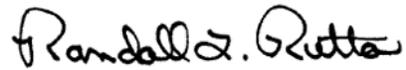
The NHC is a long-standing champion of engaging patients and beneficiaries in any decision impacting their health. The highest quality patient engagement efforts are focused on long-term, relationship-based, bi-directional communication between decision makers and patients. We recommend that CMS develop an infrastructure for this level of engagement with patients and their representatives that goes beyond simple consultation to create a feedback loop to get real time information to questions like those in this RFP and others. In addition, CMS should work with patient advocates and plans to develop guidance on patient engagement in plan design and implementation. For example, CMS can offer plans direction on implementing consumer advisory groups, inclusive of people with chronic diseases and disabilities, to regularly consult on plan design, performance, quality, and other plan activities. The NHC is a willing partner in helping CMS develop these guidelines and infrastructure. Over the years, we have developed a [wealth of tools](#) that can inform the best ways for CMS and plans to engage patients.

Patient organizations can also be a key partner in capturing the patient voice. Since patient organizations are often the first entity a patient contacts for guidance, they have a deep knowledge about how the Medicare system is and is not working for patients. Utilizing patient organizations as partners in creating a patient engagement feedback loop is critical.

Conclusion

The NHC thanks CMS for the opportunity to provide input on these important issues. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these comments in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,

A handwritten signature in black ink that reads "Randall L. Rutta". The signature is written in a cursive style with a large initial 'R'.

Randall L. Rutta
Chief Executive Officer