Date: February 10, 2023
To: The Honorable Xavier Becerra, Secretary, U.S. Department of Health and Human Services
From: Ensemble Health Partners
RE: Comments to Proposed Rule CMS-4201-P

Ensemble Health Partners (Ensemble) respectfully submits this comment to File Code CMS-4201-P, Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024. Ensemble is a revenue cycle management company that provides services to more than 20 health systems across the United States, performing a range of patient access services including obtaining prior authorization in accordance with a payer's requirements. As such, Ensemble has specific experience within the utilization management space that CMS seeks to clarify through rulemaking with respect to Medicare Advantage (MA) plans.

Ensemble supports CMS's proposed rules regarding utilization management requirements for MA plans and agrees with CMS that guardrails are needed to ensure beneficiaries enrolled in MA plans have timely and appropriate access to medically necessary care. In our experience, the disparate utilization management and prior authorization requirements of MA plans create significant, unnecessary barriers that genuinely impede Medicare beneficiaries' access to medically necessary care. To providers, these various prior authorization requirements impose significant administrative and financial costs from accurately identifying where prior authorization requirements exist, to submitting the prior authorization requests in the specific manner and with the specific documentation demanded by the MA plan, to responding or appealing prior authorization denials made by plan clinicians who do not have expertise in the field of medicine applicable to the patient and the requested service. While we may recognize that utilization management tools are an important means to coordinate care, the tools employed by MA plans are too often cynically employed to deny Medicare beneficiaries' access to care and payment to providers for care rendered.

First, CMS proposes that prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria, to ensure that a basic benefit item or service is medically necessary, or to ensure that a supplemental service is clinically appropriate. CMS further proposes to codify at § 422.138(c) that an MA plan later deny coverage or payment of an item or service for which it previously approved for coverage. Ensemble supports these changes to 42 C.F.R. § 422.138. Ensemble fully supports these proposed rules as they will remove currently existing ambiguities as to whether an MA plan will provide coverage for items and services for Medicare beneficiaries.

Second, CMS proposes that MA plans must ensure that any approvals it grants through prior authorization processes will be valid for the duration of the approved course of treatment and that it provides a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan. CMS solicits comment on these two proposals. First, Ensemble supports the requirement that a prior authorization would be valid for the duration of the course of treatment, defined by CMS 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. We believe this will provide both the patient and provider with needed certainty and assurances of coverage before beginning the course of treatment. Ensemble also agrees that a 90-day transition period is necessary to ensure continued availability and accessibility to a previously authorized course of treatment, and further provides assurances and clarity regarding coverage. As it currently stands, MA plans may issue separate authorizations for portions of treatment while denying other portions of treatment. This discourages beneficiary access to medically necessary services and increases costs to providers whose only recourse is to engage in an appeals process that unnecessarily takes resources away from patient care.

Third, CMS proposes that MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS. This proposal is designed to prohibit MA plans from limiting or denying coverage when the item or service would be covered under Traditional Medicare. The proposed revisions indicate that the Traditional Medicare coverage criteria for inpatient admissions, Skilled Nursing Facility (SNF) care, Home Health Services, and Inpatient Rehabilitation Facilities (IRF) would apply to basic benefits in the MA program.

Ensemble fully supports these proposed changes. In our experience, MA plans often use proprietary criteria that is more restrictive than Traditional Medicare's coverage criteria, particularly for inpatient admission coverage. Differing criteria between Traditional Medicare and MA plans confuses Medicare beneficiaries and frustrates providers who are left to navigate each MA plan's idiosyncrasies without assurances of coverage. Ensemble requests that CMS consider stronger regulatory language that would explicitly require MA plans to require coverage of items and services to the same extent as Traditional Medicare, including the Two Midnight Rule and the Inpatient Only List. In our experience, MA plans selectively follow Medicare coverage criteria with the goal of denying coverage. For example, we have experiences where MA plans may deny coverage of an Inpatient Only procedure that was performed inpatient because the MA plan says it could have been performed outpatient. These types of practices on the part of MA plans create unnecessary confusion and barriers to care.

Fourth, CMS proposes that MA plans cannot deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies. When there are no applicable coverage criteria in Medicare statute, regulation, NCD, or LCD, MA organizations may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers. CMS solicits comment on whether it should consider, and under what circumstances, allowing MA plans to have internal coverage criteria in addition to requirements in current regulations. Should MA plans be permitted to have their own internal criteria, CMS proposes requiring them to provide available information that discusses the factors the MA plan considered in making coverage criteria for medical necessity determinations.

Ensemble appreciates these thoughtful and measured considerations by CMS as to whether MA plans may be permitted to create their own internal criteria. Ensemble expresses, however, its concern that MA plans would exploit such permissions to deny care and take providers away from patient care. Staffing shortages and burnout are continued problems from the ongoing pandemic. Healthcare providers and practitioners do not have the time or resources to evaluate the MA plan's publicly available information and determine its appropriateness to the patient's case. In our view, any permissions granted to MA plans to create their own internal criteria outside of Traditional Medicare should be specific and narrowly tailored to avoid undue burdens on patients and providers.

Finally, CMS proposes that MA plans establish a Utilization Management Committee to review all utilization management policies annually, including prior authorization, and ensure they are consistent with current Traditional Medicare's national and local coverage decisions and guidelines. CMS solicits comment on whether it should require the UM committee to ensure that its policies and procedures are developed in consultation with contracted providers. Ensemble supports the consultation of contracted providers in the UM committee because it would provide diversity of viewpoint that would otherwise be missing for optimal value-based care. Specifically, it would be beneficial to require the consultation of physician advisors employed by or aligned with contracted facilities and who have experience with Medicare coverage policies and utilization management.

Overall, Ensemble supports all efforts to streamline the MA prior authorization and utilization management process to ensure beneficiaries receive timely access to necessary care and to remove undue burden from healthcare providers. Ensemble thanks CMS for the opportunity to submit comments on this proposed rule.