Submitted Electronically via www.regulations.gov

May17, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, D.C. 20210

Re: Comments on CMS-4207-NC: CMS, Medicare Program; Request for Information on Medicare Advantage Data (89 *Fed. Reg*. 5907, January 30, 2024)

Dear Administrator Brooks-LaSure,

Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures beneficiaries and other patients receive cost effective, safe, and reliable home care products and services. Our comments on CMS' above-captioned Request for Information (RFI) focus on issues that pertain to Medicare Part B DMEPOS suppliers.

Overall, AAHomecare supports the agency's objective to have comprehensive high-quality Medicare Advantage (MA) plans' programmatic data and promote more program transparency through increased public releases of MA data. We support enhancing data capabilities to gain better insight into current MA programs and increase MA data transparency.

Comments

1. Beneficiary access to care, including details on provider directories and networks.

MA Plans Should be Required to Publish Data Demonstrating They Provide Sufficient Access to Care: CMS should require MA plans to establish clear network adequacy criteria by DMEPOS product category and by geographic area to ensure there is real patient choice. For example, some DMEPOS suppliers only provide respiratory items and services while others only provide complex rehab technology (CRT) items and services. There should be multiple DMEPOS suppliers providing the same product category in a geographic area. CMS and/or the MAPs should establish

metrics to determine when network adequacy has been met for each product category in the DMEPOS space. CMS currently has established time and distance requirements for many other provider types (e.g., hospitals, skilled nursing facilities, physicians and home health agencies). CMS should track and analyze these metrics on an annual basis to determine whether there are access to care issues. AAHomecare recommends that MA plans be required to include these network adequacy metrics in their published in their provider directories. AAHomecare would be happy to work with CMS to develop metrics that would ensure access to care.

When a DMEPOS supplier identifies a potential access issue, there should be a clear channel within CMS for DMEPOS suppliers to escalate its concerns. In the DMEPOS market, access issues can be due to a lack of competition in a market for a particular product category, resulting in essentially no patient choice of supplier.

Data Request: In lieu of a MA plan's attestation of access to care, CMS should require MA plans to confirm compliance via submission of data that meets prescribed access to care metrics, such as:

- Beneficiary satisfaction, complaints, and
- The number of in-network DME suppliers, by product category and by geography. The number should be based upon the number of in-network DME suppliers that have submitted claims within the last 12 months to ensure that only active suppliers are counted.

If an MA plan falls short in meeting any of these metrics, it must add providers to its network to fill the deficiencies within a specified timeframe.

2. **Prior Authorization and Utilization Management, Focusing on Denials of Care and Beneficiary Experiences with Appeals Processes.**

We have the following recommendations to improve the MA plans' prior authorization (PA) processes, with the concomitant need for MA plans to provide data demonstrating that their PA processes are not in appropriately denying access to care.

- AAHomecare recommends that MA plans be required to publish data regarding its appeal process for PA decisions. Our members' experience is that many MA plans lack an objective/impartial and expeditious appeal process for negative PA determinations. We recommend that CMS require MA plans to establish a timely, objective PA appeal process that is available to providers/suppliers and enrollees, to quickly appeal a negative PA determination and ensure access to care. The deficiencies of current MA plan appeal processes are primarily lack of timeliness and a lack of impartiality/objectivity.

  For example, MA plans often deny beneficiaries non-invasive ventilator (NIV) coverage based on application of the wrong Medicare local coverage determination (LCD), the one for respiratory assist devices. Medicare has a national coverage determination (NCD) for

NIVs, but no LCD for NIVs. MA plan coverage should therefore be based on the CMS published NIV NCD.

Furthermore, when a physician prescribes NIV for a patient's lifetime, and the patient meets the Medicare NCD coverage criteria, MA plans often only approve temporary authorizations and later deny continued authorization requests with the same medical documentation originally submitted. This creates gaps in coverage for medically necessary life-sustaining devices. Requiring MA plans to publish data on MA plan PA appeals will reveal access to care issues that other data will not.

- MA Plans should be required to publicly disclose and report whether they are using any form of Artificial Intelligence (AI) as part of the claims processing or PA processes. The algorithms and AI technology standards should be available for free to the public. MA plans often utilize AI for claims processing and PA processes, often incorrectly denying medically necessary services.

- MA Plans should be required to publicly disclose and report all PA statistics for DMEPOS items, by product category. In addition, if an MA plan utilizes third party administrators (TPAs), or if an MA plan owns a DME supplier, those TPAs should be required to report the same metrics, including:

    - The number of PAs requested,
    - The number of PAs approved,
    - The number of PAs denied,
    - Number of PAs that are partially approved or denied,
    - The number of PAs appealed,
    - The number of PAs that are overturned after appeal, and at what level those reversals occurred,
    - The total number of PAs approved and denied within prescribed timeline, such as quarterly, and
    - The number of PAs that are denied based upon technical versus medical need reasons.

- CMS Should Require MA Plans to Publish Data Regarding Its PA Activities, confirming that Affirmative PA Decisions Should Not be Subject to Reversal Based Upon Medical Need: Based upon our members' experiences, many MA plans that issue affirmative PA decisions later reverse those decisions based upon medical need. This obviates the entire purpose of the PA process and should therefore not be allowed. An affirmative PA decision for a DMEPOS item should be conclusive with respect to the medical necessity for that item. Therefore, in the event of an audit, a claim that received an affirmative PA could only be audited for technical issues such as proof of delivery. The audit should not include medical necessity because that is the objective of obtaining a PA decision. MA plans should be required to disclose, with other PA statistics, data confirming that PA decisions do not get reversed based on medical need, in the event of an audit.

- We recommend that MA plans be required to report the credentials and certifications of the individuals who participate in the "peer to peer" reviews that are conducted during the appeals processes.

- We recommend that MA plans should accommodate medical necessity reviews for any provider requested items and services. MA plans could utilize the same PA process that is required of some items/services.

- CMS Should Require MA plans to report the number of PA approvals from Medicare fee for service that it honors, consistent with Medicare requirements of payers honoring prior payer PA decisions for 90 days.[1]

3. Utilization and reliance on algorithms in care provision and decision-making

CMS Should Require MA plans to Report Use of Artificial Intelligence: MA plans often utilize AI for claims processing and PA processes, often incorrectly denying medically necessary services.

4. Comprehensive insights into MA marketing and consumer decision-making processes

Brokers should be required to publicly disclose how many beneficiaries enroll in which MA plan, after the broker communicates the details of those MA plans to beneficiaries. Therefore, brokers should be required to disclose the specific benefits, geographic coverage, and number of beneficiaries enrolled in each MA plan.

5. Data topics specific to Medicare Advantage prescription drug plans (MAPDs)

CMS should require MA plans to disclose data on what benefits they cover under Part D that are also covered under Part B. For example, despite the fact that Medicare has determined that continuous glucose monitors (CGMs) are covered as DME under Part B, and that MA plans are required to provide CGMs under Part B, many MA plans are instead covering these devices and related supplies under Part D prescription drug plans. Many MA plans have recently changed their coverage for CGMs and related supplies from the durable medical equipment (DME) medical benefit to the Part D pharmacy benefit.

We recommend that CMS clarify that CGMs and their related supplies, are excluded from Part D covered drugs, along with other items covered by Medicare Part B within the DMEPOS benefit. This is consistent with the Medicare Part D Manual definition of Part D covered drugs, which states:

> "…medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and

[1] *See* 88 Fed. Reg. 22120 (April 12, 2023), 42 C.F.R. §422.112.

needlefree syringes, can satisfy the definition of a Part D drug. CMS defines those medical supplies to include syringes, needles, alcohol swabs, gauze, and those supplies directly associated with delivering insulin into the body."

Current Medicare policy allows certain medical supplies to be covered under the Pharmacy benefit, but only when those items are not otherwise covered under Medicare Part B. Since CGMs and their supplies are clearly covered under the Medicare fee-for-service DMEPOS benefit, MA plans must provide coverage for CGMs and related supplies under the DMEPOS benefit. Our members have seen a number of MA plans exclude CGMs from their DME benefit and move it to their pharmacy benefit. CMS needs to require MA plans to report what benefits they are providing under the DME benefit versus under the pharmacy benefit to ensure the MA plans are following the requirement that coverage of CGMs and related supplies is under the DME benefit.

6. **Special considerations for specific populations within MA, such as those dually eligible for Medicare and Medicaid, individuals with end-stage renal disease (ESRD), and other enrollees with complex conditions.**

Medicare should require MA plans to report data regarding what denial codes it requires so that other payers, such as state Medicaid programs, can cover items and services denied by the MA plan. Under Medicare fee-for-service, DME suppliers use a GA modifier (with an Advance Beneficiary Notice), to communicate that Medicare is unlikely to cover the item and services, and therefore communicate to secondary payers that Medicare coverage is not available. If MA plans were to utilize the Medicare FFS GA modifier, it would facilitate more seamless coverage for dual eligible beneficiaries.

CMS should require that MA plans report what denial codes or other mechanisms exist to communicate to the provider that it will not cover an item; these denials are necessary to secure coverage from secondary payors. If the MA plan does not have such a modifier, CMS should require MA plans to establish a claim modifier that communicates a denial that can be used for a secondary payer.

Conclusion

Thank you for the opportunity to submit comments on this RFI. Please contact me at TomR@aahomecare.org if you would like any further information.

Sincerely,

Tom Ryan
President & CEO