ALLIANCE of SAFETY-NET HOSPITALS

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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Subject: 42 CFR Parts 401, 405, 417, 422, 423, 455, and 460; Office of the Secretary; 45 CFR 170; [CMS-4201-P]; RIN 0938-AU96; Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

Attention: File Code CMS—4201-P

To Whom it May Concern:

I am writing on behalf of the *Alliance of Safety-Net Hospitals* (formerly the National Alliance of Safety-Net Hospitals), a group of private community safety-net hospitals that serve economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on selected aspects of the rule proposing contract year 2024 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit program and other aspects of Medicare that was published in the *Federal Register* on December 27, 2022 (Vol. 87, No. 247, pp. 79452-79749).

The Alliance of Safety-Net Hospitals (ASH) would like to bring to your attention our views on three aspects of the proposed rule: provisions that address Medicare Advantage plans' utilization management requirements; improving access to behavioral health services; and health equity.

Medicare Advantage Plan Utilization Management

The proposed rule calls for requiring Medicare Advantage plans to establish a utilization management committee to review policies annually to ensure their consistency with Medicare fee-for-service and local coverage decisions and guidelines. When there are no applicable Medicare statutory, regulatory, or national coverage determinations establishing whether an item or service must be covered, the plans must provide current evidence cited in widely used treatment guidelines or clinical literature to CMS, their members, and providers as justification for their internal clinical coverage criteria.

The proposed rule would require Medicare Advantage prior authorization denials to be made only by health care professionals with specific expertise in the medical fields in which they are making such decisions. ASH enthusiastically supports this aspect of the proposed regulation.

ASH also supports the proposed addition of continuity-of-care requirements that make prior authorization approvals valid for the full course of treatment and require Medicare Advantage plans to provide a minimum 90-day transition period when an enrollee in the midst of treatment switches to a different Medicare Advantage plan.

In addition, ASH supports CMS's proposal to permit coordinated care plans to use prior authorization policies only to confirm the presence of diagnoses and other clinical criteria and/or ensure that a service or item is medically necessary.

Improving Access to Behavioral Health Services

The proposed regulation calls for a number of changes designed to enhance Medicare Advantage participants' access to behavioral health services. One such proposal would add clinical psychologists, licensed clinical social workers, and prescribers of medication for opioid use disorders to the list of specialists for which Medicare Advantage plans must meet network adequacy standards; these practitioners also would be eligible for the current 10 percentage point telehealth credit. It also would establish standards for appointment waiting times for both behavioral health and primary care services. ASH believes this proposal would improve access to behavioral health services and supports it.

ASH strongly agrees with a provision in the proposed rule that would clarify that behavioral health services provided on an emergency basis to evaluate and stabilize an emergency medical condition must not be subject to prior authorization.

In addition, ASH agrees with the proposed requirement that Medical Advantage plans must notify their members when those members' primary care or behavioral health providers are dropped mid-year from their plan's provider network.

The proposed regulation also calls for establishing care coordination programs, including coordination of community, social, and behavioral health services, to help move toward parity between physical health and behavioral health services. ASH supports this requirement but urges CMS to delegate responsibility for implementing it to Medicare Advantage plans, not providers and to ensure that it is not burdensome for providers.

Health Equity

In the proposed rule, CMS calls for expanding the list of populations that Medicare Advantage plans must provide services to in a culturally competent manner to include, among others, people who live in rural areas and other areas with high levels of deprivation and who otherwise are adversely affected by persistent poverty or inequality. ASH strongly supports this proposal and hopes that in the future CMS will use its position to do even more to improve access to care and enhance health equity.

ASH is strongly committed to health equity – so much so that we have developed our own proposal for how to use federal health care reimbursement policy to advance health equity. Our proposal to advance health

equity, which we outline briefly for you here, is built around the introduction of new Medicare and Medicaid health equity payments for community safety-net hospitals that play the greatest role in caring for communities across the country with the greatest needs.

A growing consensus has emerged that Americans today do not enjoy equitable access to quality health care. One of the major factors driving this inequity is who pays for care. When Medicare and Medicaid pay they generally do so poorly, driving some providers out of medically vulnerable communities and leaving those who remain with inadequate resources, consigning them to struggle unendingly with older and often outdated infrastructure, limited access to modern medical technologies and treatments, and patients who also need non-medical community and social supports and services for which no payment system, public or private, will ever reimburse them.

The cumulative impact of these and other factors on low-income communities can be seen in the poor health status of their residents: people who are more likely to suffer from heart problems, hypertension, diabetes, asthma, and other medical problems – problems heavily influenced by social determinants of health. Over the years, state and federal governments have attempted to respond to this problem by supplementing their inadequate Medicare and Medicaid payments. These supplemental payments, such as Medicare DSH, Medicaid DSH, and others, have helped – but not enough. The problem remains.
ASH's proposal calls for new, supplemental Medicare and Medicaid payments targeted to communities with the greatest needs. This new approach introduces new, data-based concepts, too, such as "Health Opportunity Zones," "Composite Health Disparity Scores," and "Critical Community Partner Hospitals."

ASH's proposed supplemental Medicare payments – one inpatient and one outpatient payment – are based first on identifying the specific communities where the needs are greatest; then, identifying the individual hospital or hospitals that play outsized roles in serving the disadvantaged residents of those communities; and finally, directing supplemental payments to those community safety-net hospitals based on their service to those individuals. Such communities would be identified based not on county or city or hospital market area but on individual zip codes and the health care utilization and health status of their residents based on data that in the past was not available on such a granular level.

In addition, ASH proposes a new supplemental Medicaid payment to be made only to community safety-net hospitals that meet federal standards for being "deemed" a Medicaid disproportionate share hospital or that provide more than 35,000 days of care to Medicaid-eligible individuals annually. In this manner, these federal resources would be much more finely targeted to the communities facing the greatest challenges and with the greatest needs rather than being administered so broadly to so many recipients that they fail to achieve their policy objectives.

A copy of ASH's full proposal is appended to this letter or you can find it *here*.

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ASH appreciates the opportunity to submit these comments and welcomes any questions you may have about them.

Sincerely,

Ellen Kugler, Esq.

About the Alliance of Safety-Net Hospitals

The Alliance of Safety-Net Hospitals is a coalition of like-minded community safety-net hospitals without dedicated sources of public funding that work together to advocate policy decisions on government health care programs, most notably Medicare and Medicaid, that ensure equitable access to care for the medically vulnerable residents of the communities they serve and adequate public resources for the safety-net hospitals that serve those communities.