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February 13, 2023

The Honorable Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: 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 [CMS-4201-P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Calendar Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Prescription Drug Benefit Programs issued by the Centers for Medicare & Medicaid Services. Founded in 1964, The Society of Thoracic Surgeons is a not-for-profit organization representing more than 7,600 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

Utilization Management (UM) and Prior Authorization (PA) Reform

In the rule, CMS proposes to provide less flexibility for Medicare Advantage organizations (MAOs) to deny or limit coverage of basic benefits than they currently have. Among other UM reforms, CMS proposes to:

- *Codify standards for coverage criteria to ensure that basic benefits coverage for MA enrollees is no more restrictive than traditional Medicare. MAOs would not be able to deny coverage of an item or service based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies. Essentially, plans will have to follow the applicable National Coverage Determination (NCD), Local Coverage Determination (LCD), or Medicare statute or regulation.*
- *When coverage criteria are not fully established in Medicare statute, regulation, NCD, or LCD, an MA plan may create internal coverage criteria that are based on current evidence and widely used treatment guidelines or clinical literature that is publicly available. The plan must provide a*

publicly accessible summary of evidence used to develop the internal coverage criteria, a list of the sources of such evidence, and an explanation of its rationale. Note that CMS is not requiring plans to provide a pre-determination explanation or opportunity for public comment.

- *Current policy permits MAOs to choose who provides benefits through creation of contracted networks. CMS proposes to maintain this, but limit MAOs' ability to curtail when and how benefits are furnished, when traditional Medicare will cover different provider types or settings.*
- *CMS proposes to replace the requirement that practice and UM guidelines be based on reasonable medical evidence or a consensus of healthcare professionals in the particular field with a requirement that UM guidelines be based on current widely used treatment guidelines or clinical literature.*

Additionally, CMS proposes other reforms specific to the use of PA:

- *CMS proposes to limit the use of PA only to confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service, to ensure basic benefits are medically necessary based on standards specified in regulation, or to ensure that the furnishing of supplemental benefits is clinically appropriate.*
- *CMS proposes to codify sub-regulatory guidance that, if a plan approves the furnishing of a service through an advance determination of coverage, it may not later deny coverage or payment based on medical necessity.*
- *CMS proposes limitations on the use of PA to ensure continuity of basic benefits. First, MA coordinated care plans must have, as part of their arrangements with contracted providers, policies for using PA for basic benefits reflecting that all approved PAs must be valid for the duration of the entire approved prescribed or ordered course of treatment or service. Second, CMS proposes that MAOs must have a PA transition policy reflecting that there is a minimum 90-day transition period for any ongoing course(s) of treatment when an enrollee enrolls in an MA plan. During the initial 90 days of enrollment, the MA plan cannot subject any active course of treatment to PA requirements, even if the service is furnished by an out-of-network provider.*

Utilization management tools such as prior authorization have a large impact on the availability and outcome of care. For patients and providers prior authorization requirements can cause unnecessary burden, care delays, and negative outcomes. The American Medical Association (AMA) recently published [data from a recent survey](#) that shows 93 percent of physicians report care delays or disruptions associated with PA and that 34 percent of physicians report that PA has led to a serious adverse event (e.g., hospitalization, permanent impairment, or even death) for a patient in their care. The survey also showed 91 percent of physicians see PA as having a negative effect on their patients' clinical outcomes. Additionally, a [2022 report from the Office of Inspector General \(OIG\)](#) showed that 13 percent of PA requests denied by Medicare Advantage (MA) plans met Medicare coverage rules, and 18 percent of payment request denials met Medicare and MA billing rules.

STS supports CMS' proposals to address the concerns that PA presents to MA beneficiaries and the reform of UM tools to protect timely access to health care. Specifically, STS supports the proposal that MA plans cannot use PA as a tool to delay care and that MA PA requirements should be no stricter than those of traditional Medicare. STS believes that MAOs should work with specialty societies to determine internal coverage criteria and work with newly established UM committees to review clinically appropriate policies and procedures.

Programs of All-Inclusive Care for the Elder (PACE) Proposals

CMS proposed updates to the PACE regulations to address delays in accessing medical specialists for PACE participants. Specifically, CMS proposes to specify in its PACE regulations a list of medical specialty services that PACE organizations must ensure access to as a minimum requirement. PACE organizations are required to execute and maintain a contract with a comprehensive list of specialists including vascular and thoracic surgeons.

STS supports providing comprehensive care for medically fragile patients and we applaud CMS' recognition that in order for this to be achieved, thoracic surgery needs to be included.

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or 202-787-1221 should you need additional information or clarification.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas E. MacGillivray". The signature is fluid and cursive, with the first name "Thomas" being the most prominent.

Thomas E. MacGillivray, MD
President