RRC
Regulatory Relief Coalition

Protecting patients' timely access to care.

Filed Electronically

January 27, 2025

Mr. Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: [CMS-4208-P]. RIN 0938-AV40 Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (2026 MA Proposed Rule)

Dear Mr. Wu:

The Regulatory Relief Coalition (RRC) is pleased to have the opportunity to comment on the Contract Year 2026 Medicare Advantage (MA) Proposed Rule (the "Proposed Rule") referenced above. The RRC is a coalition of national physician specialty organizations seeking to reduce regulatory burdens that interfere with patient care. Our recent activities focus on ensuring that utilization review policies are not a barrier to timely and equitable access to care for the patients we serve.

The 2026 MA Proposed Rule includes several provisions of interest to the RRC, including provisions related to prior authorization (PA), provider directories, MA plans' internal coverage criteria policies, and the Medicare Loss Ratio (MLR). Our comments are set forth below.

Disaggregation of PA Data

First, and most importantly, we are extremely pleased that, consistent with the RRC's prior comments on PA transparency, the Proposed Rule would require that MA plans' PA data reporting be disaggregated and reported based on the individual item or service involved. In its comments on the 2024 and 2025 MA Proposed Rules, the RRC had urged CMS to require MA plans to disaggregate all PA data that is required to be made public under Medicare rules. The RRC believes that it is critical that PA data be disclosed on an individual service basis, since disclosure on an aggregate basis is virtually meaningless to both providers and patients. Moreover, we have long believed that, unless PA data is available on a service level, it will not be possible to focus efforts to reduce the potential disproportionate impact of PA on disabled and dual eligible enrollees to target the particular service lines requiring priority attention.

RRC Recommendation: *The RRC strongly supports CMS' proposal to require MA plans to report PA data on an individual item/service basis.*

RRC Recommendation*: The RRC urges CMS to obtain from MA plans and to publish on the CMS website all PA data that MA plans are required to make public, including, but not limited to, the PA equity analysis data. Publication of these data on a single governmental website will facilitate public access to such data and enable Medicare beneficiaries, providers, and researchers to easily compare MA plans' PA practices.*

The Use of Artificial Intelligence (AI) by MA Plans

The Proposed Rule also emphasizes the ubiquitous role that AI and decision support tools that use machine-based learning have come to play in the healthcare system and the potentially pernicious impact such tools may have on equity and access to care.

RRC Recommendation*: The RRC strongly supports the provisions of the Proposed Rule that state unequivocally that, if an MA plan uses AI or automated systems, it must ensure that these tools do not facilitate or otherwise result in discrimination against Medicare beneficiaries on the basis of any factor that is related to health status*.

Provider Directory

The Proposed Rule also would require MA provider directory data to be submitted for use to populate the Medicare Plan Finder (MPF) tool in a format, manner, and timeframe determined by CMS/HHS and to require MA organizations to attest that this information is accurate and consistent with data submitted to comply with CMS's MA network adequacy requirements.

RRC Recommendation*: We appreciate CMS's effort to ensure provider directories are accurate and accessible. We encourage CMS to work with the provider and patient communities to ensure that provider directories meet patients' needs without imposing significant ongoing administrative burdens on providers.*

Internal Coverage Criteria

The Proposed Rule would enhance the regulations from the April 2023 final rule, specifically those related to the use of internal coverage criteria, by defining "internal coverage criteria," establishing policy guardrails to ensure access to benefits, and adding more specific rules about publicly posting internal coverage criteria content on MA plan websites.

We very much appreciate CMS addressing the ongoing confusion surrounding MA plans' establishment of internal coverage criteria. The Proposed Rule makes it clear that:

> "… internal coverage criteria cannot be used to add new, unrelated (that is, without supplementary or interpretive value) coverage criteria for an item or service that already has existing, but not fully established, coverage policies."

In monitoring MA plans' compliance with the rules surrounding internal coverage requirements, it is helpful that the Proposed Rule explicitly requires MA organizations to identify the plain

language of the applicable Medicare coverage and benefit criteria that they are interpreting or supplementing and provide an explanation of the rationale that supports the adoption and application of the internal coverage criteria in publicly available materials.

***RRC Recommendation**: The RRC strongly supports the changes and clarifications set forth in the Proposed Rule with respect to internal coverage criteria. We believe that adoption of these clarifications, the establishment of the proposed guardrails, and the addition of more specific rules about where internal coverage criteria can be accessed will help ensure that MA enrollees' coverage more closely mirrors the coverage afforded to Medicare Fee-for-Service beneficiaries. In particular:*

- *We support CMS' proposal to require that MA organizations demonstrate <u>through evidence</u> that any additional criteria included in a MA plan's internal coverage policies support <u>patient safety</u> and believe that this requirement is clearer than the current rule, which requires MA plans to balance the benefits and risks of applying internal coverage criteria.*
- *We support adoption of CMS' clear regulatory definition of the term "internal coverage criteria."*
- *We appreciate CMS' reminder that just because an item or service is not included in a Local Coverage Determination, that does not mean that it is not covered.*
- *We support the proposed regulatory text that specifically addresses coverage criteria developed by third parties, and CMS' reiteration that MA plans are ultimately responsible for ensuring that any third party criteria they apply in denying care must meet regulatory requirements.*
- *We support CMS' clarification that MA organizations must understand whether any internal coverage criteria have been built into an automated system, and if so, the specific details of the criteria that are built into the tool must be publicly accessible and meet evidentiary standards.*

***RRC Recommendation**: The RRC strongly supports CMS' adoption of regulatory language that specifically precludes an MA plan from imposing additional coverage criteria that do not have any clinical benefit, and that exist to reduce utilization of the item or service. We believe it is likely that many, if not most, internal coverage criteria adopted by MA plans are adopted solely to contain costs and are unlikely to meet this regulatory requirement. We urge CMS to establish a mechanism for physicians and other providers to report violations of this standard directly to CMS.*

***RRC Recommendation**: The RRC supports the adoption of regulatory language that makes it clear that internal coverage criteria cannot be used to automatically deny coverage of basic benefits without the MA organization first making an individual medical necessity determination.*

***RRC Recommendation**: The RRC supports the adoption of the proposed requirements related to posting of internal coverage criteria. Consistent and accessible reporting of MA plans' internal coverage policies will also provide beneficiaries with the information they need to choose among plans and will provide physicians and other providers with a means to quickly determine whether a particular MA plan imposes special coverage restrictions on a service needed by their patients.*

We also recommend that a link to the MA plan's internal coverage policies be included in the MPF.

Medical Loss Ratio

The Proposed Rule would establish clinical and quality improvement standards for provider incentives and bonus arrangements included in the MA MLR numerator and prohibit administrative costs from being included in quality improvement activities in both the MA and Part D MLR numerator.

***RRC Recommendation**: The RRC supports CMS' proposal to ensure that only bona fide clinical and quality improvement activities are included in the MA MLR numerator and to prohibit administrative costs from being included in the quality improvement activities in both the MA and Part D MLR numerator. We note that while PA requirements are often characterized by MA plans as policies intended to improve quality (i.e., by ensuring that enrollees' care is clinically appropriate), the RRC believes that PA restrictions are generally adopted to cut (or defer payment of) costs, rather than to ensure quality. We believe that the changes described in the Proposed Rule will help ensure that MLR numerator is not inflated through the inclusion of expenditures that are unrelated to legitimate quality improvement activities.*

The RRC very much appreciates the opportunity to comment on the Proposed Rule and applauds CMS for the steps that it is taking to ensure that PA requirements are transparent and that MA plans internal coverage criteria are supported by sound clinical literature and practice.

Respectfully,

Regulatory Relief Coalition Members

American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Osteopathic Association
Association for Clinical Oncology
Congress of Neurological Surgeons
Medical Group Management Association
The Society for Cardiovascular Angiography and Interventions

Regulatory Relief Coalition Allies

National Association for Proton Therapy
Premier, Inc.