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January 27, 2025

Jeff Wu
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically via: regulations.gov
RE: Medicare & Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, and Medicare Cost Plan Programs, and PACE (CMS-4208-P)

Dear Mr Wu:

On behalf of AMGA and its members, we appreciate the opportunity to comment on the "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."

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high-performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. There are over 177,000 physicians practicing in our member organizations, delivering care to more than one in three Americans. Many of our member medical groups participate in the Medicare Advantage (MA) program, both under contract with MA plans and via their own sponsored MA plan offerings. Thus, AMGA is uniquely positioned to comment on various components of the proposed rule.

We appreciate CMS's commitment to promoting patient-centered and high-quality health care across the country. AMGA is pleased to offer the following recommendations for your consideration:

Social Risk Factors and Prior Authorization: While AMGA appreciates CMS' focus on the ramification of prior authorization on health equity, we recommend CMS pursue policies to reduce the use of prior authorization, as opposed to simply reforming it.

Enhancing Rules on Internal Coverage Criteria: AMGA supports CMS' proposal to implement two guardrails for patient access related to plans' use of internal coverage criteria for Part A and Part B benefits.

Equitable Access to Behavioral Health: AMGA supports the implementation of a cost-sharing limit no greater than Traditional Medicare for MA beneficiaries receiving behavioral health services.

Guardrails for Use of Artificial Intelligence (AI): While AMGA supports CMS's proposal to require MA plans cover benefits equitably, regardless of whether the services are provided by humans or automated systems, we believe further action is needed to create patient centric standards across the healthcare industry on use of AI tools.

Part D Coverage of Anti-Obesity Medications: AMGA supports CMS's reinterpretation of Section 1927 (d) of the Social Security Act to permit Medicare D coverage of anti-obesity medications (AOMs).

Promoting Informed Choice: AMGA supports expanding agent and broker requirements to include providing beneficiaries with information on programs that lower costs, and suggests a health literacy-informed approach to information sharing.

Our detailed comments on these provisions of the proposed rule are below:

Social Risk Factors and Prior Authorization

Prior authorization (PA) has the potential to negatively affect underserved communities. CMS previously finalized policies requiring MA plans to conduct an annual health equity analysis of their use of prior authorization, based on certain metrics. This analysis involves evaluating the impact of prior authorization policies on enrollees with specified social risk factors (SRFs) at the plan level by comparing metrics related to the use of prior authorization for enrollees with SRFs versus those without. Currently, metrics are reported in aggregate for all items and services. Under the proposed rule, Medicare Advantage plans would need to analyze how their prior authorization processes affect beneficiaries with identified social risk factors, comparing them to beneficiaries without such factors. CMS is proposing to require more detail in MA comparisons by examining the data by individual services, instead of looking only at the overall impact across all services.

While AMGA supports efforts to better identify trends in the use of PA in order to address its impacts on enrollees with specified SRFs, we believe eliminating prior authorization, rather than adding additional measures or evaluations, would better service patients and providers, while also addressing health equity concerns. PA and restrictive coverage policies continue to be significant barriers that contribute to inequitable care access. We are concerned that seeking alternative ways to enhance the annual health equity analysis, while laudable, can lead to further administrative burdens rather than aiding efforts to advance equity in MA program. We advocate for expedited approvals and removal of PA policies to alleviate the burden of overly restrictive PA policies on all communities and beneficiaries.

Enhancing Rules on Internal Coverage Criteria

CMS proposes to implement two guardrails for patient access related to plans' use of internal coverage criteria for Part A and Part B benefits. The first would prohibit a coverage criterion when it does not have any clinical benefit, and therefore, exists to reduce utilization of the item or service; and the second would prohibit a coverage criterion when it is used to automatically deny coverage of basic benefits without the MA organization making the individual medical necessity determination.

AMGA supports these proposals. Our members are concerned that coverage criteria in MA plans inappropriately limit access to some services in the inpatient and outpatient settings, and the rate of

coverage denials for MA is problematic for beneficiaries enrolled in the program. [1,2] Additionally, in 2022 OIG published a report on MA denials for services that should have been covered under Medicare's statute and the effect of these denials on patients and providers. The OIG stated, "Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers."[3] AMGA believes the proposed guardrails are an important step towards reducing barriers to medically necessary care.

Equitable Access to Behavioral Health Access

CMS proposes to require MA and Cost Plans' in-network cost sharing for behavioral health services to be no greater than the cost sharing in Traditional Medicare. These proposals include:

- A 20% coinsurance or an actuarially equivalent copayment limit for outpatient substance abuse services, partial hospitalization/intensive outpatient services, psychiatric services, and mental health specialty services,
- Zero cost sharing for opioid treatment program services, and
- Coverage of 100% of estimated FFS Medicare cost sharing for inpatient hospital psychiatric services (current standard is 100% to 125% of estimated Medicare FFS cost sharing).

AMGA supports the implementation of a cost-sharing limit no greater than Traditional Medicare for MA beneficiaries receiving behavioral health services, and believes this will help increase access to valuable services for more beneficiaries who are most vulnerable, particularly for those in rural or underserved areas.

Guardrails for Use of Artificial Intelligence (AI)

AMGA agrees with CMS it is necessary to ensure the use of AI does not result in inequitable treatment and/or bias, and is instead used to enhance access to care and person-centered care. If deployed properly, AI has the potential to reduce disparities and advance health equity. For example, providers can use AI to identify disparities and flag patients in need of additional care. However, algorithms reflect both the biases in the data they are trained on and the biases of the people who use them. It is critical these biases are identified and mitigated before deployment to ensure this technology closes gaps in health outcomes rather than widens them.

While AMGA supports CMS's proposal to require MA plans to ensure their services are provided equitably, regardless of whether the services are provided by humans or automated systems, we believe further action is needed to create patient centric standards across the healthcare industry on use of AI tools.

Part D Coverage of Anti-Obesity Medications

AMGA supports CMS's reinterpretation of Section 1927 (d) of the Social Security Act to permit Medicare D coverage of anti-obesity medications (AOMs). Obesity is a chronic disease and has been recognized as

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[1] Gondi S, Kadakia KT, Tsai TC. Coverage Denials in Medicare Advantage—Balancing Access and Efficiency. *JAMA Health Forum.* 2024;5(3):e240028. doi:10.1001/jamahealthforum.2024.0028

[2] The Commonwealth Fund. Medicare Advantage: A Policy Primer. 2024 Update. January 2024. Available at: https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer

[3] U.S. Department of Health and Human Services Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022. Available at: https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/

such by many modern medical associations, including the American Heart Association.[4] The American Medical Association has recognized obesity as a disease since 2013.[5]

The University of Southern California Schaeffer Center for Health Policy and Economics estimates the savings to federal spending from Medicare coverage for AOMs would result in $175 billion in savings of cost-offsets over 10 years.[6] It is well known that untreated cases of obesity lead to other high burden cardiovascular diseases such as diabetes, heart failure, and liver disease. Coverage of AOMs will yield cost offsets and improve health outcomes.

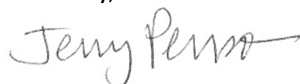
AMGA supports the reinterpretation of the statutory exclusion of "agents when used for weight loss" to allow Medicare Part D coverage of AOMs for individuals diagnosed with obesity, defined by a BMI of 30 or greater, regardless of the underlying causes of the condition. Additionally, we support the expansion of this reinterpretation to Medicaid coverage.

Promoting Informed Choice- Expand Agent and Broker Requirements regarding Medicare Savings Programs, Extra Help, and Medigap

CMS proposes to expand the responsibility of agents and brokers to include providing beneficiaries with information on programs that lower costs, such as the Medicare Savings Programs (MSPs), Extra Help (Low Income Subsidy (LIS)), and Medigap, for MA organizations and Part D plans, to ensure all beneficiary questions are answered. We support CMS's proposal to require MA organizations and Part D plans to require agents and brokers to assist patients in making informed decisions about their health care coverage, particularly for programs that can help decrease patients' out-of-pocket costs.

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, Senior Director of Regulatory Affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,



Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer

[4] Powell-Wiley TM, Poirier P, Burke LE, Després J-P, Gordon-Larsen P, Lavie CJ, Lear SA, Ndumele CE, Neeland IJ, Sanders P, St-Onge M-P; on behalf of the American Heart Association Council on Lifestyle and Cardiometabolic Health; Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; Council on Epidemiology and Prevention; and Stroke Council. Obesity and cardiovascular disease: a scientific statement from the American Heart Association. *Circulation.* 2021;143:e984–e1010. doi: 10.1161/CIR.0000000000000973

[5] The New York Times. A.M.A. Recognizes Obesity as a Disease. 2013. Available at: https://www.nytimes.com/2013/06/19/business/ama-recognizes-obesity-as-a-disease.html

[6] University of Southern California Schaeffer Center for Health Policy and Economics. Benefits of Medicare Coverage for Weight Loss Drugs. 2023. Available at: https://healthpolicy.usc.edu/research/benefits-of-medicare-coverage-for-weight-loss-drugs/#:~:text=After%2030%20years%2C%20we%20estimate,diseases%20in%20the%20Medicare%20population.