National Organization of Rheumatology Management

January 27, 2025

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

Re: CY 2026 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4192-P)

Dear CMS Administrator:

The National Organization of Rheumatology Management (NORM) is a nonprofit organization that promotes education, expertise, and advocacy for rheumatology managers and their practices. We are focused on supporting our patients and pursuing excellence in medical practice management. From that perspective, we submit the following comments on the aforementioned proposed rule.

Utilization Management

Ensuring Equitable Access – Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137)

Medicare Advantage plans frequently employ utilization management strategies such as prior authorization, step therapy, and non-medical switching, which often result in unnecessary delays and barriers to accessing medically necessary care. These practices disproportionately affect Medicare beneficiaries with rheumatologic diseases, where most therapies are subject to these restrictions. Consequently, patients experience prolonged suffering and disease progression due to interrupted or delayed access to essential treatments, along with increased healthcare costs stemming from preventable complications.

To address these issues, we reiterate our prior recommendations that CMS to the following action:

- **Apply Uniform Prior Authorization Policies**: Ensure that prior authorization, including electronic prior authorizations, as well as public reporting requirements, apply equally to medications, including those covered under Parts B (provider-administered) and D (self-administered).
- **Eliminate Step Therapy Policies**: Withdraw the 2018 step therapy policy, which requires patients to "try and fail" less-effective treatments before receiving the therapy originally prescribed by their physician, to reduce delays and barriers to essential therapies that lead to unnecessary suffering, prolonged illness, and increased costs.
- **Address Vulnerabilities in Utilization Management**: Implement recommendations from the HHS Office of Inspector General to reduce errors and improve audit protocols. CMS should direct MA plans to identify and address vulnerabilities that can lead to

manual review errors and system errors, enhancing the overall efficiency and accuracy of the utilization management process.

Marketing Practices

Promoting Informed Choice – Expand Agent and Broker Requirements regarding Medicare Savings Programs, Extra Help, and Medigap (§§ 422.2274 and 423.2274) and Enhancing Review of Marketing & Communications (§§ 422.2260 and 423.2260)

We greatly appreciate CMS' ongoing efforts to address misleading marketing practices that adversely impact enrollees. Many of the concerns we raised previously were addressed through modifications to the pre-enrollment checklist (PECL), and we appreciate that CMS proposes further improvements to address other significant concerns. As we have shared before, beneficiaries who choose an MA plan during their initial enrollment or switch to an MA plan from traditional Medicare with a Medigap plan find it difficult to return to traditional Medicare. This is particularly true for those with rheumatologic and musculoskeletal diseases, as patients often cannot pass the medical underwriting required by supplemental insurers due to their conditions. These enrollees find themselves "trapped" in an MA plan that winds up being cost-prohibitive despite promises of substantial cost savings.

In addition, we remind CMS that a particularly confusing aspect for beneficiaries is the difference between coverage of Part B (provider-administered) and Part D (self-administered) medications. Our Medicare patients tell us that MA plans often obscure these distinctions, leaving them unaware of which medications are covered under each part and what their financial responsibilities will be. This can lead to unexpected high costs when patients need treatments like infusion therapy, which can cost as much as $7,500 per year out-of-pocket for some enrollees. Plans must be held accountable when they knowingly, or unknowingly, provide inaccurate information to potential enrollees, or face enforcement action.

To address this issue, we urge CMS to:

- **Further Enhance the Pre-Enrollment Checklist**: Require MA plans to provide detailed, clear information about the differences in coverage and payment for medications, both self- and provider-administered. Specifically, the Pre-Enrollment Checklist (PECL) should include comprehensive details on the coverage and utilization management requirements associated with their medications, as well as the change in their out-of-pocket costs.
- **Improve Oversight and Enforcement of Marketing and Enrollment**: Perform regular audits of marketing materials and enrollment practices to ensure compliance with CMS regulations and guidance. In addition, implement strict penalties for plans that engage in misleading marketing including termination from the MA program, for providing inaccurate information to potential enrollees during the enrollment process. Further, tie beneficiary complaints and the resultant impact on quality and outcomes to quality ratings and payments.

Provider Networks

Medicare Advantage Network Adequacy (§ 422.116) and Format Medicare Advantage (MA) Organizations' Provider Directories for Medicare Plan Finder (§§ 422.111 and 422.2265)

We appreciate CMS' proposals to modify network adequacy requirements and improve provider directories, both aimed at better informing enrollees about the availability of providers in the plans' network. The proposed policies should also assist plan brokers and agents in their pre-enrollment discussions.

Despite these improvements, however, inadequate access to rheumatology care within Medicare Advantage is an increasing challenge. Current CMS standards have led to insufficient network adequacy because the standards are primarily focused on access to primary care and behavioral health, rather than specialty care. As an example, our members in Florida report that a significant number of rheumatologists were terminated from a large MA plan's network, drastically reducing patient access to care for permanent residents and "snow birds," as well as a growing number of Employer Group Waiver Plan (EGWP) enrollees.

To help address this challenge, we recommend that CMS:

- **Revise Network Adequacy Standards**: Adjust physician-to-beneficiary ratios and time/distance standards to better reflect the needs of beneficiaries, particularly in specialties with increasing rates of chronic illness and workforce shortages, such as rheumatology.
- **Implement Wait Time Standards**: Establish and enforce standards for specialist wait times to ensure timely access to care.
- **Strengthen Provider Directories**: Enforce accurate, real-time provider directories and impose penalties for non-compliance. CMS should consider requiring MA plans to populate directories using information from the Provider Enrollment Chain and Ownership System (PECOS), which would create additional uniformity across traditional and MA plans.

Formulary Inclusion and Placement of Generics and Biosimilars

We appreciate CMS' request for input on access to biosimilar medications. These therapies are vital in treating autoimmune diseases, such as rheumatoid arthritis, yet they are becoming increasingly difficult to access ***in the office setting***.

To secure favorable "fail first" positioning, manufacturers provide rebates for these medications, driving their average sales price (ASP)—the basis for Part B reimbursement—below our acquisition costs. This creates untenable financial pressure on rheumatology practices, forcing many to refer patients to higher-cost hospital settings for infusions. Such referrals not only increase Medicare program costs and out-of-pocket expenses for beneficiaries but also disrupt care continuity and elevate infection risks for immunocompromised patients.

Given it will take an act of Congress to address the ASP methodology, we urge CMS to:

- **Rescind the 2018 step therapy memorandum**. To empower rheumatology practices to offer alternative therapies, it is critical for CMS to allow patients to bypass "fail first" requirements when a biosimilar's reimbursement rate is unsustainable for practices. This will help maintain patient care in the lower-cost office-based setting and mitigate disruptions that harm Medicare enrollees.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.166 and 423.186)

Accurate quality measures are essential for evaluating plans performance and ensuring accountability. CMS has previously suggested it might collect information from physician practices, and we continue to believe this is a worthwhile endeavor. Therefore, we again recommend that CMS:

- **Adopt a Physician/Plan Interaction Survey**: Implement a composite measure based on physician surveys covering topics such as network adequacy, payment practices, utilization management, and administrative burden.

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NORM appreciates the opportunity to provide comments on the aforementioned issues of importance to our practices. We believe these recommendations will significantly improve data and information collection and use, thereby enhancing patient care and administrative efficiency within MA plans. Should you have any questions or would like to set a time to discuss these issues in more detail, please contact Andrea Zlatkus, CMPM, CRMS, CRHC, Executive Director, NORM, at andrea@normgroup.org.

Sincerely,

Michelle A. Owen, CPC
President, NORM