August 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC,
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-4203-NC; Medicare Program; Request for Information on Medicare

Dear Administrator Brooks-LaSure,

I am pleased to submit these comments on behalf of the Association for Clinical Oncology (ASCO) in response to the request for information from the public regarding various aspects of the Medicare Advantage program, which was published in the Federal Register on August 1, 2022.

ASCO is a national organization representing nearly 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans.
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Advance Health Equity

Statement of need to address SDOH

ASCO applauds CMS’s commitment to enhance health equity for all enrollees through MA. ASCO’s mission – conquering cancer through research, education, and promotion of the highest quality, equitable patient care – reflects our commitment to equity. We agree that MA plans play an essential role in improving health equity and addressing the social determinants of health that impact millions of seniors and people with disabilities. To better ensure that all MA enrollees receive the care they need, CMS should consider a variety of approaches.

A significant challenge to overcome in the pursuit of equity is standardized data capture, metrics and reporting. In 2017, ASCO released a joint statement with the American Association for Cancer Research (AACR), the American Cancer Society (ACS), and the National Cancer Institute (NCI) to foster cooperation across the cancer research community. The current peer-reviewed research supports the assertions in the joint statement—disparities are driven by a range of multi-level patient, community, and structural factors, including inequities in health care quality and delivery. Our collective understanding of the underlying drivers of cancer disparities is growing, but the joint statement makes several recommendations for continuing to advance the research on, and the science of, disparities. The first recommendation, defining and improving data measures and tools for cancer disparities research, is particularly relevant. According to the joint statement, patient data are often incomplete, inaccurate, or overly simplified and usually do not consider many social and community factors. Moreover, cancer disparities research is limited by a lack of comprehensive, consistent data on factors that impact disparities in cancer care and patient outcomes, including a patient’s social status and demographics, community and lifestyle factors, and biology and genetics. Widespread variation in data collection methodologies has also compromised the utility of select data sets for disparities research. Having a recognized standard set of demographic questions and variables would demonstrably benefit stakeholders’ ability to document, understand, and begin to address systemic inequities.

Therefore, ASCO supports the standardized collection of demographic elements and use of relevant data for quality improvement. We recommend that, to the extent possible, the most granular measures be selected, and in the case of race and ethnicity, questions address ancestry, immigration status and enclave effects. Measures of the built environment should be included, or patient address should be collected and geocoded, to assess neighborhood and structural effects on health, so that physical and other contextual effects can be considered.

ASCO is also committed to addressing the needs of sexual and gender minority populations as a diverse group at risk for receiving disparate care and having suboptimal experiences, including discrimination,

throughout the cancer care continuum. 2 Sexual and gender minority (SGM) is an umbrella term that encompasses lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms. This includes individuals with disorders or differences of sex development (DSD), sometimes known as intersex. 3 SGM populations bear a disproportionate cancer burden. The disparities in cancer outcomes stem from the unique cancer risks, needs, and challenges faced by SGM populations, including discrimination and gaps in quality of care. 4, 5 SGM populations exhibit low rates of uptake of cancer screening and may therefore present with late-stage disease. 6 Because of fear of discrimination and stigmatization, SGM populations often do not disclose their sexual orientation to their health care providers, and this may create additional barriers to high-quality care. 7 ASCO supports policies that bolster the rights and protections of SGM patients and enhance the anti-discrimination requirements on health insurers and medical providers. CMS should ensure that Medicare Advantage plans and their officials, employees, agents, and representatives do not employ marketing practices or benefit designs that would discourage the enrollment of individuals based on sexual orientation and gender identity. Prohibiting discrimination based on sexual orientation and gender identity has the potential to improve access to equitable cancer care, and adequate insurance coverage to meet the needs of SGM individuals affected by cancer.

Programs that advance equity in MA

To enhance the care of MA enrollees of disadvantaged socioeconomic status, CMS should consider interventions to address financial toxicity. Financial toxicity is particularly important for patients with limited financial resources who may be at risk of disproportionate harm because of cost-containment strategies deployed in oncology care. ASCO supports the appropriate implementation of novel programs that contain cancer care costs and emphasize high-value care, but with appropriate safeguards to ensure that such interventions are benefitting, rather than harming or restricting, care access for patients with public insurance or limited financial resources. Accountable care organizations (ACOs), for example, can improve access to high-value cancer care services. However, ACOs vary in the comprehensiveness of services they cover. 8 Other steps, such as payer-provider collaborations that

3 National Institutes of Health, Sexual and Gender Minority Research Office. https://dpcpsi.nih.gov/sgmro
incentivize high-value cancer care services among low-income, elderly, and minority patients, have recently been undertaken to lessen place-based geographic disparities; these steps also include rural access to care or financing for known interventions that can reduce disparities (e.g., telephone-based health interventions).9,10 These collaborations can also address access to care by financing aspects of health equity, such as housing, transportation, childcare, and food, that fall outside of the traditional medical sector but can affect appropriate cancer care delivery. One such payer-provider collaboration is currently being tested in a randomized study to determine the impact on cancer health disparities.11 In conjunction with state Medicaid programs and ACOs, novel collaborations in Medicare Advantage should be prioritized to ensure financing for known interventions that can reduce disparities.

Medicare Advantage plans should also leverage partnerships with community-based organizations to drive equitable care; addressing the social determinants of health is critical to achieving health equity, and community-engaged strategies are an essential way to do so. Community efforts may address multiple conditions that are important drivers of health and wellness, including safe, physical environments and neighborhoods that promote health; affordable housing; structurally safe sidewalks; open spaces, such as parks; and clean drinking water, food, and transportation. MA plans should also pay attention to local capacity building. Such efforts to enhance community capacity building include partnering with and expanding collaboration with local health professionals and health care teams, community health workers, and other community leaders. These efforts can assist in identifying strategies to address the social determinants of health and can promote and sustain the infrastructure, policies, and implementation activities that are crucial to reducing disparities.12,13 Partnering with communities is key to understanding how best to support local programs and research led by the community to improve cancer health equity.

Ensuring equitable access to clinical trials is another important avenue through which CMS can guarantee that cancer patients enrolled in MA receive the care they need. Rates of participation in clinical trials remain low for racial and ethnic minority groups, which results in study samples that do not accurately reflect the populations that could benefit from the interventions being tested. Moreover, racial and ethnic minority groups may be especially likely to be affected by financial barriers to study participation. Medicare, Medicaid, and most private payers generally provide coverage for the costs of routine care associated with clinical trials that are either (1) funded by the federal government, (2) submitted to the US Food and Drug Administration (FDA), or (3) exempt from FDA submission requirements.14,15 However, these payers often do not cover all trial-related costs. Because insurers are not required to cover nonmedical or ancillary costs such as lodgings, meals, child or companion care,
and transportation, these are generally paid out of pocket by patients and contribute to financial burden. CMS should explore the effectiveness of models in Medicare Advantage to encourage clinical trial accrual, particularly through the lowering of patient out-of-pocket or other nonmedical ancillary costs.

Expand Access: Coverage and Care

Beneficiary-focused

Cultural and linguistic barriers faced by enrollees and potential enrollees

During Medicare’s Medicare Open Enrollment Period, tens of millions of beneficiaries compare coverage options and enroll in health insurance coverage. For 2022, the average Medicare beneficiary has access to 39 Medicare Advantage plans, more than double the number of plans per person in 2017, and the largest number of options available in over a decade. Navigating these options can be a fraught experience. Many beneficiaries have questions, such as whether to enroll in Traditional Medicare or select a Medicare Advantage plan and, subsequently, how much these options will cost. Analyses of the open enrollment process have found that many beneficiaries find the process of choosing a plan to be arduous and frustrating; nearly half of people on Medicare opt to never or rarely compare their coverage options. Few use Medicare’s official information resources. Individuals in relatively poor health, who may have the most at stake during the open enrollment period, are least likely to compare their plan options, which can lead to unanticipated outcomes, such as higher out-of-pocket costs.

Many consumers, especially those with limited English proficiency, inadequate internet access, complex medical needs, and low health literacy, do not have the time or ability to analyze plan options. These consumers often focus on premiums, rather than total cost-sharing, which can result in unexpected financial harm, especially for those with a cancer diagnosis. To support these consumers in plan selection, CMS should ensure that Medicare Advantage plans provide enrollment and communication materials that are culturally appropriate and address the specific communication and language assistance needs of MA beneficiaries with limited English proficiency (LEP).

Information that may support enrollees

Beneficiaries weigh considerable trade-offs when deciding whether to enroll in a Medicare Advantage plan or Traditional Medicare. Traditional Medicare requires considerable cost sharing from its beneficiaries (20%) and does not include an out-of-pocket (OOP) maximum. Although Medicare Supplement Insurance coverage (“Medigap”) can minimize OOP costs, considerable heterogeneity exists

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17 https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/
in the design of benefits, placing beneficiaries at variable financial risk. Medicare beneficiaries who obtain their benefits through a Medicare Advantage face similar variation in the design of benefits.

With its annual limit on out-of-pocket costs for Part B drugs (including chemotherapy) and many zero-premium plans, Medicare Advantage may appear to be an attractive option for cancer patients; however, these patients may face unexpected financial harm from switching to Medicare Advantage coverage and between Medicare Advantage plans. While Medicare Advantage plans may charge a lower premium than the combination of Traditional Medicare, Medigap and Part D coverage, MA enrollees with cancer can be exposed to higher cost-sharing requirements for their drugs when they are administered by an out-of-network provider. Some patients already enrolled in Medicare Advantage may change plans due to promises of lower premiums or waived visit copays, yet not understand that they will have higher co-insurance and out-of-pocket maximums on drug therapies.

Patients wishing to switch from Medicare Advantage back to Traditional Medicare may not be able to purchase affordable supplemental insurance (or any supplemental insurance at all) unless they meet a defined “trial right” or other defined forms of guaranteed issue—and those patients may not have been aware of these requirements when first opting for Medicare Advantage. A new diagnosis of cancer imposes significant financial strain on Medicare beneficiaries who lack supplemental insurance. According to a 2017 study, nearly 10 percent of elderly patients with Traditional Medicare alone spent more than 60 percent of their annual household income on OOP expenditures following a diagnosis of cancer; the high cost of OOP payments can lead some patients on Medicare to forgo treatments altogether18.

Other patients may instead be hesitant to change plans due to their condition and the unknown impact on coverage and reimbursement. Providing beneficiaries with condition-specific information, such as their historical out of pocket obligations and estimated new out of pocket amounts under an MA plan would allow them to make better informed decisions. CMS must also make clear to Medicare beneficiaries what choices and options they will lose when switching between Traditional Medicare and different types of Medicare Advantage plans.

18 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5441971/

MAO-focused

Prior Authorization

Many provider organizations have reported that the prior authorization process is a significant source of burden for patients, providers, and payers. It contributes to provider burnout and poses a health risk to patients when it delays their care. Disparate payer policies, provider workflow challenges, and technical barriers all contribute to this burden.

Association for Clinical Oncology

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It is also reported that Medicare Advantage prior authorization policies can limit beneficiaries’ access to care. To strengthen beneficiary access, CMS needs to take significant action to streamline prior authorization (PA). MA plans use utilization management techniques, including prior authorization, to restrict or deny coverage, undermining patient access to diagnostics and medically necessary care. Patients with cancer often face delays in approval for treatment, and many oncology drugs do not have substitutes that are both equally effective and less expensive for a given patient. Consequently, policies that attempt to incentivize, force, or coerce patients to accept anti-cancer therapy alternatives that are not recommended by their oncologist can threaten both the outcomes for patients and the well-being of their families or caretakers.

Multiple reports and surveys document the increasing burden of prior authorization. A recent survey of physicians by the American Medical Association found that the reported burden of PA is significant:

- On average, practices complete 41 PAs per physician, per week
- Physicians and their staff spend almost two business days each week completing PAs
- Forty percent of physicians have staff who work exclusively on PA
- Eighty-eight percent of physicians describe the burden associated with PA as high or extremely high

Requirements for prior authorization are also increasing, as shown by another recent survey released by the Medical Group Management Association (MGMA); this March 2022 survey found 79% of respondents saying said that prior authorization requirements increased over the past year. MGMA members reported the following as their most significant challenges: lack of response or slow response from payers for approvals; increased time spent by practice staff working to obtain prior authorizations; and a lack of automation in payers’ PA processes.

We offer here a series of recommendations on the substance and process of prior authorization; many of these recommendations can also be found in the American Society of Clinical Oncology’s policy statement and prior comment letters to federal agencies, including CMS and ONC.

We recommend that CMS alleviate administrative burdens associated with PA by immediately following the recommendations issued by the Office of Inspector General’s Report on Medicare Advantage Organization (MAO) denials of prior authorization requests, including:

- Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews
- Update audit protocols and direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors
- Enforcement action process by CMS for noncompliant MAOs
- Additional enforcement by CMS for MAOs that demonstrate a pattern of inappropriate payment denials

In its previously referenced policy statement, the American Society of Clinical Oncology put forth the following recommendations for payers:

- Develop and use standardized prior authorization request forms and processes to alleviate the administrative burdens placed on treating oncology teams or practices
- Use a public process by which they determine prior authorization policies for cancer treatment, reflecting the most up-to-date standards of care and including consultation with oncologists
- Restrict prior authorization policies to drugs where specific concerns about inappropriate use and/or undesirable variation exist
- Ensure oncologists make prior authorization determinations in cancer care and provide treating oncologists with direct access to that oncologist to discuss the clinical circumstances as necessary
- Integrate prior authorization processes into electronic health records to support authorization at the points of care, minimizing delays in treatment and administrative burden on providers
- Establish efficient and responsive appeals processes, including 48-hour completion of review/decision on appeals for oncology and expedited review for patients whose clinical circumstances require urgent treatment
- Do not use the appeals mechanisms to compensate for underlying deficiencies in prior authorization policies or process
- Monitor and remedy the predictable, adverse consequences that individuals with cancer may experience from barriers or delays in receiving preferred oncology therapies as a result of prior authorization requirements, including suboptimal clinical outcomes, increases in adverse events, and increases in emergency department visits

• Ensure continuity for patients receiving a course of therapy upon enrollment in a health plan to prevent mandatory substitution or interruptions in treatment

In subsequent communications to CMS, we have emphasized transparency and accountability of payers. To align data on prior authorization and other utilization management techniques, ASCO believes that payers, including MAOs, should report their metrics to the agency about patient use, among other reporting requirements, including but not limited to plan accountability for timeliness of determinations, requiring plans to report the extent of PA use, and the prohibition of additional PA requirements for added medical necessary services performed during an invasive procedure that already received PA. ASCO has also previously supported CMS proposals requiring that information about any pending or active prior authorization decisions for items and services be made available to patients through the Patient Access API no later than one business day after a provider initiates the request. Additionally, ASCO strongly supports usage of a Documentation Requirement Lookup Service (DRLS) API (Application Programming Interface) that would include information on the list of services and items and details on documentation requirement and require that payers provide this information on a public-facing website. Prescription and covered outpatient drugs should be included on the public-facing list of items and services along with the documentation requirements.

The Pressing Need for Electronic Prior Authorization. The manual nature of much of this process adds significantly to its burden and the impact on physicians and patients. While many prior authorizations may be initiated electronically via separate payer portals, subsequent interactions and requests for additional information are frequently conducted via fax or phone, leading to delayed communication, slower response times, and delays in patient care.

Studies\textsuperscript{24} have shown the benefits of implementation of electronic prior authorization, including decreased faxes and phone calls and faster time to patient care. Moreover, according to a recent report from the Council for Affordable Quality Healthcare (CAQH),\textsuperscript{25,26} the healthcare industry could save $20 billion by handling 9 common transactions electronically. Of special note, only 26% of prior authorization requests are handled fully electronically. CAQH also found that 39% of prior authorizations were partially electronic in 2021, while 35% were still fully manual (submitted by phone, fax, e-mail, or mail). CAQH estimates that if all prior authorization claims were submitted fully electronically, the healthcare industry would save $437 million annually.


\textsuperscript{25} 2021 CAQH Index. Working Together: Advances in Automation During Unprecedented Times. Available at: https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf

\textsuperscript{26} Southwick, R. Healthcare companies do more electronically, but there’s room to improve, study finds. Chief Healthcare Executive, February 1, 2022. Available at: https://www.chiefhealthcareexecutive.com/view/healthcare-companies-do-more-electronically-but-theres-room-to-improve-study-finds
As we have noted in earlier comments to the Office of the National Coordinator for Health Information Technology (ONC),

necessary documentation or data elements should be pulled directly from electronic medical records without additional manual entry from the user such as the creation of additional forms or templates to complete within an electronic PA process. Further, although PA requests can often be submitted electronically (usually through a separate payer portal), it is much less common that responses are returned electronically. These manual responses (fax, mailed letters, calling for updates) add unnecessary delay to the process, especially when the response contains a request for additional information, which must also be exchanged manually. Electronic responses are critical to any electronic PA process. If a response is a denial, the reason for the denial should be very specific. If, for example, an oncologist is adhering to NCCN guidelines in the care of a patient but is not aware that the payer uses non-NCCN guidelines in its determinations, this will significantly impact the appeals process and is something the provider should be made aware of immediately.

In their earlier comments to ONC, the American Society of Clinical Oncology (ASCO) and members of the mCODE® Initiative Collaborators noted that much of the information required for prior authorizations in oncology is not currently present in structured fields that may be exchanged between clinicians and payers and is also not included in the first iterations of the US Core Data for Interoperability (USCDI; “US Core”). This includes basic data that both clinicians and payers consider integral to subsequently formulated treatment plans that will often be subject to prior authorization. Unless these data elements—as captured by mCODE—are included in standards for electronic prior authorizations, oncologists and their patients will remain mired in the outdated manual system that leads to care delays or disruptions in the face of a disease where even a few days or weeks can be crucial to outcomes.

The mCODE elements are currently being tested through a variety of implementation use cases managed through the CodeX HL7 FHIR Accelerator. One of those use cases is Prior Authorization in Oncology, which uses mCODE data elements in prior authorization transactions. The goal is reduction of costs by automation and standardization of health system-to-payer prior authorization interaction, which also has the potential to greatly reduce oncologist burden, which is a known factor in physician burnout. A target outcome of the project is to provide a standard method to supplement the Da Vinci Coverage Requirements Discovery (CRD), Document Template Rules (DTR) and Prior Authorization Support (PAS) FHIR-based information exchange framework with cancer specific data as defined by mCODE, to enable prior authorization auto-approvals.

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28 Codex Home: mCODE. Available at https://confluence.hl7.org/display/COD/mCODE
29 mCODE is a focused set of data elements selected based on their broad applicability to people living with and surviving cancer and to support a variety of cancer care and research applications across a variety of cancer types. mCODE elements were developed by a collaboration of oncology experts, and as a Health Level 7 (HL7) Standard for Trial Use these elements were refined with broad input and review through the ballot.
30 https://confluence.hl7.org/display/COD/CodeX+Home
This project is currently in the planning phase for a radiation oncology prior authorization pilot for breast and prostate cancer. In this phase, the goal is to validate workflows and define process and requirements (including demographic and patient clinical data elements); it is anticipated that future phases may expand into additional cancer types and medical oncology.

We urge CMS to coordinate with ONC to leverage these existing efforts and align improvement in MA prior authorization processes with ONC’s exploration of electronic prior authorization processes in Certified Electronic Health Record Technology (CEHRT).

**Telemedicine**

CMS also seeks feedback on the role that telehealth plays in providing access to care in MA. ASCO strongly believes that achieving permanent Medicare coverage of telehealth services for patients is important for patient access to care. Providers who use telemedicine have reported that its benefits include decreased travel time for patients, immediate access to care, early detection of health issues, increased patient autonomy, reduced caregiver burden, and increased patient satisfaction with health care.\(^\text{32}\) Many aspects of telemedicine have demonstrated efficiency comparable to in-person care. For instance, virtual visits can provide effective follow-up and enhanced convenience compared with traditional office visits. Notably, a major benefit has been the ability of telemedicine to provide access to care irrespective of geographic location and health care resources (facilities and practitioners). Therefore, telehealth flexibilities such as the elimination of the geographic and originating site restrictions in Medicare should be made permanent.

In addition, telemedicine interventions in chronic disease management have been shown to lead to a decline in hospital admissions/re-admissions, length of hospital stays, and emergency department visits as well as reductions in mortality.\(^\text{33}\) Even prior to the COVID-19 pandemic, telemedicine was gaining traction in oncology, with providers citing improved documentation, better continuity of care, enhanced communication between provider and patient, greater treatment compliance, and potential availability of data for scientific evaluation.\(^\text{34}\) Cancer patients have reported an overall level of high satisfaction with telemedicine in radiation oncology and in survivorship care planning.\(^\text{35}\)\(^\text{36}\)

As the realities of the pandemic continue, there remains uncertainty regarding future federal telemedicine policy. Most of the regulatory flexibilities and telemedicine policies implemented under

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\(^{35}\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6293044/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6293044/)
the PHE are currently structured as temporary. In considering how CMS could advance equitable access to telehealth in MA, ASCO offers the agency the following recommendations:

- ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID-19 public health emergency (PHE); we urge CMS to extend those expanded telemedicine policies after the expiration of the PHE.

- Federal policymakers should make permanent coverage and reimbursement for audio-visual and when appropriate, audio-only services and continue to expand coverage for all modes of delivery of telemedicine.

- Policymakers should ensure broad coverage and adequate reimbursement for all telemedicine services by all plans and payers through service parity and payment parity reforms.

- CMS should work to promote health equity through encouraging the use of telemedicine in all care settings, including but not limited to rural and safety net providers.

- Patient education efforts by all health care stakeholders should include information on utilizing telemedicine.

- Federal and state governments should promote universal access to high-speed broadband through expanding digital infrastructure.

- Medical liability policies should provide comprehensive coverage for telehealth; providers should ensure they are covered across all states in which they practice.

- Finally, neither public nor commercial payers should apply burdensome utilization management policies to telemedicine

Network Adequacy

To ensure that cancer patients have immediate access to the necessary anti-cancer therapies, ASCO recommends the inclusion of medical, radiation, surgical, and gynecological oncology as standalone specialty types to which the network adequacy evaluation for plans in Medicare Advantage applies. The inclusion of oncology specialties network standards will better assure cancer patients and survivors have meaningful access to medically necessary cancer care services in a timely manner. ASCO supported CMS’s decision in the CY 2023 Medicare Advantage and Part D Final Rule to require plans that are applying for initial or expanded service areas to demonstrate they meet MA network adequacy standards as part of the application process starting with the 2024 contract year application cycle. This is a positive change from the agency’s previous approach to oversight, which required MA organizations to only attest—not demonstrate—that they meet network adequacy requirements before submitting a bid for the following contract year.
Drive Innovation to Promote Person-Centered Care

Value-based contracting and health information exchange

Value-based contracting between MAOs and providers can generate cost efficiencies and improve clinical outcomes in MA—supporting the ultimate aims of payment reform. Similarly, advancing health equity has been appropriately embraced as a central goal of value-based contracting, with significant attention now being paid on how exactly value-based arrangements should be designed to effectively promote health equity.

For value-based contracts, one of the most significant differentiators is a demonstrated ability to deliver quality care. Physician practices that can demonstrate that they provide efficient clinical care while maintaining high quality outcomes are highly desirable from a MA plan’s perspective. Factors such as physician group size, location, and specialty can also play a significant role in contract negotiations. Single-specialty practices, small practices, and providers in rural areas may find themselves without an MA plan willing to engage in value-based agreements. The shared population between an MA plan’s beneficiaries and a provider’s patients is another key factor in deciding whether to enter into a value-based arrangement; providers in markets where no single MA plan has sufficient market share may have little cause to engage in MAO value-based contracting.

Often, the MAO has all of the pieces in place to pursue value-based care, such as claims data, member engagement, and community resources. However, its provider partners may not have the bandwidth to serve at a similar capacity, which could impede value-based care efforts. Having accurate, actionable performance data is essential to success in all value-based arrangements. However, sharing of quality data from the practice, sharing of claims data from the payer, evaluating care transformations undergone by the practice, and determining financial reconciliation all present administrative expenses to the plan and provider. Therefore, Medicare Advantage must enable payers to connect providers with the resources they need to engage in value-based care.

Currently, most payers in the United States use their own set of specific measures that practices must adopt to demonstrate delivery of high-quality cancer care. Adhering to all of these differing measures is extremely time-consuming, duplicative, and inefficient, yet still leaves practices and patients without a standard objective measurement for high-quality cancer care. Particularly, providers that participate in the Innovative Center’s (CMMI) multi-payer models, such as the Oncology Care Model, often find that participating MA plans have duplicative and often conflicting requirements and financial arrangements when compared to Traditional Medicare. Also, model activities such as submission of clinical and quality data by providers, sharing of claims data with providers, confirmation of care transformations undergone by the practice, and design and execution of financial models are undertaken by each MA plan separately, adding administrative expense for each MA plan to execute the model on their own and for each provider who must submit data to multiple parties or attempt to reconcile multiple feedback reports.
ASCO therefore supports CMS’ aim to better align policy between MA and value-based care programs in Traditional Medicare and offers recommendations to decrease discrepancies in performance measurement. To help ensure expansion of value-based contracting in MA, CMS should consider the following innovations.

- Include MA plans in initiatives such as Data at the Point of Care and the Beneficiary Claims Data API (BCDA).
- Include MA plans in CMMI registries that collect sociodemographic, clinical, and quality data from providers.
- Include MA data in provider feedback reports.
- Share risk adjustment and trending methods to align performance and financial methods.
- Use solutions proffered by groups including medical specialty societies to establish and confirm required care transformations and practice redesign activities.

For example, within cancer care, CMMI will execute its own monitoring plan to include interviews, audits of charts, site visits, and documentation review to ensure that practices have complied with practice redesign activities. Each individual MA plan entering value-based contracts may execute their own monitoring plan. This creates administrative burden for the practice, which must subject itself to duplicate documentation, chart, and site visit requests, and will limit how many providers an MA plan can realistically manage within their own model. Use of third-party solutions could alleviate burden on all parties. For example, both Traditional Medicare and MA plans could allow practices to forgo certain monitoring activities if they maintain recognized certification, such as PCMH for primary care providers or APEx or ACR accreditation for radiation oncology providers. ASCO is piloting its own Patient-Centered Cancer Care Certification (APC4) that is well-aligned to the requirements of CMMI’s newly-announced Enhancing Oncology Model (EOM) and includes documentation review, chart audit, and site visits.

*Date Interchange / Data Exchange Arrangements.* The cost of data interchange, a fundamental component of alternative payment models (APMs), is another significant barrier to growth of APMs in the MA market; it is likewise a key consideration for MA plans and providers opting to engage in data exchange arrangements to inform population health management and care coordination efforts. Payers often encounter providers who do not have the means to transform raw claims data feeds into meaningful insights, and therefore must expend resources developing more-consumable feedback reports per participating practice. Providers, in turn, often face differences in scope, format, and value sets in data requests from Traditional Medicare and MA plans, each having their own registry; the incompatibility between these data systems creates additional burden for providers who must report and interpret multiple streams of data from the MA plans. Including MA plans in CMMI registries would allow for alignment of format and value sets, as well as a single API and other data collection options, for providers who wish to participate in multi-plan models. Practices who do participate in models with more than one MA plan often face discrepancies in performance measurement and the format of claims data between Traditional Medicare and MA and across MA plans. Inclusion of MA claims data in point of care initiatives (such as BCDA) and/or within multi-plan feedback reports could help alleviate this burden and spur growth of value-based contracting in MA.
Overall, practices looking to engage in value-based contracting often have a common primary objective: to make an investment in sustainable care delivery changes that improve outcomes and total cost of care. To further support care delivery innovations in MA, CMS should look to solutions within the provider community that address topics of access, quality, equity, and patient-centeredness. To establish core elements needed to deliver equitable, high-quality cancer care and achieve broad consensus among all stakeholders on what patients with cancer should expect and receive from their cancer care teams, ASCO and the Community Oncology Alliance (COA) published a set of Oncology Medical Home Standards which are now being piloted in ASCO’s Patient-Centered Cancer Care Certification. By using one single set of standards, the new two-year oncology medical home pilot aims to empower patients by providing an objective measurement for high-quality cancer care, reducing administrative burden for practices, and demonstrating to payers that meeting evidence-backed measurement of high-quality cancer care can result in efficiencies and cost savings.

Support Affordability and Sustainability

It is widely understood that Medicare Advantage plays an increasingly important role in the Medicare program, with enrollment in MA plans doubling over the past decade and continuing to grow. In 2022, approximately 43 percent of Medicare beneficiaries are enrolled MA; soon, enrollment in the program will surpass 50 percent of the Medicare population. While ASCO supports MA as an option for beneficiaries and acknowledges the potential of MA plans to coordinate and organize the delivery system to improve care, there is considerable evidence that MA plans are overpaid relative to traditional Medicare. To improve the MA market and foster competition, CMS should look to where the MA payment system has failed to optimally promote high quality care.

Upcoding/Coding Intensity

The widely documented overpayments in MA stem largely from incentives that lead MA plans to report enrollee diagnoses more completely than physicians billing Traditional Medicare, thus making beneficiaries in MA appear sicker than those in Traditional fee-for-service (FFS) Medicare. More diagnoses lead to higher risk scores and thus higher payments to plans; this practice is generally referred to as “upcoding.” Because of upcoding, by 2020, risk scores for beneficiaries in Medicare Advantage were 9.5 percent higher than what they would have been for a similar beneficiary in Traditional Medicare, resulting in approximately $12 billion in excess payments to plans. CMS is supposed to adjust payments to account for differences in diagnostic reporting (referred to as “coding intensity”). Yet, the agency’s adjustments have fallen well short of correcting this upcoding behavior.

Recognizing the likelihood that MA plans would report diagnostic information differently than how it is reported in Traditional Medicare, Congress gave CMS the authority to implement a coding intensity

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37 https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-overview
adjustment to adjust for differences in coding patterns between MA and Medicare FFS. The Affordable Care Act, and subsequently the American Taxpayers Relief Act of 2012, created a schedule of minimum adjustments, starting at 4.71 percent in 2014 and increasing to 5.91 percent in 2018. Despite strong evidence that a larger adjustment is needed to compensate for differences in coding patterns between MA and Traditional Medicare, CMS has yet to implement an adjustment larger than this statutory minimum. MedPAC and others have recommended that CMS develop and apply a coding intensity adjustment that fully accounts for the remaining differences in coding between MA plans and traditional Medicare.

Future of MA

As enrollment in Medicare Advantage continues to grow, so too will the implications of MA on the Medicare program, writ large. Higher MA payments have led to higher Medicare spending than would have occurred under Traditional Medicare; as more Medicare beneficiaries enroll in MA plans, these differences in payments will lead to even higher spending levels. These trends have obvious implications for program sustainability. Beneficiaries and taxpayers simply cannot afford chronic MA overpayments, especially with the Medicare Hospital Insurance Trust Fund, which provides 42 percent of Medicare Advantage funding, facing insolvency within the next six years.39

MA beneficiaries can ill afford further delay to receive the care they need. The administrative burdens associated with prior authorization in MA contribute to major delays and denials in patient care. Despite many efforts from providers asking for more collaboration and reform in the PA process, requested changes to the PA process have largely gone unheeded. The harms caused by the process of prior authorization and the denial of payments for services that met Medicare coverage rules in MA warrants further action by CMS, including guidance to MAOs and oversight audits.

ASCO is pleased that CMS has directed its focus on addressing health equity and is soliciting information from the public on ways to enhance equity for all enrollees through MA. ASCO supports policies and practices that address the social determinants of health, and our members know that achieving cancer health equity requires broad approaches that address the social, economic, and environmental factors that influence health.

To advance health equity, CMS should ensure that MA plans address the needs of vulnerable MA beneficiaries; CMS should also appreciate that many consumers do not have the time or ability to analyze MA plan options and total cost sharing obligations. These consumers may face unexpected financial harm, especially for those with a cancer diagnosis: they may not understand financial implications of switching plans; they may not know their historical out of pocket costs with Traditional Medicare and Medigap; and they may not understand how those out-of-pocket costs may change under an MA plan. For cancer patients with insurance, out-of-pocket expenses associated with cancer treatment may still be substantial and lead to financial distress. We urge CMS to better educate

beneficiaries on their options under Traditional Medicare and Medicare Advantage, especially in those areas where earlier beneficiary choices may lead to an unexpected narrowing of options in the future.

**Engage Partners**

Finally, CMS is requesting feedback regarding how it can better engage valued partners and other stakeholders to continuously improve MA. ASCO is pleased to see that CMS has made engaging beneficiaries such a priority to inform MA policy development. CMS should work to ensure that MA plans incorporate the physician and consumer experience into the design of their systems of care. We encourage the agency to use its statutory and administrative authority to spur change that makes the Medicare Advantage program more responsive to clinicians and patients, particularly those who are most vulnerable.

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We appreciate the opportunity to comment on the Request for Information on Medicare Advantage. Please contact Karen Hagerty (karen.hagerty@asco.org) with any questions or for further information.

Sincerely,

Lori Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology