PREMIER TRANSFORMING HEALTHCARE TOGETHER®

February 10, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
7500 Security Blvd
Baltimore, MD 21244

Submitted electronically to: http://www.regulations.gov

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 (Docket No. CMS-4201-P)

Dear Administrator Brooks-LaSure:

Premier Inc. appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Notice of Proposed Rulemaking (NPRM) on Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit (Part D) Programs for Contract Year 2024. The proposed rule seeks public comment on CMS' proposals to ensure timely access to care, protect beneficiaries from predatory marketing practices, strengthen quality through the Star Ratings Program, advance health equity, improve access to behavioral health services and improve drug affordability and access in Part D.

Premier appreciates CMS' commitment to enabling access to high-quality, equitable care, as evidenced by the proposed policies in this rule. In our detailed comments below, Premier specifically recommends the following:

- Improve collection and reporting of social risk factor data alongside industry stakeholders to target social determinants of health more directly before proceeding with the proposed Health Equity Index reward;
- Limit significant year-over-year changes to the MA and Part D Star Ratings Program methodology to improve stability and incentivize multi-year quality improvement investments;
- Codify standards for coverage criteria to ensure that basic benefits coverage for MA enrollees is no more restrictive than under Medicare fee-for-service (FFS);
- Develop demonstration programs to provide MA plans with additional flexibilities and/or financial rewards for implementing real-time prior authorization programs with contracted providers;
- Finalize proposals that leverage network adequacy and other MA and Part D program requirements to improve access to behavioral health services, while limiting the use of flexibilities that may unintentionally encourage plans to use telehealth services as substitutes for existing in-person services;
- Finalize proposals that enhance beneficiary protections against predatory marketing practices;
- Finalize proposed changes to expand beneficiary access to medication therapy management (MTM) programs, while ensuring beneficiaries residing in long-term care (LTC) settings have access to MTM services; and
- Codify transitions of care protections for beneficiaries who experience a change in the level of care.

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I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company and national supply chain leader, uniting an alliance of 4,400 hospitals and approximately 250,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,300 manufacturers to source the highest quality and most cost-effective products and services. Premier's work is closely aligned with healthcare providers, who drive the product and service contracting decisions using a data driven approach to remove biases in product sourcing and contracting and assure access to the highest quality products. In addition, Premier operates the nation's largest population health collaborative, having worked with more than 200 accountable care organizations (ACOs).

A Malcolm Baldrige National Quality Award recipient, Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. PROPOSED CHANGES TO THE MA AND PART D STAR RATINGS PROGRAM

Since its codification as the quality rating system for MA and Part D plans in 2018, the Star Ratings program has undergone a number of methodological changes aimed at improving beneficiaries' ability to compare performance among plans and more precisely target rewards for high-quality plans through quality bonus payment ratings and rebate retention allowances. In the CY 2024 NPRM, CMS proposes additional changes to the Star Ratings methodology, including adding a Health Equity Index (HEI) to the rating system and significantly reducing the weight of patient experience/complaints and access measures.

Health Equity Index (HEI) Reward

Consistent with CMS' goals to advance health equity, CMS proposes to adopt a new HEI reward to encourage MA and Part D plans to improve care for enrollees with certain social risk factors. Specifically, CMS proposes to replace the current Star Ratings system's rating-specific reward factor with a contract-level, rating-specific HEI reward beginning with the 2027 Star Ratings. The HEI reward would recognize high measure-level scores for enrollee subsets with specified social risk factors – namely dual eligibility, receipt of low-income subsidies and disability status – that are associated with poorer health outcomes. ***While Premier supports the HEI reward in concept, we have several concerns with the policy as proposed.***

First, Premier is concerned that replacing the current MA reward factor with the proposed HEI award will dilute the effectiveness of the current quality incentive structure. The current reward factor is added to MA plan contracts if the contract has both high and stable relative performance, providing ample incentive for MA plans to continue to invest in quality improvement. In contrast, the HEI award is based on *both* contract-level measure performance *and* the contract's combined percentage of enrollees with the designated social risk factors. If an MA plan contract's percentage of enrollees with the specified social risk factors is less than half of the median percentage for all contracts, the MA plan contract *would not be eligible* for the HEI award. While we understand that limiting HEI awards to contracts that excel in enrolling and serving beneficiaries with social risk factors aligns with CMS' goals, ***Premier believes the policy may undermine market competition and disincentivize quality improvement investments*** among some MA plans. Both new market entrants and existing plans with contracts that are at or below the threshold enrollment target for receiving an HEI award may be dissuaded from offering a plan in a given geography, resulting in market

consolidation and more limited beneficiary choice. Additionally, substituting the HEI award, with its limited availability based on certain enrollment thresholds, for the current reward factor means that fewer high-performing MA plans will receive these types of performance incentives. This could result in MA plans shifting resources away from existing investments in value-based care and other quality-focused initiatives.

Premier is also concerned that CMS intends to use only dual eligibility, receipt of low-income subsidies and Medicare disability status as social risk factor data points for the index methodology as there is mixed evidence on these variables as effective indicators for health equity, with recent evidence that dual eligibility is an insufficient proxy for social risk, obscuring important social risk factors affecting duals disparately.[1] Further, given state-by-state differences in Medicaid eligibility criteria, it is impossible to accurately compare dual-eligible beneficiaries nationally.[2] It is clear that a more nuanced approach is needed to adequately account for social risk.

Additionally, CMS notes in the proposed rule that the agency considered but decided against using the Area Deprivation Index (ADI) as part of the initial set of social risk factors for use in the HEI award methodology. CMS further notes that analyses indicated that ADI addition explains very little of quality variation not already captured by the use of dual eligibility, receipt of low-income subsidies and Medicare disability status. These findings appear inconsistent with the justification CMS presented in the CY 2023 Physician Fee Schedule Final Rule for using ADI national percentile rank as a factor in calculating the health equity adjustment in the Medicare Shared Savings Program (MSSP). Specifically, CMS' proposed policy in the CY 2024 MA and Part D NPRM to use Medicare disability status as a social risk factor proxy rather than ADI is inconsistent with CMS' past characterization of ADI as "the best available option for assigning a risk factors-based score to a beneficiary who does not have the LIS or dual eligibility status designation." Before developing a health equity index, CMS should explore other variables to include and pursue strategies to improve data collection on important demographic factors that contribute to health disparities such as race, ethnicity, language and gender identity. These strategies should include communication and education efforts to build trust with beneficiaries, as many may be hesitant to report this data because of the history of healthcare discrimination against racial/ethnic minorities and women.[3]

Premier urges CMS to collaborate with stakeholders to create data collection and reporting processes that result in accurate and actionable data without placing undue burden on providers, as well as avoiding unintended consequences of shifting to a health equity index model. Specifically, Premier recommends that CMS convene a dedicated Task Force or Expert Panel of stakeholders to support advancing standards and collection of sociodemographic factors. The Task Force or Expert Panel should include, at a minimum, representation from MA plans, acute and non-acute providers, vendors and suppliers and beneficiaries. ***Including the provider voice in this discussion is critical, as it ensures CMS is aware of what flexibilities may be needed in the selection and implementation of screening and other data collection tools.***

Modifications to Measure Weights

In the CY 2021 MA and Part D Final Rule, CMS doubled the measure weights for patient experience/ complaints measures and access measures from 2 to 4. This policy change was reflected in the 2023 MA and Part D Star Ratings. At the time, CMS indicated that the shift in measure weights was responsive to stakeholder feedback, empowering beneficiaries to have a more formal voice in quality ratings based on their experiences with their health plans. In the CY 2024 NPRM, CMS proposes to revert to the previous weighting methodology, reducing the weights assigned to patient experience/complaints and access measures from 4 back to 2, beginning with the 2024 measurement period and 2026 Star Ratings. Affected measures include *Consumer Assessment of Healthcare Providers and Systems (CAHPS)* experience-of-care survey measures, *Members Choosing to Leave the Plan, Appeals, Call Center*, and *Complaints*.

[1] https://journals.lww.com/md-journal/fulltext/2020/09180/dual_eligible_patients_are_not_the_same__how.68.aspx
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7864213/
[3] https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/

In the NPRM, CMS notes that the previously finalized methodological change has created an imbalance between the experience/access measures and the clinical outcomes measures, which CMS fears could cause plans to reduce their focus on improving clinical outcomes. However, Premier argues that providers have never lost sight of their focus on providing high-quality care under the current methodology. ***In fact, 2023 Star Ratings data indicates that <u>despite</u> the increased weighting of patient experience measures, the very measures that CMS proposes to diminish showed some of the most significant year-over-year <u>decreases</u> in national average Star Ratings performance.***[4] Further, CMS reported that *Members Choosing to Leave the Plan* and *Call Center – Foreign Language Interpreter and TTY Availability* were actually the measures for which 2023 Star Ratings dropped most significantly in national average MA contract performance – yet CMS proposes to remove plans' incentive for continued focus on improvement by slashing the weights of these measures in half. These results do not support CMS' proposal to reduce plans' incentives to focus on improving beneficiaries' experiences with their health plans.

Simultaneously, providers continue to be held to high standards under CMS programs that directly measure the quality of care provided, including through Medicare fee-for-service payment rules' quality programs, through the MSSP quality requirements for ACOs and through quality-focused performance standards in demonstrations conducted by the CMS Innovation Center. Even within the 2023 MA and Part D Star Ratings results, the only CMS-reported national average measure-level scores that showed year-over-year improvement, aside from *Special Needs Plan Care Management* and *Reviewing Appeals Decisions*, were clinical process and outcomes measures. For example, national average results for *Diabetes Care – Blood Sugar Controlled* and *Osteoporosis Management in Women who had a Fracture* each climbed > 2 points, the highest increase among MA Star Ratings measure results. These results do not support CMS' argument that plans need to refocus on clinical outcomes at the expense of improving beneficiaries' experiences with their MA plans.

Additionally, it is essential that CMS take a consistent approach in its policies across different Medicare programs to clearly align incentives for meaningful change in healthcare. The proposal to reduce the weight of Star Ratings measures that directly capture the beneficiary voice is not aligned with stated priorities of other CMS programs. The CMS Innovation Center recently reiterated its commitment to incorporating patient and caregiver perspectives across the lifecycle of its models by implementing more patient-reported outcome measures and evaluating patient and caregiver experience in models.[5] If CMS is truly committed to achieving person-centered care across its programs, reducing the weight of patient experience measures in the MA and Part D Star Ratings program is not aligned with the agency's stated goals.

Finally, Premier notes that CMS has made significant changes to the Star Ratings program methodology over the past several rulemaking cycles, including the aforementioned shift to the current measure weighting policy for the 2023 Star Ratings. Significant methodological changes year-over-year make it difficult for payers and providers to make stable, strategic investments in targeted quality improvement, as CMS' incentives are frequently shifting. ***Premier strongly encourages CMS to avoid making significant year-over-year changes to the Star Ratings — such as the current proposal to cut the patient experience/complaints and access measure weights in half — until there is compelling evidence of the policy effects of the current methodology.*** Only then can CMS argue that proposed methodological changes are data-driven. ***If evidence exists that clinical outcomes in MA warrant stronger improvement incentives, Premier recommends reducing patient experience/complaints and access measure weights more gradually, such as from 4 to 3 for a given contract year, while monitoring for adverse impacts on patients and providers.***

4 https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf
5 https://innovation.cms.gov/data-and-reports/2022/cmmi-strategy-refresh-imp-report

III. PROPOSED REQUIREMENTS FOR UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION

Utilization management tools, including prior authorization, are designed to help MA plans determine the medical necessity of services and minimize the furnishing of unnecessary services, thereby helping to contain costs and protect beneficiaries from receiving unnecessary care. The statute requires MA plans to have a procedure for making determinations regarding whether an enrollee is entitled to receive a healthcare service and that such determinations must be made on a timely basis, which applies to both prior authorization determinations and to post-service decisions about coverage and payment.

However, prior authorization can also limit timely patient access to medically necessary services and be costly, time-consuming and burdensome for healthcare providers. Last year, the HHS Office of the Inspector General (OIG) issued an alarming report[6] finding that MA plans often denied or delayed patients' access to medically necessary services and created additional burden for physicians, even though the requests met Medicare coverage rules. The OIG report recommended that CMS (1) issue new guidance on the appropriate use of MA plans' clinical criteria in medical necessity reviews; (2) update its audit protocols to address the issues related to the use by Medicare Advantage Organizations (MAOs) of clinical criteria and/or examining particular service types; and (3) direct MA plans to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

In the proposed rule CMS proposes clarifications and revisions to regulations governing when and how MA plans develop and use coverage criteria and utilization management policies to ensure MA enrollees receive the same access to medically necessary care they would receive in Medicare fee-for-service. Specifically, CMS proposes the following:

- Limiting coordinated care plans' use of prior authorization solely to confirming diagnoses or other criteria for medical necessity;
- Requiring that prior authorization approvals be valid for the duration of the course of treatment;
- Mandating that plans provide a minimum 90-day transition period when an enrollee currently undergoing treatment switches to a new MA plan;
- Requiring MA plans to comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage and benefit conditions included in Medicare FFS statutes and regulations;
- Prohibiting coverage denials of a Medicare covered item or service based on internal, proprietary or external clinical criteria not found in FFS coverage policies;
- Only allowing MAOs to create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees and providers; and
- Requiring all MA plans to review utilization management policies (including prior authorization criteria) annually to ensure they are consistent with current Medicare NCDs and LCDs.

Coverage Criteria for Basic Benefits

Premier strongly supports CMS' proposals to codify standards for coverage criteria to ensure that basic benefits coverage for MA enrollees is no more restrictive than under the FFS program. Premier was particularly appreciative of CMS' clarification that these proposals also apply to substantive coverage criteria and benefit conditions found in Medicare FFS regulations, such as transfers to post-acute care settings, which are not governed by an NCD or LCD. Thus, an MA plan could only deny a request for Medicare-covered post-acute care services in a particular setting if the MA plan determines that the Medicare FFS coverage criteria for the services cannot be satisfied in that particular setting. While these clarifications would not preclude plan use of prior authorization or post claim review to ensure items and

[6] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

services meet Medicare coverage rules, they are a step in the right direction to ensuring MA beneficiaries' access to medically necessary post-acute care.

Appropriate Use of Prior Authorization

Premier applauds CMS' efforts to ensure that MA plans' use of prior authorization aligns with the intent of statute and existing Medicare program regulations. With regard to CMS' proposal that plans provide a minimum 90-day transition period when an enrollee undergoing treatment switches to a new MA plan, ***Premier encourages CMS to require plans to extend the transition period for longer than 90 days in situations where continuation of an existing treatment protocol is essential for sustaining life.*** For example, if a patient transitions plans in the midst of cancer treatment, the patient should be permitted to continue on their current treatment protocol for its intended duration given concerns with disease progression, resistance and mutations. Expanding the proposed policy ensures that beneficiaries' life-saving care is shielded from interruptions due solely to plans' administrative processes. The finalization of the more expansive policy will ensure necessary treatments are not interrupted midcourse and that the best interests of beneficiaries are served.

Premier appreciates that CMS utilizes the proposed rule to remind plans that prior authorization policies cannot be used to discriminate or direct enrollees away from certain types of services, reaffirming beneficiaries' rights to medically necessary treatment and providers' clinical autonomy to provide the right course of care. Premier also notes that CMS includes insights from stakeholders who have experienced forced interruptions in ongoing treatment and delays in access to necessary care as a result of prior authorization policies. ***Premier further recommends that CMS require MA plans to provide the criteria used in making prior authorization determinations to current or prospective contracted providers or suppliers and to enrollees upon request, consistent with the provisions of the Improving Seniors' Timely Access to Care Act (H.R. 3173, 117th Congress).***

Gold Carding Policies

CMS notes in the proposed rule that the agency supports gold carding programs, which are policies used by MA plans to relax or reduce prior authorization requirements for contracted providers that have demonstrated a consistent pattern of compliance with plan policies and procedures. CMS further encourages MA plans to adopt gold carding policies to exempt providers from prior authorization. Premier recommends that CMS introduce additional incentives for MA plans to reduce the administrative burden for providers and care delays for beneficiaries. The lack of end-to-end real-time automation of prior authorization between payers and providers perpetuates inefficiencies and negative impacts on clinical outcomes. CMS' Proposed Rule on Advancing Interoperability and Improving Prior Authorization Processes[7] represents a meaningful first step in improving adoption of electronic prior authorization.

Premier recommends that CMS develop demonstration programs to provide MA plans with additional flexibilities and/or financial rewards for implementing real-time prior authorization programs with contracted providers. For example, clear appropriate use criteria (AUC) exist for certain advanced diagnostic imaging services, as required by the Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b). Qualified Clinical Decision Support Mechanisms (CDSMs) can provide near-instant determinations of whether orders adhere to AUC. Incentivizing MA plans to accept CDSM verification of a provider's compliance with AUC or other plan-determined criteria would reduce provider burden from prior authorization request submissions, improve beneficiary care experiences by expediting determinations so that they know the plan of care before leaving the provider's office and significantly reduce MA plan expenses associated with more manual prior authorization request review processes.

[7]https://www.govinfo.gov/content/pkg/FR-2022-12-13/pdf/2022-26479.pdf)

IV. IMPROVING ACCESS TO BEHAVIORAL HEALTH SERVICES

For CY 2024, CMS proposes a number of changes to MA and Part D program requirements to increase Medicare beneficiaries' access to treatment for mental health and substance use-related conditions. Specific policies in the proposed rule include the following:

- Adding clinical psychologists, licensed clinical social workers (LCSWs), and prescribers of medication for Opioid Use Disorders (OUD) as specialty types that will be evaluated as part of network adequacy reviews, and making these specialties eligible for the 10-percentage point telehealth credit;
- Expanding general access to services standards to explicitly include behavioral health services;
- Codifying standards for wait times that apply to both primary care and behavioral health services;
- Clarifying that some behavioral health services may quality as emergency services and must not be subjected to prior authorization requirements; and
- Extending current requirements for MA organizations to establish a program to coordinate covered services with community and social services to behavioral health services programs.

Premier supports CMS' proposals to leverage network adequacy and other MA and Part D program requirements to improve access to behavioral health services. However, Premier remains concerned that adding clinical psychologists, LCSWs and prescribers of medication for OUD to the 10-percentage point telehealth credit list may unintentionally encourage plans to use telehealth services as substitutes for existing in-person services, and hinder enrollee access to and choice of in-person providers in their geographical proximity. ***Premier recommends limiting the use of this flexibility to circumstances in which MA plans can demonstrate with evidence that the existing behavioral health workforce in a given area is insufficient to satisfy published time and distance standards.***

V. ADDRESSING ABUSES IN MA AND PART D MARKETING PRACTICES

Premier applauds CMS for proposing a number of policy changes to tackle deceptive marketing practices that target Medicare beneficiaries enrolling in MA plans. Both CMS data and Congressional investigations have demonstrated a significant rise in beneficiary complaints related to the marketing of MA plans in recent years. A recent Senate Finance Committee report exposed numerous tactics, particularly among brokers and third-party marketers, to steer beneficiary enrollment through misleading promises and in-person intimidation.[8] Of particular concern were reports across states of agents changing health plan elections on behalf of seniors and individuals with disabilities without their consent.

CMS proposes a number of new marketing oversight requirements for the MA and Part D programs, including the following:

- Annual notices of opt out rights for phone calls regarding MA and Part D plan business;
- Requiring that agents explain the effect of a beneficiary's enrollment choice on current coverage whenever an enrollment decision is made;
- Requiring simplification of plan comparisons, with medical benefits to be in a specific order and listed at the top of a plan's summary of benefits;
- Clarification on the prohibition on door-to-door contact without a prior appointment;
- Stronger requirements for third-party marketing organizations; and
- Requirements for MAO and Part D sponsor oversight plans to monitor agent/broker activities and report agent/broker non-compliance to CMS.

[8]https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf

Premier supports CMS' proposals to enhance beneficiary protections against these predatory marketing practices. When patients are confused by their health plan benefits, it often falls to frontline healthcare providers, whom the beneficiary likely sees face-to-face more often than agents, brokers or health plan representatives, to help them navigate their coverage. This adds both a layer of administrative burden on providers and the potential for additional confusion. The beneficiary's health plan should be the source of truth on their health benefits and network information. Holding bad actors accountable would bring welcome relief to patients, providers and the many health plans that are currently working to empower beneficiaries with transparent information to make well-informed enrollment decisions. ***Premier recommends that CMS develop resources for frontline providers to help better educate beneficiaries on the most appropriate points of contact for questions or complaints about their health plans.***

VI. IMPROVING ACCESS TO MEDICATION THERAPY MANAGEMENT (MTM) SERVICES

Premier commends CMS for the proposed changes to expand beneficiary access to MTM programs. Specifically, CMS proposes to require that:

- Plan sponsors update their eligibility criteria for targeting beneficiaries for MTM to include all 10 core chronic diseases identified by CMS, including HIV/AIDS;
- Lower the maximum number of covered Part D drugs a sponsor may require from 8 to 5 (including all Part D maintenance drugs); and
- Revise the cost threshold methodology to the average annual cost of five generic Part D drugs.

Taken together, the proposed changes would increase the number of beneficiaries eligible for MTM under Part D, including those at high risk for adverse health events and those with complex drug regimens. ***Premier urges CMS to finalize these requirements designed to include more beneficiaries in MTM programs, as it is clear that they will result in improved health outcomes while lowering Part D program costs.***

Premier also supports the changes to refine and clarify comprehensive medication reviews (CMR) under MTM programs and urges CMS to finalize the changes as proposed. While these proposed changes codify existing program guidance, it is important that CMS specify in regulation the requirement that CMR must include an interactive consultation that is conducted in real-time, regardless of whether it is done in person or via telehealth. Premier also supports the CMS proposal to codify current guidance that a beneficiary is unable to accept an offer to participate in the CMR only when the beneficiary is cognitively impaired and cannot make decisions regarding their medical needs.

Further, Premier urges CMS to ensure beneficiaries residing in long-term care (LTC) settings have access to MTM services. CMS should advance protections for LTC beneficiaries that (1) standardize MTM services; (2) engage LTC pharmacists and pharmacies to ensure efficient delivery of MTM services; and (3) require adequate payment from plans to LTC pharmacists and pharmacies for MTM services. Through these reforms, CMS will improve care for LTC beneficiaries while eliminating duplication of efforts to improve medication therapy for these vulnerable patients.

Finally, Premier also encourages CMS to continue to examine policy options that expand access to MTM and improve patient outcomes. ***Premier urges CMS to expeditiously release the findings from the fifth and final year of the Part D Enhanced Medication Therapy Management model that ended in 2022***. Premier encourages CMS to collaborate with stakeholders to leverage these findings to identify best practices in MTM and scale nationally, as well as to guide future reforms.

VII. TRANSITIONS AND CONTINUITY OF CARE POLICES – LEVEL OF CARE CHANGES

Since the inception of the Part D program in 2006, CMS has required 90-day transitional drug fills for beneficiaries starting a new prescription drug plan (PDP). CMS proposes to codify in regulation the current

guidance that 90-day transitions must be provided to accommodate beneficiary level of care changes. Over the years of the Part D program, these requirements have been extremely beneficial to the efforts of LTC pharmacies to protect beneficiaries. With these protections in place during the 90-day transition period, LTC pharmacies have the opportunity to perform a drug regimen review, make medication therapy recommendations, navigate medication access issues due to formularies, and work with prescribers and the LTC health team to protect beneficiaries. ***Premier encourages CMS to codify its current transitions of care protections for 90-days for beneficiaries, but to also add requirements that transitions for longer than 90 days be required in situations where continuation of an existing treatment protocol is essential for sustaining life.*** For example, if a patient transitions plans in the midst of cancer treatment, the patient should be permitted to continue on their current treatment protocol for its intended duration given concerns with disease progression, resistance and mutations. In another example, a patient on a long-term antibiotic should be permitted to continue for longer than 90 days given concerns with antibiotic resistance. While there are opportunities for patients to request continuity in care during these transitions, they require significant action and effort on part of the patient whereas Premier recommends that these special circumstances be proactively evaluated and approved by the plans. The finalization of such policy will ensure necessary treatments are not interrupted midcourse and that the best interests of beneficiaries are served.

VIII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments on the Notice of Proposed Rulemaking on Policy and Technical Changes to the MA and Part D Programs for Contract Year 2024. If you have any questions regarding our comments, or if Premier can serve as a resource on these issues to the agency in its policy development, please contact Mason Ingram, Director of Payer Policy, at Mason_Ingram@premierinc.com or 334.318.5016.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.