COLLEGE of AMERICAN PATHOLOGISTS

January 26, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, MD 21244-8013

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

Re: Request for Information on Future Directions in Medicare Advantage

Dear Administrator Oz:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the request for information on "future directions in Medicare Advantage." As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

With this request for information (RFI), the Centers for Medicare & Medicaid Services (CMS) solicits comment on modernizing and strengthening the Medicare Advantage (MA) program. This effort is critically important because, as CMS notes, the MA program now covers over half of all Medicare beneficiaries. The CAP applauds CMS for its work to improve the MA program, and we thank the agency for the opportunity to provide recommendations. Specifically, the CAP recommends (1) adding hospital-based specialties to MA network adequacy requirements, (2) prohibiting in-network steering in the MA program, (3) expanding efforts to ease the burden of prior authorization, (4) reducing reporting complexity through continued, consistent coding, (5) further increasing transparency and accountability in MA plans, and (6) ensuring stakeholder input opportunities in CMS Innovation Center actions.

Network Adequacy

42 CFR § 422.116 outlines MA network adequacy metrics, requiring plans to maintain sufficient numbers of providers and facilities (currently encompassing 27 specialties and 13 facility types) within defined time and distance parameters to ensure beneficiaries have adequate access to covered services. However, many hospital-based specialties, including pathologists, are excluded from these metrics[1]. In its 2019 Medicare Advantage Final Rule[2], CMS noted its intent to consider new measures that would hold MA

[1] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf
[2] https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

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plans accountable for access to medical specialists. To date, CMS has not proposed or implemented such measures. As a result, MA plans face little incentive to enter into fair and reasonable contracts with hospital-based specialists, including pathologists, at appropriate in-network rates. Consequently, many MA plans have inappropriately restricted access by limiting the number of in-network pathologists, or exclusively contracting with a limited number of pathologists or facilities. These practices hinder access to local and community-based pathology services, which can adversely impact coordinated care including diagnostic accuracy, timeliness of care, treatment decisions, and ultimately patient outcomes. Further, the exclusion of hospital-based specialists from network adequacy requirements has contributed to the persistent problem with "surprise billing," as the current policies fail to address the root cause: the absence of a requirement for MA plans to maintain adequate physician network.

We understand the agency's interest in simplifying the network review process. However, by failing to explicitly account for hospital-based specialties, the agency has effectively relinquished a critical federal responsibility to establish and enforce comprehensive network adequacy standards. This gap leaves states and accrediting organization to safeguard patient access to physicians. Unfortunately, most states have failed to adopt laws – such as those included in the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act – to ensure all insurers maintain adequate provider networks. Similarly, accrediting bodies generally do not assess access to specific physician specialties. More importantly, even when broad measures of physician access exist, these entities lack meaningful enforcement capabilities or authority to remedy deficiencies.

To address these challenges, we urge CMS to revise MA network adequacy requirements by adding hospital-based specialties to the list for which MA plans have a specific standard. In addition, we urge CMS to develop Star Ratings measures that link bonus payments and capitation rates to whether plans maintain adequate physician networks. In the best interest of the patient, regulators should ensure that health plans maintain robust physician networks to ensure timely access to care.

In-Network Steering

In addition to network adequacy, the CAP is concerned about inappropriate in-network steering, whereby insurers steer services away from in-network community laboratories, typically in favor of a single, external laboratory, through – for example – referral requirements, exclusive contracts, or credentialing limitations. This practice prioritizes administrative convenience and short-term cost control over timely, coordinated, and patient-centered medical decision-making. While the CAP is committed to addressing escalating health care costs, fracturing care through in-network steering can delay testing and results, limit patient and provider access to pathologists familiar with local patient populations, and weaken direct communication between physicians and laboratory professionals – communication that is often critical for accurate diagnosis, appropriate test selection, and rapid clinical response.

For example, redirecting services can add unnecessary time to treatment since it is typical, and often required, that the hospital-based pathologist confirm the diagnosis and assume responsibility for the patient's care. Because obtaining outside materials can significantly delay diagnostic confirmation, patients may even require a second biopsy in the hospital setting to ensure timely care, thereby incurring

costs that could have been avoided. There are also logistical challenges and risks associated with dividing increasingly small diagnostic specimens, which can compromise complete diagnostic and prognostic evaluation. In addition, certain conditions require a rapid diagnosis to initiate treatment (e.g., small cell carcinoma), which is not always possible when patient specimens are sent to outside laboratories, potentially leading to serious, even life-threatening delays.

In addition, this practice seriously undermines the important ongoing deliberation and collaboration among pathologists and other physicians involved in a patient's care. Local pathologists play a critical role in care coordination, real-time consultation, and quality improvement initiatives, including cancer diagnosis, infectious disease management, and chronic disease monitoring. When an insurer requires patient samples to be sent outside the health system, it impedes the participation of local pathologists in multidisciplinary conferences with the treating physicians (e.g., oncologists, surgeons) as care plans are being developed. This also introduces fragmentating interference with established care pathways, designed to optimize outcomes and reduce downstream costs. For example, when an initial diagnostic biopsy (for example, an office-based fine-needle aspiration to diagnose cancer) leads to subsequent hospital-based care, in-network steering prevents the local pathologist from participating in care coordination at the time of initial diagnosis and from correlating these critical initial findings with later surgical specimens obtained in the hospital. Over time, these disruptions can lead to delays in diagnosis, avoidable hospitalizations, and higher overall health care spending.

Finally, for patients who live further away from their health system or hospital, returning to receive care after such delayed initial results are available may be difficult, potentially resulting in delayed care and compromised health outcomes. Such access barriers disproportionately harm vulnerable populations, including rural patients, seniors, individuals with limited transportation, and those dealing with chronic or complex conditions. What may appear to be a narrow contracting decision can therefore widen health disparities and negatively affect health outcomes.

Therefore, we urge CMS to implement prohibitions on the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians or facilities based primarily on cost of care factors. These prohibitions should include restrictions on anticompetitive "exclusive" or "preferred" contracts that are in opposition to local, coordinated care in the patient's community.

Prior Authorization

Pathologists are acutely aware that the right test at the right time can make all the difference in a patient's diagnosis, treatment, and outcome. Unfortunately, prior authorization often interferes with a patient's ability to receive timely and appropriate services/care. The CAP is committed to improving patient care and addressing escalating health care costs. However, it is imperative that cost-control measures are balanced with other considerations, to continue to ensure access to timely and appropriate care. As such, we urge CMS to continue efforts to ease the burden of prior authorization by streamlining and automating prior authorization processes, increasing public reporting of prior authorization processes, strengthening requirements for decision timeframes, and expanding "gold carding" programs for prior authorization.

As we have previously commented, we believe prior authorization in Medicare Advantage should be streamlined, with consistent use of technology and terminology across payers. The CAP also strongly supports improved communication and increased transparency from payers, including public reporting of prior authorization process and impact metrics. Access to this information helps beneficiaries make informed decisions about their coverage while also incentivizing plans to improve performance.

With respect to decision timeframes, we support efforts to align prior authorization decision timeframes across payers, and we encourage CMS to shorten the expedited timeframe to 24 hours and the standard timeframe to 48 hours across all payers. Delays associated with prior authorization have serious consequences for patients, ranging from negative effects on clinical outcomes to outright treatment abandonment. We also urge CMS to adopt policies (including audits and penalties) to ensure enforcement of and accountability on these timeframes.

In addition, we continue to support changes that would encourage adoption of gold-carding approaches, which can alleviate provider burden and allow clinicians to deliver care in a timely and value-based manner. Indeed, gold-carding programs further the CAP's goal of targeting prior authorization where it is needed most, while easing the burden on health care providers as much as possible. As CMS has noted previously, requiring prior authorization for "certain items and services that are almost always approved" or for providers who have demonstrated a "consistent pattern of compliance" is neither efficient nor cost-effective. Gold-carding helps address these issues. We also strongly urge CMS to incorporate appropriate protections against retrospective plan denials or reimbursement reductions applicable to health care services subject to a gold-carding waiver. Especially for pathologists and clinical laboratories who seek to render health care services promptly upon the request of an exempt ordering provider, it is critical to ensure plans cannot retroactively deny coverage after provision of services. Such denials would increase administrative burdens and payment uncertainty for physicians, and ultimately harm patient care – contrary to the public policy intent of prior authorization waivers.

Finally, as CMS looks at improving prior authorization requirements, we would also highlight increasing challenges around laboratory benefits management programs (LBMs), which are health insurance payer protocols or programs that are administered by a health insurance payer or another entity under contract with the payer. These programs often dictate or restrict health care provider decision-making relating to the use of clinical laboratory/pathology services, and the CAP believes that regulation of LBMs is fundamentally needed to prevent conflict of interests by entities that administer these programs, and to ensure these programs do not conflict with, subordinate, or unduly encumber the practice of medicine.

Coding and Reimbursement

Non-standard coding and/or reimbursement practices have serious adverse consequences for pathologists and laboratories trying to comply with conflicting requirements. Guidelines that deviate from or distort standard billing practices not only limit the ability of laboratories to provide care for patients, but also create fraud concerns, issues with state health plan contracts, and – of particular concern to many patients – potential denials from secondary insurance coverage. Such nonstandard billing requirements

risk interfering with the ability of patients to receive timely and appropriate services, and adversely affect patients, providers, and the entire health care system.

For example, Medicare Advantage plans operated by UnitedHealthcare, Optum Care, and Humana have implemented the requirement that molecular pathology claims contain DEX Z-codes, which are proprietary alpha-numeric codes obtained from the Palmetto DEX Registry. The CAP considers this requirement to be highly disruptive, administratively burdensome, and cost prohibitive for pathologists and laboratories, and ultimately believes it will impede patient access to medically necessary testing.

The CPT code set is universally used by the medical community and transparently developed with broad stakeholder input, including the CMS and other payers who are represented on the CPT Editorial Panel. CPT codes are also recognized by the US Department of Health and Human Services (HHS) as a HIPAA-compliant Level I HCPCS code set. By contrast, Z-codes do not fit these criteria or undergo this level of input and scrutiny. We also strongly advise adhering to the use of CPT for reporting of molecular pathology and genomic procedures, as this approach does not impose additional requirements or reporting complexity for processing claims for medically necessary services, and maintains alignment with the reporting requirements established by other private payers.

Further, the CAP believes Medicare Advantage payment rates should be required to be at least at the levels in traditional Medicare as a means of ensuring parity across programs and providing robust access to high-quality specialty care for all Medicare patients.

Transparency and Accountability

Outside of increased transparency around prior authorization, the CAP also urges CMS to look at transparency and accountability more broadly in the MA program. For example, MA program requirements must include clear mechanisms that allow providers and enrollees to file formal complaints with regulators. Reliance solely on reporting network issues to state departments of insurance is insufficient. Meaningful enforcement of MA requirements should also include conducting market examinations with a review of provider network adequacy, requiring plans to maintain transparent, accessible, and regularly updated provider directories, and conducting outreach to providers regarding challenges in contracting with insurers.

CMS Innovation Center

The CAP appreciates the CMS Innovation Center's commitment to building healthier lives through evidence-based prevention, patient empowerment, and greater choice and competition. As the percentage of Medicare beneficiaries choosing MA plans grows, innovative health care payment and delivery models that lower costs while preserving or enhancing the quality of care will be needed for MA. However, to fulfill the vision of empowering beneficiaries to achieve their health goals and maximizing cost savings, physicians participating in new health care delivery models must understand them. Models should accurately reflect the value physicians are providing to the system and to patients. Therefore, stakeholder input is essential as models are developed to ensure that they are feasible, meaningful, and

will improve the health of patients while protecting taxpayers. Specifically, pathologists provide critical input to identify relevant patient populations, establish accurate baselines for disease, and track meaningful outcomes. Pathology allows the care team to replace surrogate descriptors (e.g. obesity) with precise, actionable measurements (e.g. blood sugar, cholesterol levels, kidney function).

The CAP applauds the CMS Innovation Center's recent focus on partnership, including efforts to highlight the medical societies who support the new Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model, however, we are concerned about models being developed by the Innovation Center dramatically changing providers' clinical decision-making without considering the input of those specialties impacted by the model. The CAP encourages the Innovation Center to solicit input from physicians, especially the societies that represent physicians participating in and affected by new payment models, as models are in development. Specifically, the Innovation Center should consult with clinical and analytical experts with expertise in medicine, health care management, and quality improvement. Consultation with specialty associations will help ensure that models developed in a manner that is transparent and focused on the best interests of the patient consistent with sound clinical input and practices. As noted above, the role of pathology as a critical part of the care team from establishing the baseline patient population to quantifying meaningful improvement cannot be overstated.

More innovative health care payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models. Physician buy-in is essential to ensuring effective delivery system reform that will benefit Medicare patients and achieve the value-based goals of this Administration.

Summary

The CAP appreciates CMS's interest in modernizing and strengthening the MA program. We believe the CAP's aforementioned recommendations, including (1) adding hospital-based specialties to MA network adequacy requirements, (2) prohibiting in-network steering in the MA program, (3) expanding efforts to ease the burden of prior authorization, (4) reducing reporting complexity through continued, consistent coding, (5) further increasing transparency and accountability in MA plans, and (6) ensuring stakeholder input opportunities in CMS Innovation Center actions, should help inform future CMS action in this area. Please direct questions on these comments to Elizabeth Fassbender (202) 354-7125 / efassbe@cap.org.

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