May 29, 2024

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

Re: CMS–4207–NC

Dear Ms. Brooks-LaSure,

On behalf of AMGA and its members, I would like to thank you for your continued and ongoing support of the Medicare Advantage (MA) program, which currently enrolls about 51% of the Medicare population. Given its popularity with patients, it is critical that policymakers, stakeholders, and beneficiaries have the data necessary to evaluate the program and the performance of individual plans.

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for over one in three Americans. Our members work diligently to provide innovative, high-quality, patient-centered care in an efficient and cost-effective manner. Many of our member medical groups participate in the MA program, both under contract with MA plans and via their own sponsored MA plan offerings.

We applaud CMS' efforts to understand better how the MA program is implemented in practices across the country. MA not only is growing in popularity but has also taken on a critical role in the transition to value-based care. Given our members' experience not only with MA, but also with value-based payment arrangements within MA, we are pleased to offer the following comments in response to your request for information.

Key Recommendations

- **Prior Authorization:** To build on changes to prior authorization in the MA program finalized in recent rules, CMS should gather, analyze, and publicly report detailed and specific prior authorization data from plans, including the number of denials and successful appeals. In addition, CMS should collect, analyze, and publicly report data from plans on the results of prior authorization stratified by beneficiary characteristics and types of services. CMS also should require plans to report on the use of artificial

intelligence and subcontractors in the prior authorization process. Improved data will help identify health equity concerns with the prior authorization process, pinpoint plans limiting the use of prior authorization and help providers and patients identify those plans with aberrant or aggressive use of prior authorization. AMGA believes this will quantify the problems that result from prior authorization. Ultimately, we hope this data helps CMS identify areas where prior authorization can be eliminated entirely.

- **Value-Based Care:** The MA program has carved out an integral role in the transition from fee-for-service to value-based care. The benefits of value-based payment arrangements in MA are difficult to quantify using traditional encounter data. We urge CMS to consider the intrinsic value of benefits that may not be billable when evaluating the MA program and when implementing new data collection initiatives, while remaining cognizant of the administrative burdens associated with data collection.

- **Supplemental Benefits**: Supplemental benefits are instrumental to MA's role in the transition to value-based care. Accordingly, we urge CMS to collect, analyze, and publicly report data around supplemental benefits from plans, so providers have a better understanding of how beneficiaries are using the benefits. In addition, this would help beneficiaries understand the availability of such benefits when selecting a plan.

- **CMS-HCC Risk Adjustment Model Changes**: AMGA has identified a number of issues with the transition to version 28 of the hierarchical condition category (HCC) model, including additional complexity in the coding requirements, coding accuracy challenges, and data integrity and interoperability. CMS should reconsider the continued transition to version 28.

- **Standard Definitions**: CMS should ensure that any data collected on beneficiary characteristics, particularly data related to health equity efforts, have standard definitions so CMS, providers, and other stakeholders can make meaningful and informed decisions on how best to address equity concerns.

Our detailed responses are included below:

Prior Authorization
We appreciate CMS' efforts to improve prior authorization in MA through the Interoperability and Prior Authorization Final Rule[1] and the Contract Years 2024 and 2025 Medicare Advantage and Part D Final Rules.[2] Public reporting of prior authorization metrics will help consumers make informed decisions when choosing MA plans and help policymakers identify concerning trends in the program. CMS' stated goal of public reporting prior authorization metrics "is to help providers and patients gain insight into the payers' prior authorization practices and performance and to assist payers in evaluating their prior authorization practices." To that end, CMS finalized that the following measures be reported annually at the contract level:

- A list of all items and services that require prior authorization.
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated

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[1] 89 FR 8758
[2] 88 FR 22120 and 89 FR 30448

for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the payer, plan, or issuer for expedited prior authorizations, aggregated for all items and services.

AMGA appreciates CMS finalizing these requirements, which will provide additional transparency into the prior authorization process. However, while this information may be useful for patients and consumers who are shopping for a health plan, aggregate level data is insufficient for providers. Transparency into the process is unlikely to achieve both of CMS' stated goals: patients and providers gaining insight and plans evaluating their processes. AMGA recommends CMS expand on its previously finalized requirements by collecting from the plans and reporting the total number of denials and successful appeals and the timeframes for any prior authorization decisions. While the percentages are helpful, providers would gain additional insight by knowing exactly how many prior authorization requests are processed and how long it takes to receive a decision from the plan.

AMGA believes this data will confirm our concerns with the prior authorization process. While transparency of the data may help patients, AMGA disagrees it will substantially improve the prior authorization process, which has devolved from a way for plans to ensure care is medically appropriate and necessary to a tool used to delay care. The raw data likely will confirm what providers already suspect; prior authorization is blunt tool used to control utilization, not to verify treatment is medically necessary.

MA plans regularly deny medically necessary care to beneficiaries; an OIG report examining 2019 denials made by Medicare Advantage Organizations (MAOs), for example, found that 13% of prior authorization denials and 18% of payment denials met Medicare coverage rules.[3] Multiple studies have also found that more than 75% of appealed denials in MA are overturned,[4][5] meaning that patients are frequently denied access to medically necessary and appropriate care. This broken system places the burden on patients and clinicians to navigate an overly complex appeals process simply to move forward with treatments that plans never should have denied in the first place. At best, this appeals process delays medically necessary care. At worst, it causes patients to abandon their care plans. A 2022 American Medical Association (AMA) physician

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[3] Office of Inspector General Report in Brief April 2022, OEI-09-18-00260
[4] Kaiser Family Foundation Issue Brief, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021" Feb. 2023
[5] Office of Inspector General Report in Brief Sept. 2018, OEI-09-16-00410

survey found that 94% of physicians reported that prior authorization sometimes, often, or always led to delays in care, while 80% reported it caused patients to abandon treatment entirely.[6] These care delays can have cascading effects across the healthcare system when applied to patients who are transitioning between settings. When prior authorization delays patient's admission into long-term care facilities, for instance, it needlessly keeps them in the hospital, occupying beds that otherwise would be available for other patients. Prior authorization also places a heavy administrative burden on clinicians, who find themselves completing paperwork instead of caring for patients. For example, the AMA survey found that, on average, physicians and their staff spend 14 hours a week addressing prior authorization requirements.

For these reasons, AMGA urges CMS to eliminate prior authorization in MA wherever possible. In cases where prior authorization is necessary, it should be expedient, especially in situations where the authorization process is delaying a patient's discharge from a facility. Additionally, it should be waived for providers with a history of providing high-quality care. Better data on prior authorizations in the MA program would help identify these possibilities, assist beneficiaries in choosing between MA plans, and allow CMS to quantify the negative impact prior authorization has on patient outcomes and to examine this impact through a health equity lens.

In the meantime, AMGA has specific recommendations for collecting data on the prior authorization process as it relates to health equity, the use of subcontractors in the prior authorization process, and beneficiary education.

Health Equity

Currently, MA prior authorization data lacks information on beneficiary race, ethnicity, or sexual orientation, making it difficult to understand how prior authorization affects different communities. Without data, we cannot definitively say if prior authorization has a different effect on access to care across communities. CMS' commitment to health equity was evident in the recently finalized MA rule (CMS-4201-F3), which will require MA plans to conduct an annual health equity analysis of the use of prior authorization. This is an important first step, but the social risk factors considered in this analysis do not include variables such as race, sexual orientation, or English proficiency, or status in a rural area, which are necessary to examine prior authorization through a health equity lens. While we acknowledge collecting these variables would pose an administrative burden to plans, AMGA believes that adding them to the annual analysis would provide critical insight into the health equity issues posed by prior authorization.

In addition to the potential of marginalized groups being disproportionately flagged for prior authorizations, the paperwork or online steps associated with these authorizations could place a heavier burden on low-income or disabled beneficiaries or beneficiaries for whom English is a second language. A 2019 survey of patients on the burden of administrative tasks related to their healthcare found that roughly one third reported delaying or foregoing care due to an administrative task.[7] Non-White patients, disabled patients, and patients without a college

[6] American Medical Association 2022 Prior Authorization Survey
[7] Kyle MA, Frakt AB. Patient administrative burden in the US health care system. Health Serv Res. 2021 Oct;56(5):755-765. doi: 10.1111/1475-6773.13861. Epub 2021 Sep 8. PMID: 34498259; PMCID: PMC8522562.

degree were more likely to report a burden associated with administrative tasks.

Use of Subcontractors in PA Process

Many MAOs delegate their prior authorization processes to subcontractors. While we lack the data to quantify the effect these vendors have on prior authorization, anecdotal evidence suggests they frequently deny medically necessary care and slow response times due to unfamiliarity with the coverage rules of the contracted MAO. For example, in response to a past RFI on the MA program, the American Hospital Association referenced a member that experienced a 28% decrease in approvals for admissions to inpatient rehabilitation facilities after the MAO began using a subcontractor to handle post-acute care admissions.[8] It is critical CMS understands any factors contributing to the current state of prior authorization in MA. For this reason, CMS should collect data on which MAOs subcontract for the prior authorization processes, the financial terms and incentives of the arrangement between the MAO and the contractor, as well as the denial rates and timelines for subcontractor-performed prior authorizations.

Informed Beneficiary Plan Choice

As MA has become more widespread, the number of plans that beneficiaries can select has increased substantially. In 2023, the average Medicare beneficiary had access to 43 MA plans.[9] Given this high volume of plans and the negative impact that improper use of prior authorization can have on patient care, it is critical that beneficiaries are able to identify plans overusing prior authorizations, resulting in the denial or delay of medically necessary care. Plan-level statistics on prior authorization approval and denial rates, denial appeal rates, and timelines, as required by the CY 2025 MA PD final rule, will help beneficiaries make this choice. However, these statistics will be aggregated across all items and services, making it impossible for beneficiaries to identify plans whose prior authorization patterns would raise red flags for their specific health needs. We are pleased that CMS intends to require some level of disaggregation in the coming years, and we urge the agency to do so as soon as possible and to disaggregate this data to as specific a level as possible.

Disaggregating this reporting would also allow CMS to identify services that are routinely approved and for which prior authorization could be removed as a requirement. In addition, CMS could identify services that are routinely denied but approved upon appeal, which could merit an investigation into plan practices.

Value-Based Care

AMGA firmly supports the transition to value-based care. Team-based, person-centered care has the potential to help beneficiaries take ownership of their health, leading to better health outcomes. Through a focus on preventative care and social drivers of health, value-based care can result in savings to the Medicare program. MA, which historically has offered regulatory

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[8] American Hospital Association, Re: CMS-4203-NC, Medicare Program; Request for Information on Medicare, Aug. 31, 2022
[9] Kaiser Family Foundation, Medicare Advantage in 2023: Enrollment Update and Key Trends, August 2023

stability, as well as benefits designed to better address social drivers of health and emphasize care coordination, is an ideal framework for value-based care. For AMGA members, MA has become the dominant risk payment model across all organization types.

Data sharing is a critical aspect of any successful value-based endeavor, and AMGA appreciates the steps CMS took in the recently finalized Interoperability and Patient Access Final Rule, which requires plans to share individual claims and encounter data through an application program interface. AMGA recommends MA plans share standardized data sets with providers in value-based arrangements. These data sets should include, at a minimum, full claims information for beneficiaries and summaries of patient care. AMGA recommends CMS further require histories of hospitalizations, as well as prescription drug information.

AMGA believes value-based payment arrangements between providers and MA plans have the potential to yield better health outcomes for patients at lower costs. However, these arrangements also make data collection more complex, as innovative benefit designs can be difficult to capture via traditional encounter data. For example, consider unbilled telehealth services, which some plans offer to beneficiaries as an anonymous service. These services have a positive impact that is nearly impossible to quantify, as the services are not attributed to a specific beneficiary. As new and creative benefits are included in MA, we recommend CMS consider the value they add, even if this value is difficult to quantify through existing data.

Further, additional transparency in MA data will aid providers in value-based risk arrangements or contracts. By treating MA data in a fashion comparable to traditional Medicare, providers would have more details on their patient populations. For example, some MA plans address end-of-life care needs by including hospice services as a benefit. By requiring details—such as the type of services, the timing of hospice benefits, and cost data—providers will be in a better position to understand how MA beneficiaries use hospice services, which in turn will allow them to have meaningful discussions on end-of-life options with their patients.

Supplemental Benefits

Supplemental benefits are an attractive feature of the MA program. In theory, these benefits allow providers and plans to work together to address social drivers of health by covering services not traditionally considered medical, such as transportation, which helps address access to care issues faced by some beneficiaries. Supplemental benefits are one of the primary reasons why value-based care has flourished in MA. By tending to a patient's non-medical needs, providers are able to address patient needs that may not be medical, but have an outsized influence on their health.

AMGA applauds recent efforts by CMS to improve data collection and increase the transparency around supplemental benefits. The February Memorandum on "Submission of Supplemental Benefits Data on Medicare Advantage Encounter Data Records" will improve the data available to policymakers, while the requirement that plans notify enrollees of unused supplemental benefits will ensure that Medicare beneficiaries are using all of the services to which they are entitled. To build on these positive changes, we believe that plans should report prior authorization timelines, approval rates, and appeal rates for the supplemental benefits they offer. We recognize that CMS does not have coverage criteria for supplemental benefits, as they are not covered under traditional Medicare. However, given how supplemental benefits are

marketed to members by plans and CMS' recent rulemaking on marketing requirements, we encourage CMS to build on this work to ensure providers and patients understand if access to these benefits will be limited by prior authorization processes or are subject to utilization management policies. AMGA also recommends that MA plans report data on how supplemental benefits are used. Data on utilization of supplemental benefits—which patients are using the benefits and what benefits they are using—will help providers identify care gaps. Further, CMS should disclose the payment amounts MA plans receive for each supplemental service or service. This would allow for comparisons to be made against the actual cost to the plan for the benefit. It also would ensure the plans, as opposed to the providers, are covering those expenses.

CMS-HCC Risk Adjustment Model Changes
In CY 2024, CMS introduced the CMS-HCC risk adjustment model, with plans to implement it fully by 2026. The model includes updates such as restructuring condition categories, using ICD-10 codes, and incorporating more recent data. For the 2024 payment year, CMS calculated risk scores as a blend of the 2020 CMS-HCC model, known as version 24, and the updated 2024 model, also known as version 28. For 2025, CMS is proposing to continue the phase-in, with risk scores calculated as a blend of 33% from the 2020 model and 67% from version 28.

When CMS first proposed these changes, AMGA recommended CMS not finalize them due to the short timeframe for implementation, the uncertain effects changes to the model would have, and the anticipated downstream implications for providers and the patients they serve. AMGA was particularly concerned the proposals would reduce payments to plans and, ultimately, to providers. CMS should reconsider the continued transition to version 28.

Unfortunately, as anticipated, AMGA members are experiencing significant reimbursement reductions from MA plans. They report the phase-in of the HCC changes is already affecting group practices and integrated systems of care that have a significant number of their patients enrolled in MA. For example, AMGA members report MA plans are eliminating benefits, which has a direct effect on patients. As provider organizations, AMGA members are facing the possibility of reducing staff, eliminating programs, and reevaluating their strategic plans to account for the reductions in MA. The effect of these changes to MA will not be restricted to the plans or the insurance industry. Rather, the ramifications quickly will reach patients and providers, who already are facing financial challenges due to a reduction in the Part B conversion factor, as well as increasing labor and supply costs.

AMGA has identified a number of additional issues with the transition to version 28, which are detailed below.

Complex Coding Requirements: The HCC model uses specific diagnosis codes to calculate risk scores, which can be complex and require a detailed understanding of coding guidelines. Physicians and their care teams may need additional training or resources to accurately assign HCC-related codes and ensure compliance with coding regulations. Version 28 assigns a risk score to 2,264 fewer diagnosis codes, necessitating updated training.

Impact on Reimbursement: The HCC model directly influences reimbursement rates for MA plans, with lower risk scores leading to decreased payments to health plans. Now, plans reimburse physician less for providing the same care for patients with certain complex, chronic

conditions, solely due to a change in in the risk model.

Coding Accuracy Challenges: Accurate coding is crucial for the HCC model, as incorrect or incomplete coding can lead to underestimation or overestimation of patient risk scores. Physicians may face challenges in accurately coding conditions that affect risk adjustment without compromising clinical accuracy. These risk scores help provider organizations identify the patients who would benefit the most from additional services, such as care management, disease specific programs, transportation assistance, and other population health initiatives. The shift from version 24 to version 28 removed thousands of codes from the model, which makes risk stratification less accurate. As a result, it is more difficult to identify which patients are in most need of these services, which given resource and staffing constraints, must be targeted to those who would benefit the most.
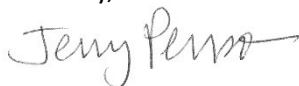
Data Integrity and Interoperability: The HCC model relies on the integrity and interoperability of electronic health record (EHR) systems and health information exchange platforms. Physicians may encounter challenges related to data completeness, accuracy, and accessibility when using EHRs to support risk adjustment activities.

Standard Definitions
For meaningful comparisons across providers and plans, it is critical that any new data collected on beneficiary characteristics have standardized definitions. For example, health equity, health disparities, and health inequities often are used interchangeably. CMS' understanding of the importance of standardized data collection is evident in the recent Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and Inpatient Prospective Payment System (IPPS) proposed rules, which added four new standardized social drivers of health measures to the data collection required under each of the respective reporting requirements for these payment systems. Having standardized data also will enable policymakers and providers to incorporate intersectionality into their analyses. Ensuring consistent definitions in data collection efforts in MA will be an important aspect of any effort to address equity concerns. CMS should work with stakeholders to ensure data collected on beneficiary characteristics, particularly data related to health equity efforts, have standard definitions so CMS, providers, and other stakeholders can make meaningful and informed decisions on how best to address equity concerns.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Director of Regulatory and Public Policy Darryl Drevna at 703.833.0033 ext. 339 or ddrevna@amga.org.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer