AMERICAN ACADEMY OF FAMILY PHYSICIANS

May 23, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–4207–NC; Medicare Program; Request for Information on Medicare Advantage Data

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 130,000 family physicians and medical students across the country, I write to provide comments on the request for information *Medicare Program; Request for Information on Medicare Advantage Data* from the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS), as requested in the January 30, 2024, Federal Register. The AAFP commends CMS for seeking input on all aspects of data related to the Medicare Advantage (MA) program, and we appreciate the opportunity to offer feedback from the family physician perspective. As detailed further below and in addition to other recommendations, **the AAFP urges CMS to:**

- **Require all MA plans to participate in a single data collection process, which would allow family physicians to report data once to a centralized repository that can be used by MA plans to populate their network provider directory, instead of physicians having to update information for each MA plan for which they are in-network.**
- **Expand prior authorization transparency and reporting requirements to prescription drug coverage and Part D plan sponsors.**
- **Propose and implement additional requirements to monitor the use of prior authorization more broadly, including expanding the reporting requirements to allow for disaggregated reports.**
- **Improve transparency of how payments and incentives earned from MA contracts are directed, including whether they are invested in equipping primary care practices to deliver high-quality primary care to their patients**.

Data-related Recommendations Related to Beneficiary Access to Care Including Provider Directories and Networks

The AAFP appreciates CMS' interest in improving MA plans' data collection and use for provider directories, which serve a number of functions across the health care ecosystem. We believe a more centralized data collection process would contribute to improved, more accurate provider directories that would more effectively help patients find in-network clinicians and health care facilities while also reducing the administrative burden placed on physicians and their practice staff. Plans collect information from physicians, other clinicians, and facilities to inform patients about where to seek in-

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network care in their community, provide practice information (e.g., phone number, address, and hospital affiliations), indicate whether a practice is accepting new patients, and more. Plans also use information from physicians and other clinicians to process billing, claims, and other expenses, as well as to understand where gaps of available clinicians may exist in their networks. As enrollment in MA continues to grow, recently reaching half of all people enrolled in Medicare for the first time, the AAFP supports CMS' interest in increasing the efficiency and accuracy of clinician data collection.

Most primary care physicians are in-network with several private payers, in addition to Medicaid, Medicaid managed care, Medicare, and Medicare Advantage plans. A 2023 internal survey of 20,000 AAFP members showed that 30% of respondents reported receiving payments from 14 or more payers within the past 12 months; almost half contracted with more than 10 payers. As a result, physician practices are required to submit duplicative information to multiple payers, requiring dedicated staff time that increases practice costs and uses valuable time that could otherwise be spent on tasks in support of direct patient care. Moreover, payers require some information to be updated regularly, such as when a physician is accepting new patients. Practices report a significant amount of staff time working to update various directories and registries.[i] Physicians and other clinicians lack a streamlined and efficient way to provide such information to plans on a regular basis, leading to inaccurate or out of date information. The accuracy of provider directories remains a significant challenge, leading to frustration among patients, physicians, and plans. Inaccurate directories create barriers to timely, affordable care for patients and add more administrative tasks for primary care physicians when referring patients to specialists or other services.

The AAFP strongly recommends CMS require all MA plans to participate in a single data collection process, which would allow family physicians to report data once to a centralized repository that can be used by MA plans to populate their network provider directories and support other functions, such as assessing network adequacy more efficiently and accurately. CMS would need to ensure participation across MA payers for this to be effective and for it to meaningfully reduce burden. In prior RFIs, CMS has suggested one standardized approach of using an Application Programming Interface (API) to collect and share standardized MA data. The AAFP supports this approach so long as CMS ensures the API is affordable and accessible to practices, includes security measures, and relies on streamlined and consistent data use requirements. We agree that using an API could make MA data more accessible for patients and could facilitate data sharing among practices, payers, vendors, and other health care stakeholders. APIs must always perform successfully in real-world testing in physician practice environments before implementation and broad use of the API are required. If CMS chooses an API approach, the AAFP recommends placing compliance requirements on source systems such as EHR vendors to ensure physician practices can access and use the API without needing additional implementation support or having to pay additional fees.

The AAFP is supportive of data that is descriptive of the practice and helpful to patients selecting where to receive their care being required submissions for the purpose of developing provider directories, such as requiring practices to report languages offered in a standardized format; whether a translator will be physically present or accessed via audio/video or audio-only technology; and office accessibility considerations, such as accommodations for individuals with disabilities. These are crucial factors for patients to ensure that physician practices and other facilities are equipped to provide accessible, inclusive, person-centered care. Requiring reporting of these data could also aid MA plans in identifying accessibility gaps in their networks. However, CMS should allow other data to

be voluntarily reported, such as specific services offered at individual practice locations and physicians' personal demographic data. We are concerned that making some of these data public could threaten physicians' privacy and ability to safely practice, particularly since the directory would inherently include the address of the physicians' practice. We urge CMS to take a balanced approach that enables physicians and other clinicians to voluntarily report most information and only require the inclusion of certain data elements that are essential to accessible care.

Prior Authorization and Utilization Management, Including Denials of Care and Beneficiary Experience with Appeals Processes as well as Use and Reliance on Algorithms

Prior authorization (PA) is a health plan utilization management process by which physicians must obtain advanced approval from a health plan before delivering a procedure, device, supply, or medication for insurance to cover that service's cost. Health plans frequently describe their use of prior authorization as a mechanism to ensure health care services are medically necessary, appropriate, and evidence-based, in addition to serving as a cost-control mechanism. However, repeated evidence has shown that many plans use PA inappropriately, causing care delays and worsening patient outcomes and satisfaction. A 2022 report from the HHS Office of Inspector General (OIG) confirmed that MA plans sometimes deny prior authorization requests that meet Medicare coverage rules by using clinical criteria not in Medicare coverage rules and requesting unnecessary documentation, as well as making errors. A 2018 OIG report found that MA plans overturned approximately 75% of denied prior authorizations on appeal. A more recent 2023 OIG report found that 13% of MA denials met the requirements of Medicare coverage rules; in other words, 13% of the services should have been approved. In addition to increasing administrative burden for physicians, these unwarranted denials often prevent or delay patient treatment. In fact, a recent survey found that 22% of MA patients experienced delays in care compared to 13% in traditional Medicare.[ii]

Family physicians continually report that prior authorization requirements for prescription drugs are a significant, if not the greatest, contributor to their overwhelming administrative workload. They also note that such requirements prevent patients from initiating treatment in a timely manner, causing care delays, worsening symptoms, and increasing patient frustration and distress. **The AAFP strongly urges CMS to expand PA transparency and reporting requirements to prescription drug coverage and Part D plan sponsors**.

The AAFP applauds CMS' decision to finalize requirements for MA plans to establish a UM committee to conduct an annual review of all UM policies and procedures. The required annual review ensures coverage criteria in MA is consistent with traditional Medicare, and that any internal coverage criteria is based on current evidence or guidelines and publicly posted. We also supported CMS' recent decision requiring UM committees to include one member with "expertise in health equity" and to publish an annual health equity analysis on the use of PA. The report must be posted publicly starting July 1, 2025, and will examine PA outcomes for dually eligible individuals and those enrolled in Medicare due to disability. We encourage CMS to expand these requirements to compare the use and outcomes of PA to enrollees with other social-risk factors (SRFs), such as poverty or inequality.

The AAFP urges CMS to propose and implement additional requirements to monitor the use of PA more broadly. We commend CMS for increasing transparency around the use of PA by requiring plans to publish performance metrics on PA use, including statistics on PA approval and denial rates,

and average timeframes for decisions. Publishing this information is a step in the right direction, but aggregating performance for all plans offered within a contract may obscure individual plan performance and will make it difficult for patients to choose accordingly when selecting coverage. We request CMS consider expanding the reporting requirements to allow for disaggregated reports including:

- PA process metrics by individual plan;
- PA process metrics by service and/or item; and
- Reason for PA denial.

As noted above, allowing patients to see process metrics at the plan level will improve their ability to assess accessibility to care when evaluating MA plans during enrollment. Reporting these metrics by service or item will identify services with variable denial rates and possibly enable CMS to identify specific services where plans have implemented PA standards that fail to meet traditional Medicare coverage criteria.

Cost and Utilization of Different Supplemental Benefits

The AAFP believes MA plans—and all private payers—should be required to provide evidence or reports on the value of supplemental benefits categories. A March 2023 Medicare Payment Advisory Commission (MedPAC) status report to Congress on the MA program states, "the use and value of many supplemental benefits currently offered is unclear. Current supplemental benefits are well above historical levels, and the Commission has maintained that payments to plans could be reduced without substantial cuts to extra benefits that are highly valued by beneficiaries, such as lower premiums and cost sharing." **We support CMS' implementation of MA plan reporting requirements on the utilization and cost associated with supplemental benefit offerings, and the addition of standards to ensure supplemental benefits for the chronically ill (SSBCI) have evidence demonstrating their ability to improve patient outcomes.**

The AAFP further commends CMS for implementing the two Government Accountability Office (GAO) recommendations from a January 2023 report, including: (1) clarifying guidance on the extent to which encounter data submissions must include data on the utilization of supplemental benefits, and (2) addressing circumstances where submitting encounter data for supplemental benefits is challenging for MA plans, such as when a given benefit lacks an applicable procedure code. The AAFP would also support CMS expanding the extent to which data submissions must include data on the utilization of supplemental benefits.

Care Quality and Outcomes, including Performance Measures, Value-based Care Arrangements, and Health Equity

The AAFP understands that patients benefit from longitudinal primary care provided by family physicians, as seen in improved patient outcomes. We are committed to developing strategies that promote health equity through identifying and incorporating social determinants of health (SDoH) in all health care delivery systems **–** with the goal of prioritizing preventive health and management of chronic conditions. We understand that achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Recent GAO reports show that patients have high rates of disenrollment in the last year of life from MA plans to join traditional Medicare. This may indicate issues with quality of care, including potential limitations accessing specialized care under some MA organizations' clinician networks. While reports suggest that patients with severe illness are more likely to disenroll from MA plans, it is unclear whether this is due to physician access issues or access to other services such as hospice care. We ask CMS to consider publishing data collected on the reason why a patient chooses to disenroll from an MA plan and to report these statistics by certain characteristics or conditions.

Healthy Competition in the Market, including the Impact of Mergers and Acquisitions, High Levels of Enrollment Concentration, and the Effects of Vertical Integration, Data Topics Related to Medicare Advantage Prescription Drug Plans (MAPDs)

The AAFP recently submitted comments in response to a tri-agency RFI on health care consolidation. Large health systems and private insurers frequently view primary care physicians as the front door to other higher margin products or services offered by their organizations. In addition to the ability to direct patients to other services the parent entity owns—such as highly specialized services, an urgent care center, or a pharmacy—primary care physicians can also coordinate care and control utilization, which improves performance in risk-based contracting arrangements, including some MA contracts.[iii,iv,v]

We surveyed AAFP members on the impact of consolidation and learned that family physicians often experienced a reduction in autonomy after being acquired or employed by a larger organization. For example, one physician acquired by a private insurer with MA contracts expressed frustration over increased documentation and coding requirements. Physicians acquired by private insurers often choose to resign, which may result in reduced patient access. There are also potentially negative impacts to patients, such as reports of patients being turned away from a clinic after their physician resigned unless they agreed to accept virtual health services or switch to a different insurer.[vi,vii]

The AAFP increasingly hears from family physicians that their employers (whether health system, private insurer, or private equity firm) are using primary care as a mechanism to drive success in other aspects of their business and are failing to invest in the infrastructure (e.g., technology and teams) needed to support high-quality, comprehensive primary care practices and clinicians. This prevents primary care practices from making the practice improvements that can advance quality and bolster patient health outcomes. **The AAFP urges CMS to improve transparency of how payments and incentives earned from MA contracts are directed, including whether they are invested in equipping primary care practices to provide high-quality primary care to their patients.**

Conclusion

The AAFP commends CMS' efforts to receive feedback on all aspects of data related to the MA program. We appreciate the opportunity to comment and look forward to continued partnership with CMS to advance appropriate and clear data collection practices for MA plans that will reduce family physicians' administrative burdens and improve patients' ability to make informed choices about their care. Please contact Mandi Neff, Regulatory and Policy Strategist, at mneff2@aafp.org with any questions or concerns.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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[ii] Gretchen Jacobson et al., What Do Medicare Beneficiaries Value About Their Coverage? Findings from the Commonwealth Fund 2024 Value of Medicare Survey (Commonwealth Fund, Feb. 2024). https://doi.org/10.26099/gq43-qs40

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[v] "Medicare Advantage, Direct Contracting, And The Medicare ‘Money Machine,’ Part 1: The Risk-Score Game", Health Affairs Blog, September 29, 2021. DOI: 10.1377/hblog20210927.6239

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[vii] Rebecca Hansen-White, “Lane County patients turned away from Oregon Medical Group in possible corporate pinch,” KLCC News, April 8, 2024. https://www.klcc.org/health-medicine/2024-04-08/lane-county-patients-turned-away-from-oregon-medical-group-in-possible-corporate-pinch