May 29, 2024

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

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4207–NC
P.O. Box 8013
Baltimore, MD 21244–8013

RE: Medicare Program; Request for Information (RFI) on Medicare Advantage (MA) Data

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) is pleased to submit comments in response to the Medicare Program; Request for Information on Medicare Advantage Data, published in the Federal Register on Jan. 30, 2024.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following feedback.

The Congressional Budget Office (CBO) projects that the share of all Medicare beneficiaries enrolled in MA will rise to 61% by 2032.[1] As the number of MA beneficiaries continues to grow, it is imperative that the MA program ensures adequate and transparent coverage to patients, timely payment to medical groups, and remains a viable pathway for medical groups to participate in value-based payment arrangements. These priorities cannot be achieved without accurate and robust data on MA utilization management practices including prior authorization, onerous care denials, and value-based contracts.

Prior authorization

Prior authorization is routinely identified by medical groups as the most challenging regulatory burden to running a practice and delivering high-quality care. In March of 2023, MGMA surveyed over 600 medical groups to understand the critical impact of prior authorization within the MA program. Findings overwhelmingly showed that prior authorization in MA is increasingly onerous for medical group

[1] KFF, Medicare Advantage in 2023: Enrollment Update and Key Trends, Aug. 9, 2023.

practices, with 98% of medical groups reporting that prior authorization requirements had stayed the same or increased over the previous 12 months. Seventy-seven percent of groups reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups surveyed reported that there were at least three different employees involved in completing a single prior authorization request.[2]

New prior authorization rules

MGMA applauds the administration for finalizing both the *Interoperability and Prior Authorization Final Rule* and the *Contract Year 2025 Medicare Advantage and Part D Final Rule*. The increased transparency provisions — requiring health plans to provide clarity on the reasoning behind care denials, publicly report aggregated metrics about their prior authorization programs annually, and requiring utilization management committees to conduct a health equity analysis of prior authorization policies and procedures — will help shine a light on the egregious abuse of prior authorization by payers under the guise of looking out for patients' best interests. These final rules are an important step forward toward MGMA's goal of reducing the overall volume of prior authorization requests. However, there is still more work to be done as these requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests.

MGMA urges the Centers for Medicare and Medicaid Services (CMS) to collect more granular data on the use of prior authorization in the MA program. The oversight and transparency provisions in the *Interoperability and Prior Authorization Final Rule* require MA plans to post aggregate metrics about prior authorization to their websites. We urge CMS to require this data be publicly accessible in a central location on the CMS website to enable patients, providers, and researchers to easily compare MA plan prior authorization data. Further, we encourage CMS to require MA plans to report metrics categorized by each item and service. This granular data is essential to identify and reduce the number of prior authorizations MA plans require for routine items and services.

The *Improving Seniors' Timely Access to Care Act*, which we anticipate will be reintroduced soon in both the House and Senate, would increase the oversight of prior authorization within the MA program. However, the legislation's transparency provisions are more comprehensive than those included in the rules finalized this year and outline more robust data collection requirements aimed at ensuring patients timely access to care. This legislation has garnered support from over 500 patient-provider organizations and 350 co-sponsors last Congress. We would encourage CMS to use its authority to expand on the existing prior authorization data reporting requirements by collecting the following additional data from MA plans as outlined in the legislation:

- Percentage and number of specified prior authorization requests approved/denied during the previous plan year (both in aggregate and categorized by each item and service).
- Percentage and number of prior authorization requests denied during the previous plan year that were subsequently appealed.
- Number of appeals of prior authorization requests resolved during the preceding plan year categorized by each applicable item and service categorized by each level of appeal (including judicial review).
- Percentage and number of resolved prior authorization appeals that resulted in approval of the item or service that was the subject of such request categorized by each level of appeal (including judicial review).

[2] MGMA Spotlight: Prior Authorization in Medicare Advantage, May 2023.

- Percentage and number of prior authorization requests that were denied/approved by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, and clinical decision-making technology.
- The percentage and number of specified requests that were excluded from the calculation of the time elapsed based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.
- A disclosure and description of any decision support technology that the plan utilized during the previous plan year that were related to a prior authorization requirement.
- The number of grievances received by a such plan during the previous plan year that were related to a prior authorization requirement.

Value-based care

Despite challenges medical groups face from contractual arrangements with MA plans, the program enables medical groups to invest in important value-based care initiatives through participation in MA risk arrangements and the administration of provider-offered MA plans. In contrast to fee-for-service (FFS) Medicare, participation in value-based care initiatives within MA allows medical groups to take on full or partial risk for services and in turn, make important investments in value-based care.

Strengthening these value-based care initiatives in MA is imperative as CMS aims to have 100% of Medicare beneficiaries participating in a value-based payment arrangement by 2030. In response to a 2023 survey, 78% of medical groups reported Medicare did not offer a clinically relevant Alternative Payment Model (APM).[3] Value-based care arrangements with MA plans are important options for medical groups in the wake of decreasing Medicare payments and the transition from FFS to value-based care.

We recommend CMS collect more robust information from MA plans about the application of value-based arrangements, such as the frequency of incorporation of value to payment methodologies and the successes of such arrangements across provider types. This information can help support lessons learned in value-based care in the MA program to encourage further adoption of value-based arrangements.

Succeeding in taking on risk from MA plans requires predictability. Data sharing from MA plans to providers is essential to allow practices to continue taking on risk and make informed investments in practice transformation. Unlike Medicare ACO programs, MA plans are not required to share comprehensive data with providers who enter risk-bearing arrangements. It is imperative for MA plans to share data files relevant to managing risk for attributed patient populations in a readable format and timely manner. This includes encounter data, monthly membership reports, model output reports, risk adjustment eligibility, and prescription drug event data. MGMA members that assume risk for Part D note challenges related to managing medications and their costs due to lack of data on the components of the net cost for Part D that are outside of the provider's control — including rebates and discounts. MA plans should be required to share all components of the net cost for Part D with at-risk providers in a timely manner.

Supplemental benefits

We encourage CMS to bolster MA encounter data collection efforts. Without complete and accurate MA encounter data, patients and providers cannot make meaningful comparisons between MA and traditional FFS, nor determine the use and value of supplemental benefits being used within the program. MGMA

[3] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.

members in risk-sharing relationships note that costs related to supplemental benefits such as dental, vision, and in-home support services are often not shared with providers despite being included in their care risk pool. We encourage CMS to require MA plans to share all costs associated with supplemental benefits with at-risk providers to ensure providers understand whether they are being held accountable for care they have little or no control over.

Conclusion

MGMA thanks CMS for its recent work to alleviate the burden of prior authorization stemming from many government payers and its leadership in strengthening the availability of data related to the MA program. We strongly urge the agency to continue working to collect and make available robust data on prior authorization and value-based care in the MA program. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs