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May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G 200
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-4207-NC. Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) Request for Information (RFI) on Medicare, published in the Federal Register on January 30, 2024 (89 Fed. Reg. 5907). This RFI allows continued engagement with stakeholders aimed at refining and enhancing the quality of data used to guide policymaking and improve the Medicare Advantage (MA) program. We appreciate CMS for its previous RFI, published on August 1, 2022 (87 FR 46918), which the AMA responded to with detailed comments focusing on strategies to enhance the MA framework, aligning closely with CMS' Strategic Pillars.[1] This follow-up RFI provides an invaluable opportunity to build on these discussions, ensuring that we maintain momentum in our collective efforts to address key issues impacting the MA landscape.

MA Encounter & Utilization Data

In CMS' MA data RFI, CMS stated that their "… eventual goal is to have, and make publicly available, MA data commensurate with data available for Traditional Medicare to advance transparency across the Medicare program." The AMA commends CMS for working extensively on this issue already and continuing to work towards this important objective. We have several recommendations on how to continue to make progress in achieving this goal.

The AMA appreciates that CMS has recently released the following MA encounter datasets as research-identifiable files (RIF) through its contractor, the Research Data Assistance Center (ResDAC):

- Inpatient (Encounter)
- Outpatient (Encounter)
- Carrier (Encounter)
- Skilled Nursing Facility (Encounter)
- Durable Medical Equipment (Encounter)
- Home Health Agency (Encounter)

[1] File Code CMS-4203-NC. Medicare Program; Request for Information (RFI) on Medicare.

These files have many of the same data as their traditional Medicare fee-for-service (FFS) RIF counterparts, including Current Procedural Terminology® (CPT®) Healthcare Common Procedure Coding System (HCPCS) codes, diagnosis codes, utilization data, National Provider Identifier, HCPCS modifiers, beneficiary information, provider specialty, place of service, date of service, locality, etc. Unfortunately, the impact of this initial MA encounter data release has been limited due to the numerous steps required to acquire RIF file data, the limited ways RIF datasets can be used and their size/complexity. RIF files contain protected health information (PHI) and/or personally identifiable information (PII), and CMS allows organizations to access RIFs solely for research purposes. Also, these files do not currently include any payment information. Requests for these data require many steps, including a research protocol and an extensive Data Use Agreement, among other documents, followed by review and approval from CMS' Privacy Board.

Limited Data Set Files

Unlike Medicare FFS claims data, MA encounter data are not yet available in the limited data set (LDS) format, which are permitted to be used more broadly. LDS files are also available as higher summary-level files and as claim level files with a random sample of beneficiaries (i.e., five percent sample or 20 percent sample of Medicare beneficiaries), making these datasets much more accessible and broadly helpful to many more stakeholders. Some LDS files, such as standard analytic files (SAF) files, do contain beneficiary-level health information and are considered identifiable files, but they do not contain specific direct identifiers as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Therefore, these data files have data-use agreements that have fewer requirements, are less costly to acquire and require less sophisticated data infrastructure to access and analyze.

Traditional Medicare FFS LDS data files greatly help inform decisions made by the CPT Editorial Panel, the AMA/Specialty Society RVS Update Committee (RUC), CMS officials in the CMS Hospital & Ambulatory Policy Group, staff for CMS' National Correct Coding Initiative (NCCI) program, national specialty associations, health care systems, Congress, payers, and many other stakeholders. As a majority of Medicare beneficiaries now have MA plans, it is critical to provide all stakeholders with a pathway to access MA encounter data as soon as possible for purposes beyond research, so stakeholders can make informed decisions based on representative data from both the traditional Medicare and MA programs. **As a next step and to further increase transparency, the AMA recommends that CMS use these RIF files to also create LDS standard analytic files (SAFs) and separately to create higher-level summary files using MA encounter data.**

Although not the subject of this RFI, we would also like to highlight that CMS has recently made Medicaid utilization data available, though only as RIF files for researchers. **The AMA recommends that CMS use Medicaid Utilization RIF files to create LDS and public use files to make data from the Medicaid program more widely available.**

Examples of LDS Datasets

An example of a file that would be greatly beneficial to many stakeholders would be an MA encounter version and a Medicaid utilization version of the Physician/Supplier Procedure Summary (PSPS) Limited Data Set (LDS) file. This traditional Medicare data file does not drill down to the individual claim level and does not contain PII or PHI. Instead, these data are aggregated at a higher level, drilling down to carrier, locality, CPT/HCPCS code, code modifier, provider specialty and place of service. The summarized fields in the PSPS LDS file are total submitted services and charges, total allowed services

and charges, total denied services and charges, and total payment amounts. If CMS created a similar file for MA data and Medicaid data, many stakeholders would find this information especially useful.

Similarly, the traditional Medicare claim-level data are available as an LDS file in the Medicare Carrier Standard Analytic File (SAF). This file is available as a 5 percent or 20 percent sample of Medicare beneficiaries, as well as separate version with 100 percent of claims. These claim-level files enable stakeholders to see detailed information on CPT/HCPCS codes as well as ICD-10-CM codes on a representative sample of Medicare claims. Stakeholders would get broad use out of MA and Medicaid data provided in a similar format as well.

Limitations of MA Encounter Data

Over the past several years, the Medicare Payment Advisory Commission (MedPAC) has recommended that CMS increase incentives for MA plans to submit complete and accurate MA encounter data.[2] MedPAC has also highlighted that, although a majority of beneficiaries who received a service had a record in the MA encounter data, these data were still incomplete.[3,4] **The AMA recommends for CMS to continue to develop new mechanisms to improve the quality of these MA encounter data and to consider collecting encounter data submitted by plans through Medicare administrative contractors to improve the quality and representativeness of these data.** The AMA does not think the current state of MA encounter data would prevent the Agency from creating and releasing LDS MA data files, provided the documentation for these files clearly specifies limitations.

Public Use File Data

The AMA appreciates that CMS has taken an initial step to make MA encounter summary data publicly available by aggregating MA encounter procedure volume data with traditional FFS data in the Medicare Physician Compare tool (https://www.medicare.gov/care-compare/) for the following 12 procedure groupings:

1. Cataract surgery
2. Colonoscopy
3. Coronary angioplasty and stenting
4. Coronary artery bypass graft
5. Hernia repair - groin (open)
6. Hernia repair (minimally invasive)
7. Hip replacement
8. Knee replacement
9. Mastectomy
10. Pacemaker insertion or repair
11. Prostate resection
12. Spinal fusion

[2] MedPAC, 2020. Report to Congress: Medicare payment policy (Chapter 13). Washington, DC: MedPAC.
[3] MedPAC. 2022. Medicare Advantage encounter data. https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf.
[4] MedPAC, 2024. Assessing consistency between plan-submitted data sources for Medicare Advantage enrollees. https://www.medpac.gov/wp-content/uploads/2023/10/MA-assessing-plan-data-April-2024-SEC.pdf.

The AMA encourages CMS to continue to work towards making more MA Encounter data and Medicaid Utilization data available in high level summary public files, similar to the datasets publicly available for traditional Medicare (https://data.cms.gov/provider-summary-by-type-of-service).

Behavioral Health/Substance Use Disorder Treatment Access

In a recent report, the Legal Action Center (LAC) found that of the nearly six million Medicare patients with a substance use disorder (SUD), less than a quarter received treatment in 2022. In addition, the rate of overdose deaths among adults ages 65 and older has quadrupled over the past two decades, and the Centers for Disease Control and Prevention reports that Black men over age 65 are seven times more likely to die from an overdose than their White peers. The AMA urges CMS to improve data collection from MA plans on access to SUD treatment and use this data to help reduce that gap between patients diagnosed with an SUD and those receiving treatment.

Toward this end, the AMA supports the new requirement that MA plan networks include Outpatient Behavioral Health. We recommend enhanced monitoring of patient access to these treatments and ensuring team-based care is physician-led to maximize the effectiveness of the new Outpatient Behavioral Health facility-specialty. CMS should require MA plans to report on the number of patients who have been diagnosed with opioid use disorder and who are receiving medications for opioid use disorder (MOUD), including the type of medication—buprenorphine or methadone. Information reported should also include whether that care is being provided in- or out-of-network. This data collection should also include how easily patients were able to obtain MOUD, for example, whether they faced drug utilization management barriers such as prior authorization, quantity limits, formulary limitations on the specific MOUD product or formulation they were prescribed, or other types of barriers (see recent correspondence on new MOUD ordering and dispensing barriers that patients are encountering). Within the patient population with OUD, patients released from incarceration who may enroll in MA during a Special Enrollment Period may warrant some special attention as leaving incarceration is an extremely high risk period for overdose.

The AMA strongly encourages CMS to require MA plans to conduct analyses where people with opioid use disorder (OUD) get MOUD—to ensure that within the time/distance standards, there are adequate numbers of in-network OUD physicians who offer both medications. Similar to the LAC report cited above, a recent Office of the Inspector General (OIG) report found that nearly 52,000 Medicare beneficiaries had an opioid-related overdose in 2022, but fewer than one in five Medicare beneficiaries with an OUD receives medications for their OUD. Rates to receive medications for OUD varied considerably by state—from only six percent of beneficiaries in Florida with an OUD to 60 percent in Vermont. The OIG report also highlighted multiple inequities in OUD treatment: 15 percent of female enrollees received MOUD compared to 23 percent of male enrollees; White enrollees were more likely to receive MOUD than Black, Hispanic or Asian/Pacific Islander enrollees; Black and Hispanic enrollees were less likely to receive buprenorphine from a community-based physician. While buprenorphine and methadone both are evidence-based MOUD options, methadone currently can only be accessed at Opioid Treatment Programs, which often require individuals to travel far distances daily, arrange for childcare and manage employment-related requirements.

The AMA is also concerned by reports that MA plans may impose cost-sharing for SUD treatment, including Opioid Treatment Program services, that patients do not face in regular Medicare, and we agree with the LAC that plans should be required to provide data on their cost-sharing requirements for SUD services. In addition, little is known about MA plan supplemental benefits and their utilization even though funding for these benefits has doubled in just the past five years. Do MA

plans offer any supplemental benefits that focus on helping patients with an SUD obtain comprehensive care for this condition? If so, the AMA recommends that CMS obtain data on the utilization of these supplemental benefits by patients.

Prior Authorization & Utilization Management Data

The AMA strongly advocates for transparency in health plans' prior authorization and other utilization management programs. In fact, the 2017 Prior Authorization and Utilization Management Reform Principles,[5] which were created by the AMA and 16 other organizations representing physicians, medical groups, hospitals, and patients and endorsed by over 100 additional groups, call for public reporting of prior authorization program data, as this information is critical in evaluating the effectiveness, potential impact, and costs of authorization processes on patients, physicians and other providers, health insurers, and the system as a whole. Unfortunately, limited data are currently made publicly available for research and analysis. Utilization review entities need to provide industry stakeholders with relevant data, which should be used to improve efficiency and timely access to clinically appropriate care. Such public reporting and data analysis are key to identifying and addressing the negative impacts of these administrative processes on patients and their health that are all too common today.

Negative Impact on Patient Care

The AMA conducts an annual survey of around 1,000 practicing physicians to study the impact of prior authorization on patients and physician practices. Surveyed physicians consistently report the continuing negative impact of these requirements on patient health.[6] For example, 94 percent of 2022 survey respondents state that prior authorization delays care, and 89 percent report that the process has a negative impact on patient clinical outcomes. Most alarmingly, 33 percent of surveyed physicians reported that prior authorization has led to a serious adverse event for a patient in their care. In addition to these quantitative findings, the devastating patient and physician stories captured on the AMA's grassroots reform website FixPriorAuth.org highlight the human cost of the prior authorization problem.[7]

Patient burden and harm are common themes in other studies and reports on prior authorization. A 2022 survey done by the American Society for Clinical Oncology found that nearly all oncology providers reported that a patient had experienced harm because of prior authorization processes, including significant impacts on patient health such as disease progression (80 percent) and loss of life (36 percent).[8] Similarly, prescription prior authorization implementation for medications to treat diabetes, depression, schizophrenia, and bipolar disorder has been associated with worsening disease status, increased hospitalization, and higher net medical costs.[9,10] But conversely, the *removal* of prior authorization requirements can increase patient access to medically necessary care and improve patient

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[5] https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.
[6] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[7] https://fixpriorauth.org/stories.
[8] https://old-prod.asco.org/news-initiatives/policy-news-analysis/nearly-all-oncology-providers-report-prior-authorization#:~:text=Prior%20authorization%20is%20harming%20individuals,from%20caring%20for%20their%20patients.
[9] Bergeson JG, Worley K, Louder A, Ward M, Graham J. Retrospective database analysis of the impact of prior authorization for type 2 diabetes medications on health care costs in a Medicare Advantage prescription drug plan population. *J Manag Care Pharm*. 2013;19(5):374-384. doi:10.18553/jmcp.2013.19.5.374.
[10] Seabury SA, Goldman DP, Kalsekar I, Sheehan JJ, Laubmeier K, Lakdawalla DN. Formulary restrictions on atypical antipsychotics: impact on costs for patients with schizophrenia and bipolar disorder in Medicaid. *Am J Manag Care*. 2014;20(2):e52-e60.

outcomes. For example, a 2020 study found that Medicare Part D plans that removed prior authorization for buprenorphine-naloxone medications showed a 29 percent *decrease* in emergency room visits related to SUD and a 28 percent *decrease* in SUD-related inpatient admissions.[11]

Administrative Burdens and Increased Costs

While patient harm leads the AMA's concerns about prior authorization, we must also stress the enormous administrative waste associated with fulfilling plan requirements. In the AMA's most recent physician survey, practices reported completing 45 prior authorizations per week, per physician, with this weekly workload for a *single physician* consuming nearly two business days of physician and staff time.[12] Given these demands, we should not be surprised that 35 percent of physicians report having staff who exclusively work on prior authorization tasks. Prior authorization clearly diverts valuable time and resources away from patient care to low-value paperwork tasks.

In addition to the costs associated with these administrative hassles, prior authorization can lead to higher health care costs, with 86 percent of physicians reporting that the process can increase overall health care resource utilization.[13] Physicians indicate that ineffective initial treatments, additional office visits, and immediate care or emergency room visits resulting from prior authorization requirements can all contribute to this increased resource utilization. Both the tremendous administrative waste and increased medical spending associated with prior authorization cast doubt upon health plans' claims that the process saves money and adds value to our health care system.

Need for Granular Data on Utilization Management Programs

We applaud CMS for finalizing regulations that improve the oversight of prior authorization in MA plans. Specifically, we appreciate provisions in the CY 2024 MA final rule that address the clinical validity of prior authorization programs and protect continuity of patient care. In addition, we enthusiastically support the reporting requirements included in the CMS Prior Authorization and Interoperability Final Rule (CMS-0057-F) that will take effect in 2026. However, there remains a pressing need for more robust data reporting to assess the impact of prior authorization and other utilization management tools on patient care and outcomes, as well as enhanced enforcement to bring much-needed accountability to the MA program. Despite CMS' recent actions, some MA plans continue to engage in questionable practices. For example, Premier's recent national survey of hospitals and health systems found that 53 percent of initial MA claims denials were eventually overturned, with the administrative cost of fighting each MA claim denial averaging $47.77.[14] These troubling data highlight that CMS must develop more robust data collection and enforcement mechanisms to address inappropriate MA denials, ensure that plans employ evidence-based clinical criteria, and safeguard the interests of beneficiaries. **The AMA urges CMS to build upon its strong efforts to reform prior authorization and other utilization management programs through the following data collection, analysis, and enforcement activities:**

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[11] Mark TL, Parish WJ, Zarkin GA. Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. JAMA Netw Open. 2020;3(4):e203132. doi:10.1001/jamanetworkopen.2020.3132.

[12] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[13] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[14] Premier. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. March 21, 2024. Available at: https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims.

- **Clinical criteria:** The CY 2024 MA rule, as well as CMS guidance released earlier this year,[15] requires MA plans to follow Medicare FFS clinical criteria (i.e., National Coverage Determinations [NCDs] or Local Coverage Determinations [LCDs]). If NCDs or LCDs are not available for a particular service, MA plans may use internal coverage criteria based on well-established clinical guidelines, and these internal criteria must be hosted on the MA plan's website. Unfortunately, there is evidence that certain MA plans are not abiding by these requirements: providers report that plans are inappropriately using internal coverage criteria (thereby denying MA beneficiaries care that they would have received under Medicare FFS) and/or not publishing internal criteria on their websites.[16] Vague disclosures with sparse information should not be considered compliant. In particular, they should disclose if there are known race-based factors included in calculations or known disparate impact from calculations without explicit race-based factors that systematically disadvantage historically minoritized patients. This should also be considered for other historically marginalized groups such as patients with disabilities. While the CY 2024 MA rule requires every MA plan to establish a Utilization Management Committee charged with ensuring compliance with these new requirements surrounding clinical criteria, the problems already being reported indicate that this internal oversight is not sufficient. **The AMA therefore urges CMS to create a formal oversight and audit process that would require MA plans to submit documentation regarding clinical criteria—whether they be LCDs, NCDs, or internally developed—and the specific, publicly accessible web URLs where physicians and patients can access these criteria.** CMS can leverage these data to review/audit plans and appropriately enforce prior authorization program requirements, from issuing corrective action plans through contract termination.

- **Continuity of care:** To prevent interruptions in care, the CY 2024 MA final rule requires prior authorization approvals to remain in place for the entire course of treatment. In addition, MA plans must allow a 90-day transition period for new enrollees during which the new MA plan cannot require prior authorization for any active course of treatment. We are disappointed to learn that these continuity of care protections have not been uniformly implemented across plans, with some providers reporting expending considerable resources on appeals to authorize ongoing care that had been previously approved.[17] **The AMA therefore urges CMS to collect data on MA plans' policies and procedures related to transition periods and duration of prior authorization approvals and enforce compliance with the new continuity of care protections.**

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[15] https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf.

[16] Pugh T. Hospitals want tough enforcement of private Medicare plan rules. *Bloomberg Law*. May 14, 2024. Available at: https://news.bloomberglaw.com/health-law-and-business/hospitals-want-tough-enforcement-of-private-medicare-plan-rules#:~:text=The%20Biden%20administration%20should%20tighten,a%20meaningful%20difference%2C%20hospitals%20say.

[17] Pugh T. Hospitals want tough enforcement of private Medicare plan rules. *Bloomberg Law*. May 14, 2024. Available at: https://news.bloomberglaw.com/health-law-and-business/hospitals-want-tough-enforcement-of-private-medicare-plan-rules#:~:text=The%20Biden%20administration%20should%20tighten,a%20meaningful%20difference%2C%20hospitals%20say.

- **Data granularity:** The AMA applauds CMS for finalizing its Prior Authorization and Interoperability rule (CMS-0057-F), which will require MA and other government-regulated plans to report data on their prior authorization programs, to include number of approvals, denials, denials overturned upon appeal, and average processing time. However, we stress the need for detailed data on prior authorization and utilization management practices, including service-specific reporting. Without access to detailed data on utilization management practices, policymakers, researchers, and beneficiaries have a limited ability to assess the quality of care provided by MA plans. **The AMA urges CMS to require MA plans to report detailed data on prior authorization requests, denials, and appeals, to include information by service type (at least at the category level), beneficiary characteristics, and specific plans within a contract.** These granular data can help identify patterns of utilization management problems and assess their impact on patient care. In addition to tracking the number of prior authorization denials, CMS should also collect information on the reasons for these denials to ensure that MA plans are not denying medically necessary care (as reported in a 2022 OIG report).[18] Understanding the rationale behind denials can provide valuable insights into the effectiveness and appropriateness of utilization management. In addition, granular information can uncover issues with specific services or categories of services; for example, high denial rates for imaging could suggest a problem with the underlying clinical criteria, while long processing times for surgery authorizations could indicate substandard performance with the third-party utilization management vendor employed by the plan for those services. Timely access to care is essential for MA beneficiaries, and monitoring response times by service type can help identify areas for improvement.

- **Data access:** While the AMA appreciates that CMS-0057-F requires MA plans to post prior authorization data on their websites beginning in 2026, we anticipate that both physicians and patients will experience difficulty locating this information. We note that for MA beneficiaries researching plans prior to enrollment, it would be much easier to have these data posted in a central location to facilitate comparison in plan performance. **For these reasons, we urge CMS to expand MA plan data reporting requirements to include submission of prior authorization program information to CMS (as well as posting on the plan's individual website) so that this information can be collated and posted in a centralized location on a CMS-hosted website.** This direct data access will also support increased audit and enforcement activities by CMS.

- **Health equity:** We applaud CMS for finalizing regulatory changes that address health equity issues in MA prior authorization programs beginning in 2025. Specifically, we appreciate that plans will need to (a) include at least one member with expertise in health equity on their Utilization Management Committee and (b) conduct an annual health equity analysis of the impact of prior authorization at the plan-level that is made publicly available on the plan's website and addresses the impact of utilization management on beneficiaries who receive the low-income subsidy, are dually eligible for Medicare and Medicaid, and/or have a disability. **While CMS has taken strides to incorporate health equity considerations into program**

[18] US Department of Health and Human Services Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022. Available at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

oversight with these requirements, we believe that the persistent, systemic inequities within our health care system that disproportionately affect marginalized communities and exacerbate disparities in health outcomes require a far more robust and detailed data collection and analysis effort. Specifically, we urge CMS to require additional populations in MA plans' health equity analyses, to include (this list is not exhaustive):

- Members of racial and ethnic communities that have been historically minoritized;
- Members of the LGTBQ+ community;
- Members of rural communities;
- Members of economically marginalized communities;
- Individuals who have visited the emergency room in the past year;
- Individuals who were hospitalized and sought post-acute care;
- English language learners (formerly limited English proficiency);
- Members with mental health conditions, including depression, anxiety, and SUD;
- Individuals with chronic diseases such as asthma, chronic obstructive pulmonary disease, cancer, obesity, cardiovascular disease, diabetes, pregnancy; and
- Individuals with a combination of chronic conditions/diseases (e.g., physical and behavioral health, including SUD).

The demographics of the MA program highlight the importance of this more robust health equity analysis for prior authorization programs. In 2021, 55, 59, and 67 percent of Asian or Pacific Islander, Black, and Hispanic Medicare beneficiaries, respectively, were enrolled in MA plans.[19] Concerningly, members of these racial and ethnic groups tend to be in MA plans with lower quality ratings.[20] Given the demographics of the MA beneficiary population, CMS should hold plans accountable for conducting thorough health equity analyses, identifying disparities within their beneficiary population due to prior authorization requirements, and implementing targeted interventions to address these inequities.

Moreover, to support CMS enforcement of these requirements, increase plan accountability, and improve transparency, MA plans should be required to submit these health equity analyses to CMS for posting on a centralized website, in addition to making the data publicly available on their own company's website. With these data in hand, CMS can boost enforcement efforts and hold MA plans accountable for ensuring equitable health care access across the diverse MA beneficiary population. Moreover, posting collated data in a centralized web location will ensure easy access for both patients and health care professionals.

- **Post-acute care transitions:** A 2022 OIG report found a trend of inappropriate denials of medically necessary post-acute care services among MA beneficiaries.[21] A widely publicized

[19] Kaiser Family Foundation. Disparities in Health Measures By Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature. December 13, 2023. Available at: https://www.kff.org/report-section/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-report/.

[20] Park S, Werner RM, Coe NB. Racial and ethnic disparities in access to and enrollment in high-quality Medicare Advantage plans. *Health Services Research*. March 27, 2022. Available at: https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13977.

[21] US Department of Health and Human Services Office of Inspector General. Some Medicare Advantage

investigation in late 2023 found that an MA plan leveraged an algorithm to draconianly restrict patient access to rehabilitative care, including a case of an older man being expected to learn how to "butt bump" up and down stairs upon hospital discharge following knee surgery.[22] Most recently, Premier's 2024 national survey of hospitals and health systems found that over 20 percent of requests for post-acute care admissions were initially denied.[23] The AMA finds these reports alarming, given the particular vulnerability of these patients and the very real possibility of negative long-term health outcomes if they cannot access critically important rehabilitation and other services following hospital discharge. **We therefore urge CMS to devote resources to specifically collecting and analyzing data on MA plans' denial of post-acute care admissions and take swift and decisive enforcement action if utilization management requirements are preventing beneficiaries recovering from serious illnesses or surgery from accessing crucial post-acute care.**

- **Step Therapy for Part B drugs:** As stated in previous AMA correspondence and sign-on letters with other physician organizations, **we urge CMS to reinstate the prohibition against use of step therapy for Part B drugs in MA plans.** Step therapy requirements for Part B drugs have proliferated in MA plans since CMS lifted this prohibition, and physicians are alarmed by the resulting care delays and negative clinical outcomes for patients with life-threatening, complex, chronic conditions, such as autoimmune diseases and cancer. **However, in absence of reinstation of this important policy, we urge CMS to collect data regarding MA plans' step therapy programs for Part B drugs.** Such data should be reported at a granular (i.e., drug-specific) level to provide meaningful information and capture the number of step therapy override requests that are approved, denied, and approved upon appeal, as well as the average processing time for step therapy override requests. In addition, MA plans should be required to report the number of patients who fail the initial "step" of treatment and progress to treatment with the drug subject to the utilization management requirement. If most patients do indeed "fail first" on the plan's required first "step" of treatment, this suggests an inappropriate step therapy protocol that is resulting in dangerous care delays and overall increased medical costs, as the plan ultimately is paying for two drugs rather than a single effective option.

The AMA urges CMS to accept our recommendations outlining increased data reporting requirements for MA plans' prior authorization and utilization management programs. Removing the "black box" surrounding these programs will vastly increase plans' accountability, ensure that MA patients receive the care they need in a timely manner, and empower CMS to take enforcement actions against plans that are inappropriately and unethically using these tools to profit at the expense of beneficiaries' health.

Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022. Available at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[22] Ross C, Herman B. UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care. *STATNews*. November 14, 2023. Available at: https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/.

[23] Premier. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. March 21, 2024. Available at: https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims.

Use of Artificial Intelligence (AI) Algorithms

There is growing concern among patients and physicians about increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his Executive Order on AI, President Biden addressed this issue as an area of concern, directing the HHS to identify guidance and resources for the use of predictive and generative AI in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.[24]

There are only limited regulatory requirements on use of AI and other automated decision-making tools by payers. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term actions. Congress has also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

Evidence indicates that payers are using automated decision-making systems to deny care more rapidly, often with little or no human review. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[25] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in MA plans with both companies. Plaintiffs also claim that payers used the model despite knowing that 90 percent of the tool's denials were faulty.

Rather than payers making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[26,27,28,29]

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[24] https://www.whitehouse.gov/briefing-room/presidential-actions/2023/10/30/executive-order-on-the-safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence/.

[25] https://www.propublica.org/article/cigna-health-insurance-denials-pxdx-congress-investigation#:~:text=The%20letter%20follows%20an%20investigation,PXDX%20system%2C%20spending%20an%20average.

[26] Obermeyer, Ziad, et al. "Dissecting racial bias in an algorithm used to manage the health of populations." Science 366.6464 (2019): 447-453. https://www.science.org/doi/10.1126/science.aax2342.

[27] Ross, C., Herman, B. (2023) "Medicare Advantage Plans' Use of Artificial Intelligence Leads to More Denials." https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/ (Accessed September 14, 2023).

[28] Rucker, P., Miller, M., Armstrong, D. (2023). "Cigna and Its Algorithm Deny Some Claims for Genetic Testing, ProPublica Finds." https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims (Accessed September 14, 2023).

[29] Ross, C., Herman, B. (2023). "Medicare Advantage Algorithms Lead to Coverage Denials, With Big Implications for Patients." https://www.statnews.com/2023/07/11/medicare-advantage-algorithm-navihealth-unitedhealth-insurance-coverage/ (Accessed September 14, 2023).

While AI can be used inappropriately by payers with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

Although payer use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payer's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payers use these systems for coverage, claim determinations, and benefit design.

We urge CMS to consider leveraging its policies and regulatory authority to implement the following concepts to prevent payer misuse:

- Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payer criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- Payers should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances, and payers' use of such systems should allow for flexibility to override automated decisions. Payers should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- Payers using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payers should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- Payers using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical

necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

- Individuals impacted by a payer's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- Payers using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payers using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payer use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payer use of automated decision-making systems must conform to all relevant state and federal laws.

Administrative Burden

The current processes for collecting and reporting quality data pose significant administrative burdens on physicians. This burden arises from the complexity, redundancy, and volume of data collection requirements imposed by various payers, including MA plans. Physicians are often required to report on numerous quality measures, many of which overlap or are inconsistent across different payers. This redundancy not only consumes valuable time and resources but also diverts attention away from direct patient care. To address these challenges, it is important for CMS to implement strategies that streamline quality data collection, reduce administrative workload, and enhance the usability of collected data. One such way to reduce administrative burden, and repeatedly highlighted by the AMA to CMS, is the need for the Star Ratings program to focus more on compliance and communication, as opposed to the current focus that relies on physician action. For health plans to increase their Healthcare Effectiveness Data and Information Set (HEDIS) scores and earn greater incentives from CMS, plans are requiring practices, as part of their clinical data submission requirements, to submit data on all patient lab results and tests and the plans state it is due to the Star Ratings HEDIS requirements. Many of the measures, particularly the HEDIS Effectiveness of Care measures, have more to do with physician quality than assessment of a health plan.

The Effectiveness of Care measures are really targeting clinical quality, which is a physician or facility issue—and therefore physicians and facilities have the data. In addition, the patient experience ratings are heavily based on Health-Plan, Consumer Assessment of Healthcare Providers & Systems (CAHPS) that emphasizes physician communication and behavior. While communication between a physician and patient is important, asking the questions in a de-identified survey does not lead to quality improvement or address potential challenges patients experience when seeking care. Similar questions are also in the hospital and clinician-group CAHPS survey and the more appropriate avenues for addressing provider communication in the context of patient experience. Without a better focus the MA ratings program is just one more burden on physicians and does not provide beneficiaries with the information they need to determine the most appropriate and high-quality MA or drug plan. Therefore, to further improve the information CMS receives about patients' experience with their plans, we encourage CMS to work with

The Agency for Healthcare Research and Quality (AHRQ) to update the Health Plan CAHPS survey. The last update to the health plan survey was May 2012 and the private insurance market has significantly changed in the last eight years.

As health care continues to evolve, the administrative burdens placed on physicians, particularly concerning coding and reimbursement, have become increasingly significant. These burdens often divert essential time and resources away from patient care. In response, there are several measures CMS could implement to alleviate these pressures. Standardizing coding guidelines and reimbursement policies across all payers, including MA plans, would reduce variability and simplify the administrative processes. This standardization would decrease the workload on physicians, allowing them to focus more on patient care. Furthermore, CMS should enhance support and training for physicians and their administrative staff to keep pace with changes in coding systems and reimbursement policies. This could include the provision of webinars, detailed guides, and a dedicated help desk for coding queries. Additionally, streamlining the reimbursement process would minimize claim denials and delays. CMS could work towards more transparent and straightforward reimbursement protocols that clearly communicate compensation details, thus reducing the financial pressures on physicians.

The methodologies used by MA plans can pose considerable administrative challenges due to their complexity and the need for detailed data submission. To streamline this process, CMS should implement uniform risk adjustment models across all MA plans. This uniformity would aid physicians in understanding and applying the necessary data submission requirements efficiently. Also, the development of simplified data submission tools would help in accurately capturing comprehensive patient data, reflecting the true complexity of patient conditions without imposing an undue burden on physician practices.

In addition, the lack of transparency around the rules and requirements of different MA plans creates significant challenges for physicians. Navigating the varying prior authorization processes, formulary restrictions, and coverage rules across different plans can be daunting and time-consuming. To address this, **CMS should ensure that all MA plans provide clear, consistent, and easily accessible information about their rules and requirements.** This information should be made available on a centralized online platform. Furthermore, standardizing certain key operational procedures, such as prior authorizations and claim submission processes, would reduce the learning curve and administrative efforts required by physicians. Establishing direct lines of communication between physicians and MA plans would also facilitate quicker resolutions of discrepancies and questions regarding plan rules.

Data on Utilization of Supplemental Benefits in MA Plans

Supplemental benefits, funded through rebates generated when MA plans bid below their benchmarks, play an important role in the value these plans provide to enrollees. These benefits cover services not typically included in traditional Medicare. However, more information is needed to fully understand the actual utilization and effectiveness of these benefits. Gathering comprehensive data on how these benefits are used and their impact on health outcomes is important for assessing the overall value of MA plans and making informed policy decisions.

Medicare payments to MA plans are based on a comparison of a plan's bid to provide Medicare Part A and Part B benefits against a benchmark calculated from FFS spending in the plan's service area. When a plan bids below this benchmark, it retains a portion of the difference as a rebate to fund supplemental benefits.

The AMA urges CMS to prioritize the collection of detailed data on the utilization and impact of supplemental benefits in MA plans. This data will not only enhance the value provided by these plans but also ensure that supplemental benefits effectively contribute to the health and well-being of Medicare beneficiaries. It is also important to understand whether supplemental benefits are being provided in a way that is likely to improve health equity or, at a minimum, not exacerbate current inequities and health disparities.

Collecting data on the utilization of supplemental benefits is important for understanding their impact and for guiding policy decisions. This effort will enable MA plans to adopt best practices and improve health outcomes for enrollees.

Care Quality and Outcomes Data

Star Ratings

To further improve the utility of information publicly reported to beneficiaries and the information CMS receives about patients' experience with their plans, we encourage CMS to work with AHRQ to update the Health Plan CAHPS survey. The last update to the health plan survey was in May 2012, and the private insurance market has significantly changed in the last eight years.

Increasingly common in private insurance markets, including MA, is the utilization of narrow networks. Narrow physician networks create challenges for patients seeking care and pose potential patient protection issues. Specifically, a narrow network might have shortages of specific specialties, and plans may purposefully understaff specialties to avoid attracting enrollees with expensive pre-existing conditions, like cancer and mental illness. Generally, such plans offer enrollees a narrow set of physicians and hospitals in a geographic area in exchange for lower premiums. Although the traditional Medicare program allows seniors to visit any physician or hospital that accepts Medicare patients, access for MA beneficiaries is limited to physicians and hospitals within plan networks. More than one in three MA enrollees are in a narrow physician network, which is defined as participation of less than 30 percent of physicians in the corresponding county. Another 43 percent of enrollees are in medium networks, defined as participation of 30 to 69 percent of physicians within the corresponding county. On average, MA networks include less than half of all physicians in a given county.

Out of the 39 questions included in health plan-CAHPS only four ask about access and in a very broad context:

1. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
    a. Never
    b. Sometimes
    c. Usually
    d. Always
2. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

3. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
    a. Never
    b. Sometimes
    c. Usually
    d. Always
4. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
    a. Never
    b. Sometimes
    c. Usually
    d. Always

The current survey also does not assess the extent to which physicians in the network are willing and able to see new patients or the extent to which patients want to use the physicians in the network. If most plan members are receiving services only from a subset of physicians in the network, that subset may not represent the "true" network that is available to patients. Therefore, we encourage CMS to work with AHRQ and consider expanding the "Your Health Care in the Last 6 Months" and "Getting Health Care from Specialists" sections of the survey. Preferably, this should include questions assessing whether patients are able to find physicians who accept new patients, including specialists within their insurance network, maintain utilization of physicians who have longitudinally provided them treatment, distance needed to travel to obtain care, the average time required to make an appointment when actively seeking care, ability to obtain care at an in-network hospital and at an in-network hospital where the patient's physician has staffing privileges.

Stability of Networks: There is a need to evaluate patients' experience with the stability of insurance network plans. There is currently no way to determine if MA plans tend to have the same physicians in-network each year or if their networks change significantly from year-to-year. Patients need to know whether they are likely to need to keep changing physicians if they choose a particular plan.

Accuracy of provider directories: We recommend AHRQ and CMS consider expanding the content of the survey to include questions about the accuracy of provider directories and ease of accessing the information. MA plans are required to maintain accurate provider directories on a real-time basis, but they are currently only required to submit provider directories to CMS when the plan first begins operations in an area, and then once every three years unless CMS requests a review based on significant terminations of contracts or complaints. Since CMS has begun conducting triennial reviews of directories, it has found significant inaccuracies, which impact a patient's experience with a health plan and obtaining care.

Finding out whether a patient's physicians are in each plan's network requires navigating each health plan's website, finding the directory, and then successfully searching for appropriate physician information. If a patient receives care from multiple physicians, this requires considerable time and effort. Additionally, there is no mechanism in place for a physician to determine whether they are being accurately reported as in-network by contracted plans, and out-of-network by other plans. It is also difficult for patients to determine which plans will have physicians available nearby if new conditions arise or their existing condition worsens. The inadequate availability of this important information makes it difficult for patients to effectively compare plans based on the relative size and specialty structure of their networks.

Streamline Data Methodologies

As value-based payment is increasingly seen as the path forward, alignment across traditional Medicare, MA, and other private insurance plans data collection and reimbursement models is essential so that physicians can provide high-quality care to all their patients, regardless of the type of insurance they have, and to reduce the administrative burden and cost for physician practices. In addition to mitigating burden on practices, streamlining similar quality and payment data collection across payers could also help to inform patients to make more educated choices not only across providers, but across types of coverage options as well. The need for such alignment is becoming more important every year as the payments physicians receive for delivering services to Medicare beneficiaries increasingly come from MA plans operated by private insurance companies. In particular, CMS and other payers should move away from proprietary data portals to standardized data measures and processes for data sharing that can be seamlessly integrated into a single EHR or practice management system.

Data Sharing Playbook

The AMA also refers you to our data sharing playbook, which was developed in collaboration with America's Health Insurance Plans and the National Association of ACOs. The playbook is a collection of best and promising practices for data sharing to advance value-based care arrangements informed by physicians, accountable care organizations, and payers from across the country with a diverse background in value-based care arrangements. The playbook is divided into five subcategories which include creating an interoperable data ecosystem, complete and comprehensive data, leveraging data to advance health equity, sharing data in a timely, actionable way, and having transparent methodologies to enhance trust and accuracy in the data.

Data Sharing with Physicians

In that playbook, one of the chapters covered is the importance of sharing timely, relevant, and actionable data with physician practices so that they can leverage that data to improve patient care. Participating practices and their clinical staff need actionable, consistent, and reliable data on a timely basis to help inform proactive care interventions and workflow process improvements, which are critical to improving performance and succeeding in value-based care arrangements. Making data actionable means presenting relevant insights in a way that can be easily leveraged to help make decisions, displayed in their proper context, accurately, and in a place where the people who need it can view it and use it. Equally important, they require clinical outcomes and cost data on the backend to meaningfully identify and implement workflow changes or care interventions that can improve quality and lower the cost of care. Importantly, different practices have varying capabilities to filter and interpret data so there is not a one-size-fits-all solution to the level of information participating practices find helpful when participating in value-based care. Accordingly, data should be provided in a variety of formats to meet varying practice uses and needs for the data. Many small, rural, and safety net practices face disproportionate resource barriers and may have more limited staff and financial capacities to integrate new technologies into workflows, train staff on how to use them, and maintain and update these technologies over time. These practices may want access to more dashboards with pre-calculated analytics. On the other hand, more resourced practices may have significant capacity and interest in ingesting large quantities of raw data and performing analytics to improve efficiency and value-based care performance.

Data also should be tailored to its intended use. For example, data at the point of care should be limited to relevant, actionable information to improve clinical decision-making. Attribution updates should be shared on a regular basis, ideally monthly, to support up-to-date patient rosters and allow for accurate

performance monitoring and forecasting with larger performance goals for the performance year. In the long-term, CMS and other payers should move toward real-time data exchange.

Antitrust/Competition

The AMA holds a long-standing perspective that competition in health insurance, not consolidation, is the right prescription for health insurer markets. Competition in MA markets will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

Most MA markets are ripe for the exercise of health insurer market power, which, in turn, harms consumers and providers of care. Where insurers exercise market power, health plan premiums tend to be higher, and payments to providers and the quantity of health care are lower than where health insurance markets are competitive. High market concentration tends to lower competition and facilitate the exercise of market power. A market is considered highly concentrated if its Herfindahl-Hirschman Index (HHI) is greater than 1800.[30] Unfortunately, the vast majority of MA insurance markets are highly concentrated, as documented in a comprehensive study of U.S markets.[31] The study finds that 97 percent of MA markets were highly concentrated (HHI>1800) in 2022. The average market had an HHI of 3183. UnitedHealth Group—the largest MA insurer nationally—had the largest share in 42 percent (161) of Medical Savings Accounts (MSAs), and Humana was the biggest in 22 percent (83) of MSAs. This high degree of market concentration in MA markets should prompt federal and state antitrust authorities to vigorously examine the competitive effects of proposed horizontal and vertical mergers involving MA insurers.

Given that there is some uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed to be consummated end up causing competitive harm. For example, in 2008, regulators authorized a merger between UnitedHealthcare and Sierra under the condition that UnitedHealthcare divest most of its MA business in the Las Vegas area. Nonetheless, premiums in the commercial health insurance markets in Nevada increased in the wake of the merger.[32] Consolidation also reduces the number of potential market entrants who may contribute to lower prices or increased quality in the MA market.

Further, where a health insurer has market power in their output market of health insurance, it is very likely it also has monopsony power in their input market of physician services, as geographically these markets roughly coincide.[33] Physicians doing business with MA plans that hold monopsony power face significant challenges, including the evisceration of physicians' ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the

[30] The HHI is the Herfindahl-Hirschman Index—measure of market concentration. The new 2023 Department of Justice (DOJ) and Federal Trade Commission (FTC) Merger Guidelines lowered the HHI threshold for a highly concentrated market from 2500 to 1800.

[31] Guardado, J., Kane, C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets. 2023 Update.* American Medical Association Division of Economic and Health Policy Research. 2023. Available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.

[32] Guardado, J., Emmons, D., Kane, C. *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*. HMPI. 2013;1(3):16-35. Available at https://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf.

[33] See e.g., Corry Capps, *Buyer Power in Health Plan Mergers*, J. Comp Law and Econ (2009).

quality or quantity of services that physicians are able to offer patients. For example, facing little if any competition in the market for health plans, a merged entity in a highly concentrated MA market would lack any incentive to refrain from imposing upon physicians "take it or leave it" contracts, resulting in anticompetitive reimbursement levels that hinder physician investment in practice infrastructure, force physicians to spend less time with patients to meet practice expenses, or motivate them to leave the physician workplace altogether. The monopsony injuries to the physician marketplace that would result from mergers of market power MA plans would be profound.

Even in markets where the merged health insurer lacks monopoly or market power to raise premiums for patients, the insurer still may have the power to force down physician compensation levels, raising antitrust concerns. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the Department of Justice (DOJ) required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[34]

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more traditional Medicare and Medicaid patients. However, physicians cannot increase their revenue from traditional Medicare and Medicaid in response to a decrease in commercial health insurer payment. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to traditional Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing traditional Medicare and Medicaid patients from their existing physicians. Moreover, public programs underpay providers. Thus, even if a physician dropping a commercial health insurer could attract traditional Medicare and Medicaid patients, this strategy would be a losing proposition, especially at a time when value-based payment models require practice investments. For all these reasons, the AMA urges enforcement agencies to consider in a scrutiny of any proposed merger of MA plans the effects of the merged firm's monopsony power on physicians and physician practices.

Finally, after years of largely unchallenged consolidation among health insurers, DOJ closely scrutinized two attempted mergers involving four of the country's largest health insurers in 2015. Since then, there has been a slowdown of proposed major horizontal acquisitions in the health insurance market. Instead, health insurers have been turning to vertical integration with other firms in their supply chain, such as pharmacy benefit managers (PBMs). Indeed, the seven largest MA insurers nationally are already vertically integrated with PBMs. The AMA will continue to monitor competition in health insurance markets and evaluate vertical mergers involving health insurers to assess whether they pose anticompetitive effects, and we encourage the administration to do the same.

[34] See Gregory J. Werden, Monopsony and the Sherman Act: Consumer Welfare in a New Light, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, Buyer Power Concerns and the Aetna-Prudential Merger, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.

Health Equity & Special Populations

Beneficiary enrollment among minoritized groups in MA is higher than ever before and is continuing to grow.[35] Unfortunately, while Black, Asian, and Hispanic enrollees sign up for MA at higher rates than White enrollees, members of these minoritized racial and ethnic groups tend to be in plans with lower quality ratings.[36] This disparity is largely due to the current design of the MA program, which is less profitable for covering enrollees with more complex clinical or social needs, conditions that disproportionately affect racial and ethnic minoritized groups due to longstanding structural racism and social disadvantages. Consequently, this leads to systematic underpayments for these groups and provides little incentive for providers to offer health plans in communities with a large presence of racial and ethnic minoritized group members.[37]

In order to correct for these systemic issues and proactively increase access to high-quality MA plans for historically minoritized populations, CMS should leverage current known data about gaps in offerings in high-quality MA plans to historically minoritized communities by:

- Offering incentives to encourage payers to offer five-star plans in areas that do not currently have them through premium subsidies, rebates, and/or tax exemptions;
- Adjusting quality star ratings to account for social factors;
- Reimbursing physicians for collecting data by race/ethnicity and making this data publicly available;
- Revisiting risk-adjustment methodologies to ensure they are not disadvantaging entities serving populations of color, low-income patients, or people with complex health needs;
- Providing more robust payment adjustments for members with complex health and social risks so that physician-led care teams can work in concert with community-based providers to overcome barriers to accessing health services, such as reimbursing for transportation to medical appointments; and
- Pay for high performance on targeted equity-related quality and outcomes data metrics.

Social Determinants of Health Data Collection

Monitoring and addressing social determinants of health (SDOH) is another key factor to advancing health equity amongst MA plans. To fully understand community risks related to social drivers, it is necessary to access additional data sets beyond currently available clinical and claims data. There is currently a lack of social and health equity measures and no comprehensive data standard for collecting and reporting sociodemographic information (e.g., race, ethnicity, gender identity), making it difficult to identify and address disparities at the individual or population levels. Including, as appropriate, Health-Related Social Needs focused standards, such as z-codes, in contracts could help improve adoption and consistent use within clinical encounters and claims submissions.

Importantly, in collecting this data, payers must consider the limited bandwidth for already overburdened clinical and administrative staff, along with limited funding for support services to help patients to help overcome SDOH barriers. Practice teams can struggle to prioritize and adopt workflows and data

[35] https://bettermedicarealliance.org/blog-posts/advancing-health-equity-inmedicare/.
[36] https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13977.
[37] https://ldi.upenn.edu/our-work/research-updates/why-are-there-disparities-in-enrollment-in-medicare-advantage.

collection methods for documenting social data without sufficient positive incentives, guidance, and consistent metrics that are fair, feasible, and within their locus of control. Additionally, health-equity focused data collection efforts must be supplemented by adequate financing for social services and other supports to help address any identified gaps in access and clinical outcomes. Including SDOH data from public health and community sources also yields more comprehensive patient profiles while mitigating burden on medical practice staff for collecting all this data.

Data sharing is another barrier to addressing SDOH. This includes data sharing between health systems and physicians, as well as between physicians and community-based organizations that assist individuals and localities with getting access to essential social services. Developing exchange standards, such as through the Fast Healthcare Interoperability Resources® (FHIR®) SDOH Clinical Care Implementation Guide, would help to support a framework for documenting and exchanging both clinical and SDOH data. These clinical activities can be organized into health data classes and data elements defined in the United States Core Data for Interoperability (USCDI), a standardized set of health data classes and elements for exchange. SDOH data classes and elements were added to USCDI v2 and v3.

Another critical consideration for collecting SDOH data is ensuring appropriate privacy and security protections are in place for this potentially sensitive health information, particularly as it relates to behavioral health or SUD services. Also, proactively communicating with patients about how this data will and will not be used is critical to ensuring patient trust and willingness to provide this type of data and overcome generational distrust in the medical system among historically minoritized communities.

Dually Eligible Individuals

Regarding dually eligible individuals, the AMA appreciates CMS' continued attention to the experiences of individuals dually eligible for Medicare and Medicaid and the need to monitor data to ensure sufficient access to care for these enrollees. The AMA recognizes that without proper integration of eligibility and coverage information across both networks, care for dually eligible individuals can be fragmented, poorly coordinated and difficult for patients to navigate, and that suboptimal care coordination can in turn compromise patient care and increase overall program spending. The AMA maintains that the same protections we advocate for all MA plans, including network adequacy requirements, should apply to dual eligible special needs plans. Additionally, integrated care plans should meet certain evidence-based criteria to improve the care quality and life quality of dually eligible individuals.

The AMA appreciates the opportunity to provide input and thanks you for considering our recommendations. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD