AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

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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-4203-NC. Medicare Program; Request for Information (RFI) on Medicare

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 August 1, 2022 (87 Fed. Reg. 46918). Specifically, our comments focus on strategies to strengthen Medicare Advantage (MA) plans in alignment with CMS' Strategic Pillars with the goal of improving access to care and health outcomes for MA beneficiaries. A number of the topics that CMS included in this RFI were also addressed in the AMA's March 2022 comment letter on the recent MA proposed rule, and we encourage the agency to consider those comments and recommendations as well.

This letter will address the following CMS requested topics:

A. Advance Health Equity;
B. Expand Access: Coverage and Care;
C. Drive Innovation to Promote Person-Centered Care; and
D. Support Affordability and Sustainability.

A. Advance Health Equity

In order to ensure that all patients receive the care they need, it is imperative to increase residency slots, which will increase the number of physicians who are available and, thus, decrease wait times and increase the quality of care available.

I. Addressing the physician workforce

The United States faces a looming physician shortage, the most drastic effects of which will disproportionately fall on rural and underserved communities. Workforce experts predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 13 years. In particular, the Association of American Medical Colleges (AAMC) predicts a shortage of

124,000 physicians by 2034.[1] This in part is due to the aging U.S. population, which is growing in size and has more complex health needs, meaning that the demand for health professionals across the country will continue to grow. This shortage is also due to our aging physician population, many of whom will soon retire leaving gaps in community care since there has not been a significant enough increase in medical students to fill their spots upon retirement.[2]

Moreover, there are more than 7,200 federally designated health professional shortage areas (HSPAs) where dire access issues persist for patients in both rural and urban underserved communities, and in both primary and specialty care.[3] The Health Resources and Service Administration (HRSA) estimates that an additional 32,494 physicians are required to eliminate all current primary care, dental, and mental health HPSAs.[4] With the existing and projected physician shortage, and the increased demands that have been placed on physicians during the pandemic, additional support for residency slots is desperately needed.

Furthermore, additional scholarship or loan repayment programs from CMS for physicians would benefit the entire patient population. In general, reducing medical student indebtedness promotes diversity within medicine and may lead to an increase in the primary care physician workforce as well as other undersupplied specialties. Rising medical school debt disproportionately impacts students who are low income. Due to the cost of medical school many low-income individuals are completely deterred from attending medical school in the first place. According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[5] Additional surveys by the AAMC support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school.[6]

Since Black, Asian, Hispanic, and other minority students are more likely to enter primary care than their White counterparts, the immense debt burden of medical school has not only precluded diversity among physicians, but also has limited the potential number of primary care physicians and thus diminished improvement in patient care in underserved communities.[7] With recent health reforms seeking to eliminate health care disparities among the U.S. population, increasing the number of historically underrepresented physicians is important to ensure a health care workforce that is more reflective of the general population so that individualized care for racial, ethnic, religious, socioeconomic, and other minority groups can be provided.

II. Access to care for underrepresented populations

To increase access to care for underrepresented populations, MA plans should change the way that they structure their payment plans. Black, Asian, and Hispanic enrollees sign up for Medicare Advantage at higher rates than White enrollees—but members of racial and ethnic minority groups tend to be in plans

[1] https://searchlf.amaassn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-10- Letter-to-Pallone-and-Murray-re-HR-3671-the-DOC-Act.pdf.
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/.
[3] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[4] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[5] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760863/.
Grayson, M. S., Newton, D. A. and Thompson, L. F. (2012), Payback time: the associations of debt and income with medical student career choice. Medical Education, 46: 983–991.
[7] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.

with lower quality ratings.[8] This lack of access to higher quality plans based on race is not acceptable and is based on a lack of access to higher quality plans. In a study, when Black enrollees had access to the highest-rated plans they chose five-star plans more often than White enrollees by 3.2 percentage points.[9]

This structural barrier that Black Americans are experiencing is due to the way that the MA program is designed, according to recent research:

> [The current structure] de-incentivize[s] insurers from offering "plans in areas with a large number of racial and ethnic minority group residents. The current payment adjustment used by Medicare Advantage tends to overpay plans for healthier enrollees and underpay for complex enrollees, the researchers note. Decades of structural racism and social disadvantage often result in increased clinical complexity among racial and ethnic minority groups. Because payments to Medicare Advantage plans do not account for race or ethnicity as a social risk factor, this may lead to systematic underpayments for racial and ethnic minority enrollees, providing little incentive to offer health plans in communities where a large number of racial and ethnic minority group members reside. Having more enrollees with poorer health also affects Medicare Advantage performance scores, adding to insurers' reasons to restrict access in areas where residents might need more care. In fact, Medicare Advantage performance scores are known to decrease as the proportion of enrollees with complex health and social needs increases. Because performance is linked to payment bonuses, decreases in performance scores worsen finances for insurers."[10]

This payment structure must be changed in order to provide a meaningful increase in access to high-quality care.

In order to increase access to high-quality MA plans, CMS should encourage insurers "to offer five-star plans in areas that do not currently have them with premium subsidies, rebates, and tax exemptions, and also by including more robust payment adjustments for members' health and social risks. Adjusting quality ratings for social factors could increase the incentives to provide five-star plans in areas that lack them, ensuring that racial and ethnic minority enrollees have equal access to high-quality health plans."[11] As such, in order to increase access, MA programs need to change their incentive structure.

III. Language services

Language services are an essential part of providing holistic health care in a patient-centered, language, and culturally appropriate way. "Language access services are designed to promote effective communication between [limited English proficiency] (LEP) persons and non-LEP persons. LEP persons do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. Language access services can include oral interpretation and written translation."[12]

Access to language services has been proven to improve communication, improve adherence to treatment regimen, improve diagnosis and treatment, and result in fewer complaints.[13] However, one of the top deterrents to providing language services is cost and the fact that "[l]imited reimbursement is available for

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[8] https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13977.
[9] *Id*.
[10] https://ldi.upenn.edu/our-work/research-updates/why-are-there-disparities-in-enrollment-in-medicare-advantage/.
[11] *Id*.
[12] https://oig.hhs.gov/oei/reports/oei-05-10-00051.pdf.
[13] https://oig.hhs.gov/oei/reports/oei-05-10-00050.pdf.

language access services. Medicare does not reimburse providers for language access services."[14] Due to the price associated with language services, physicians cannot be expected to provide and fund these translation services for their patients; when trained medical interpreters are needed, the costs of their services should be paid directly to the interpreters by MA plans and physicians should not be required to participate in payment arrangements. Therefore, MA plans should cover language services and directly pay interpreters for such services to ensure that proper and effective care can be provided.

Beyond ensuring that payment by MA plans is provided for language services, it is important that plans inform individuals both verbally and in writing that language services are available and MA plans publish and validate standard patient assessment tools in multiple languages. This is especially important since there is evidence that beneficiaries have difficulty accessing language services that plans provide through call centers. "For example, one study found that only 69 percent of LEP persons calling plans could reach someone who spoke their primary language and were often unable to access translated documents from the plans."[15] Since it is vitally important to provide access to language services to ensure that high-quality health care is provided, MA plans must start providing verbal and written language services as well as standard patient documents in multiple languages.[16]

Moreover, MA plans should provide training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College's "Guidelines for Use of Medical Interpreter Services" to ensure optimal patient care.[17] Ideally language services should include translators who have some health background or understanding because it is easy for miscommunications to occur when the translator does not know what a provider is referring to. Moreover, it is important to have an environment that is conducive to language services. Phone lines are often the only way that hospitals have language services available but, in a busy and loud environment such as the emergency department, they are very ineffective and all parties—physician, patient, and translator—have difficulty understanding what any given person is saying. This could be improved with in-person translation services or designated areas that are quiet and conducive for conversation.

Overall, language services are a vital part of patient care and should be paid for by MA plans so that these services, both written and verbal, can be provided to every LEP patient and optimal health outcomes can be achieved.

B. Expand Access: Coverage and Care

I. Provider directories

MA Provider Directory Accuracy

A July 2019 report from the U.S. Government Accountability Office (GAO) highlighted the need to improve the accuracy of MA plans' network directories and the way this information is communicated to patients. The report reviewed research, including a CMS-sponsored study, that identified access to particular physicians as a key consideration for Medicare beneficiaries when selecting their Medicare coverage. The GAO also conducted a survey in which respondents stated that the Medicare Plan Finder (MPF) provides incomplete information on MA plan networks.

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[14] https://oig.hhs.gov/oei/reports/oei-05-10-00050.pdf.
[15] https://oig.hhs.gov/oei/reports/oei-05-10-00051.pdf; http://www.nsclc.org.
[16] https://oig.hhs.gov/oei/reports/oei-05-10-00051.pdf.
[17] https://www.aamc.org/system/files/c/2/70338-interpreter-guidelines.pdf.

MA plans are also required to maintain accurate directories of in-network physicians on a real-time basis. However, currently they are only required to submit network directories to CMS when the plan first begins operations in an area, and then every three years unless CMS requests a review based on significant terminations of contracts or complaints. The triennial reviews of network directories by CMS have found significant inaccuracies. For example, a 2019 review found errors in half of all network directories reviewed, including physicians not practicing at the listed location, incorrect phone numbers, or physicians who were not accepting new patients when the directory indicated they were. The persistently high error rates justify more frequent reviews and more significant penalties for noncompliance. MA plans could reduce the administrative burden on themselves and on physicians if they would develop and use a common system for updating provider directory information.

The AMA urges CMS to boost its efforts to ensure directory accuracy by:

- Requiring MA plans to submit accurate network directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change to the status of the physicians included in the network;
- Auditing directory accuracy more frequently for plans that have had deficiencies;
- Publicly reporting accuracy scores on the Medicare Plan Finder;
- Taking enforcement action against plans that fail to either maintain complete and accurate directories or have a sufficient number of in-network physician practices open and accepting new patients;
- Encouraging stakeholders to develop a common system to update physician information in their directories; and
- Requiring MA plans to immediately remove from network directories physicians who no longer participate in their network.

Ensuring Lists of Contracted Physicians Are Easily Accessible

The GAO report confirmed that determining whether a patient's physicians are in each MA plan's network required going separately to each plan's website, finding the directory, and searching it. There have been some recent improvements to the MPF, with beneficiaries now having the ability to link from plan choices in the MPF to view the MA plan's directory and, for some plans, to filter it according to which network physicians are accepting new patients. The AMA appreciates this change. Still, the MPF continues to be of limited utility in searching for plans based on whether the patient's physician(s) are in the MA plan's network. Since the advent of the Medicare Part D prescription drug benefit, patients have been able to input information about their prescription drugs and obtain comparisons on the MPF showing what their out-of-pocket costs would be for their drugs in different Part D plans offered in their community. The MPF would be considerably more useful for patients if they could similarly put in the name of one or more physicians and see information displayed for each MA plan in their area indicating whether the physician is in the plan's network. In addition to being unable to determine whether or not the physician(s) they are currently seeing are in various MA plans' networks, it is difficult for patients to determine which plans will have physicians available nearby if new conditions arise or their existing conditions worsen. Patients should have a way to use the MPF or another method to compare plans based on the relative size and specialty structure of each plan's network. According to the GAO report, CMS officials indicated that they were examining how to integrate network information into the MPF, but this was not part of any redesigned MPF released to date.

Currently, there is also no simple way for physicians to determine whether a plan is accurately identifying them as in-network when they have a contract and out-of-network when they do not have a contract. MA plans are already required to submit their initial list of network physicians to CMS in an electronic form that includes the physician's National Provider Identifier, so it should be feasible to make the lists downloadable, as well as link the information in the lists and make it available in one place. **A site where <u>both physicians and patients</u> could see all the MA plan networks in which a physician participates in one place would help provide more accurate, real-time information.**

The AMA recommends that CMS adopt the following policy changes to improve communications with patients about MA plan networks:

- Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the MPF website in both a web-friendly and downloadable spreadsheet form;
- Linking the provider lists to a website where patients can first find a physician and then find which health plans contract with that physician; and
- Simplifying the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on the MPF website to include: the number of contracted physicians in each specialty and county; the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.

II. Provider network adequacy

The AMA appreciates the policy changes recently adopted by CMS aimed at improving the adequacy of MA provider networks, including the requirement that MA plans must provide information demonstrating that they meet network adequacy requirements when they seek approval to market the plan instead of simply providing an attestation. However, we still have concerns that MA provider networks may not be meeting the needs of beneficiaries.

As such, the AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:

- Incorporating additional measurements into their network adequacy requirements, including wait-time standards, to better assess patient access to care;
- Consider placing Essential Community Provider (ECP) network requirements, similar to those required of Qualified Health Plans (QHPs), on MA plans to increase access to care for beneficiaries, including for historically minoritized and marginalized communities;
- Requiring plans to report the percentage of physicians in the network, broken down by specialty and subspecialty, who actually provided services to plan members during the prior year;
- Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy;
- Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; and
- Evaluating alternative/additional measures of adequacy.

Additionally, MA plans should be prevented from making material contract changes during the plan year in order to promote and ensure continuity of care for patients. This would include changes that terminate

physicians from the MA plan's network or contract changes that make it unattractive or unsustainable for a physician to remain in network. CMS should also monitor network plans throughout the year for their continued adequacy while requiring plans to immediately report changes to the network that may impact access to care for patients.

Finally, the AMA urges CMS to initiate a Network Adequacy Task Force that would allow CMS to engage on a regular basis with multiple stakeholders, including MA network physicians and Medicare patients or their representatives, to review current policies and develop new policies to address network adequacy issues. The AMA believes that this task force would ensure that CMS continues to obtain ongoing input from physicians, patients, and other stakeholders on needed improvements.

III. Access to behavioral health services in MA plans

Recent MA beneficiary customer satisfaction research reveals that MA plans may not provide adequate access to behavioral health services. The J.D. Power 2022 Medicare Advantage Study, which is based on survey responses from 3,094 MA beneficiaries across the United States from May through July 2022, found significant deficiencies in MA plans' coverage of mental health and substance use disorder services.[18] Only 38 percent of MA patients reported having sufficient coverage for mental health treatment, compared with 39 percent in 2021. In addition, only 27 percent of MA patients indicate they have adequate coverage for substance use disorder services. In comparison, 91 percent and 89 percent of MA beneficiaries report having sufficient coverage for routine diagnostics and preventive and wellness services, respectively. These data suggest significant discrepancies in coverage between physical vs. mental health services among MA plans, a finding that is particularly alarming given the high prevalence of diagnosed substance use disorders and mental health conditions in the Medicare population.[19,20]

Based on these concerning data, the AMA urges CMS to increase oversight and enforcement of MA plans' coverage of behavioral health treatment to ensure parity with other service types. Specifically, MA plans should be required to submit comparative analyses to CMS assessing the plan's coverage limitations for medical/surgical benefits relative to those for mental health and substance use disorder treatments. The process should be similar to that described in the 2022 Mental Health Parity and Addiction Equity Act Report to Congress for non-MA plans.[21] Using these data, CMS should require MA plans to remedy and appropriately document corrective actions to any identified gaps in coverage parity between medical and behavioral health services. We also request that CMS refer to the AMA's March 7, 2022, letter, which contains more detailed comments and recommendations on behavioral health services in MA plans.[22]

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[18] Medicare Advantage Plan Coverage of Mental Health and Substance Abuse Services, J.D. Power Finds. Available at: https://www.jdpower.com/business/press-releases/2022-us-medicare-advantage-study.

[19] Parish WJ, Mark TL, Weber EM, Steinberg DG. Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers. *Am J Prev Med*. 2022 Aug;63(2):225-232. doi: 10.1016/j.amepre.2022.01.021.

[20] The Commonwealth Fund. Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities.

[21] 2022 Mental Health Parity and Addiction Equity Act Report to Congress. Available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[22] See https://searchltf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-3-7-Letter-to-Brooks-LaSure-re-MA-NPRM-v3.pdf.

IV. Telehealth in MA plans

The AMA continues to study the changing landscape as it relates to coverage, payment, and access to telehealth, and data suggests that telehealth has and will continue to play an important role in increasing access to quality care. Studies suggest that telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities; however, drivers impacting inequitable access to telehealth need to be addressed, including gaps in broadband infrastructure, lack of affordable internet connectivity, lack of access to devices and other necessary technologies, and gaps in digital literacy among patients.

It is important for CMS and MA plans to establish policies for telehealth as a modality for delivering care and not a service separate or distinct from care provided via other modalities such as in-person. Clinical requirements may dictate fluid movement between modalities, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. Additionally, patient preferences and situations may change from one appointment to the next and patients should always have the opportunity to access care in-person if they choose. Therefore, telehealth should remain a supplement to, not a replacement for, in-person physician networks.

Moreover, MA plans should allow all contracted physicians to provide care via telehealth. Prior to the pandemic, many insurers established a separate network for telehealth or select telehealth providers, which did not always include contracted physicians who provided in-person services. With the increased demand and changing regulatory environment during the pandemic, more physicians have implemented telehealth in their practices and patients are more likely to seek care via telehealth from their regular physician who also provides care in-person. As telehealth has become integrated into physician practices, the perpetuation of separate telehealth networks is no longer justified. In addition, it is confusing for patients and threatens continuity of care and the patient-physician relationship. Therefore, the AMA urges CMS to ensure that telehealth services should not replace in-person services for MA network adequacy purposes and to pursue requirements that all contracted physicians in MA networks be permitted to provide services via telehealth to improve access to care.

Broadband and audio-visual telehealth services are clearly not accessible by all Medicare patients, so it is important for MA plans to continue supporting audio-only telehealth services. The experience physicians have had providing patient care through audio-only visits demonstrates that they do not diminish quality relative to audio-visual visits and, because some patients are more comfortable speaking with their physicians without video and the quality of telephone service may be better than they can obtain over the internet for audio-visual services, some patients report better health care experiences with telephone than audio-visual visits. CMS should also allow information provided during audio-only visits to be included in MA risk adjustment models.

V. Utilization management policies: Impact on patients and physicians

Prior Authorization

Physicians are alarmed by the negative impacts of prior authorization (PA) and other utilization management techniques on both patients—including MA patients—and practice burdens. In a 2021 AMA survey, more than one-third (34 percent) of physicians reported that PA led to a serious adverse event,

such as hospitalization, disability, or even death, for a patient in their care.[23] Also, more than nine in 10 physicians (93 percent) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82 percent) said patients abandon treatment due to authorization struggles with health insurers. Nearly one-third of physicians said that health plans rarely or never use evidence-based criteria in their PA programs, and 91 percent of physicians reported a negative impact on clinical outcomes due to the PA process.

Moreover, physicians report that PA wastes valuable health care resources: the AMA survey found that practices complete an average of 41 PAs per week per physician, and that this weekly workload for a *single physician* consumes nearly two business days of clinician and staff time. Given these significant administrative burdens, it is not surprising that 40 percent of physicians employ staff specifically to manage PAs. The AMA's quantitative research illustrates the critical need to streamline PA requirements in the MA program to minimize harmful delays or disruptions in care delivery and reduce time-consuming paperwork demands.

The many patient and physician stories and videos captured on the AMA's grassroots PA reform website, FixPriorAuth.org, put a human face on these troubling survey statistics.[24] Both clinicians and patients report that PA has delayed critical treatment for weeks or even months, with patients sometimes giving up and visiting the emergency room to get necessary care. The most recent addition to this collection is a video story from Gerald E. Harmon, MD, AMA Immediate Past President, describing how MA PA requirements delay patient care—including that of his 92-year-old mother, who suffers from multiple chronic health conditions.[25]

An April 2022 report by the HHS Office of Inspector General (OIG) further underscores concerns about beneficiary access to medically necessary care under MA plans.[26] In its review, OIG found that among the PA requests denied by MA plans, 13 percent met Medicare coverage rules and would have been approved for beneficiaries under original, fee-for-service Medicare. OIG noted that MA plans are denying PA and payment requests by using clinical criteria that are not contained in Medicare coverage rules, such as denying magnetic resonance imaging due to the size of a patient's adrenal lesions or refusing to cover a walker for a beneficiary who already had a cane. OIG also stated that MA plans request unnecessary documentation from physicians and make manual review and system errors. **Taken in aggregate, the AMA's qualitative and quantitative data, as well as the 2022 OIG report, clearly reflect an immediate need for improvements in the MA PA process to prevent negative clinical outcomes for this vulnerable patient population.**

Step Therapy for Part B Drugs

The AMA remains disappointed by the 2019 recission of the prohibition against the use of step therapy requirements on Part B drugs in the MA program. Since this policy change, physician and patient groups have presented CMS leaders with clear instances of patient harm resulting from MA step therapy requirements, including hospitalizations, infections, increased disease activity, disability, and vision loss. Of note, Part B drugs treat some of the most medically vulnerable Medicare beneficiaries, making the inevitable care delays associated with "fail first" policies especially dangerous. Moreover, this policy

[23] 2021 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[24] FixPriorAuth Story Gallery. Available at: https://fixpriorauth.org/stories.
[25] How Prior Authorization is Personal to Dr. Harmon. Available at: https://www.youtube.com/watch?v=3o77qS-ZWyc.
[26] HHS OIG. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. Available at: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

creates a clear disparity in care access between patients covered under MA plans vs. traditional Medicare. **To protect MA beneficiaries from harmful care delays and disruptions that can lead to devastating, long-term negative health outcomes, we urge CMS to reinstate the prohibition of step therapy for Part B drugs in the MA program.**

Health Equity and Utilization Management in MA Plans

New data have shown that minority beneficiary enrollment in MA is higher than ever before. Nearly 44 percent of Hispanic Medicare beneficiaries and over 31 percent of African American Medicare beneficiaries are enrolled in MA plans. Data show an increasing trend in minority enrollment.[27] For this reason, PA denials by MA plans have a bigger impact on historically minoritized Medicare patient populations. MA PA requirements also disproportionately harm those with disabilities or chronic illness, as they create barriers to treatment for sicker patients needing medical devices, Part B drugs, or inpatient rehabilitation services—further undermining efforts to advance health equity in MA. **The AMA supports CMS' efforts to prioritize health equity, and we urge CMS to consider the health equity implications of the use of PA and step therapy in the MA program, given the demographics of the MA patient population.**

VI. Current state of prior authorization reform

In this RFI, CMS rightfully asks for information regarding MA plans' exemption of clinicians or specific medical services from PA requirements. Reduction in the overall volume of PA requirements was a key provision of the Consensus Statement on Improving the Prior Authorization Process, released by national health care professional associations and health insurer trade organizations in early 2018.[28] Along with "rightsizing" the overall number of drugs and medical services that require PA, health plans also agreed to improve transparency and communication in their PA programs, to ensure protections for continuity of care during plan changes, and to streamline the process through automation.

Unfortunately, although health plans agreed to these important, common-sense changes over four-and-a-half years ago, meaningful progress on these reforms has been limited. AMA physician survey data show that only nine percent of physicians contract with health plans (including MA plans) that offer programs that exempt providers from PA, and that a strong majority of physicians indicate that the volume of medical services and drugs that require PA has grown over the last five years.[29] **Of note, these AMA survey results align with Kaiser Family Foundation data, which show that nearly all (99 percent) of MA enrollees are in plans that require PA for some services,[30] compared with 80 percent in 2018.[31]** Physicians consistently report difficulty in determining which drugs and services require PA, and 88 percent indicated that PA can interfere with continuity of patient care. Finally, despite widespread industry interest in electronic PA, physicians report that phone is still the most commonly used method for completing PAs.

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[27] Advancing Health Equity in Medicare. Available at: https://bettermedicarealliance.org/blog-posts/advancing-health-equity-in-medicare/.

[28] Consensus on Improving the Prior Authorization Process. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

[29] 2021 Update: Measuring progress in improving prior authorization. Available at: https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.

[30] Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings, Figure 7. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

[31] Prior Authorization in Medicare Advantage Plans: How Often Is It Used? Available at: https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/.

VII. Path forward: Recommendations for improving utilization management in the MA program

The AMA urges CMS to take a holistic approach to reforming utilization management in MA plans. We are encouraged by our recent conversations with CMS staff in which there was mutual agreement that more must be done by the federal government to address the shortcomings in MA PA programs identified by physicians, patients, and the 2022 OIG report. **Moreover, we commend CMS for its increasing recognition that ensuring timely access to care for MA beneficiaries will necessitate changes not only in the PA process but also PA decision-making.**

We point CMS to the fundamental reforms outlined in the Consensus Statement on Improving the Prior Authorization Process as a blueprint for protecting MA patients' access to medically necessary care:

1. **We urge CMS to require MA plans to offer programs that exempt physicians with high rates of PA approvals and/or a history of adherence to evidence-based clinical guidelines from PA requirements.** Such "goldcarding" programs reward high-performing physicians with reduced administrative burdens and support faster care delivery for patients. However, despite these obvious benefits and the fact that states are beginning to require insurers to offer such programs,[32] few, if any, MA plans offer such PA waiver programs to physicians.
2. **The AMA urges CMS to address another key component of reducing PA volume by requiring MA plans to regularly review the drugs and services that require PA or step therapy and eliminate low-value (e.g., consistently approved) and/or potential harmful requirements.** Despite agreement on the need to reduce the number of services requiring PA, physicians consistently report that the number of requirements has grown in recent years. As mentioned earlier, allowing MA plans to use step therapy for Part B drugs contradicts industry consensus that the overall volume of utilization management requirements should be reduced—especially for treatments used in particularly vulnerable patient populations, and we request CMS revert to prohibiting this barrier to care in the MA population.

We note that experience with PA waivers on certain services during the COVID-19 Public Health Emergency (PHE) has shown promising reductions in administrative burden with no negative impact on health care costs or utilization. For example, temporary removal of PA requirements for high-tech imaging, durable medical equipment, prosthetics, and orthotics in the Vermont Medicaid program during the PHE did not result in a significant increase in utilization and led to a recommendation to permanently remove these requirements.[33] These results further support the AMA's advocacy to reduce the overall volume of PA protocols.

PA waivers during the PHE also provided the opportunity to reconsider the overall value and potential harm associated with PAs for certain types of services. In our response to CMS' RFI on PAs for hospital transfers to post-acute care during a PHE, the AMA noted that most MA plans had reinstated PA for transfers to post-acute care by January 2021.[34] In the absence of waivers, transfers from acute inpatient

[32] For example: Texas Prepares to Implement "Gold Card" Prior Auth Bill. Available at: https://www.texmed.org/TexasMedicineDetail.aspx?id=57955.
[33] Report to the Vermont Legislature-- Clinical Prior Authorization Requirements in the Vermont Medicaid Program: Findings and Recommendations. Available at: https://legislature.vermont.gov/assets/Legislative-Reports/DVHA_Act-140-of-2020_Prior-Authorizations-Report_Final-with-Appendices.pdf.
[34] Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-3-7-Letter-to-Brooks-LaSure-re-MA-NPRM-v3.pdf.

settings to lower levels of care were subject to PA for most of the PHE, including during the Omicron variant surge of early 2022. As a consequence, there were delays in appropriate movement of patients between inpatient hospitals and post-acute settings, bed shortages while determinations were being made, and postponements in patients receiving timely rehabilitative care during the height of the pandemic. Further complicating the situation was the highly variable, constantly changing patchwork of waivers enacted across MA plans that were virtually impossible for inundated providers to track during the PHE.

Beyond the specific challenges of the COVID-19 PHE, the AMA, as part of our consistent advocacy to reduce the overall volume of PA requirements, maintains that CMS should direct MA plans to permanently eliminate PAs for transfers to post-acute care settings. This much-needed change would ensure timely transfers to care settings that offer the vital rehabilitative services, such as physical and occupational therapy, needed to support patients' successful, prompt recovery and transition to independence. Moreover, removing PA for these transfers supports the overall health and wellness of an entire community by preventing bed shortages for incoming patients needing acute inpatient care. Our recommendation aligns with the results of the previously cited 2022 OIG report, which found that transfers to post-acute facilities were one of three prominent denied service types that met Medicare coverage rules. MA beneficiaries should be able to access the same vital treatment in post-acute care facilities as fee-for-service Medicare patients, rather than being subject to proprietary MA plan criteria.

3. **We urge CMS to increase the transparency of MA plan PA requirements to both beneficiaries and the physicians who care for them.** First and foremost, MA plans should publicly disclose (in a searchable electronic format) accurate, patient-specific, and up-to-date PA requirements that can be relied upon both by physicians and patients, including prospective patients engaged in the enrollment process.[35] Patients researching a potential new MA plan should easily be able to determine which services require PA *prior to* enrolling in the plan to support informed plan selection. In addition, physicians must be able to determine the services that require PA and the necessary supporting documentation; ideally this information would be accessible in the electronic health record (EHR) workflow at the point of ordering.

The AMA also urges CMS to require more strict reporting of MA PA program data to the agency. Much like Medicare Part D plans are required to submit formulary files listing covered drugs and any restrictions to CMS, **the agency should require MA plans to submit the complete list of services subject to PA on at least an annual basis.** In addition, and to address the problems identified in the OIG report, **MA plans should be required to report to CMS all clinical criteria used in PA programs, along with the source (e.g., medical specialty society guidelines) for each specification. CMS should closely review these data and issue new guidance to ensure that MA plans' clinical criteria cannot be misapplied and lead to care denials that would be covered by fee-for-service Medicare.** To protect the health and quality of life for MA beneficiaries, it is essential that the clinical criteria used in MA programs are no more restrictive or stringent than those used in traditional Medicare. The AMA urges CMS to collect and analyze all of the MA plan data needed to determine the appropriate corrective actions and protect MA patients from inappropriate care denials and delays.

The AMA also recommends that CMS require MA plans to report to the agency, as well as to the general public, plan performance on certain key PA program metrics, such as approval and denial rates, denials overturned on appeal, and average processing time for routine and urgent PAs. Again, this reporting mirrors what CMS requires for Part D plans and would allow for increased agency

[35] See Prior Authorization and Utilization Management Reform Principles, Principle #8. Available at: https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.

oversight of MA plan processes and protect beneficiary access to care. In addition, the AMA maintains that the public—in particular, MA patients contemplating a change in plan—should be able to evaluate an insurer's PA program performance. **As such, CMS should require MA plans to report key PA processing metrics either via a publicly available website or as part of the Star Rating program, as discussed later in this document.** Of note, in our response to an Office of the National Coordinator for Health IT (ONC) RFI on electronic PA, the AMA recommended that the ability to support the capture of payer PA program data and public reporting metrics, such as percentage of denials, be added as a required functional capability of any PA certified health IT module.[36]

4. **The AMA urges CMS to increase protections in the MA program to ensure that patients changing plans or facing mid-year changes will not suffer from care delays due to PA or step therapy requirements.** As stated earlier, an overwhelming majority of physicians report that PA can interfere with continuity of patient care. We urge CMS to require more detailed and stringent protections for care continuity by MA plans. For example, Part D plans are required to cover transition refills of chronic medications when patients change plans to prevent treatment disruptions. Similarly, CMS should require MA plans to institute "grace periods" for patients changing plans during which any step therapy or PA protocols are waived to prevent interruptions in ongoing treatment. Notably, CMS issued a proposed rule in late 2020 that would require health plans to electronically exchange data regarding authorized care for patients transitioning between plans using payer-to-payer application programming interfaces.[37] **In any future rulemaking on this topic, we urge CMS to take the additional step to require the patient's new plan to honor a previously approved PA or step therapy override to ensure that plan changes do not place beneficiaries in danger of harmful care disruptions.**
5. **We urge CMS to require MA plans to implement standardized electronic transactions that would allow clinicians to determine and complete PA requirements within their EHR workflow.** We appreciate CMS' efforts to bolster new technology standards that will ease clinician PA burdens and support timely access to care. However, as the AMA has previously indicated, it is critical that any new electronic standards under consideration for a federal mandate be sufficiently piloted and demonstrate adequate return on investment across stakeholders of all sizes, including small and rural physician practices. New technologies involving payer access to EHR data must also include privacy and security safeguards to protect against unwarranted access to protected health information—particularly if an insured patient chooses to self-pay for a certain service.

We commend CMS for seeking information on how MA plans could align on the data needed to process PAs. Increased uniformity in the data elements required by MA plans to evaluate PA requests for a specific service has the potential to reduce physician burdens and increase efficiency. Moreover, we note that building the technology to support highly variable PA documentation requirements across many different MA plans for a large number of medical services will likely be time- and resource-prohibitive for health plans, intermediaries, and EHR vendors. **The AMA, therefore, strongly supports efforts to standardize at least a "super set" of data elements needed to support PA decisions for specific**

[36] See https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-3-23-Letter-to-Tripathi-re-EPA-Comments-v3.pdf.

[37] Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients'Electronic Access to Health Information. Available at: https://www.cms.gov/files/document/121020-reducing-provider-and-patient-burden-cms-9123-p.pdf.

services, even though coverage determinations are bound to differ from payer to payer. We urge CMS to strongly encourage payer participation in this effort to increase uniformity, as we believe that harmonization in PA data sets across payers will be necessary for any standardized electronic PA model to be scalable across a large number of health plans, medical services, and PA criteria.

We must also underscore that automation alone cannot curb patient harm, delays in care, and physician burden associated with PA. If new electronic PA technologies simply automate the PA processes used by MA plans today, they will do nothing to address the serious delinquencies reported by the OIG. We urge CMS to undertake a holistic, cross-agency approach to PA reform in the MA program, as relying on electronic processes alone to solve the PA problem will make it easier for MA plans to abuse faulty coverage rules and arrive at "no" faster—essentially automating patient harm.

C. Drive Innovation to Promote Person-Centered Care

I. Health information exchange opportunities and considerations

The AMA appreciates CMS' desire to promote the access, exchange, and use of data to inform population health management and care coordination. Physicians need access to the right information about the right patient at the right time. This "triple need" is fundamental to ensure physicians have access to patients' longitudinal health record. While progress has been made to expand the availability of medical information, more can be done to improve the usefulness of and trust in exchanged information.

Many of our members report that they can connect to local health information exchange (HIE) networks, yet they often cannot access the complete health history of their patients. This results in a lack of trust and a belief that important medical information is missing. Physicians will forgo using an HIE if they do not feel they can find and receive a complete patient record. Furthermore, physicians often experience a unidirectional flow of information. While patient information is often requested from physicians' EHR systems, physicians regularly do not receive information when they make similar requests. **This asymmetry often occurs when exchanging with payers. CMS must consider how its policies can rebalance this disparity.**

Additionally, CMS' efforts to increase HIE among health care stakeholders must ensure patient data is protected, safe, and secure. Patients are most comfortable with physicians and hospitals having their data and are least comfortable with their data leaking outside the provider space.[38] Trust is a fundamental aspect of the patient-physician relationship. Even well-informed and knowledgeable patients have to rely on their physicians to provide them with appropriate information, keep personal information confidential, and act in their best interests.[39] In a recent survey of 1000 patients, nearly 75 percent said they are concerned about protecting the privacy of their health data. Six in 10 patients are worried about health data being used by companies to discriminate against them or their loved ones or to exclude them from opportunities to find housing, gain employment and receive benefits. The survey identified that over 50 percent of patients are "very" or "extremely" concerned that unnecessary access to their data could result in negative repercussions related to insurance coverage, employment, or opportunities for health care.[40] The evidence is clear: patients recognize the value of information exchanged among their providers but worry about the consequences of their information being misused by businesses or other entities,

[38] See https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.
[39] See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1500897/pdf/jgi_204.pdf.
[40] See https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.

including payers. **Data privacy and data liquidity are not mutually exclusive; CMS has a responsibility to encourage both with equal emphasis.**

To promote trust, strengthen data privacy, and create a more equitable information exchange paradigm between physicians and payers, CMS should consider building its HIE policies on top of the following principles:

- Develop and implement data exchange policies, processes, and programs to better address inequities and disparities among exchange parties. Advancing information exchange equity requires filling gaps in data completeness and quality and developing an information sharing infrastructure capable of consolidating and curating individuals' demographic and health information.
- Create policies that positively incentivize the collection, exchange, and use of actionable and timely information while ensuring information symmetry between physicians and MA plans. CMS' MA policies should enable physicians to better understand and manage health needs and conditions at the level of the individual, within communities, and across MA populations. CMS should assess the impact of its programs, operations, and MA plan arrangements to promote opportunities and new strategies to improve quality, experience, and outcomes of care and services. MA models should advance and support population health improvement and the delivery of value-based care—centered on the patient and care team.
- Policies should elevate the collection, exchange, and use of electronic health information in a secure manner while promoting trust, ensuring data integrity, individuals' safety, and adhering to federal and state privacy laws. For example, the Health Insurance Portability and Accountability Act (HIPAA) minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards to limit unnecessary or inappropriate access and disclosure of protected health information. Our members are concerned that by participating in HIEs with payers, MA plans could overreach into their EHRs and access unnecessary medical information. The Office for Civil Rights emphasizes that "appropriate limits should be set on the type and amount of information collected, used, and disclosed, and that authorized persons and entities should only collect, use, and disclose information necessary to accomplish a specified purpose."[41] CMS should reinforce this safeguard through its MA policies. CMS should require that MA plans meet the needs of their beneficiaries, perform their roles within trading partner agreements, and explicitly limit MA plan HIE data requests to the minimum necessary information needed to meet their business practices.
- Use of consistent and uniform data exchange standards is critical for interoperability. Physicians are required to utilize certified health information technology (health IT) which goes through federal testing and accreditation. This creates a common information exchange framework between health IT products because they are tested and shown to conform to the same standards. CMS should explore how reciprocal MA policies can be developed to require MA plans to demonstrate a similar level of conformity. This is particularly important as CMS explores how new technologies can address the burden and patient harm caused by MA PA practices. As an example, CMS could require that MA plans adopt, implement, and use health IT that conforms to equivalent industry standards, policies, best practices, and technical guides used in the ONC Certification Program. As an initial step, MA plans should be required to document and provide evidence demonstrating how their health IT systems comply with and conform to the same technical guides EHR vendors must meet in ONC's programs.

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[41] See https://www.hhs.gov/hipaa/for-professionals/faq/collection,-use,-and-disclosure-limitation/index.html.

As CMS explores polices to promote HIE use, we urge CMS to also consider the technical and resource limitations many physicians face. The vast majority of physicians believe it is important to share electronic health information to provide quality care, yet the lack of a convincing value proposition for physicians has been a major barrier to HIE use.[42] Although there is likely a net societal benefit of participating in HIEs, the return on investment for individual medical practices may not materialize. Apart from capital expenses and fees, medical practices must also adapt their workflow to benefit from HIEs. HIE adoption can be risky for small medical practices. Implementation costs, including the loss of productivity, can undermine practices' financial stability. Many medical practices lack staff with the skills and experience necessary for HIE implementation. The AMA urges CMS to review its HIE policies through the lens of burden, costs, and other resource limitations affecting small, rural, and solo practices. To ensure all medical practices can benefit from CMS' HIE efforts, policies should be crafted to avoid large-scale disruption and huge up-front capital investments by physicians. CMS should ensure that any HIE incentives are conditioned to support medical practices of all sizes and geographic locations, and that any requirements leverage existing certified hardware and software, i.e., EHRs, already used by physicians.

II. MA Star Ratings

The AMA has repeatedly highlighted to CMS the need for the Star Ratings program to focus more on compliance and communication, as opposed to measures that rely on physician action. For example, many MA plans require practices to submit patients' lab results to support plans in achieving increased Healthcare Effectiveness Data and Information Set (HEDIS) scores and earning greater incentives from CMS. Many of the measures, particularly the HEDIS Effectiveness of Care measures, have more to do with physician quality than assessment of a health plan. **As a result, MA plans are placing burdensome data demands on physician practices to support reporting of measures that provide little insight into the quality of an MA plan.**

The AMA urges CMS to rework the Star Rating program so that it will instead provide useful, actionable information to beneficiaries regarding the access to care under a particular MA plan. As noted earlier, one possibility would be to add measures that assess MA plans' PA programs, such as approval and denial rates, denials overturned on appeal, and average processing time for routine and urgent PAs. Of note, in our response to an ONC RFI on electronic PA, the AMA recommended that the ability to support the capture of payer PA program data and metrics, such as percentage of denials, be added as a required functional capability of any PA certified health IT module.[43] Metrics assessing network adequacy for various types of care would represent another invaluable addition to the Star Rating program. These new Star Rating measures would allow patients to evaluate if care access under a particular MA plan is sufficient to support their own personal health care needs. Moreover, such metrics would rely on plans' internal program data instead of requiring burdensome data collection from physician practices.

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[42] See https://www.ama-assn.org/system/files/2018-10/cybersecurity-health-care-infographic.pdf.

[43] See https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-3-23-Letter-to-Tripathi-re-EPA-Comments-v3.pdf.

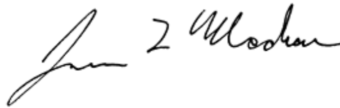
D. Support Affordability and Sustainability

I. Competition in MA markets

The AMA will be producing the 21st edition of its annual publication titled *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* in Fall 2022. This study assesses competition in health insurance markets. Using 2021 data from the Decision Resources Group, it will report market shares of the two largest health insurers and concentration levels at the metropolitan statistical area and state level markets, as well as at the 10 largest insurers' market shares at the national level. Previous editions have focused on commercial markets. Although the AMA has also been assessing competition in MA markets internally since 2017, for the first time, this year's edition of *Competition in Health Insurance* will also report those measures for MA markets. The AMA will forward the new edition of the study, including the MA market data, to CMS upon its publication.

In conclusion, 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 or 202-789-7409.

Sincerely,



James L. Madara, MD