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May 29, 2024

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

SUBMITTED ELECTRONICALLY VIA <http://www.regulations.gov>

Re: Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

The Society of General Internal Medicine (SGIM) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for information on Medicare Advantage (MA) data. With over half of Medicare beneficiaries enrolled in MA, CMS must adopt policies that support the delivery of high-quality care for patients and reduce administrative burden for physicians. As such, we are encouraged to see that CMS aims to enhance MA data capabilities and increase public transparency.

SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internal medicine physicians, who are dedicated to delivering high-quality clinical care, improving access for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to ensuring patients have equitable and affordable access to the highest quality of care possible.

SGIM recognizes that CMS has already taken efforts to improve transparency and strengthen the MA program through recent rulemaking, including, but not limited to, improved data capabilities, prior authorization processes, and interoperability requirements. We are pleased to share additional feedback for your consideration.

Having access to specific data elements at both the MA plan and enrollee levels can help empower patients to make informed healthcare decisions. Comprehensive and publicly available data is essential to enhancing quality care. As the services offered by a plan vary between counties within the same state, with underserved counties receiving fewer benefits, data should be available on additional services covered by plans (e.g., hearing and visual aids and dental care) at the county level. The recognition that underserved communities receive fewer benefits and the inclusion of this data element is important, as this exacerbates existing inequalities and limits access to necessary services for vulnerable populations. This data should also consider the rural or urban status of the enrollees' residences. This information would encourage plans to provide standardized services across all counties or enhanced services in rural and disadvantaged areas. Additionally, a plan's covered benefits, including those not covered by Medicare fee-for-service like dental coverage, vision coverage, gym discounts, etc., should be made available to beneficiaries.



SGIM appreciates CMS' recent efforts to improve prior authorization processes in the MA program. As general internal medicine physicians committed to providing comprehensive care to patients, our members are bearing a heavy burden from the increasing number of prior authorization requests generated for the growing number of patients in MA plans. We recognize that prior authorization plays a role in ensuring that patients receive medically appropriate care. However, the process is complex, burdensome, and time consuming and often lacks transparency about what will be approved leading to delays in patients receiving recommended medications, tests, procedures, or other services.

Regarding prior authorization metrics, CMS should develop a plan for efficiently collecting and reporting key data on the enrollees in the plans. When considering data on enrollees, CMS should make this available by race, which is an indicator of health inequity and disparities in access to care in the United States. Data related to plans should include rates of approval of services for specialty care and institutionalized post-acute care services, such as skilled nursing facility (SNF) visits, and rates of approval of durable medical equipment, such as wheelchairs. CMS should categorize rates of prior authorization requests that are approved by item or services (e.g., prescription drugs, diagnostic tests, specialty treatments, etc.). Additionally, data should reflect the average amount of time for payers to complete prior authorization requests, categorized by standard (non-urgent) and expedited (urgent) requests, as delays in prior authorization processes contribute to delays in patient care.

Subsequently, data collected may help to inform efforts to address barriers in access to care. By improving the availability of the following data elements, we can improve access to care and promote health equity.

- Rates of receipt of care by mental health providers for serious mental health illnesses;
- Rates of receipt of specialty care in outpatient settings for enrollees with high-risk diagnoses (e.g., heart failure, advance chronic kidney disease, chronic obstructive pulmonary disease, diabetes, liver cirrhosis);
- Rates of receipt of transplantation services for individuals with end stage renal and liver disease;
- Rates of patients discharged from a hospital to a SNF;
- Rates of hospital admissions and emergency department visits; and
- Rates of mortality.

When publicizing this information, CMS should also report the differential impact on Black and Hispanic patients compared to non-Black and non-Hispanic patients.

Moreover, data related to social determinants of health, such as food insecurity, housing situation, and access to transportation, should also be made available as these factors can significantly impact a patient's health. CMS should collect this information and use it to examine the effect of prior authorization processes. By collecting this and making it publicly available, MA plans can be monitored to ensure they are providing equitable access to services for all patients.



Moreover, to promote more equitable healthcare outcomes, patients should have access to data on the availability of in-network providers. This will lead to better care coordination and lower costs for patients. Additionally, there should be disclosure of out-of-network benefits to assist patients in making more informed decisions and to improve access to specialized care. A summary of out-of-pocket costs will provide greater transparency to help patients understand their financial responsibilities. This data should include explicit information on patient cost sharing for items and services, such as hearing aids, hearing aid fitting assessments, visual aids, and resources for low vision beneficiaries. Data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio, will provide additional transparency and accountability.

Lastly, the following data elements related to MA prescription drug plans (MAPDs) should be made publicly available for enrollees and the data should also be available based on race and ethnicity of enrollees (Black, Hispanic, non-Black/non-Hispanic) as research has identified racial and ethnic disparities in access to these lifesaving therapies. For example, the following data can support oversight efforts of MA and ensure equitable access to evidence-based therapies for all eligible patients.

- Enrollees with chronic diseases who are on appropriate guideline-directed medical therapy (GDMT); and
- Enrollees with medical indications for anti-coagulation who are on direct oral anticoagulation (DOAC) vs warfarin.

MAPD prior authorization approval rates and average time for prior authorization approval should also be available to CMS and publicly to help consumers make informed decisions when selecting appropriate insurance plans.

SGIM appreciates your consideration of these comments. We are committed to working with you to ensure that MA plans best meet the needs of beneficiaries. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Bussey-Jones", with a stylized flourish at the end.

Jada Bussey-Jones, MD, FACP
President, Society of General Internal Medicine