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May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted electronically via regulations.gov

RE: [CMS–4207–NC.] Medicare Program; Request for Information on Medicare Advantage Data

Dear Administrator Brooks-LaSure:

On behalf of the 8,500 members of the American College of Rheumatology (ACR), I write to provide comments in response to the Center for Medicare and Medicaid Services' (CMS) Request for Information (RFI) on potential routes for making Medicare Advantage (MA) data more transparent. Rheumatologists and rheumatology healthcare professionals provide ongoing care for MA enrollees with complex chronic and acute conditions that require specialized expertise. They provide primarily non-procedure-based care to MA enrollees with severe conditions that can be difficult to diagnose and treat, including rheumatoid arthritis and other forms of inflammatory arthritis, vasculitis, systemic lupus erythematosus, and multiple other debilitating diseases that require complex diagnosis and treatments.

With more than half of Medicare beneficiaries now choosing Medicare Advantage, the utilization of rheumatological care along with its cost-sharing and marketing practices needs to be further scrutinized. The information collected through this proposal is essential to understanding the rheumatological needs of Medicare beneficiaries, while highlighting potential access to care issues that may arise with the rapid growth of Medicare Advantage. The ACR supports data transparency of Medicare Advantage plans in the following areas:

Prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms.

The ACR supports CMS reporting of the following MA prior authorization and utilization management metrics to the public:

- ✓ Number of prior authorization requests, denials, and appeals by type of service.
- ✓ Prior authorization response rates by type of service
- ✓ Reasons for prior authorization denials by type of service
- ✓ Frequency of prior authorization denials by type of service

These metrics around utilization are essential in helping improve patient care. With these metrics, rheumatologists and other care team members can verify whether procedures are positively impacting overall population health. For too long, prior authorization policies by MA managed care plans have been burdensome and time-consuming and have delayed care for beneficiaries. This delay in care is exacerbated by the fact that MA beneficiaries must also rely on patient assistant programs to subsidize the cost of prescription drugs due to MA plans not allowing the red, white, and blue Medicare card to be used for health care. The resulting administrative burden has led some physicians to stop accepting MA patients. Further, this exposes a deep divide in prior authorization policies between the MA program and traditional Medicare.[1,2]

To address the assorted problems with prior authorization policies, a range of public policies have been proposed.[3,4] These have included "gold carding" at the state level and electronic prior authorization at the federal level.[5,6] However, despite the increasing policy attention to controversial prior authorization practices, there is limited data on how prior authorization is used by MA plans and how it has changed over time. The requirement for additional information to process the authorization leads to increased burden on physicians and their staff, and results in delays in care and an increased likelihood of negative patient outcomes.

Care quality and outcomes, including value-based care arrangements and health equity.

The ACR supports CMS collecting and reporting of the following MA metrics that involve care quality and outcomes and health equity:

- ✓ Percentage of MA beneficiaries of color with certain diseases.
- ✓ Percentage of MA beneficiaries that are younger than 65.
- ✓ Percentage of MA beneficiaries of color that are enrolled in low-rated plans.
- ✓ Percentage of MA beneficiaries of color that have access to 5-star plans.
- ✓ Care outcomes for MA beneficiaries of color (i.e. discharge, readmission, death).
- ✓ Average annual premium per MA beneficiary of color.

Enrollment in MA plans in recent years has significantly increased in communities of color. Despite the increasing size of the MA market, and the increasing variety of benefit plan types that MA insurers can and do offer, there's limited data on how outcomes vary by certain socioeconomic factors under different types of plans. Specifically, there is limited understanding of how specific plan features, such as out-of-pocket costs and coverage design, impact who ends

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[1] https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

[2] Gupta R, Fein J, Newhouse J P, Schwartz A L. Comparison of prior authorization across insurers: cross sectional evidence from Medicare Advantage *BMJ* 2024; 384 :e077797 doi:10.1136/bmj-2023-077797

[3] Abelson R. Medicare Advantage plans often deny needed care, federal report finds. *New York Times.* April 28, 2022. Accessed April 24, 2024. https://www.nytimes.com/2022/04/28/health/medicare-advantage-plans-report.html

[4] Grimm CA. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*.HHS Office of Inspector General report in brief OEI-09-18-00260; April 2022. Accessed April 24, 2024. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[5] https://www.beckershospitalreview.com/finance/texas-physician-gold-card-rules-take-effect-oct-1.html

[6] https://www.congress.gov/bill/117th-congress/house-bill/3173

up enrolling in those plans and the healthcare utilization of those who do enroll in specific plan types.

Healthy competition in the market, including the impact of mergers and acquisitions, high levels of enrollment concentration, and the effects of vertical integration.

The ACR supports CMS collecting and reporting of the following MA metrics that involve the impact of healthcare consolidation on the quality of care provided to beneficiaries:

- ✓ Bidding figures from each MA plan on an annual basis juxtaposed to the Herfindahl-Hirschman Index score of the markets in which each MA plan operates.
- ✓ Average annual premiums per MA plan pre- and post-merger based on beneficiary state of residence, plan type, and calendar year.
- ✓ Number of rheumatologists each MA beneficiary has in network pre- and post-merger within a reasonable geographic difference.

The ACR has been steadfast in its support for a truly competitive healthcare market. We are concerned about the potential negative impacts that the mass consolidation of both the health insurance and provider markets have had on access to high quality rheumatological care. The unfortunate reality is that decades of insurance and provider consolidation has left too many communities across the U.S. without timely access to rheumatological care. It has also squeezed many independent rheumatologists out of practice and left them with limited choices for employment. This has led to soaring healthcare prices and costs, and many beneficiaries in underserved communities being without convenient access to a rheumatologist.

Having access to these data points will allow researchers to better assess the impact that private equity and monopolies are having on access to specialist care, healthcare costs, and the quality and depth of provider networks. It will also give rheumatology professionals a more comprehensive view of the market in their geographic area, which will help them make better choices for employment and for how to structure their practice to better serve the needs of their patients.

Data topics related to Medicare Advantage prescription drug plans (MAPDs).

- ✓ Quarterly listings of medications to which MA beneficiaries have access.
- ✓ Percentage of MA beneficiaries who reach their out-of-pocket limits every year.

The ACR firmly believes that MA prescription drug plans must promote and protect access to high-quality, affordable health care and health insurance in today's value-based care environment. However, there are several gaps in MA prescription drug plans that these data points will help rheumatology care teams provide better care to MA beneficiaries given the current regulatory environment. First, while biosimilars have a legitimate role in the care of rheumatological patients, current policy (i.e. requirement for prior authorization) makes it difficult for patients to revert to the reference product if the biosimilar fails. We strongly support patients having access to the right treatment at the right time and having the opportunity to access a reference product if needed.

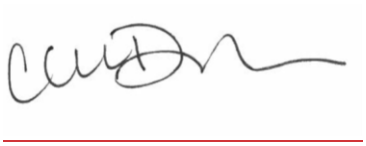
Second, we are strongly opposed to continuing formulary changes quarter by quarter or year by year. We recognize that formulary changes in preferred products are often driven by rebates offered by manufacturers, and/or price differences. However, we worry that financial incentives may lead payers to continually switch one product to another when a different manufacturer offers a better deal, and we feel strongly that repeated changes from one biosimilar to another needlessly exposes patients to risk of differential treatment response and/or of side effects. Frequent formulary changes also lead to significant administrative burden for physicians, which is a leading cause for many leaving the profession, thus leaving their patients with limited access to quality care and exacerbating the physician workforce shortage.

Lastly, we have strongly urged CMS to enforce the recent court ruling that outlawed the use of copay accumulators. Copay accumulators disproportionately impact the most vulnerable patients who rely on certain high-cost specialty medications. When the manufacturer assistance runs out for these patients, some will be unable to afford their prescriptions and will be too far from meeting their annual deductible to receive assistance from their insurer. This will inevitably lead to some patients rationing their doses or even abandoning treatment altogether. Research shows that over 70% of new patients opt not to fill a prescription with a copayment of $250 or more.[7]

Conclusion

The ACR is dedicated to working with CMS to ensure that rheumatologists and rheumatology interprofessional team members are equipped to provide patients with quality care.
We look forward to serving as a resource to you and working with the agency to explore changes and improvements needed to ensure MA enrollees with rheumatic diseases have better access to quality care. Please contact Colby Tiner, MA, Manager of Regulatory Affairs, at ctiner@rheumatology.org if you have any questions.

Sincerely,



Christina Downey, MD
Chair, Government Affairs Committee
American College of Rheumatology

[7] https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/bltec5337f5cb15fa98/medicine-use-and-spending_in-the-us.pdf