AMERICA'S
PHYSICIAN
GROUPS

May 24, 2024

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/commenton/CMS-2024-0008-0001

Re: Centers for Medicare & Medicaid Services Request for Information on Medicare Advantage (MA) Data (CMS–4207–NC)

Dear Administrator Brooks-LaSure:

America's Physician Groups (APG) appreciates the opportunity to respond to the Request for Information (RFI) on Medicare Advantage (MA) data. APG welcomes your agency's openness to stakeholder input and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposals, (III) a summary of APG's recommendations, and then (IV) our fuller comments and recommendations. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Medicare beneficiaries have consistently accessible, high-quality, equitable, person-centered health care. This commitment pertains to all Medicare beneficiaries, regardless of whether they receive their benefits through the traditional, fee-for-service program or through a Medicare Advantage or Medicare Prescription Drug Benefit Program plan.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. CMS's Request for Information (RFI)

The agency's MA RFI is an extension of its ongoing work on MA data. CMS now solicits stakeholder feedback on how best to meet the goals of 1) enhancing data capabilities to have better insight into agency programs, 2) considering areas to increase MA data transparency, and 3) proposing future rulemaking. CMS indicates that the agency's 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, and to allow for analysis in the context of other health programs like ACOs, the Marketplace, Medicaid managed care, integrated delivery systems, and others.

CMS requests that stakeholders provide feedback provide that reflects: 1) operational considerations based on a deep understanding of MA data; 2) ways that CMS could improve current MA data collection and release methods, including recommendations on the preferred cadence of data releases; and 3) detailed information on common challenges and experiences in the MA program for which limited data are currently available.

Considering the topics that are most germane to APG members, CMS specifically requests stakeholder input on the following:

- Prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms
- Cost and utilization of different supplemental benefits
- Care quality and outcomes, including value-based care arrangements and health equity

III. Summary of APG's Recommendations

A. Recommendations Related to Prior Authorization and Utilization Management

- **APG recommends that CMS establish a uniform, national set of standard prior authorization denial codes and require all payers to use only these codes in prior authorization processes.**
- **APG recommends that CMS revise policies limiting the use of prior authorization to explicitly allow prior authorization to be used to alert patients to coverage and cost-**

sharing differences for in-network and out-of-network providers and facilities.

- **APG recommends that CMS require that MAOs report more detailed information on prior authorizations, including specific service or service category, reason for denial, and time elapsed between each process step, at the plan rather than contract level and relying on empirical data rather than survey data that puts additional reporting burden on physicians and patients.**

- **APG recommends that CMS encourage MAOs to incorporate AI in prior authorization processes responsibly and with appropriate guardrails.**

B. Recommendations Related to Cost and Utilization of Supplemental Benefits

- **APG recommends that CMS set a short-term goal of collecting detailed information from MA organizations (MAOs) about the following:**
  - **the supplemental benefits they offer,**
  - **the evidence supporting the inclusion of these supplemental benefits,**
  - **enrollees' utilization of supplemental benefits, and**
  - **evidence of the impact of supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs.**

  APG further recommends that CMS (1) analyze and report data on the impact of MA supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs, and (2) make the dataset available to researchers who have data use agreements in place and are qualified to access CMS data.

- **APG recommends that CMS adopt similar guardrails inherent in value-based care arrangements between MAOs and contracted providers in any future rulemaking on MA supplemental benefits.**

- **APG recommends that CMS monitor the impact of the new requirement that MA organizations provide the agency with evidence of the efficacy of services provided under special supplemental benefits for the chronically ill (SSBCI). The policy should be reviewed and revised, as needed, after the agency also finalizes and adopts policies to collect, analyze, and report data on the impact of all supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs, and makes the dataset available to researchers who have data use agreements in place and are qualified to access CMS data.**

C. Recommendations Related to Care Quality and Outcomes, Including Value-based Care Arrangements and Health Equity

- **APG recommends that CMS reflect value-based care arrangements in MA in the agency's 2030 goal of having all Medicare beneficiaries in an accountable relationship.**

- **APG recommends that CMS offer incentives to MAOs for incorporating value-based care arrangements with contracted providers, e.g., by adding a Star Ratings measure**

for availability of value-based care arrangements.

- **APG recommends that CMS set clear expectations with MAOs to share all data that the MAOs report to the agency with their delegated providers.**
- **APG recommends that CMS continue to move toward adoption of Universal Foundation quality measures and accelerate the timeline for adoption of these measures.**
- **APG recommends that CMS curtail the number of new Star Ratings measures introduced and focus on maintaining a limited number of high-value, outcomes measures to assess the characteristics of MA plans that are of greatest value to enrollees.**
- **APG recommends that CMS not adopt SDOH measures, such as those related to social connection and utility insecurity screenings, until it has (1) considered from a cost-benefit standpoint the relative value of adding more measures that will increase the reporting burden for patients, providers, and plans; (2) provided clarity on the interventions that plans or providers would be expected to undertake to address these particular challenges, if any; (3) evaluated whether the sought-after information about social connection and utility insecurity could be collected about beneficiaries in alternative ways, and potentially by other entities better positioned to address these issues directly on behalf of beneficiaries; and (4) provided clear evidence that this information would not be collected unless linked to a Star Ratings measure.**
- **APG recommends that CMS assess the quality of MA and FFS Medicare using comparable measures and data to allow Medicare enrollees and policymakers to compare the relative performance of each option.**
- **APG recommends that CMS switch to a default opt-in approach to payer-to-payer data sharing when an MA enrollee changes plans, with an option for patients to opt-out.**
- **APG recommends that CMS require MA health plans to share historical claims and encounter data with new plans when individual change their enrollment by any means available sooner than the January 1, 2027 required date to share these data through a Payer-to-Payer API.**

IV. APG's Detailed Comments and Recommendations

APG appreciates CMS's ongoing efforts to refine the MA program and address challenges as they arise. The agency clearly strives to be a responsible steward of the Medicare program while improving MA for the growing number of beneficiaries who choose this enrollment option. APG is especially grateful that CMS continues to solicit stakeholder input and incorporate this feedback into proposed policies.

Although APG welcomes CMS's focus on MA data, there is a need for caution about policies that increase data collection. Too often data collection efforts, even when targeted at Medicare Advantage organizations (MAOs), translate to additional reporting burden for physicians and even patients. Physicians have identified administrative burden as a top concern and asked CMS to address the issue for years. The burnout resulting from leaving the problem to worsen has left many providers to question why CMS continues to ask for input on the issue rather than taking action to address it. As APG member, Dr. Colleen Inouye of the Hawaii Independent Physicians Association, observed, "Physicians want to take care of their patients, and they would like to enjoy it. Some of that joy has been taken away" by virtue of burdensome practices such as excessive data collection and reporting.

As CMS and Congress have adopted new ideas to improve MA, especially those that include data collection and reporting, the resulting policies often cause MAOs to place additional burdens on the physicians and other clinicians with whom they contract. Often physicians must hire outside consultants or expand their administrative teams to handle the additional work. As CMS develops the rules for each new policy, the agency should consider the impact on providers for each of the topics included in this RFI, especially for smaller physician practices and those that serve marginalized communities. CMS should carefully consider whether each new policy will place additional burdens on providers and potentially affect patients' access to care.

Clinicians are burdened not just by policies implemented by CMS, but also by variations on policies implemented by other payers and programs. Synchronizing reporting requirements and other policies across payers should be the goal whenever possible – for example, by using the same quality measures, designing a single website that could populate every application and form that providers must complete, and implementing an all-payer claims clearinghouse.

A. Prior Authorization and Utilization Management

CMS requests stakeholder feedback on prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms.

Amid the ongoing provision of low-value care, utilization management techniques such as prior authorization are necessary and critical to assuring the value of health care for all stakeholders and the wellbeing and safety of patients. Yet policymakers have increasingly heard concerns that prior authorization may in too many instances be serving as an overly restrictive impediment to patients' receipt of high-quality care. Hence, APG welcomes CMS's efforts to make electronic prior authorization more efficient by addressing process challenges.

APG members are especially grateful that CMS is invested in applying prior authorization policies to multiple payers, and wholeheartedly endorses the agency's efforts to streamline prior authorization rules and processes across payers. Physicians often find it extremely problematic to comply with multiple payers' rules and processes.

As one APG member noted, multiple, often-conflicting requirements mean that "implementation [of prior authorization] is a nightmare." Physicians' efforts to stay on top of implementation for prior authorization and other tools required of medical practices requires time and resources that add to administrative costs. In fact, the multiple rules and application interfaces, along with the expertise needed to implement them, continue to drive physician consolidation as well as payer consolidation. The cost to implement prior authorization programs is the same for a solo physician practice as it is for 100-physician practice. Similarly, the cost is the same from a payer perspective for a 10,000-life plan as for a one-million-life plan.

Given ongoing pressure to keep costs low, such as through contract negotiations with payers and medical loss ratio rules, it is essential that physician groups keep administrative costs as low as possible. Standardizing prior authorization rules and processes across payers could help to keep administrative costs down. A key element of prior authorization that remains heterogeneous across payers is the denial codes reported back to physicians. There are various prior authorization denial codes; and payers can each use a unique set of authorization denial codes, which increases the burden on physicians who must understand and interpret what the various denial codes mean.

In summary:

- **APG recommends that CMS establish a uniform, national set of standard prior authorization denial codes and require all payers to use only these codes in prior authorization processes.**

As part of the 2024 MA and Part D final rule, CMS implemented several new prior authorization policies, including limiting prior authorization so that it may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary.[1] APG appreciates that CMS has attempted to address potential confusion about the application of prior authorization and other utilization management tools. However, APG notes that this limitation overlooks an essential function of prior authorization, which is to ensure that patients are aware of the implications of their choice of provider or place of service. Plans use prior authorization not only to notify enrollees when a service is not covered, but also to alert them to the possibility that switching a planned procedure to an in-network provider or location would ensure compliance with coverage requirements or result in reduced cost-sharing for them. This use of prior authorization can be of tremendous benefit to enrollees that they may find well worth the extra step and time by helping them to avoid coverage denials or higher cost sharing. APG recommends that CMS revise this policy so that prior authorization works better in the interest of patients.

In summary:

- **APG recommends that CMS revise policies limiting the use of prior authorization to explicitly allow prior authorization to be used to alert patients to coverage and cost-sharing differences for in-network and out-of-network providers and facilities.**

According to data reported by MAOs, prior authorization denials are infrequently appealed by enrollees (11 percent in 2021), but the vast majority (82 percent in 2021) of these appeals result in the MAO fully or partially overturning the initial denial.[2] To the extent that CMS considers new prior

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[1] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[2] https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

authorization data collection and reporting efforts, APG urges the agency to minimize physician and patient burden by eschewing survey instruments in favor of direct measures of prior authorization and utilization collected from MAOs based on empirical data. As noted by the Kaiser Family Foundation, there is opportunity to require MAOs to report more detailed information on prior authorization to fill gaps in currently available data, such as the following:

- Information on the specific service or service category, so that CMS can track prior authorization requests, denials, and appeals by type of service;
- The reason a prior authorization request was denied;
- Data reporting at the plan rather than contract level, so CMS can track prior authorization requests, denials, and appeals by plan type; and
- Time between each prior authorization request and subsequent approvals, denials, appeals, and redeterminations.[3]

In summary:

- **APG recommends that CMS require that MAOs report more detailed information on prior authorizations, including specific service or service category, reason for denial, and time elapsed between each process step, at the plan rather than contract level and relying on empirical data rather than survey data that puts additional reporting burden on physicians and patients.**

The use of artificial intelligence (AI) offers an opportunity to improve upon existing prior authorization practices and address issues that negatively affect patients. For example, in a 2022 report from the Office of the Inspector General that found that some MAOs inappropriately denied prior authorization requests, it was noted that most of the payment denials for care that met Medicare coverage rules and MAO billing rules were caused by human error during manual claims-processing reviews and system processing errors.[4] It is possible that prior authorization processes that responsibly incorporate AI and other algorithm-based review would result in fewer problematic denials. If such algorithms are incorporated into prior authorization, it will be essential to ensure that sufficient guardrails are in place to avoid unintended consequences, such as the perpetuation of biases. APG supports the AI roadmap offered by a bipartisan group of senators in the *Driving U.S. Innovation in Artificial Intelligence* report and encourages CMS to reflect these ideas in future rulemaking.[5]

In summary:

- **APG recommends that CMS encourage MAOs to incorporate AI in prior authorization processes responsibly and with appropriate guardrails.**

B. Cost and Utilization of Supplemental Benefits

CMS requests stakeholder input on the cost and utilization of different supplemental benefits.

Given the importance of MA supplemental benefits and the lack of transparency about their

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[3] Ibid.

[44] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[5] https://www.schumer.senate.gov/imo/media/doc/Roadmap_Electronic1.32pm.pdf

effects on enrollees' health outcomes and quality of life, APG lauds CMS's efforts to ensure that supplemental benefits deliver value to enrollees. In fact, given this importance and lack of transparency, APG supports many of CMS's new policies, such as requiring MAOs to report supplemental benefit cost and utilization data beginning with plan year 2024, and urges CMS to consider even bolder efforts. APG proposes that CMS set a short-term goal of collecting detailed information from MAOs about the following:

- the supplemental benefits they offer,
- the evidence supporting the inclusion of these supplemental benefits,
- enrollees' utilization of supplemental benefits, and
- evidence of the impact of supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs.

All these data should be drawn from MAO's existing data without imposing additional reporting requirements on physicians and patients. CMS should then analyze and report on MAOs' supplemental benefits data, as well as make the dataset available to researchers who have data use agreements in place and are qualified to access CMS data.

In summary:

- **APG recommends that CMS set a short-term goal of collecting detailed information from MA organizations (MAOs) about the following:**
    - **the supplemental benefits they offer,**
    - **the evidence supporting the inclusion of these supplemental benefits,**
    - **enrollees' utilization of supplemental benefits, and**
    - **evidence of the impact of supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs.**

  APG further recommends that CMS (1) analyze and report data on the impact of MA supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs, and (2) make the dataset available to researchers who have data use agreements in place and are qualified to access CMS data.

As physician groups who take responsibility for the quality and total cost of care for the patients whom they serve, APG members recognize the unparalleled value that supplemental benefits can provide. For example, well-managed transportation benefits can ensure that patients with low socioeconomic status, significant health-related social needs, and/or multiple chronic conditions, can readily have regular visits with their primary care providers, specialists, and diagnostic service providers. The support that transportation benefits provide can vastly improve patients' quality of life by allowing their providers to effectively manage their care and deliver high-quality outcomes.

However, not all supplemental benefits necessarily yield improved outcomes, especially when they are poorly targeted to enrollees' needs. For example, benefits that cover over-the-counter drug costs, or that offer flexible spending cards, can serve as an important support for some enrollees, while simultaneously adding unnecessary spending for enrollees who are not in need to these benefits. In the latter cases, these spending cards are little more than a marketing tool for MAOs. Overall, supplemental benefits are best implemented in conjunction with value-based care arrangements between MAOs and contracted provider groups, so that these contracted physicians can help to effectively coordinate these benefits for the patients whom they serve. In fact, CMS should keep these value-based care arrangements in mind if the agency pursues future rulemaking on MA supplemental benefits.

In summary:

- **APG recommends that CMS adopt similar guardrails inherent in value-based care arrangements between MAOs and contracted providers in any future rulemaking on MA supplemental benefits.**

Once CMS collects, analyzes, and reports the impact of supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs, the agency could then seek to improve supplemental benefit design through future notice-and-comment rulemaking. CMS and all MAO's could learn from these results about how to design supplemental benefit options that will lead to better outcomes.

In this year's Medicare Advantage and Part D Final Rule, CMS adopted a final policy that requires MAOs to provide CMS with evidence of the efficacy of services they select to include as special supplemental benefits for the chronically ill (SSBCI).[6] This new requirement includes a bibliography of "relevant and acceptable evidence" that demonstrates that an item or service is reasonably expected to improve or maintain the health or overall function of a chronically ill enrollee.

"Relevant and acceptable evidence" will be interpreted to include large randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, designed to investigate the item or service's impact on health or overall function. If these types of studies are unavailable, "relevant and acceptable evidence" can include large systematic reviews or meta-analyses summarizing literature of the same. In the absence of publications that meet these standards, bibliographies may include case studies, federal policies or reports, internal analyses, or any other investigation of the items/service's impact. MAOs must include all relevant acceptable evidence published within 10 years of the preceding month in which the bid is submitted, not just supportive evidence. CMS requires evidence of efficacy only when MAOs opt to offer SSBCI, not when they opt to reduce cost sharing. CMS also does not apply the requirement to the Value-base Insurance Design (VBID) model.

In a comment letter on the MA and Part D Proposed Rule, APG urged caution regarding CMS's proposal to apply the evidence of efficacy proposed policy only when MAOs opt to offer SSBCI, not when they opt to reduce cost sharing.[7] The obvious choice for too many MAOs will be to opt to reduce cost sharing in lieu of offering SSBCI. This outcome will be undesirable.

At this point, policymakers and other stakeholders have concerns that not all SSBCI are optimally designed to support better outcomes. Yet they lack the data to discern which SSBCIs achieve optimal outcomes for MA enrollees. Abandoning SSBCIs before studying their impact will waste the learning opportunity afforded by the testing of the effects of these benefits. It would be far better to maintain these options and view the MA plans that provide SSBCI – combined with data collection, analyses, and reporting – as a much-needed experiment in the relative value to enrollees of various supplemental benefits.

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[6] https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

[7] https://www.apg.org/news/apg-comment-letter-to-cms-on-proposed-policy-changes-to-medicare-advantage-and-medicare-part-d/

In summary:

- **APG recommends that CMS monitor the impact of the new requirement that MA organizations provide the agency with evidence of the efficacy of services provided under special supplemental benefits for the chronically ill (SSBCI). The policy should be reviewed and revised, as needed, after the agency also finalizes and adopts policies to collect, analyze, and report data on the impact of all supplemental benefit utilization on enrollees' quality of care outcomes and out-of-pocket costs, and makes the dataset available to researchers who have data use agreements in place and are qualified to access CMS data.**

C. Care Quality and Outcomes, Including Value-based Care Arrangements and Health Equity

CMS requests stakeholder input on care quality and outcomes, including value-based care arrangements and health equity.

MA is an essential pathway for incorporating value-based care arrangements into Medicare. Given the relative scale of enrollment in MA, with more than 33 million Medicare beneficiaries, versus prominent value-based care arrangements existing ACOs available in FFS Medicare – the Medicare Shared Savings Program, ACO REACH, and the Kidney Care Choices model, all of which pertain to more than 13 million Medicare beneficiaries – the MA pathway to value should not be overlooked. APG urges CMS to consider value-based care arrangements in MA as part of the agency's goal of having 100 percent of Medicare beneficiaries in accountable relationship by 2030 – a goal that APG strongly supports.

As CMS has noted, MAOs have been increasingly embracing value-based care arrangements, but this growth needs to be better understood and accelerated.[8] APG encourages CMS to offer incentives to MAOs for incorporating value-based care arrangements with contracted providers, e.g., by adding a Star Ratings measure for availability of value-based care arrangements.

To encourage growth of value-based care arrangements, it will also be essential to offer participation incentives to physicians and other clinicians. One such incentive should include addressing participating physicians' challenges with data transparency. The lack of data access is especially problematic in value-based care arrangements because physicians are at risk for quality and total cost of care, yet too often lack line of site on information that the MAOs have even though the MAOs are delegating risk from the plan to the physicians. APG urges CMS to set clear expectations with MAOs to share all data that the MAOs report to the agency with their delegated providers.

In summary:

- **APG recommends that CMS reflect value-based care arrangements in MA in the agency's 2030 goal of having all Medicare beneficiaries in an accountable relationship.**
- **APG recommends that CMS offer incentives to MAOs for incorporating value-based care**

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[8] https://www.healthaffairs.org/content/forefront/medicare-value-based-care-strategy-alignment-growth-and-equity

arrangements with contracted providers, e.g., by adding a Star Ratings measure for availability of value-based care arrangements.

- **APG recommends that CMS set clear expectations with MAOs to share all data that the MAOs report to the agency with their delegated providers.**

APG supports CMS's continued movement toward adopting Universal Foundation measures to align quality measures across all programs, including MA, traditional FFS Medicare, ACOs, and others. Moving to a standardized group of quality measures will not only decrease provider burden but will also facilitate CMS's ability to measure and compare quality differences across different Medicare populations, such as traditional Medicare, ACOs, and MA.

In summary:

- **APG recommends that CMS continue to move toward adoption of Universal Foundation quality measures and accelerate the timeline for adoption of these measures.**

In rulemaking this year, CMS finalized technical changes to several MA quality measures, including updating the breast cancer screening guidelines, the clinical codes used for eye exams, the statin therapy denominator, and the denominator for follow up after hospitalization for mental illness.[9,10] In addition, the importance of reviewing test result scores will be reinforced with the addition of two new questions regarding care coordination. CMS also indicated that the agency is considering adding multiple additional measures in future years, including those related to substance use disorder, cancer screening follow-up, social connection screening, chronic pain assessment, and functional status assessment follow-up.

APG welcomes CMS's efforts reflected in technical changes to improve the accuracy of measurement and to better reflect the populations being measured. APG also appreciates that CMS indicates that any new substantive change to quality measures will remain on a display page for at least two years before it has any impact on quality scores, as this time will allow providers to modify workflow to capture information related to these updated measures.

At the same time, APG is concerned with the scope of measures that CMS is considering adding in future years. The expansion of Star Ratings measures seems to be at odds with moving toward a Universal Foundation of fewer measures aligned across multiple CMS programs. APG urges CMS to carefully weigh the benefit of each new proposed Star Ratings measure against the cost in terms of increased reporting burden.

In summary:

- **APG recommends that CMS curtail the number of new Star Ratings measures introduced and focus on maintaining a limited number of high-value, outcomes measures to assess the characteristics of MA plans that are of greatest value to enrollees.**

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[9] https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and-the-medicare-prescription-drug-benefit

[10] https://www.apg.org/news/apg-comment-letter-on-2025-medicare-advantage-advance-notice/

In addition, APG members have expressed concerns about some specific measures under consideration for future inclusion that relate to social determinants of health (SDOH) challenges, such as social connection and utility insecurity screenings. Although it would no doubt be useful to know that MA enrollees lack social connections or cannot afford their utility bills, it is not clear what actionable steps MA plans, or the providers who may have to collect these data, could or should take with this information. It is also possible that there are even better sources of this information that CMS or even MA plans could access at the aggregate level on beneficiaries' behalf.

Although APG shares CMS's desire to address Medicare beneficiaries' SDOH challenges, it urges the agency not to adopt SDOH measures, such as those related to social connection and utility insecurity screenings, until it has (1) considered from a cost-benefit standpoint the relative value of adding more measures that will increase the reporting burden for patients, providers, and plans; (2) provided clarity on the interventions that plans or providers would be expected to undertake to address these particular challenges, if any; (3) evaluated whether the sought-after information about social connection and utility insecurity could be collected about beneficiaries in alternative ways, and potentially by other entities better positioned to address these issues directly on behalf of beneficiaries; and (4) provided clear evidence that this information would not be collected unless linked to a Star Ratings measure.

In summary:

- **APG recommends that CMS not adopt SDOH measures, such as those related to social connection and utility insecurity screenings, until it has (1) considered from a cost-benefit standpoint the relative value of adding more measures that will increase the reporting burden for patients, providers, and plans; (2) provided clarity on the interventions that plans or providers would be expected to undertake to address these particular challenges, if any; (3) evaluated whether the sought-after information about social connection and utility insecurity could be collected about beneficiaries in alternative ways, and potentially by other entities better positioned to address these issues directly on behalf of beneficiaries; and (4) provided clear evidence that this information would not be collected unless linked to a Star Ratings measure.**

A key issue with the measurement of MA plan quality is that there is a lack of comparable measures for traditional, fee-for-service (FFS) Medicare that would allow Medicare beneficiaries to compare the relative performance of MA and FFS. APG strongly agrees with the longstanding MedPAC recommendation that CMS should assess the quality of both MA and FFS using comparable measures.[11]

In summary:

- **APG recommends that CMS assess the quality of MA and FFS Medicare using comparable measures and data to allow Medicare enrollees and policymakers to compare the relative performance of each option.**

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[11] https://www.medpac.gov/recommendation/report-on-comparing-quality-among-medicare-advantage-plans-and-between-medicare-advantage-and-fee-for-service-medicare-6-2-march-2010/

To manage the care of the patients whom they serve effectively, physicians need access to information on patients' longitudinal care, including historical claims and medical records. But all too often these data are not provided in a timely manner when Medicare beneficiaries enroll in new Medicare Advantage plans.

In the 2024 Interoperability and Prior Authorization Final Rule, CMS adopted new policies that require payers to use a Payer-to-Payer application programming interface (API) to exchange patient data with the patient's permission when a patient changes health plans.[12] These data are to include claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the USCDI, and information about certain prior authorizations (excluding those for drugs). Impacted payers are only required to share patient data with a date of service within five years of the request for data. However, these new requirements will not be implemented until January 1, 2027, and will require a patient opt-in process for that CMS is still finalizing.

APG is concerned about the delay in implementation and potential challenges presented by requiring patients to affirmatively opt-in to the exchange of their data when they change health plans. APG also notes that, when a patient changes health plans, the patient may also need to switch providers to be within a new plan's network. Therefore, it seems more reasonable to have a default opt-in option that would require the patient's former health plan to exchange the patient's data with the new health plan unless the patient opts out. Such a system would in the long run be best for patients, as it would assure the smooth transfer of patients' data to the new plan and therefore also assist patients' new providers (who in theory will also have access to patients' electronic health records).

In summary:

- **APG recommends that CMS switch to a default opt-in approach to payer-to-payer data sharing when an MA enrollee changes plans, with an option for patients to opt-out.**
- **APG recommends that CMS require MA health plans to share historical claims and encounter data with new plans when individual change their enrollment by any means available sooner than the January 1, 2027 required date to share these data through a Payer-to-Payer API.**

V. Conclusion

APG appreciates CMS's request for stakeholder input and supports the agency's ongoing efforts to refine the MA program so that it best meets the needs of enrollees. APG encourages CMS to consider the recommendations and modifications to policies described as further refinements that will also help to avoid unintended negative consequences.

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[12] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Sincerely,

Susan Dentzer

Susan Dentzer
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America’s Physician Groups
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