May 29, 2024

Secretary Xavier Becerra
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; Request for Information on Medicare Advantage Data (CMS–4207–NC)

Submitted electronically

Dear Secretary Becerra:

Aimed Alliance is a 501(c)(3) not-for-profit health policy organization that seeks to protect and enhance the rights of healthcare consumers and providers. We appreciate the opportunity to contribute to the request for information on improving data capabilities for the Medicare Advantage (MA) program. As a non-profit entity committed to promoting transparency and access to health care, we recognize the importance of ensuring the Centers for Medicare and Medicaid Services (CMS) has appropriate data and information on the MA program to properly assess how certain policies and practices impact consumers access, quality, and affordability of care.

Moreover, considering MA plans serve an increasingly diverse older population, with one report finding that 69 percent of Latino, 65 percent of Black, and 60 percent of Asian Medicare-eligible individuals opted for MA over Original Medicare coverage,[1] it is critical that CMS gathers appropriate data to understand how policies and practices across MA are impacting diverse communities.

I. Examining Medicare Advantage's Utilization of Prior Authorization and Step-Therapy

Prior authorization is a process used by health insurance companies, including MA plans, to determine if they will cover a prescribed procedure, service, or medication.[2] It requires healthcare providers to obtain approval from the insurance company before the service or prescription can be provided to the patient.[3] This process is intended to ensure that the proposed treatment is medically necessary and cost-effective, however, overutilization, improper denials, and delays are hindering consumer's ability to access necessary treatments and services.

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[1] Better Medicare Alliance, *New Report: Black, Latino, and Asian Beneficiaries Choose Medicare Advantage Over Traditional Medicare*, https://bettermedicarealliance.org/news/new-report-black-latino-and-asian-beneficiaries-choose-medicare-advantage-over-traditional-medicare/#:~:text=Altogether%2C%2027%25%20of%20MA%20enrollees,Medicare%2C%20the%20new%20analysis%20finds.&text=impacts%20of%20climate%20change (Aug. 4, 2023).

[2] American Medical Association, *Prior Authorization Practice Resources* (May 18. 2023), https://www.ama-assn.org/practice-management/sustainability/prior-authorization-practice-resources.

[3] *Id.*

For example, in 2021, approximately two million prior authorization requests were denied across MA plans.[4] Of these denials, 11 percent were appealed, and the vast majority of these appeals (82 percent) resulted in the denial being overturned.[5] This high overturn rate raises concerns about the initial decision-making process, suggesting that many denials might have been unwarranted. However, without comprehensive data on the specific reasons for these denials, it is challenging to determine whether the initial denials should have been approved or if only the most compelling cases were appealed and subsequently overturned. In addition, the limited numbers of appeals may also be unrelated to the merits of the appeal, but rather associated with the consumer's familiarity and level of comfort with the appeals process.[6]

Similarly, step-therapy policies, also known as "fail first," require patients to try and fail on alternative treatments, sometimes with adverse effects, before gaining access to the originally prescribed treatment.[7] These policies can be unethical and inconsistent with established standards of care, as they may interfere with the patient-provider relationship and compromise patient health outcomes. While step therapy is prohibited in Medicare plans, a 2019 rule from the CMS has allowed MA plans to implement step-therapy protocols.[8] The exclusive use of step therapy in MA is concerning, as consumers in both programs are expected to receive *at least* equivalent baseline benefits. However, under the current program, an MA enrollee could be subjected to a step-therapy protocol for a medication, requiring them to try and fail on multiple medications before accessing the originally prescribed treatment. In contrast, a traditional Medicare enrollee would not be subject to this policy and could receive immediate access to the medication. Thus, CMS should collect appropriate data to ensure MA patients are receiving *at least* the same benefits as traditional enrollees.

Therefore, Aimed Alliance urges CMS to collect data from MA plans relating to services and enrollee demographics; prior authorization and step-therapy requests including information on denials, appeals, justifications; and post-service coverage decisions.

a. Collect Comprehensive Data on Services and Enrollee Demographics

Aimed Alliance urges CMS to recognize the lack of comprehensive data provided by plans relating to the type of service provided (e.g., inpatient admission, radiology, imaging, or chemotherapy) and enrollee characteristics (e.g., race, disability status, or dual enrollment

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[4] KFF, *Medicare Advantage 2024 Spotlight: First Look* (Nov. 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.
[5] *Id.*
[6] Beth Shyken-Rothbart and Derek Ayeh, *Integrated Appeals Are Essential, But Challenges Remain*, Health Affairs (Sept. 19, 2022), https://www.healthaffairs.org/content/forefront/integrated-appeals-essential-but-challenges-remain.
[7] Aimed Alliance, *Step Therapy Reform: Increased Reporting and Transparency* (Sept. 29, 2023), https://aimedalliance.org/wp-content/uploads/2021/03/Step-Therapy-Reform-Reporting-Transparency_Designed.pdf.
[8] Centers for Medicare & Medicaid Servs., *Medicare Advantage Prior Authorization and Step Therapy for Part B Drugs* (Aug. 7, 2018), https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-prior-authorization-and-step-therapy-part-b-drugs#:~:text=Medicare%20Advantage%20(MA)%20plans%20will,beneficiaries%20enrolled%20in%20MA%20plans.

status).[9] This lack of data hinders our ability to identify patterns and disparities that may exist across different demographic groups and types of medical services. Therefore, we urge CMS to require plans to disclose the type of services and treatments most often subject to benefit utilization and the demographics of the individuals most impacted by these policies.

b. Addressing Data Gaps in Prior Authorization and Step-Therapy Requests, Denials, and Appeals

To ensure MA plans are using benefit utilization policies like prior authorization and step therapy appropriately and not unduly burdening consumers and providers, CMS must address several existing gaps in data collection and reporting. Therefore, Aimed Alliance recommends that MA plans be required to report and make publicly available detailed information on prior authorization and step-therapy policies. This information should include:

- The specialties impact by prior authorization and step-therapy protocols;
- The number of prior authorization denials and their justifications;
- The number of prior authorization approvals and their justifications;
- The number of step-therapy override requests submitted;
- The number of step-therapy override denials and their justifications;
- The number of step-therapy override approvals and their justifications;
- The number of approvals and reversals for utilization management; and
- Any savings the plan achieved from implementing step therapy or prior authorization and how these cost-savings either lowered consumer prescription drug costs, services costs, or premiums.

While some of the above listed information is provided to plan enrollees when receiving a denial letter, this information justifying the denial is not aggregated or reported by CMS.[10] The absence of this data limits our ability to understand common reasons for denials and impairs advocates ability to assess whether denials are justified and the type of information that could have been submitted to appropriately establish medical necessity or an appropriate justification in the first instance.

c. Reporting on Medicare Advantage Post-Service Denials, Out-of-Pocket Spending and Disenrollment

Many MA claims are denied after a service has been provided; however, the share of these denied claims is not reported to CMS.[11] These denials can leave enrollees with unexpected financial burdens and other consequences, but the full scope of this issue remains unknown due to the lack of data available. Mandating that MA plans report data on claims denied after service has been provided would enable policymakers and analysts to gain a clearer understanding of the scope of post-service denials and assess whether these denials are appropriate.

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[9] Aimed Alliance and National Minority Quality Forum, *Understanding the Need for Medicare Advantage Reform* (May 10, 2024), https://aimedalliance.org/aimed-alliance-hosts-nmqf-webinar-on-medicare-advantage-reform/.
[10] *Id*.
[11] *Id*.

Moreover, while insurers report enrollee out-of-pocket spending to CMS, this data remains unpublished to the public.[12] Aimed Alliance encourages CMS to make this data public, as publishing this data would shed light on the financial burdens imposed on enrollees. This information is essential for identifying trends and disparities in cost burden and ensuring that MA plans provide affordable coverage and equitable access to healthcare services for all beneficiaries.

Lastly, financial strain due to unexpected costs is also a factor driving disenrollment from MA plans into traditional Medicare or another MA plan. However, a lack of comprehensive data on disenrollment reasons makes it difficult to identify at-risk communities and address the underlying reasons for disenrollment or switching plans.[13] Publishing detailed information on disenrollment, including breakdowns by beneficiary demographics and reasons for disenrollment, would help identify trends in challenges for consumers with particular plans and help assess any potential disparities among patient populations. Ultimately, this data would enable policymakers to develop solutions to ensure equitable access to care for all beneficiaries.

II. Conclusion

Improving the transparency of data reported by MA plans is essential for enhancing our insight into program performance and equity. By addressing the identified gaps in data on prior authorization, claim denials, and step therapy, CMS can ensure a more transparent, accountable, and effective healthcare system that better serves all beneficiaries. Aimed Alliance urges CMS to publicly share all data related to MA to further allow independent researchers and analysts to assess data sets and identify common access and affordability challenges for consumers.

We appreciate the opportunity to provide feedback and look forward to continued collaboration to enhance the MA program. Should you require any additional information from Aimed Alliance, please do not hesitate to contact us at policy@aimedalliance.org.

Sincerely,

Ashira Vantrees
Counsel
Aimed Alliance

[12] *Id.*
[13] *Id.*