799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

May 29, 2024

Submitted electronically via: www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure,

Vizient, Inc. appreciates the opportunity to comment on the request for information entitled "Medicare Program; Request for Information on Medicare Advantage Data" (hereinafter, RFI) issued by the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS). Any future policies addressing Medicare Advantage (MA) would have an impact on our providers that serve a growing number of patients enrolled in these plans. We offer the following feedback to CMS as it determines how to proceed with future rulemaking.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality, and market performance for more than 60% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

Vizient appreciates CMS's continued attention to improving the MA program, particularly as the number of patients enrolled in MA continues to grow. The Medicare Payment Advisory Committee (MedPAC) notes that in 2023, 52% of beneficiaries were enrolled in an MA plan, with over 99% of beneficiaries having access to an MA plan in 2024.[1] Figure 1 below highlights MA's projected growth to 2032 based on an analysis by Sg2, a Vizient company.

[1] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf

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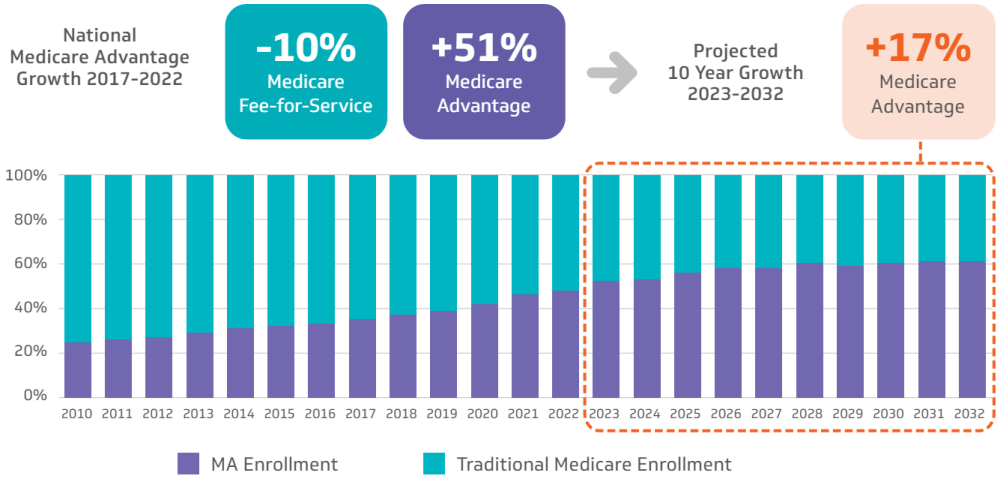

Source: Sg2 analysis of CMS Medicare Enrollment Dashboard and KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20% of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022.

Figure 1. Medicare Advantage and traditional Medicare enrollment, past and projected.

As enrollment in MA plans grows, healthcare providers are increasingly expressing dissatisfaction with myriad MA plan policies, including related implementation. A recent survey of Vizient providers demonstrated that many are considering ending contractual relationships with MA plans because of the prevalence of significant administrative burden and adverse coverage decisions, such as those related to utilization management (UM) and prior authorization (PA), DRG downgrades, failure to comply with the 2-midnight rule, and discharge delays when post-acute care is needed. Although recent CMS rulemaking and guidance has attempted to improve these practices,[2] providers continue to report challenges in providing patient care to MA beneficiaries.

In the RFI, CMS requests feedback on MA data that the agency should consider beginning to collect. In our comments, Vizient recommends several opportunities to improve upon MA data collection, but notes that the agency should also ensure that the data collection burden is not directly or indirectly passed on to other entities such as hospitals and other providers.

Prior Authorization and Denials

MA plans often require providers or suppliers to submit a request before services are rendered to a patient – this is known as prior authorization.[3] According to a 2022 report by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG), annual audits of MA plans highlight "widespread and persistent problems related to inappropriate denials of services and payment."[4] In the same report, OIG found that 13% of PA

[2] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability; https://calhospital.org/wp-content/uploads/2024/02/HPMS-Memo-FAQ-on-CC-and-UM-020624.pdf
[3] https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives
[4] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf; https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp

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requests denied were services that likely would have been approved for these beneficiaries under original Medicare.[5] Previous OIG data showed that MA plans overturned approximately 75% of their own denials, suggesting that inappropriate denials is a widespread practice impacting the healthcare system and preventing beneficiaries from receiving timely and appropriate care.[6]

Consistent with prior comments, Vizient remains concerned about the use of PA by MA plans and the impact of PA on patient care, hospital resources, and patient outcomes. We believe that increased transparency through collection and publication of the following data would increase MA plan compliance with the Medicare coverage requirements and allow hospitals to provide better and more timely patient care by ensuring MA plans do not inappropriately utilize PA practices.

Enhanced Data Collection for Prior Authorization Requests, Denials, and Appeals

Despite recent rulemaking[7] which will require plans, in 2026, to publish *some* data on requests, denials, and appeals on their websites, significantly more data is needed to be meaningful to providers and patients and rulemaking has not yet addressed this need. Additionally, CMS should also require this data be shared with the agency so that it can be available in a single location, such as a CMS website, so that it can be more easily compared. For example, while plans will soon be required to publish data on the timeliness of PA approvals, rulemaking did not institute a requirement that the plans publish data on the reasons for PA denials, which would be meaningful for providers seeking to avoid an unnecessary denial. Further, a provider or patient interested in comparing timeliness data would need to find data on each plans' website, which would be burdensome. The new rule also does not address PA requests by type of service, the reason for the denial based on specific information submitted (e.g., specific tests or documentation that may be needed), the share of claims that are provided after a service has been provided, or the timeliness of the appeals process, leaving out vital information related to hospital administrative burden and patient access to care.[8] **Vizient encourages CMS to fill these data gaps by increasing reporting by MA plans.**

Also, the new rule does not address reporting by service type. Specifically, plans are not currently required to submit data to CMS on PA requests, denials, or appeals by service type, despite indications that certain types of service types (e.g., the most costly procedures) may be denied at higher rates than others.[9] In the 2022 report, OIG noted that although PA denials occurred across a wide range of services, imaging services, post-acute care stays, and injections were among the most prominent service types that were denied when Medicare coverage rules were met. Even though some of these denials were overturned, OIG notes "denials may be particularly harmful for beneficiaries who cannot afford to pay for services

[5] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[6] https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp
[7] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[8] https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/
[9] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

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directly and for critically ill beneficiaries who may suffer negative health consequences from delayed or denied care."[10] For example, OIG notes several case examples, such when a patient with cancer was forced to wait five weeks for a CT scan.[11] In its report, OIG recommended that CMS target future audits on service types for which inappropriate denials may have a significant impact on beneficiary health and well-being, which would necessitate better data on the service types most often denied.

As illustrated in Figure 2, a recent survey of managed care leaders at hospitals showed that utilization management (UM), including PA policies, from MA plans was the most challenging payer behavior to surveyed hospitals.[12] Based on provider feedback, Vizient understands that this is caused in part by the administrative burden associated with MA plans' additional requests for information, denials and appeals. Further, variability in plans' policies and requests adds to provider burden. Vizient suggests CMS utilize this survey data as it prioritizes opportunities to address provider challenges with MA plans.

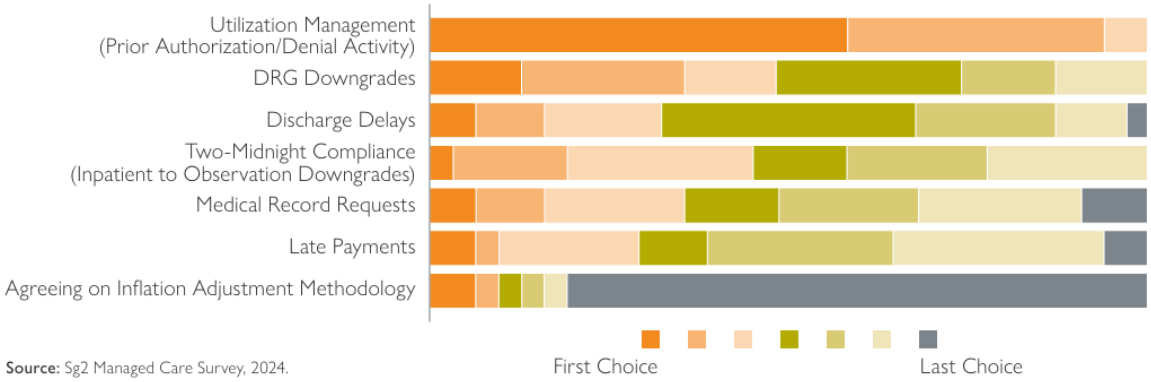

Figure 2. Survey results of payer behaviors that are most challenging to organizations.

As noted above, a large number of denials that are appealed are ultimately overturned, but the process is variable and cumbersome to the hospital. Also, patients may be forced to make difficult care decisions such as choosing to forego care or opting to self-pay. **Vizient recommends that CMS expand its policies related to denials by requiring more granular data about a plan's denial rates, services most subject to denials, and timelines related to appeals.** Also, data on overturn rates would allow CMS to provide better oversight and give providers better information when establishing policies and procedures related to MA plan operations.

Post-Acute Care Denials and Prior Authorization

One area in which PA policies, including denials, are particularly impactful is circumstances related to accessing post-acute care (PAC). Even without PA policies, patient access to care may already be limited by factors such as bed availability, plan coverage requirements, and

[10] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[11] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[12] Sg2 (May 2024). Executive Briefing – Financial Resiliency: Negotiating a Profitable Path Forward for Medicare Advantage.

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instructions related to observation care. While some of these factors are beyond a plan or provider's control, MA plans with narrow networks and rigid coverage policies effectively prevent patients from transferring to more appropriate care facilities in a timely manner. Delays in care are costly to facilities and can be devastating to patients, resulting in abandoned treatment or patient harm.[13] Additionally, as OIG determined that stays in PAC facilities are one of the most denied service types, **Vizient encourages CMS to require more data related to PAC PA requests, denials, and appeals to identify areas of potential fraud and improve patient outcomes. Specifically, Vizient also encourages CMS to include information on the timelines related to the denials and appeals process for PAC coverage, as these timelines can have a direct impact on a patient's clinical care.**

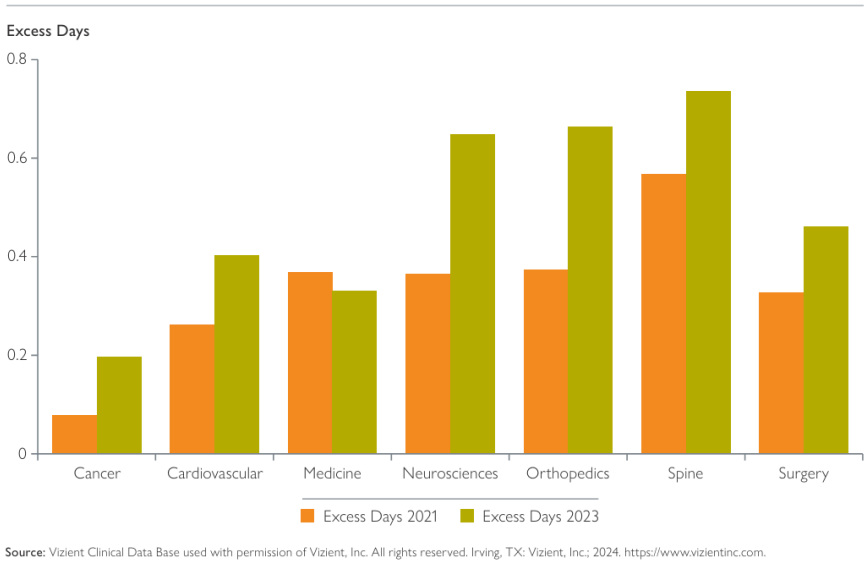

Figure 3. Length of stay for Medicare Advantage compared to traditional Medicare.

An analysis of Vizient's Clinical Database (CDB) data, as shown in Figure 3 above, found that by service line (i.e., cardiovascular, neurosciences, orthopedics, spine and surgery), that the length of stay for MA beneficiaries consistently exceeds that of those enrolled in FFS.[14] Factors contributing to this trend could be the provider's recommendation that a patient be discharged to PAC setting and challenges in having such care covered. Other factors could include issues identifying a PAC setting that will accept the patient and that MA plans tend to discharge patients to the community despite adverse functional outcomes.[15]

Data on Reviewers for Medical Necessity Determinations

CMS notes in the CY 2024 Policy and Technical Changes to the Medicare Advantage Program final rule (hereinafter, "CY 2024 MA Final Rule") that the agency received substantial feedback about the specialties of the reviewers MA plans were using to review and approve or deny

[13] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf; https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[14] Sg2 (May 2024). Executive Briefing – Financial Resiliency: Negotiating a Profitable Path Forward for Medicare Advantage.
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10907922/

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medical necessity decisions.[16] The agency finalized a requirement that if the MA plan expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, then that determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue. While this policy addresses some of the concerns related to denials that interfere with clinical care, Vizient believes additional clarity is needed given the CY 2024 MA Final Rule allows plans to determine whether a health care professional has the relevant expertise for the service at issue. For example, reporting the following would improve transparency regarding medical necessity decisions: the specialty and type of providers employed by the organization to perform medical necessity reviews, plan policies regarding how providers are selected to review medical necessity decisions, and data regarding which provider specialties and types were utilized alongside types of medical necessity review requests.

Such data could also help identify non-compliance with the CY 2024 Final Rule, for example, if a plan was noted to have a high rate of denials in a particular type of service, and it was clear that the plan did not employ a high number of individuals with relevant health care expertise in the field, then questions could be raised regarding whether the plan met the medical necessity review requirements.

Complaints Data

Currently, CMS tracks appeals and grievances but the data is only available to individuals eligible to elect an MA plan upon request.[17] Also, the Complaint Tracking Module (CTM), which can be used to submit a complaint about a plan, is not widely known and related data is not publicly available on the Medicare Plan Compare website, which beneficiaries may be more likely to review when selecting a plan.[18] While there is a legislative requirement that a model electronic complaint form be "prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman,"[19] anecdotally, providers have noted how challenging the complaints form is to find, along with any reported data. More data on complaints and resolutions that is also easy to obtain would be beneficial to potential enrollees and providers as they contemplate engaging with MA plans.

Also, while the CMS Ombudsman has disseminated some of this data to Congress, the data has very limited detail (e.g., not plan-specific), is outdated, and it is not easy to find (e.g., not available on the Medicare Plan Compare website).[20] **Vizient encourages CMS to publish more granular data on complaints and the resolution of the complaints reported through the CTM on Medicare.gov and the Medicare Plan Compare website.**

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[16] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program
[17] https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/appgrievdataformins.pdf
[18] A complaint form is available after several pages on the Medicare.gov page, https://www.medicare.gov/my/medicare-complaint
[19] Section 3311(b) of Public Law 111-148, available at: https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf
[20] https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

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Disenrollment Data

MedPAC notes in its March 2024 Report to Congress that, "a growing literature has found that a disproportionate share of the beneficiaries who leave MA for FFS are chronically ill, costly, or nearing the end of life."[21] One of the reasons a beneficiary may choose an MA plan over FFS is the appeal of the supplemental benefits, such as gym memberships, dental coverage, or meal deliveries, specifically.[22] However, the Government Accountability Office (GAO) notes that disenrollment in the last year of life may signify possible issues with care or coverage.[23] Although CMS evaluates the characteristics of beneficiaries who disenroll from MA plans, the data they use is not currently publicly available. **Vizient recommends that CMS begin publishing more granular data on the characteristics of beneficiaries who choose to disenroll from an MA plan and enroll in FFS, with a focus on data regarding beneficiaries' reported reason for disenrollment.** Accessing information on which beneficiaries choose to disenroll from MA and why would give patients and providers access to information that signals potential issues in MA plans' coverage or operations.

Quality Data

A recent MedPAC analysis determined that while the quality bonus program (QBP) accounts for at least $15 million in MA payments annually, it has serious flaws.[24] For hospitals and patients, one of the largest barriers to interpreting the quality of an MA plan is that the MA data cannot be compared to FFS data in a local market. Specifically, MedPAC noted a long history of data completeness concerns in MA plans, despite the fact that this data drives the plans' Star Ratings and quality bonus payments. Additionally, while the quality bonus payments are an additional payment to MA plans, it is not clear that these payments have been used to provide benefits to MA enrollees.[25]

One significant data gap in the QBP is that the Star Ratings are evaluated at the contract level, and not also by the regional market level. If CMS provided quality data to beneficiaries at a local or regional level, beneficiaries and providers would have better access to MA data that might help in deciding which plan is the appropriate choice, while also incentivizing MA plans to improve quality in every geographic area. **Vizient encourages CMS to evaluate what data is currently used for the MA Star Ratings that could be publicly available, particularly at a more local level. Also, Vizient recommends CMS assess whether the QBP is incentivizing plans to deliver the best quality care.**

In addition, disenrollment data is one of the measures included in the MA Star Ratings but is weighted very low in the calculation. If CMS expanded on the data collected related to beneficiary experience and disenrollment, and increased the weight of these measures, MA plans might be better incentivized to provide better quality care or address some of the

[21] https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/
[22] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf
[23] https://www.gao.gov/products/gao-21-482
[24] https://www.medpac.gov/wp-content/uploads/2023/10/MA-quality-presentation-FINAL.pdf
[25] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

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changes needed to reduce barriers to care. Vizient recommends that CMS reevaluate the measures used to calculate the MA Star Ratings, especially as the agency considers the recommendations it receives about increased data collection through this RFI.

Data Topics Related to MA Prescription Drug Plans

Payer-Mandated White/Brown Bagging[26]

Payer-mandated white/brown bagging policies complicate access to care by creating delivery and dispensing delays and slowing speed to therapy for patients. Based on a Vizient survey regarding white/brown bagging policies, 92% of provider respondents experienced patient care issues due to problems with medications received through these channels, while 23% hired additional staff to manage white/brown bagging.[27] Vizient believes there is a critical need for CMS to address the significant administrative burden and interruption to patient care stemming from these payer-mandated policies.

In addition to significant costs incurred by providers, white/brown bagging also allows for important patient safety controls to be bypassed, such as product verification. Vizient urges CMS to evaluate the impact of white/brown bagging by collecting data related to payer-mandated white/brown bagging policies, including on the impact to patient care and hospital operations and burden. Publication of this information would be beneficial to facilities as they negotiate contracts and establish policies around white/brown bagging to ensure patient safety is not compromised. Information about the volume of white/brown bagged products and the types of products would also be helpful when considering drug supply chain security. Quantifying the amount of medications that are white/brown bagged could help stakeholders better understand how many medications are not subject to typical verification processes that are otherwise required for buy-and-bill purchases under the Drug Supply Chain Security Act. Based on Vizient's review of the literature, this information has not been made available and would help identify potential safety concerns in the drug supply chain.

Reporting Burden for Provider-Offered MA Plans

As CMS contemplates additional reporting requirements for MA plans, we also request that CMS consider different ownership structures and provider-reported challenges with specific MA plans. For example, hospitals tend to report challenges with larger, national organizations, yet it is unclear from the RFI whether CMS will weigh this point when determining additional reporting requirements. Vizient provider members have continued to try and address challenges with MA, with some opting to create their own MA plan. This is not necessarily an

[26] According to the National Association of Boards of Pharmacy (NABP), 'White and Brown Bagging Emerging Practices (2018), available at: https://nabp.pharmacy/wp-content/uploads/2018/04/White-Bagging-and-Brown-Bagging-Report-2018_Final-1.pdf, "White bagging" refers to the distribution of patient-specific medication from a pharmacy, typically a specialty pharmacy, to the physician's office, hospital, or clinic for administration. It is often used in oncology practices to obtain costly injectable or infusible medications that are distributed by specialty pharmacies and may not be available in all non-specialty pharmacies. "Brown bagging" refers to the dispensing of a medication from a pharmacy (typically a specialty pharmacy) directly to a patient, who then transports the medication(s) to the physician's office for administration.

[27] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/e91a7583f7554888ba4031786e5f1430

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option available to all, however, given the time, expense, and other administrative burdens it takes to implement. With that said, providers who do have their own MA plans have reported much greater satisfaction and significantly fewer issues related to patient care delivery. To help minimize burden on these provider-offered plans, Vizient suggests CMS consider requiring additional reporting for the larger Medicare Advantage Organizations (MAOs) with the greatest share of beneficiaries. CMS could work with MedPAC to determine these organizations, as similar work has been done in a 2021 MedPAC Report to Congress.[28] Alternatively, CMS could work with OIG to identify such organizations, since OIG recently found that 20 of 162 MA companies drove a disproportionate share of the $9.2 billion in payments from diagnoses that were reported only on chart reviews and HRAs, and on no other service records.[29] Such an approach would also be consistent with OIG's recommendation that CMS provide oversight of these 20 MA companies.

Conclusion

Vizient thanks CMS for the opportunity to share feedback. Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank CMS for the opportunity to share feedback on MA data. Please feel free to contact me or Jenna Stern at Jenna.Stern@vizientinc.com if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

Shoshana Krilow
Senior Vice President of Public Policy and Government Relations
Vizient, Inc.

[28] https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf
[29] https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf