Charles N. Kahn III
President and CEO

May 29, 2024

The Honorable 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

RE: Request for Information on Medicare Advantage Data (CMS–4207–NC)

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, childrens', and cancer services.

We are writing in response to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on Medicare Advantage (MA) data published in the *Federal Register*.[1] The FAH is able to draw on the extensive experiences of our member organizations with respect to Medicare Advantage, and the need for additional data and information in several critical areas.

We commend CMS for recent actions it has taken to hold MA plans accountable to provide access to coverage for MA enrollees at the same levels as in traditional fee-for-service in the final rule for Contract Year 2024 Policy and Technical Changes in MA Program (CMS–4201–F), as well as in the Interoperability and Prior Authorization Final Rule (CMS-0057-F)

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[1] *Federal Register*, Vol. 89, No. 20:5907-5907, January 30, 2024.

streamlining prior authorization processes and public reporting finalized earlier this year – which included new requirements for MA plans. But even with the improvements in these rules – more is needed to ensure beneficiaries enrolled in MA receive access to the care they need. Given that in 2023, more than half of eligible beneficiaries are enrolled in MA, we urge CMS to quickly lay out plans to address gaps in the MA data collected by CMS that are essential for oversight of Medicare Advantage organizations (MAOs), and to address deficiencies in the public availability of MA data in a transparent and meaningful way to enable beneficiaries to engage in informed decision-making.

As part of this RFI on data and information to help improve oversight and strengthen the MA program, the FAH has identified five key gaps in information where additional data is essential:

- Beneficiary Access to Care: Utilization Management
- Beneficiary Access to Care: Network Adequacy
- Advance Health Equity (Information on Beneficiary Demographics)
- MA Encounter Data
- Transparency of Information on Medical Loss Ratio

This letter addresses these five areas. The attached appendix also provides further information regarding currently available MA data and identified gaps based on an environmental scan conducted by Dobson DaVanzo and Associates, LLC. We applaud CMS' effort as the agency expands its efforts to scrutinize actions by MAOs to ensure MA enrollees are receiving appropriate care.

Beneficiary Access to Care: Utilization Management

The Office of Inspector General (OIG) in its April 2022 report, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (hereinafter, "OIG Report")[2] outlined how MAOs systemically apply problematic operating policies, procedures and protocols that inappropriately deny and delay care that Medicare beneficiaries are entitled to receive. **We urge CMS to exercise its broad oversight authority over MAOs to require them to report to CMS information (specified below) on their use of utilization management tools to ensure beneficiaries are not denied timely access to the benefits to which they are entitled in the most medically appropriate health care setting.** The agency should use this data to require plans to improve timely access to care in the proper setting for beneficiaries according to their individual health care needs. Further, this information could be used to enhance Star Ratings under the MA Quality Bonus Program (QBP), and to enhance the information on Medicare's Plan Finder to help ensure that beneficiaries are fully informed about their choices between traditional Medicare and Medicare Advantage, or among Medicare Advantage plans.

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[2] Christi A. Grimm, U.S. Department of Health and Human Services Office of Inspector General ("OIG"), OEI-09-18-00260, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Aggressive utilization control practices are a problem that the FAH and other stakeholders have raised with CMS for several years. But stakeholders, including patients and providers, are not the only ones raising concerns. The OIG Report cited above highlighted that MAOs systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees.

The OIG Report also identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA enrollees. Specifically:

- *Improper prior authorization denials.* The OIG found that thirteen percent (13%) of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.

- *Improper denials for lack of documentation.* The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.

- *Improper payment request denials.* The OIG found that eighteen percent (18%) of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (*i.e.*, inpatient versus observation), improperly down code claims, deploy inappropriate pre- and post-payment denial policies, and even deny claims for previously authorized services. These activities are often carried out by way of MAOs' downstream at-risk physicians and contracted hospitalists, who may inappropriately steer beneficiaries to a narrower set of providers than would otherwise be indicated by the plan's provider directory (see discussion below). All of these activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.[3]

While the OIG's report on MAOs' aggressive use of utilization management techniques is compelling, and consistent with the experiences of many of our members, we note that CMS does not systematically collect, compile, and publicly report this information. Information on MAOs' utilization management practices comes largely from government oversight agencies, or from anecdotes. For purposes of informing policy development, enhancing quality measurement, and educating beneficiaries, **the FAH recommends that CMS require MA plans (a more granular level of reporting than at the MAO level) to report to the agency detailed information on their use of utilization management tools, with a particular focus on prior authorization.** We suggest that CMS require each MA plan to report to the agency on an annual

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[3] For further detail, see Federation of American Hospitals, "Re: Needed Improvements to Medicare Advantage Organization Practices," September 1, 2021 (the "September 1 Letter").

basis, information on their use of prior authorization and utilization management, including on at least each of the following:

- Services for which prior authorization is required
- Number of prior authorization requests received, by service type
- Number of prior authorization requests denied, with reason for denial
- Number of prior authorization denials appealed
- Number of prior authorization denials overturned on appeal
- Number of claim "downgrades" (*e.g.*, claim submitted as inpatient stay downgraded to observation stay)
- Average time from prior authorization request to adjudication (either approval and payment or final denial)
- Information on beneficiary experience with appeals processes

This information should be collected and reported both at the aggregate (e.g., for the entirety of services provided to the plan's enrollees), and by service line (*e.g.*, for each type of service or type of provider requiring prior authorization, how many requests did the plan receive, how many were denied (with reason for denial), *et cetera*).

We also believe that plans should be required to report information on their use of and reliance on algorithms (*e.g.*, artificial intelligence). The FAH has significant concerns about MA plans that rely heavily on algorithms that lead to prior authorization and claims payment denials – often after the care has been provided. The use of these algorithms likely has the opposite impact that CMS would hope to achieve in addressing health care disparities. To the extent these algorithms are based on historic biases, appropriate patient care could be in jeopardy. **We urge CMS to require that utilization management tools and the logic for proprietary algorithms be made public to patients and providers.**

CMS should require that this information regarding utilization management be submitted in a standardized, transparent manner that enables easy comparison of plan information and made readily available for policy analysis. This is an essential step towards enabling policymakers and stakeholders to have more complete awareness of the use of prior authorization and other utilization management requirements by MAOs (and the effects of utilization management on MA enrollees) in order for policymakers to appropriately and effectively make changes to the Medicare Advantage program to address inappropriate use of these tools, and for stakeholders, such as beneficiaries and their families, to make more well-informed decisions in their care planning.

The FAH recognizes that CMS has taken steps to make prior authorization data and metrics more publicly available in its Interoperability and Prior Authorization Final Rule earlier this year. This rule would require impacted payers to publicly report certain prior authorization metrics annually by posting them on their websites. However, we are concerned that leaving the disposition of publicly reporting this information to the plans may result in inconsistent or inaccurate information being reported to the public. We therefore urge CMS to require plans to

report this information directly to CMS, and that CMS vet and standardize the information, before the agency – not the plans – reports this information to the public.

CMS is requesting input on ways to fill the gaps in information about Medicare Advantage for patients and providers. In the same way that information about quality of care is a critical component in selecting a provider or hospital, it is also important for beneficiaries selecting a Medicare Advantage plan. **We urge CMS to consider further refinements to its MAO oversight by developing new quality metrics for MAO operations that could be included in the Star Ratings Program**. New quality measures should be developed to rate and report on patient access problems related to network adequacy and service delays, appeals and denial overturn rates for prior authorization, and appeals and overturn rates for payment denials.

The FAH is the measure steward for a new MA quality measure concept, the Level 1 Denials Upheld Rate Measure, which assesses how often MA plans' Level 1 appeals decisions are upheld by plans. This measure would supplement the current measure evaluating Level 2 Appeals. The Partnership for Quality Measurement Pre-Rulemaking Review (PRMR) Clinician Recommendation committee voted (by 86.7 percent) to recommend the measure for inclusion in the part C and D Star Ratings. This measure demonstrated a 95 percent confidence interval to differentiate between MAO performance. Additionally, the field-test data showed a positive correlation with existing Medicare part C & D Patient Experience measures, i.e. getting needed care, rating of health plan, and members choosing to leave the plan, as well as some of the intermediate quality outcome measures, i.e. diabetes control, controlling high blood pressure and plan all-cause readmissions. There was a negative correlation between the current Level 2 Appeals Star Ratings measure and the FAH Level 1 Denials Upheld Rate measure, which means MAOs that uphold more of their Level 1 appeals have Independent Review Entities uphold fewer of their Level 2 appeals. We believe the incorporation of such measures promote greater accountability, quality improvement, and transparency on these critical access-oriented dimensions of MA plan quality, rewarding and incentivizing MAOs to improve their operations and providing beneficiaries with critical information on the potential for excessive plan denials for service.

Giving beneficiaries a better picture of the utilization control practices used by MA plans, along with other plan details, during the enrollment process would provide enrollees with information about the potential access challenges they may face – essential information in decision-making to ensure access to a timely continuum of quality health care, especially for Medicare beneficiaries with a known medical condition. Consistent with our recommendation above (that CMS require MAOs to report detailed information on the use of, and statistics related to, utilization management), **the FAH also recommends that CMS require that MA marketing materials outlining plan benefits include a list of services that require prior authorization or pre-certification, the rate at which those services are approved (or denied), and the average length of time for approvals.** This information would provide invaluable details to enrollees and their families as they weigh their coverage options in MA plans and traditional FFS.

CMS has broad oversight authority over MAOs. If CMS were to collect and publicly report the data and information we suggest through regulation, we believe it would facilitate improved engagement between plans, providers, and beneficiaries. We believe that such

reporting would not implicate the non-interference clause contained in section 1854(a)(6)(B)(iii) of the Social Security Act or compromise its goals. The non-interference clause contains two discrete, narrowly drawn prohibitions. First, CMS cannot mandate an MAO contract with a specific provider. Second, CMS cannot mandate that an MAO implement a particular price structure within a provider contract. Beyond these two express prohibitions, CMS retains its broad regulatory authority – and responsibility – to ensure beneficiaries receive the Medicare benefits to which they are entitled in a timely manner and in the most medically appropriate setting; posting detailed information on MAOs' use of prior authorization and related policies would help enhance that goal.

Beneficiary Access to Care: Network Adequacy

From a network adequacy perspective, MA enrollee access to services and care is often more limited than it would appear in an MAO's Health Service Delivery ("HSD") submission or provider directory that a beneficiary reviewed and relied upon during their open enrollment decision making process to choose a Medicare Advantage plan. This is the result of two factors.

First, it is well-documented that health insurers' provider directories often do not contain accurate information on contracted providers, their contact information, or both.[4,5,6,7] In 2016, in part in response to beneficiary complaints, CMS evaluated the accuracy of a subset of MA provider directories and found that over 50 percent of entries contained at least one element of incorrect information.[8] As part of its Interoperability and Patient Access final rule (CMS-9115-F May 1, 2020),[9] CMS required CMS-regulated payers to make provider directory information publicly available via a standards-based Application Programming Interface (API). One of CMS' explicit rationales for this requirement was that "making this information more widely accessible is also a driver for improving the quality, accuracy, and timeliness of this information."[10]

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[4] https://www.finance.senate.gov/imo/media/doc/Jack%20Resneck%20MD%20Statement%20to%20Finance%20Cmt%20on%20Behalf%20of%20AMA%20Re%20Provider%20Directories%202023-5-3.pdf

[5] https://jamanetwork.com/journals/jama/article-abstract/2802329#:~:text=Consistency%20of%20information%20decreased%20as,and%2068.6%25%20for%20specialty%20information.

[6] Adelberg, M.S. *et al.*, Improving the Accuracy of Health Plan Provider Directories. The Commonwealth Fund, June 7, 2019. https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories

[7] https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf

[8] https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/provider_directory_review_industry_report_round_2_updated_1-31-18.pdf

[9] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers. *Federal Register* 85 FR 255110-25640. May 1, 2020
[10] https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet

The Consolidated Appropriations Act, 2021[11] established requirements for plans to verify, correct, and publicly post information (including in an online database) on providers in their networks effective January 1, 2022. CMS has not yet engaged in rulemaking to implement the provisions of this Act, but the agency (in conjunction with the U.S. Department of Labor) has issued guidance stating that health plans "are expected to implement these provisions using a good faith, reasonable interpretation of the statute."[12]

In 2022, CMS issued a request for information (RFI) soliciting input around the idea of establishing a National Directory of Health Care Providers and Services (NDH) that could serve as a "centralized data hub" for health care provider, facility, and entity directory information nationwide, and thus could be used to reduce the rate of errors in MA provider directories.[13] (To the best of our knowledge, CMS has not acted in response to information the agency received in response to the RFI).

All of these efforts suggest that CMS, policymakers, and other stakeholders are acutely aware of the deficiencies of MAOs' provider directories, and the potential impacts of incorrect and outdated information on MA enrollees' health and wellbeing. Given the importance of provider directories as tools for MA enrollees seeking to access care guaranteed under the Medicare statute, we urge CMS to redouble its efforts to regularly evaluate the accuracy of MAOs' provider directories in order to ensure that plans are in compliance with network adequacy requirements at 42 CFR §422.116.

The second way in which access to care under Medicare Advantage can be more limited than apparent is through MAOs' use of downstream organizations to direct care to a far narrower provider network than might be indicated by their provider directories, rendering network access to certain providers illusory. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups and their sub-capitation arrangements create a financial incentive to direct care to a particular provider or group, creating a de facto provider network at the downstream organization level that is far more limited than the MAO's advertised network. **The FAH continues to recommend that CMS take action to foster MAO network transparency to protect MA enrollees' access to care by implementing audit protocols to identify and review the adequacy of downstream organizations' provider networks and making this information publicly available. In addition, as stated above, the FAH urges CMS to incorporate network adequacy into the Star Ratings Program, so that Medicare beneficiaries contemplating enrollment in MA are as fully informed as possible regarding the potential access to care implications of their choices.**

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[11] Public Law 116-260, Div. BB, Title I ("No Surprises Act") Section 116

[12] *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49*, Aug. 20, 2021, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

[13] Request for Information; National Directory of Healthcare Providers & Services, *Federal Register* 87 FR 61018-61029, October 7, 2022. https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services

MA network adequacy is particularly problematic in post-acute care. MA enrollees routinely experience inappropriate delays in discharge from the inpatient hospital setting due to MAOs' lack of (1) adequate post-acute networks and (2) post-acute providers in MAOs' networks willing to accept beneficiary discharges. When a patient is ready for transfer from an acute-care setting to a post-acute environment (including Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), and skilled nursing facilities (SNFs)), the most appropriate course is the prompt and safe transfer of the beneficiary to the most suitable post-acute care environment. MAOs, however, often are financially incentivized to prolong beneficiaries' hospital stays (often paid at a case rate such as the MS-DRG system) rather than incurring the additional cost of post-acute provider stays, and may delay discharges based on the lack of available or willing post-acute providers. In addition, MAOs' post-acute networks often do not include an adequate number of post-acute care facilities in each post-acute care setting type to ensure that transfer to the appropriate facility is available and effectuated and post-acute care is not delayed or disrupted. **As we have stated previously, the FAH recommends that CMS require MAOs to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in MA beneficiary inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities.** As CMS conducts this monitoring, we urge the agency to develop standardized reporting so that beneficiaries and stakeholders can evaluate the variation in such delays among MA plans, and between MA and traditional FFS Medicare. Lastly, assuming the establishment of a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, the FAH urges CMS to evaluate whether it is possible to assess the frequency that physicians' discharge orders to those settings are over-ridden, and the patient ends up being treated in a lower-intensity setting (*e.g.*, SNF or home health care).

Advance Health Equity (Information on Beneficiary Demographics)

Differences in health care outcomes for patients with one or more social risk factors have been well-documented and referred to as health disparities or inequities.[14] CMS recognizes that disparities are multifactorial but is concerned that provision of lower quality health care contributes importantly to inequities for many Medicare beneficiaries.

There is growing evidence that MA enrollees experience significant disparities in access to high-quality and necessary care, and in outcomes of care, compared to traditional Medicare fee-for-service (FFS) beneficiaries. These disparities in access and quality are amplified due to the differences in the demographic distributions between the MA and FFS programs. Racial and ethnic minority beneficiaries make up a higher proportion of the MA program than FFS. In 2021, 59% of Black Medicare beneficiaries, 67% of Hispanic beneficiaries, and 55% of Asian and Pacific Islander beneficiaries were enrolled in MA, compared with 43% of White beneficiaries.[15]

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[14] Social risk factors as used herein includes items sometimes also categorized as demographic variables, sociodemographic status (SDS), socioeconomic status (SES) and social determinants of health (SDOH).

[15] Ochieng, Nancy, *et al*. (2023). *Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature*. The Kaiser Family Foundation. https://www.kff.org/medicare/report/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-a-review-of-the-literature/ .

This means that when MA plans limit enrollee access to care or obtain substandard outcomes, these practices could increase disparities in care by disproportionately affecting racial and ethnic minority Medicare beneficiaries, as well as beneficiaries dually eligible for Medicare and Medicaid (who are disproportionately from racial and ethnic minority groups).

Disparities in access to care under the MA program (as compared to under Medicare FFS) include MA plans having networks with limited access to high-quality hospitals and MA plan enrollees receiving lower-quality end-of-life care and lower-quality nursing home cares. Overall, MA enrollees are more likely than traditional Medicare enrollees to be admitted to average-quality hospitals than high- or low-quality hospitals, suggesting that MA plans may be steering their enrollees to specific hospitals for nonemergent hospitalizations.[16] Comparing end-of-life care received by MA and FFS beneficiaries, family and friends of beneficiaries enrolled in MA at the time of death or before hospice were more likely to report that care was not excellent and that they were not kept informed compared to traditional FFS.[17] MA enrollees also reported greater dissatisfaction with out-of-pocket expenses at 25.51 percentage points higher than traditional Medicare enrollees.[18] Most notably, the OIG Report cited above also found that MAOs denied or delayed care and payments that met applicable coverage and billing rules under FFS.[19] The report found that 13 percent of MA prior authorization requests met Medicare coverage rules and 18 percent of denied requests met coverage and billing rules. These findings offer overwhelming evidence that the direct and indirect actions MA plans take to cut costs and restrict networks, and the resulting disparities in MA beneficiary access to necessary care, may have an inequitable impact due to the larger proportion of minority and dually eligible MA enrollees.

As the MA program continues to grow, racial and ethnic minorities, as well as other disadvantaged populations, are entering the program at significantly higher rates than their White counterparts.[20] While there are many beneficial aspects of the MA program, more data must be collected to determine the extent to which its pitfalls may be disproportionately affecting minorities and disadvantaged populations. Excessive use of unique prior authorization and limited networks also are likely creating disparities and may be even more challenging to identify because when MAOs deny care, there are no encounter data or claims to highlight the trends. Our members have noted that disabled patients that need inpatient medical rehabilitation facility (IRF) services, as well as inpatient mental health and substance abuse services, are at particular risk.

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[16] Meyers, D. J., Trivedi, A. N., Mor, V., & Rahman, M. (2020). Comparison of the Quality of Hospitals That Admit Medicare Advantage Patients vs Traditional Medicare Patients. *JAMA network open*, 3(1). https://doi.org/10.1001/jamanetworkopen.2019.19310.

[17] Ankuda, C. K., Kelley, A. S., Morrison, R. S., Freedman, V. A., & Teno, J. M. (2020). Family and Friend Perceptions of Quality of End-of-Life Care in Medicare Advantage vs Traditional Medicare. *JAMA network open*, 3(10). https://doi.org/10.1001/jamanetworkopen.2020.20345.

[18] Park, Sungchul. (2022). Effect of Medicare Advantage on health care use and care dissatisfaction in mental illness. *Health Services Research*, 57(4). https://doi.org/10.1111/1475-6773.13945.

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

[20] Meyers, D. J., Mor, V., Rahman, M., & Trivedi, A. N. (2021). Growth In Medicare Advantage Greatest Among Black and Hispanic Enrollees. *Health Affairs* (Project Hope), 40(6), 945–950. https://doi.org/10.1377/hlthaff.2021.00118

The growing research on potential disparities in care and access to care for the sick and more diverse populations covered under MA highlight the need for more oversight and exploration on direct and indirect MA policies and practices that may be creating disparities in care – especially when compared to beneficiaries in traditional FFS. **The FAH urges CMS to continue to expand data collection, public reporting, and research on care disparities that may be affecting vulnerable populations, either directly or indirectly, due to MAO policies and practices.**

In this RFI, the agency seeks input on Medicare Advantage data that could inform "care quality and outcomes, including … health equity … and [data on] and special populations such as individuals dually eligible for Medicare and Medicaid, individuals with end stage renal disease (ESRD), and other enrollees with complex conditions."

We strongly agree that addressing the health equity gap is an essential part of transitioning as a nation towards a value-based health care system. We support the widely inclusive definition of equity adopted by CMS for its Equity RFI, derived from Executive Order 13985 issued on January 25, 2021.[21] The FAH is excited about and committed to working closely with CMS and the Administration to address health inequities.

<u>Stratification of Quality Measure Results by Race and Ethnicity</u>

CMS recently began providing confidential hospital-specific reports (HSRs) of facility-level performance on measures from Medicare's Hospital Readmissions Reduction Program (HRRP) stratified by dual eligibility. In response to results from the 2020 reporting period, CMS sought input regarding adding race and ethnicity as stratification parameters to its quality programs, focusing attention on standardized definitions and indirect estimation statistical methods for those parameters.

In our prior comments, the FAH agreed with the choice of race and ethnicity as the initial parameters for future stratified reporting and the absolute necessity of standardized definitions of these terms across all sources of performance measurement data (*e.g.*, claims, EHRs, Social Security Administration [SSA] database). We recommended as a starting point the compact, easily understood, OMB minimum standard comprised of five racial and one ethnicity categories. We noted that CMS is still early in its experience with stratified reporting and strongly advise that the process of expanding parameters not be tied to an arbitrary completion date. Addressing health equity is too important a goal to accept trading validity and credibility for speed.

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[21] The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

Health Equity Summary Score

CMS believes that a summary score, derived from results aggregated across multiple quality measures that are stratified for multiple social risk factors, would add to the value and utility of disparities reporting. CMS has previously discussed the Health Equity Summary Score (HESS) developed for use in the MA program. The HESS score, described by its developers as a "proof of concept" has not yet been applied to real-world circumstances. Of nearly 400 MA plans evaluated by the HESS developers, scores for both HEDIS and CAHPS measures were calculable for only 44 percent of plans. Smaller plans and those with less typical demographic distribution patterns were seldom evaluable.[22]

The FAH strongly advises CMS to gather real-world experience by attempting HESS scoring of all MA plans and publishing a formal, independent evaluation of the result. If results are promising, deliberate and initial steps in HESS development then would seem rational. Hasty design and implementation processes could cause long-term harm to the important and necessary work of addressing health care inequities. While the HESS is being tested, we urge CMS to proceed with refining the goal and potential uses of the HESS; for example, is the focus on patient and family decision-making or on value-based program payment? Information on plans' differential performance on quality measures stratified by race and ethnicity would be essential for policymakers and other stakeholders in identifying opportunities for improving the MA program, and for beneficiaries in helping them to choose between FFS and MA, or among MA plans to select one that best meets their needs.

Finally, we endorse the general principle that confidential reporting to plans should always precede public display of performance data, and that public reporting should not begin until sufficient time has elapsed to allow for messaging testing, conducting focus groups, and other techniques to ensure public data is comprehensible to the intended audience.

Improving Demographic Data Collection

CMS has stated previously that robust, accurate, stratified equity reporting would be facilitated by collection of a standardized set of social, psychological, and behavioral interoperable data elements by hospitals at the time of inpatient admission. CMS further stated that criteria adopted into the 2015 Edition of CEHRT by ONC would enable such data collection, though the agency acknowledged that the functionality for those criteria is not now included in the EHR requirements for hospitals under the Promoting Interoperability Program (PIP). The agency also noted that additional hospital resources would be necessary to create optimum conditions for a large set of sensitive data to be collected.

The FAH appreciates the potential value of the extensive, standardized, granular dataset described by CMS. We noted that hospitals already often collect certain demographic data (*e.g.*, date of birth) and some information that could link to certain social risk factors (*e.g.*, place of residence). However, even among hospitals, current collection is quite variable, driven by

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[22] Agniel D, Martino SC, Burkhart Q, *et al*. Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score. *J Gen Intern Med*. Published online November 11, 2019. doi:10.1007/s11606-019-05473-x

demands from states, insurers, and public health agencies, among others. The timing of data collection varies and involves the admission and discharge planning processes. We agree conceptually that hospitals are positioned to participate in enhanced data collection *relevant to the hospital care the patient* receives and want to support CMS in this effort.

However, the FAH believes that much remains to be described and clarified before the agency's vision for improved data collection can move forward. On contemplation of this RFI, while we still stand behind our previous assertion that there is a role for hospitals to play in collecting demographic information on Medicare beneficiaries that could help inform policies and programs to reduce health disparities and improve health outcomes, it is less clear to us how that information would flow to inform parallel policy development in Medicare Advantage. Arguably, many (if not most) beneficiaries contemplating enrolling in Medicare Advantage are doing so without the immediate prospect of an inpatient hospital stay via which such demographic information might be collected. Such a distributed or decentralized approach to collecting demographic information may result in inconsistent or inaccurate information being used, depending on the entity collecting the information (*e.g.*, a physician, hospital, or health plan). The FAH will continue to think through the role of its member hospitals in collecting information that can help with the development of programs to reduce disparities and improve health equity, but we urge again, as we have done in the past, that CMS consider a more centralized venue for this data collection, such as Medicare enrollment. In the interim, should CMS conclude that there is value in collecting data and information through several different vectors, we urge the agency to ensure that the burden on collecting and reporting information to CMS is equitable between providers and MA plans. Additionally, MA plans should not be asked to collect information from providers that differs from what CMS is collecting directly through FFS programs.

The FAH emphasizes its full commitment to working with CMS, HHS, and others on what must be a continuous and sustained effort to ensure health care equity nationwide. We commend CMS for undertaking and sharing its strategic thinking. We believe that reporting plans' performance on quality measures stratified by race and ethnicity is a tangible goal. The FAH also believes that practical work can begin on improving data collection, particularly the foundational steps of data element definition, a complete environmental scan of collection already occurring in the field, and exploration of strategies for safeguarding privacy at every step.

MA Encounter Data

CMS has required MAOs to submit "encounter data" – granular records of MA enrollees' service use, roughly analogous to FFS claims – for well over a decade. Plans are required to report data for inpatient and outpatient hospital services, physician services, skilled nursing and home health services, dialysis services, and, effective earlier this year,[23] supplemental benefits. Complete encounter data are essential for evaluating service use under the auspices of MA (*e.g.*, how does service use differ between MA and FFS? How does service use differ among MA

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[23] https://www.cms.gov/files/document/submissionofsupplementalbenefitsdataonmedicareadvantageencounterdatarecords508g.pdf

plans? Does service use among MA enrollees indicate that plans are covering and paying for the full range of Medicare benefits?). These data would also help in evaluating differences in quality of care and patient outcomes (*e.g.*, are differences in service use correlated with avoidable hospital readmissions, avoidable emergency department use, *et cetera*?).

Despite the requirement that plans report these data to CMS, plans are still not submitting complete encounter data. The Medicare Payment Advisory Commission has compared MA encounter data with corresponding exogenous records for which there should be a one-to-one match (*e.g.*, comparing inpatient hospital encounter records to hospital MEDPAR data, or SNF encounter records to SNF Minimum Data Set data) on a recurring basis. The Commission has found that despite incremental improvements over a decade, encounter data are still not complete relative to comparator data.[24] Across the four sectors for which comparator data are available (inpatient hospital, dialysis, SNF, and home health), even in 2021, MA encounter data completeness only ranged from 81 to 89 percent. Dobson DaVanzo & Associates also completed an environmental scan which highlights problems with encounter data completeness, validity, accuracy, and timeliness (See Appendix A) that highlights encounter data inconsistencies and problems. With limited exceptions, analyses based on this incomplete data will produce misleading information about service use under Medicare Advantage, and its implications for quality of care and patient outcomes.

Plans, however, have little incentive to submit encounter data beyond that necessary for risk adjustment (diagnoses from certain claims are used to calculate MA enrollees' risk scores). Further, CMS provides limited feedback to plans regarding their encounter data submissions, nor does the agency sanction plans whose encounter data are deficient.

Given the importance of complete and accurate encounter data, **the FAH urges CMS to rigorously evaluate the completeness of encounter data submitted by MAOs, publicly report plan-specific performance metrics on their submission of encounter data, and impose penalties on plans whose encounter data submissions are deficient**.[25] The need for this information has become critical as more than half of eligible Medicare beneficiaries are enrolled in MA, yet policymakers and other stakeholders still do not have a clear and complete picture of the care MA enrollees are receiving. In arguing for the need for complete and accurate encounter data to be made publicly available, the FAH is *not* asserting that certain information on encounter records – particularly payment fields – that is accessible to CMS and agencies with an oversight role over the Medicare program be made available to the public. We and our members understand the proprietary nature of this information, and the implications of its potential misuse.

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[24] MedPAC. 2019. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC. (Chapter 7); MedPAC. 2020. Report to the Congress: Medicare payment policy. Washington, DC: MedPAC. (Chapter 13); MedPAC. 2022. Medicare Advantage encounter data (public meeting presentation, September 2022); MedPAC 2024. Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources (public meeting presentation, March 2024).

[25] These penalties should be at least commensurate with those levied against health care providers that fail to meet Medicare's FFS administrative requirements, such as filing annual cost reports.

Transparency of Information on Medical Loss Ratio

MA plans are required by law to maintain a medical loss ratio (MLR) of 85 percent.[26] That is, plans must spend at least 85 percent of their premium revenues on medical services and quality improvement. Currently, data on MLR are publicly available by insurer/state/market (individual, small group, or large group markets). While the FAH understands that making full plan-specific MLR data publicly available may raise concerns about the proprietary nature of such data, we nevertheless believe there is merit in requiring plans to publicly report certain data about their expenditures on medical services and quality improvement.

Specifically, the FAH believes there is value in CMS requiring each plan (that is, at a more granular level than MAO) to report to the agency its aggregate medical expenditures by sector, and, to the extent such expenditures can be broken out separately, its spending on quality improvement activities. Once reported, this information should be made publicly available.
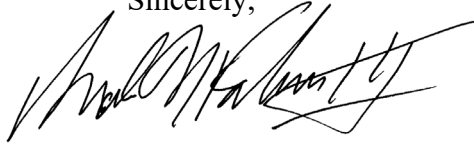
A potential starting point for such reporting would be the categories of physician specialties and provider types enumerated under the Medicare provider network adequacy requirements at §422.116(b)(1) and §422.116(b)(2), as well as for fee-for-service provider types. Short of full medical loss ratio data, such aggregate information would allow policymakers and researchers to examine differences in plan per-enrollee spending for different types of services (physician and provider), on a risk-adjusted basis, to evaluate the relationship between this spending and patient outcomes, to evaluate whether investments in quality improvement activities actually result in better patient outcomes, or for indications that plans may be inappropriately deterring their enrollees from accessing different types of specialized care. Beyond the provider types listed at §422.116(b)(2), consistent with our comments on network adequacy and provider directories above, we would recommend that the reported spending separately break down spending for IRFs and LTCHs. Such information could potentially be useful for both program oversight and beneficiary protection; collecting and reporting this information in this aggregate manner would not, however, divulge potentially sensitive information such as contracted payment rates to individual providers for specific services, or other information that might underlie the calculation of an actual MLR.

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[26] The Affordable Care Act of 2010 amended section 1857(e) of the Social Security Act to add MLR requirements for MA plans. Because section 1860D-12(b)(3)(D) of the Act incorporates by reference the requirements of section 1857(e), the MLR requirements also apply to Medicare Part D. The MLR requirements for MA organizations and Part D sponsors are codified in regulation at 42 CFR Part 422, Subpart X, and 42 CFR Part 423, Subpart X.

The FAH appreciates the opportunity to offer these insights. We are committed to working with you to ensure America's seniors in MA plans have improved access and better care. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

Appendix A: Medicare Advantage Data: Environmental Scan

Dobson DaVanzo & Associates (Dobson | DaVanzo) was commissioned by the Federation of American Hospitals (FAH) to conduct an environmental scan on the Medicare Advantage (MA) data currently available through the Centers for Medicare and Medicaid Services (CMS) and identify possible gaps in the data CMS collects and the datasets made available to the public. Our findings are summarized in the following pages.

I. The Current State of MA Data

CMS MA data can generally be categorized into three groups:

- **Research Identifiable Files (RIFs)** contain beneficiary-level protected health information (PHI) and require a Data Use Agreement (DUA) before the data are obtained from CMS;
- **Limited Data Use Files (LDS)** contain beneficiary-level PHI similar to the RIF files, however selected identifier variables are blanked or ranged; and
- **Public Use File (PUFs)** contain aggregate-level data that have been stripped of information that can be used to identify beneficiaries and is freely available to the public.

Key MA datasets in each of these three groups are described below.

RIF/LDS Data Files	
Medicare Advantage Encounter Data RIFs	The MA Encounter Data RIFs contain information on care received by Medicare Part C (MA) beneficiaries. Similar to the Medicare Fee-For-Service (FFS) claims data, the MA encounter data are organized by type of service for six (6) settings: Inpatient, Skilled Nursing Facility, Home Health, Outpatient, Carrier, and Durable Medical Equipment (DME). Encounter RIFs do not include payment variables.
The Master Beneficiary Summary File (MBSF) Part A, B, C, and D segment	The MBSF contains information on the basic characteristics of the Medicare population including MA enrollees. This includes demographics (e.g., age, gender, race, and type of residence) and enrollment information (e.g., original reason for enrollment under Medicare and monthly entitlement indicators) as well as the enrollment status of each Medicare beneficiary enrollee during a calendar year.
Part D data [for both stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs)]	The Part D Prescription Drug Event Data (PDE) contains detailed information on each drug event for PDP and MAPD plan beneficiaries, and encrypted beneficiary, pharmacy, prescriber, and plan identifiers that allow linkage with other files. The PDE contains information on each drug dispensed including the National Drug Code (NDC), the quantity dispensed, and days' supply as well as the total drug costs and patient payments.
	The Part D Plan Characteristics Files, Pharmacy Characteristics Files, and Prescriber Characteristics Files are three separate files that contain information on the PDP or MA-PDP plans, the pharmacy filling the prescription, and the individual physician or other health care provider prescribing the drug respectively.
	The Medicare Part D Formulary file is a suite of five sub-files: Formulary, Excluded Drug, Over-the-Counter Drug, Indication-based Formulary, and Part D Senior Savings (PDSS) Model that contain information on how the plan covers the prescription drugs filled (as described in the Part D Drug Event (PDE) file.
Medicare Current Beneficiary Survey (MCBS) LDS	The MCBS LDS datafile contains nationally representative estimates of health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of Medicare beneficiaries. Data from the MCBS are used to estimate expenditures and sources of payment for all services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services; to ascertain all types of health insurance coverage and

	related coverages to sources of payment; and to trace processes over time, such as changes in health status and the effects of program changes.
Part C and Part D Data Validation LDS	Contains contract-level data on beneficiary grievances, medical and drug prior authorizations and decisions, total payments to providers, drug utilization review controls, medication therapy management programs, and enrollment and disenrollment at the contract-level for Part C and D plans.

PUF Data Files	
Medicare Advantage/Part D Contract and Enrollment Data	Plan benefit data contains approved MA and Part D benefits information for all organizations that submit a bid including services covered, premiums and cost-sharing as well as supplemental benefits. The data are updated quarterly.
	Monthly MA Enrollment files contain information on the number of contracts, MA only enrollment, Part D enrollment, and total enrollment aggregated by state, county, plan, or contract.
	State/County/Contract Service area provides contract service area by state and county for all organization types.
	MA Health Plan Employer Data and Information Set (HEDIS) PUF files provide annual HEDIS performance measures for each MA plan.
Medicare Advantage Geographic Variation Public Use File (MA GV PUF)	The MA GV PUF contains aggregated data derived from Medicare Advantage Encounter data and enrollment and eligibility data and contains information on demographic characteristics and service utilization for MA beneficiaries at the contract-level.
Medicare Current Beneficiary Survey (MCBS) PUF	The MCBS PUF contains aggregate information summarized from the survey data.
MA Bid Pricing Data	MA bid pricing data contains information on plan bids including premium revenue and benchmarks accepted or approved by CMS for a contract year.
CMS Program Statistics – Medicare Advantage & Other Health Plan Enrollment	Data tables describing characteristics of the Medicare-covered populations, use of services, and expenditures under these programs, as well as Medicare providers serving beneficiaries at the state or national levels.
CMS Part C and D Performance Data	CMS provides performance data related to the Part C & D programs, including contract-level data on MA star ratings.

II. MA Data Shortcomings and Gaps

a. MA data are generally lagged

There are lags in the available MA data, with the length of the lag depending on the type of data and level of aggregation. This issue is most evident in the MA encounter data that are available with a two-to-three-year lag. For example, the most recent MA encounter RIFs available are for service year 2022 and reflect preliminary data,[1] while the annual Medicare FFS data are available with a one-year lag, and monthly FFS data are available with an approximate lag of 3 months. The longer MA lag is because MA Organizations (MAOs) are allowed to submit their encounter data records to CMS up to 13 months after a service year, for risk adjustment purposes.[2] CMS analysis indicates that historically, 90% of FFS claims across all claim types are submitted within 3 months, whereas 90% of MA encounters are submitted within 12 months.[3] As

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[1] Research Identifiable File Availability (2024). University of Minnesota School of Public Health, Health Policy & Management; Research Data Assistance Center (ResDAC). https://resdac.org/file-availability?field_data_file_category_target_id=6056&title=.

[2] Medicare Encounter Data File User Guide, Version 2.9. Chronic Conditions Warehouse, June 2023. Available: https://www2.ccwdata.org/docu-ments/10280/19002246/ccw-medicare-encounter-data-user-guide.pdf.

[3] Medicare COVID-19 Data Snapshot Overview. CMS. https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-services-through-2021-08-21.pdf.

additional examples of lagged data, the MA Geographic Variation PUF derived from MA encounter data includes data through 2021 (while the FFS version of the data are available for 2022), and the latest available MA bid pricing files include data up to 2019.

In contrast, some datasets are relatively current. For example, the Medicare Advantage/Part D Contract and Enrollment Data PUF reports 2024 information while the MBSF and Part D PDE monthly RIFs report 2024 information as it becomes available. The Part C and Part D Data Validation PUFs include information through 2023.

b. MA datasets are incomplete

No information on provider payments, out-of-pocket costs, and utilization of supplemental benefits
The currently available MA datasets do not include data on provider payments, out-of-pocket costs, and utilization of supplemental benefits. MA encounter RIF data do not include payment information (such as cost, payment, or provider reimbursement) because it is proprietary.[4] Other MA-related spending data available to CMS are not available to the public. For example, CMS does not publish information on out-of-pocket (OOP) spending by MA beneficiaries.[5, 6]

Further, information on the utilization of supplemental benefits is currently absent from MA encounter data.[7] Supplemental benefits are the additional benefits that MA plans can offer that are not covered under traditional Medicare. Examples of supplemental benefits are dental, vision, or non-health related benefits like transportation.

Finally, similar to the limitations with Medicare FFS data, MA encounter data are limited to utilization information for billed services, thereby excluding information on services not covered by Medicare and physiological data (such as blood pressure and pulse readings).[8, 9]

Available MA encounter data are not final
The available MA data may not reflect the final adjudicated encounter. MAOs provide encounter data to CMS via the standard health care claim 837 form to fulfill their mandated reporting requirements. These data contain information on each service or item provided to an enrollee, irrespective of the payment status of the claim (accepted, pending, denied).[10] MAOs then use the 835 form to indicate the payment of that claim, including the charges paid, denied, or adjusted, and deductible, co-insurance or co-pay information. Multiple 835 transactions may be associated with one 837-claim, following updates based on plan coverage of services.

Given that MAOs submit encounter data in the 837 claim submission format, encounter records do not fully reflect the final paid claims. This data submission process has further implications for researchers as it

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[4] Creighton, S., Duddy-Tenbrunsel, R., Michel, J. (2019). The promise and pitfalls of Medicare Advantage Encounter data. Health Affairs Blog. https://doi.org/10.1377/forefront.20190221.696651.

[5] Biniek, J., Freed, M. and Neuman, T. (2024). Gaps in MA Data Limit Transparency. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/.

[6] Medicare Payment Advisory Committee (MedPAC) (2024). April 11-12, 2024 Public Meeting [online transcript]. https://www.medpac.gov/meeting/april-11-12-2024/.

[7] Biniek, J., Freed, M. and Neuman, T. (2024). Gaps in MA Data Limit Transparency. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/.

[8] Jung, J., Carlin, C., & Feldman, R. (2022). Measuring resource use in Medicare Advantage using Encounter data. Health services research, 57(1), 172–181. https://doi.org/10.1111/1475-6773.13879.

[9] Creighton, S., Duddy-Tenbrunsel, R., Michel, J. (2019). The promise and pitfalls of Medicare Advantage Encounter data. Health Affairs Blog. https://doi.org/10.1377/forefront.20190221.696651.

[10] Encounter Data Submission and Processing Guide, Medicare Advantage Program. CMS. (2018) https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ED_Submission_Processing_Guide.pdf.

means that MA encounter data are not always in final action status, as MAOs may update encounter records post-RIF creation, leading to discrepancies in the files.[11]

Further, multiple submissions can be made for a single encounter, creating the possibility of duplicate records for the same encounter. Researchers and data users must therefore apply algorithms to de-duplicate the data and identify unique records, complicating the analytic process.

Additional detail on prior authorization requests, approvals, and denials as well as enrollment/disenrollment patterns needed

CMS makes available Part C and D data validation LDS files that include contract-level data on prior authorizations (coverage determinations and organization determination requests), and whether those requests were approved or denied, and appealed. These data do not include the reason for the denial, information about the type of service delivered, or the characteristics of the enrollees affected. [12,13] The public would therefore need more granular data to understand and review the MA trends in prior authorization at the service and provider-type levels.

Information on enrollment or disenrollment is also available at the contract-level. This limits the ability to analyze the characteristics of beneficiaries who switch to MA plans or disenroll to receive coverage under Medicare FFS.[14]

Finally, in contrast to Medicare FFS data, MA encounter data do not have a field to definitively identify claims for which payment was denied.

MA data are generally less complete when compared to other sources

MedPAC has conducted analyses to assess the completeness of MA encounter data by comparing utilization in MA data to external sources using data from 2017 through 2021. These analyses compared inpatient stay encounter data to MedPAR data, dialysis services encounter data to risk adjustment indicators, home health encounter data to OASIS data and SNF stay encounter data to MDS and MedPAR data.[15,16] Based on the analysis, MedPAC found that 2021 encounter data are missing approximately 6% of inpatient stays, 5% of dialysis encounters, 15% of SNF stays, and 8% of home health stays. While the comparator data sources MedPAC used in its analysis are also incomplete, limiting the comprehensiveness of this analysis, each record found only in the comparison data is a record that should have been included in the encounter data but is missing. Overall, the completeness of SNF and Home Health encounter data appears to be increasing over time.

In some cases, where there is an FFS dataset available, a corresponding complementary MA data set exists. However, these MA datasets are typically less complete than the FFS counterpart. For example, unlike the

[11] Jung, J., Carlin, C., & Feldman, R. (2022). Measuring resource use in Medicare Advantage using Encounter data. Health services research, 57(1), 172–181. https://doi.org/10.1111/1475-6773.13879.

[12] Biniek, J., Freed, M. and Neuman, T. (2024). Gaps in MA Data Limit Transparency. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/.

[13] Biniek, J., Freed, M. and Sroczynski, N. (2023). Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.

[14] Ibid.

[15] Medicare Payment Advisory Committee (MedPAC) (2024). March 7, 2024 Public Meeting [online PowerPoint]. https://www.medpac.gov/wp-content/up-loads/2023/10/MA-encounter-data_FINAL.pdf.

[16] Ensuring the accuracy and completeness of Medicare Advantage encounter data, June 2019 Report to Congress Chapter 7. MedPAC. https://www.med-pac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf.

FFS GV PUF, the MA GV PUF does not contain information on quality and payments.[17] Further, the MA GV PUF lacks the same level of geographic detail that is present in the FFS PUF. The MA GV PUF presents data at the national and state levels, while the FFS PUF is further disaggregated to the county and hospital referral region (HRR). The lack of geographic stratifications hampers analyses comparing utilization or demographic characteristics of beneficiaries at sub-national or sub-state levels. Additionally, the FFS PUF contains data disaggregated by age group, which is not present in the MA GV PUF. Lastly, the MA GV PUF is only available for acute care hospital services and SNF services, whereas the FFS GV PUF is available for a variety of settings, including inpatient, outpatient, post-acute care, hospice, physicians, laboratories, and DME supplies.[18]

c. **Data Accuracy and Comparability Issues**

Inaccurate NPI information
NPI data are sometimes inaccurate, making it difficult to track specific providers within the encounter data.[19] For instance, the OIG found that 63% of 2018 encounter data records lacked ordering NPI information for DMEPOS and for laboratory, imaging, and home health services.[20]

Inconsistencies between encounter data and other data submitted by MA plans
Medicare Advantage (MA) data present lower consistency, both within its own dataset and when compared to Fee-for-Service (FFS) records.

Sources have cited that inconsistent reporting among MAOs across the different sites of care can result in the underreporting of services by some plans.[21, 22, 23, 24] Unlike FFS, where direct payments to providers are common, CMS pays MAOs a capitated amount per enrolled beneficiary to cover services rendered. That is, CMS pays MAOs a fixed amount per beneficiary through a bidding process, irrespective of the number of services each beneficiary receives annually. This indirect payment system creates variability in service-level detail within MA encounter data. Consequently, the level of service detail in MA encounter data can vary based on factors such as how extensively an MAO captures FFS-level detail in their provider interactions.[25]

The capitated payment structure and data collection methods employed by MAOs also result in discrepancies compared to FFS claims data. For example, encounter data often show a higher frequency of '000' Diagnosis-Related Group (DRG) values compared to FFS data, indicating that some MAOs do not utilize DRGs for certain services.[26]

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[17] Centers for Medicare & Medicaid Services. (2024). Medicare Advantage Data for the Geographic Variation Public Use File: A Methodological Overview. CMS. https://data.cms.gov/resources/medicare-advantage-geographic-variation-national-state-methodology.

[18] Centers for Medicare & Medicaid Services. (2022). Geographic Variation Methodology. CMS. https://data.cms.gov/resources/geographic-variation-methodology.

[19] Creighton, S., Duddy-Tenbrunsel, R., Michel, J. (2019). The promise and pitfalls of Medicare Advantage Encounter data. Health Affairs Blog. https://doi.org/10.1377/forefront.20190221.696651.

[20] U.S. Department of Health and Human Services Office of Inspector General. CMS's Encounter Data Lack Essential Information That Medicare Advantage Organizations Have the Ability to Collect. Office of Inspector General. August 2020. OEI-03-19-00430. https://www.oversight.gov/sites/default/files/oig-reports/OEI-03-19-00430.pdf.

[21] Cotterill P. G. (2023). An assessment of completeness and medical coding of Medicare Advantage hospitalizations in two national data sets. Health services research, 58(6), 1303–1313. https://doi.org/10.1111/1475-6773.14211.

[22] Jung, J., Carlin, C., & Feldman, R. (2022). Measuring resource use in Medicare Advantage using Encounter data. Health services research, 57(1), 172–181. https://doi.org/10.1111/1475-6773.13879.

[23] Creighton, S., Duddy-Tenbrunsel, R., Michel, J. (2019). The promise and pitfalls of Medicare Advantage Encounter data. Health Affairs Blog. https://doi.org/10.1377/forefront.20190221.696651.

[24] Medicare Payment Advisory Committee (MedPAC) (2024). April 11-12, 2024 Public Meeting [online transcript]. https://www.medpac.gov/meeting/april-11-12-2024/.

[25] CCW Medicare Encounter Data User Guide, https://www2.ccwdata.org/web/guest/user-documentation.

[26] Ibid.

Following the same trend, due to potential differences in payment arrangements between MAOs and FFS, there may also be discrepancies in the bundling of services and billing cycles. This is exemplified in Home Health (HH) claims where MAOs may compensate HH providers based on episode lengths that do not align with the FFS HH episode definitions.[27]

Limited validation of MA data

The GAO recommended in 2014 that CMS validate encounter data to ensure that the soundness of payment adjustments is not compromised by incomplete or inaccurate data.[28] As CMS began relying solely on beneficiary diagnoses from encounter data to risk-adjust MA payments in 2022, validating the integrity of encounter data is now more imperative than in 2014.

In particular, GAO identified four distinct actions that CMS should undertake to better validate the quality of MA data.[29] First, that CMS expand the existing limited benchmarks to encompass all data fields in the encounter data, as the current lack of benchmarks limits CMS's ability to determine the completeness and accuracy of the data through statistical analyses. Once adequate benchmarks are established, GAO encouraged CMS to re-conduct statistical analyses of submitted data to check for data that may be unreliable or inaccurate. While the above two recommendations have been addressed by CMS in some capacity, CMS has yet to review medical records to verify that encounter data diagnoses are an accurate and true reflection of a beneficiary's condition and medical record. Lastly, GAO recommended that CMS provide reports and recommendations to MAOs regarding the accuracy and completeness of data submissions as assessed by CMS's review of medical records and statistical analyses. Given these omissions in the data validation process, GAO considers the soundness of the MA risk-adjustment payments unsubstantiated.

Coding intensity in encounter data

CMS uses the plan submitted diagnostic information in the encounter data to calculate each enrollee's risk score and risk-adjust MA plan payments. MA plans are therefore incentivized to increase their risk-adjusted payments through intensive coding in health risk assessments (HRAs) and chart reviews. In January 2024, MedPAC estimated that MA risk scores are 20% higher than the scores would be if the MA enrollees were instead enrolled in Medicare FFS.[30] In fact, CMS reduces payments by approximately 6% to account for coding intensity. This factor should be accounted for as the public draws conclusions from analyses using encounter data.

Inaccurate data on provider networks

While MAOs are required to maintain up to date provider directories, analyses suggest that provider directories are frequently out of date and formatted in ways that make it difficult to directly compare networks. A 2018 CMS review of provider directories for one third of MAOs found that approximately 49% had at least one inaccuracy.[31] Another study examining 2022 directory entries for more than 40% of US physicians found that there were inconsistencies in 81% of entries across 5 large national health insurers.[32] The U.S. Senate Finance Committee also conducted a recent review (in May 2023) and found that "secret

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[27] CCW Medicare Encounter Data User Guide, https://www2.ccwdata.org/web/guest/user-documentation.

[28] Gordon, L. (2022). Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight. United States Government Accountability Office. https://www.gao.gov/assets/gao-22-106026.pdf.

[29] Ibid.

[30] Stuart Hammond, Andy Johnson, and Luis Serna, "The Medicare Advantage Program: Status Report," MedPAC, January 12, 2024, https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

[31] CMS. Online Provider Directory Review Report. 2018. https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.

[32] Butala NM, Jiwani K, Bucholz EM. Consistency of Physician Data Across Health Insurer Directories. JAMA. 2023 Mar 14;329(10):841-842. doi: 10.1001/jama.2023.0296. PMID: 36917060; PMCID: PMC10015301.

shoppers" were able to schedule appointments using provider directories only 18% of the time. More than 80% of the listed providers were either unreachable, not accepting new patients, or not within the network.[33] Provider directory inaccuracies can negatively impact beneficiaries, providers, and the healthcare system, resulting in increased beneficiary costs, added challenges, and diminished quality of care. Accurate and complete information would be advantageous for beneficiaries who are attempting to choose an MA plan for enrollment, and for researchers interested in conducting analyses on MA provider network adequacy.

III. Progress toward Enhancements to MA Data and Needed Next Steps

CMS has made considerable progress toward MA data transparency by making more complete and accurate MA data available to the public. For instance, to provide more information on the utilization of supplemental benefits and prior authorizations, CMS will require plans to report and make available additional information on the:

- Use of supplemental benefits and related spending (Starting in 2024)
- Timeliness of prior authorization decisions (Starting in 2026)
- Use of prior authorization (Starting in 2026)

However, gaps still exist, hindering the ability for researchers and consumers to evaluate MA plans. For instance:

- Additional data variables are needed to assess MA performance on key issues such as prior authorizations and denials. As noted in our review, additional detail is needed to understand prior authorization and denial rates at the service level as the current data available are aggregated at the contract level.
- As noted by the GAO and other sources, validation efforts of the available data (specifically MA encounter data) can be strengthened.
- Finally, as with other Medicare data, MA data do not allow for a clear assessment of health equity-related topics.

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[33] Senate Finance Committee, "Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023) https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20- %20Secret%20Shopper%20Study%20Report.pdf.